STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085054	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Pike Creek	3540 Three Little Bakers Blvd Wilmington, DE 19808

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to allow family visitation for one out of 49 sampled residents (Resident (R)10). The facility restricted visitation of R10's family member (Family Member (F) 4). This failure violated R10's right as a resident of the facility. Findings include: During an interview on 04/18/25 at 12:33 PM, the Administrator stated the facility did not have a visitation policy. Observation on 04/18/24 at 8:30 PM revealed a sign was posted at the facility entrance that read, Recommended visiting hours 10:00 AM - 7:00 PM. Review of R10's undated admission Record, in the electronic medical record (EMR) under the Profile tab revealed R10 was admitted to the facility on [DATE]. Review of R10 admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/22/25, located in the EMR under the MDS tab revealed the facility assessed R10 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. During an interview on 04/14/25 at 2:25 PM, F4 stated R10 had almost fallen out of bed twice at night and he had caught her. F4 stated he visited R10 in the evening and at night to make sure R10 was safe, and to make sure her needs were met such as making sure R10 got her pain medications, assistance she needed in the evening/at night, and to follow up on everything. F4 stated he did not sleep while in R4's room and the curtain was pulled between R10 and her roommate. F4 stated he was quiet and did not disturb R10's roommate. F4 stated one of the reasons they chose the facility was because it allowed 24-hour visitation. F4 stated he was told about a week ago that he could no longer visit at night due to R10 having a roommate. F4 stated R10 wanted him there in the evenings/nights. F4 stated there was an incident about a week ago when Registered Nurse (RN) 2 was working at night and told him he could not visit R10, and if he did not leave, she was going to call the police. F4 stated he was denied visitation and left the building without visiting R10. F4 stated the facility recently posted recommended visiting hours by the entry door into the facility. (continued on next page)

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

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/15/25 at 11:02 AM, R10 stated when she was admitted to the facility, she was very weak. R10 stated the mattress was much narrower than what she was used to at home, and she almost fell out of bed twice, but F4 had caught her. R10 stated she felt safer when F4 was there at night. R10 stated the facility advertised they were open 24 hours, and she thought visitation was allowed. R10 stated the staff recently told her F4 could come after 9:00 AM but could not stay past 8:00 PM. R10 stated one-night last week F4 came to visit her, and they would not let him visit and if he did not leave, told him they would call the police. R10 stated this was upsetting to her. Review of R10's Progress Notes including Nursing, Physician, Social Services, etc. from admission through 04/18/25, located in the resident's EMR under the Progress Notes, tab revealed no documentation about F4's visitation, about him being disruptive or causing any concern. There was no mention at all of F4 in the Progress Notes. During an interview on 04/15/25 at 6:30 PM, RN2 stated F4 had a history of coming in at 9:00 PM and leaving at 11:00 PM or visiting during the night. RN2 stated F4 recently came in at 10:00 PM, and she told him that R10 had a roommate, and he needed to respect her sleep. RN2 stated she told F4 he could not visit and that she would call the police if he did not leave. RN2 stated F4 looked homeless and scary, he wore black clothing, a mask, sunglasses, and pushed a cart. RN2 stated the staff recently put the sign up for recommended visiting hours due to F4's visits. RN2 stated she was only aware of one other family that visited at night. During an interview on 04/16/25 at 9:27 AM, Licensed Practical Nurse (LPN) 14, the Unit Manager for DelCastle stated she had been notified by nursing staff that F4 was staying at the facility at night. LPN14 stated the administrative team discussed it and agreed it was not appropriate for F4 to be visiting at night. LPN14 verified R10's roommate had not complained about F4's visits. LPN14 stated F4 could visit at night if R10 wanted to come out to the dining room common area. During an interview on 04/17/25 at 11:36 AM, Certified Nursing Assistant (CNA) 16 stated R10's roommate had not complained about F4 being in the room; however, CNA16 stated the room was small and F4 was sometimes in the way. CNA16 stated there were some families on Limestone unit that spent the night, but those were private rooms. During an interview on 04/18/25 at 9:33 AM, Social Services (SS) stated she had been recently hired. She stated she was not aware that F4 was not allowed to visit at night. SS stated the visitation hours posted were recommended hours. SS stated families should not be told they could not come in. SS stated F4 visited at night and brought stuff with him; she denied he caused problems. SS stated she had not heard of any concerns from R10's roommate about F4's visits. During an interview on 04/18/25 at 10:51 AM, Director of Nursing (DON) 1 stated the facility had 24-hour visitation and recommended visiting hours. The DON stated the staff spoke with F4 about the recommended visiting hours. She stated the facility had lounge areas and F4 could visit after hours in the lounge with R10. During an interview visit on 04/18/25 at 12:33 PM, Administrator1 stated the posted hours were recommended visiting hours. Administrator1 stated it was not appropriate for F4 to visit at night in R10's room considering R10 had a roommate, and this violated the roommate's rights. Administrator1 verified R10's roommate had not alleged a concern about F4's visits.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a homelike environment was maintained for one resident (Resident (R) 90) out of 49 sampled residents. Facility nursing staff disposed of a soiled brief in R90's trash can which caused urine odor in the resident's room. This had the potential to create odors throughout the facility. Findings include: Review of R90's undated admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted on [DATE] with multiple diagnoses that included vegetative state, acute respiratory failure, and nontraumatic intracerebral hemorrhage. Review of R90's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/18/24, located in the EMR under the MDS tab, revealed R90 was always incontinent of bowel and bladder. Observation on 04/17/25 at 5:45 PM with Licensed Practical Nurse (LPN) 6 revealed a soiled brief in R90's trash can in his room. During an interview at this time, LPN6 confirmed the soiled brief in the trash can was saturated with urine. LPN6 stated she was not aware of nursing assistants disposing of briefs in the trash can until now. During an interview on 04/17/25 at 6:23 PM, Certified Nursing Assistant (CNA) 13 confirmed he was assigned to R90 and had changed his brief earlier. CNA13 stated he disposed of soiled brief in R90's trash can in his room. CNA13 also stated he should have placed the brief in the plastic trash bag and then taken it to the soiled utility room, but he was asked to assist another nursing assistant and so he had not gone back to his room to remove it yet. CNA13 indicated this practice caused R90's room to smell like urine. Observation on 04/18/25 at 9:50 AM with the Assistant Director of Nursing (ADON) and LPN21 revealed a urine-soaked brief was in R90's trash can in his room. During an interview at this time LPN21 confirmed the brief was in the trash can, but she did not know what the nursing assistants were trained to do after removing briefs from residents. During an interview on 04/18/25 at 9:45 AM, LPN6 stated she trained the nursing assistants on removing briefs and taking them to the soiled utility room for disposal. LPN6 also stated CNA20 had already changed several residents and had disposed of their briefs in the trash can prior to the training. During an interview on 04/18/25 at 10:20 AM, CNA20 stated she changed R90's brief at 8:00 AM, disposed of it in the trash can, but had not taken the trash bag to the soiled utility room yet. CNA20 also stated she had not been trained to take urine-soaked briefs out of the room during orientation at the facility. During an interview on 04/14/25 at 8:50 PM, Family Member (F) 9 stated the CNAs were disposing of R90's briefs in the trash can and he could smell feces and urine when he visited several times a week. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/18/25 at 10:13 AM, the Staffing Coordinator stated incontinence care was discussed, and competencies were provided; however, the competency and discussion did not include disposal of briefs. The Staffing Coordinator also stated disposing of soiled briefs in the soiled utility room was a standard of practice that all nursing assistants should have learned in their CNA courses. During an interview on 04/18/25 at 10:15 AM, Housekeeper (HK) 1 stated she had observed briefs disposed of in residents' trash cans on the unit while she was cleaning their rooms. During an interview on 04/18/25 at 10:34 AM, Director of Nursing (DON) 1 stated she did not know what the standard was when CNA20 was hired, but soiled briefs and wipes should be placed in the clear trash bag and then disposed of in the soiled utility room. During an interview on 04/18/25 at 2:21 PM, the Administrator stated she expected staff to dispose of the briefs in the dirty utility room on the units to decrease smells to create a homelike environment. The Administrator also stated she did not have a homelike environment policy.

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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 interview, record review, and review of facility policy, the facility failed to thoroughly investigate an allegation of an injury of unknown origin for one resident (Resident (R) 101) of 17 residents reviewed for abuse. Findings include: Review of a facility policy titled Abuse, Neglect, Mistreatment, Exploitation, and Reasonable Suspicions of Crime, dated 01/03/25 indicated .The NHA [Nursing Home Administrator] or designee shall investigate allegations and report to appropriate regulatory agencies and/or law enforcement.All persons identified as involved in or with knowledge of the occurrence will be interviewed. Review of R101's admission Record located in the resident's electronic medical record (EMR) under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R101's Care Plan located in the resident's EMR under the Care Plan tab dated 01/17/24 indicated the staff were to assist the resident with repositioning in bed as ordered. Review of R101's Physician Orders located in the resident's EMR under the Prog Note tab dated 02/20/25 indicated the resident was ordered to have two staff members to assist with bed mobility (side to side). Review of R101's quarterly Minimum Data Set (MDS), and located in the resident's EMR under the MDS tab with an assessment reference date (ARD) of 04/02/25 indicated the staff could not determine the resident's BIMS score. The resident was totally dependent on all activities of daily living by staff. Review of R101's hospital records, dated 05/08/24, indicated the resident had a history of chronic left shoulder dislocation. The hospital records revealed the resident had a CT scan, of the resident's right shoulder, which revealed the resident had a fractured humerus or scapula. The scan stated that the resident had osseous (bone) structures were mildly demineralized diffusely. There was evidence of an anterior-inferior dislocation of the humeral head in relation to the glenoid (the shallow socket of the shoulder). The remainder of the visualized osseous structures appear intact without evidence of other acute osseous abnormality or suspicious osseous lesion. Mild osteoarthrosis was demonstrated. The resident was not a candidate for surgery. Review of a document provided by the facility titled Facility Incident Investigations dated 05/14/24 indicated that the facility reported the injury of unknown origin for R101 to the State Survey Agency (SSA) timely and a follow-up five-day summary. There was no evidence that the facility interviewed potential witnesses (staff) as part of their internal investigation. This investigation was completed by the former Director of Nursing (DON) 2. During an interview on 04/17/25 at 3:24 PM, DON2 remembered R101's injury of unknown origin and stated that he typically did collect witness statements and would go back at least 48 hours to gather statements from the staff who worked with the resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/25 4:23 PM, the Clinical Consultant and the current Administrator stated they could not locate any staff interviews for the injury of unknown origin which involved R101. During an interview on 04/18/25 at 10:25 AM, the current DON1 confirmed she was the facility's abuse coordinator. DON1 stated she would gather witness statements, interview the suspect, if there was and decide what happened.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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 observation, interview, record review, and policy review, the facility failed to ensure residents who experienced a change in condition received timely treatment for one of four sampled residents reviewed for a change in condition (Resident (R)162). R162's had a fall at home prior to admission and sustained a subdural hematoma requiring a craniotomy (a surgical procedure where a neurosurgeon makes an opening in the skull to access and remove a blood clot (hematoma) that has formed to relieve pressure on the brain). R162 experienced changes in his condition after a fall he sustained on 10/10/24. On 10/14/24 R162 was emergently transferred to the hospital and was diagnosed with an acute subdural hematoma with a left to right shift requiring a craniotomy and intubation while in the hospital resulting in a delay of care. The Administrator and Director of Nursing (DON) were notified on 04/17/25 at 6:28 PM that Immediate Jeopardy existed. The failure to identify R162 exhibited symptoms of a potential head injury and failure to send R162 to the hospital timely created an immediate jeopardy situation resulting in a delay in treatment. Once hospitalized on [DATE], R162 had craniotomy surgery due to an acute re-injured subdural hematoma with left to right shift of his brain. The facility's failure to identify R162 was exhibiting signs and symptoms of a head injury and send him to the hospital timely put him at risk for significant injury and potentially death. The facility did not identify any failures from this incident and no corrective measures were implemented to ensure future residents with changes in condition would receive timely treatment. An acceptable Immediate Jeopardy Plan of Removal was provided on 04/17/25 at 8:00 PM and was validated on 04/18/25 at 1:16 PM. The Administrator was notified on 04/18/25 at 1:16 PM that the Immediate Jeopardy was removed. After the removal of the Immediate Jeopardy, the deficiency remained at a scope and severity of a D Findings include: Review of the facility's policy titled, Alert Charting dated 01/03/25 revealed It is the policy of [Name of Facility] to utilize alert charting for residents experiencing changes in condition that warrant heightened observation as determined through nursing judgment .Residents placed on alert charting are assess by the nurse each shift and assessment data entered into nursing notes .Document objective data related to the resident's condition i.e. vital signs .level of consciousness; .and response or lack of response to treatment . Report change in resident condition to the physician and the responsible party . Review of the facility's policy titled, Neurological Checks dated 01/03/25 revealed Neurological checks are initiated for residents experiencing a fall (change in plane) with a suspected head injury and/or a change from the resident's neurological baseline . Review of R162's undated admission Record in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of traumatic subdural hemorrhage. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R162's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 09/29/24 in the EMR under the MDS tab revealed R162 was admitted to the facility on [DATE] and had a goal of discharging to the community. According to the MDS the facility assessed R162 to have a Brief Interview for Mental Status (BIMS) score of four out of 15 which indicated the resident was severely cognitively impaired. R162 had clear speech, was usually understood by others, and sometimes understood others. R162 exhibited no mood or behavioral concerns. Review of R162's Care Plan dated 09/25/24 in the EMR under the Care Plan tab revealed, [R162] wishes to be discharged to home/another facility. Interventions in pertinent part were, Make arrangements with required community resources to support independence post-discharge . During an interview on 04/15/25 at 1:37 PM, Family Member (F) 5 stated R162 had been living at home with family when he experienced a fall getting into her car which resulted in the initial subdural hematoma and craniotomy in September 2024. F5 stated when R162 was admitted to the facility from the hospital, he needed assistance with walking and the goal was for him to get stronger and return home. F5 stated R162 rarely slept while at the facility and was always up, active, and often at the nursing station even at night. F5 stated when she came in to visit R162 on the morning of 10/14/24, he was not responsive at all, and she knew something was seriously wrong. F5 stated she insisted that Nurse Practitioner (NP) 1 send R162 to the hospital. The facility's Administrator was notified on 04/17/25 at 6:28 PM that Immediate Jeopardy existed related to the failure to identify and respond timely to a change in condition on 10/12/24 after Resident (R) 162 fell and hit his head on 10/10/24. The Immediate Jeopardy began on 10/11/24 when R162 experienced a change in condition. During an interview on 04/16/25 at 2:44 PM, R162's Personal Care Physician (PCP) 1 stated R162 was able to communicate his needs upon admission but was impaired in cognition. Review of R162's Nurse's Note dated 10/10/24 and located in the resident's EMR under the Progress Notes tab revealed R162 was found on the floor of his room after the staff heard a loud thud. The note read, Pt [Patient] found on floor holding the right side of his face. Pt says he did hit his head. Pt was assessed and able to move all extremities. Pt was assessed by supervisor and then helped off the floor. Pt has a superficial laceration on right side of face near right eye. Pt also sustained a skin tear on his lower left arm. The area was cleaned, and a dry dressing was applied. Pt was given an ice pack for facial laceration. NP [Nurse Practitioner (NP)1] made aware of fall and skin injuries .Pt unable to remember how he fell and what caused his fall . Wheelchair was in room near where pt was on the floor. Review of R162's Nurse's Note dated 10/10/24 at 5:00 PM and located in the resident's EMR under the Progress Notes tab revealed Resident was found on the floor in front of his bed. Resident was trying to get into bed unassisted and fell .On call notified and new orders for a CBC [complete blood count], BMP [basic metabolic panel], chest x-ray, and UA [urinalysis] C&S [culture and sensitivity]. Neuro checks initiated . Review of R162's Physical Therapy Summary of Skill Notes showed a decline between 10/09/24 and 10/11/24 as follows: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- Review of a PT Summary of Skill note dated 10/09/24 provided by the facility revealed R162 walked 118 feet on this date, completed four minutes of standing with support, and performed marching for improved balance. -Review of a Physical Therapy (PT) Summary of Skill note dated 10/10/24 and provided by the facility and signed at 4:57 PM, revealed R162 ambulated ten feet with a rolling walker. In addition, R162 completed 15 minutes on the omni cycle. It was unknown whether therapy occurred before or after R162's fall on this date. -Review of a PT Summary of Skill note dated 10/11/24 at 5:31 PM revealed R162's condition had changed from 10/10/24 as follows, Pt [Patient] sitting in WC [wheelchair] very drowsy with limited eye opening . increase confusion .Pt complete x3 STS [sit to stand] and present with difficulty completing task of pivoting. SPT [stand pivot transfer] WC [wheelchair] to recliner with Mod [moderate] of 2 person assist for proper positioning . Per the Summary of Skill R162 did not walk on this date. The PT who wrote the Summary of Skill notes no longer worked at the facility and was unavailable for interview. -Review of the next and last PT Summary of Skill note dated 10/14/24 revealed, Pt encountered in recliner very drowsy with limited eye opening. Pt [unable to] complete transfer to WC on multiple attempts due to increase resistance . Review of R162's Nurse's Note dated 10/12/24 at 11:38 AM and located in the resident's EMR under the Progress Notes tab revealed R162 was experiencing a change in his mental status as follows, Resident is not able to wake up for medication tried waking him to transfer him to bed but not waking up resident is snoring breathing but will not open eyes not safe to give medication resident vital signs were taken but unable to get temp [temperature] due to him sleeping and not waking up to close his mouth while sleeping tried to take [sic] wake up several times will continue to monitor was not able to eat breakfast will try lunch. Review of R162's Nurse's Note dated 10/12/24 at 2:22 PM and located in the resident's EMR under the Progress Notes tab revealed, Resident continue to sleep resident did not eat lunch was able to only take small bite of cheesecake but coughed and then offered ginger ale and water . could not drink eyes are closed was telling resident to open eyes resident would mumble but not verbalize using words resident son was here and notified him of the situation that he did not eat breakfast or lunch and was not able to get medications this shift on the on call NP [Nurse Practitioner] was notified and he said can hold medication for 24 hr [hours]. Review of R162's Nurse's Note dated 10/12/24 at 9:10 PM and located in the resident's EMR under the Progress Notes tab revealed, Patient slept most of the shift. Alert. Not oriented. Open eyes to voice. Vitals wnl [within normal limit]. Med [medications] melatonin/buspirone on hold. Review of R162's Nurse's Note dated10/13/24 at 3:07 PM and located in the resident's EMR under the Progress Notes tab revealed Resident post fall resident was on nuero [sic] checks resident was more awake and alert this shift ate about 50-75% breakfast did not eat lunch son was here and offered but refused this morning when he was done eating breakfast I tried taking vital signs and giving medication but resident was pushing me away and saying no resident speech was not clear was not able to communicate clear this shift . resident was also very weak and unable to do two person assist to take to the bathroom had to use the sit and stand lift to use the bathroom . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R162's Nurse's Note dated 10/14/24 at 12:21 PM and located in the Progress Notes tab revealed, Patient is noted with increased lethargy this shift. NP evaluated; patient's daughter was at bedside. Daughter wishes for patient to be sent to ER [emergency room] for eval. 911 was called, NP called report to ER. 911 arrived to facility at 1221, was transported to ER with all appropriate paperwork. Review of R162's NP's Encounter note dated 10/14/24 and located in the resident's EMR under the Progress Notes tab revealed, Nursing reporting that patient has increased lethargy and generalized confusion. Patient is currently out of bed to the chair and awakens to verbal commands, but does not communicate needs and has increased confusion. Patient's daughter is at the side of the chair and requesting patient to be sent to the hospital for acute change of mental status. Patient awakens eyes to verbal commands and unable to follow simple commands, even with redirection. Nursing reports acute change in mental status overnight . 1. Acute delirium: Pt with acute onset of change in overall mentation. Pt is not currently at baseline, and workup is still pending including urinalysis. Family at the bedside and requesting patient to be sent to the hospital for further evaluation. Discussed with nursing staff and orders given to send the patient to the ED. Review of R162's Neurological Flow Sheet provided by the facility and initiated on 10/10/24 at 4:30 PM and completed on 10/13/24 on the 7:00 AM - 3:00 PM shift, revealed a change in R162's level of consciousness that started on the 7:00 AM - 3:00 PM shift on 10/12/24 with a change from fully conscious - awake, aware and oriented to lethargic - responds slowly to verbal stimuli that persisted through 10/13/24, the end of the monitoring period. In addition, the Neurological Flow Sheet revealed a change in R162's speech from clear to slurred that started on 10/12/24 on the 7:00 AM - 3:00 PM shift and persisted through 10/13/24, the end of the monitoring period. Review of 162's hospital ED [Emergency Department] Physician Record dated 10/14/24 and provided by the facility revealed, I reviewed the patient's CT head once it was available in the [name] system and on my interpretation, I am concerned for a large left sided subdural hematoma with midline shift. I immediately active a trauma alert given the patient's age, intracranial hemorrhage, and altered mentation . Review of R162's hospital CT [computed tomography] Head Scan dated 10/14/24 and provided by the facility revealed, Impression: Left cerebral convexity and left parafalcine subdural hematoma measuring up to 15 mm in thickness resulting in 7 mm left to right midline shift. During an interview on 04/15/25 at 5:59 PM, Registered Nurse (RN) 2 stated LPN12 should have contacted the Unit Manager regarding the change in condition (change in level of consciousness) observed on 10/12/24 (Saturday). RN2 stated there was no NP in the facility on the weekends at the time of the change in R162's mental status occurred. RN2 stated, considering R162's history of a subdural hematoma and change in level of consciousness, she would have had R162 sent to the hospital on [DATE]. During an interview on 04/16/25 at 11:15 AM, LPN12 stated on 10/12/24, she could not wake R162 up for breakfast and he did not eat lunch or dinner either. In addition, he refused to take his pills. LPN12 stated she was concerned R162 was experiencing a change in condition and was aware the change in cognition could be a trigger for a head injury from the fall on 10/10/24. LPN12 stated she conveyed all information to the weekend on call NP on 10/12/24 who instructed her to hold medications for 24 hours and monitor him. LPN12 stated the NP did not instruct her to send R162 to the hospital. LPN12 stated R162 was a little better on 10/13/24 as he was able to eat breakfast and was more alert. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/16/25 at 1:14 PM, NP1 stated she assessed R162 on 10/10/24 after his fall and on 10/14/24 when notified he experienced a change in condition. NP1 stated when she evaluated R162 on 10/14/24, he was different from his baseline and had experienced an acute change in cognition. NP1 stated R162 was not usually sleepy and had previously been more alert and able to communicate his needs. She stated on 10/14/24 R162 was not making sense. When reviewing the description of R162 documentation by LPN12 on 10/12/24, NP1 stated LPN12's documentation of symptoms was similar to the acute change in mental status that she witnessed on 10/14/24 when she sent the resident out to the emergency room. During an interview on 04/15/25 at 10:22 AM, Forensic Nurse (nurses who conduct comprehensive medical examinations to assess injuries, document findings, and determine the need for medical intervention) (FN) 3 from the hospital stated R162 was admitted to the hospital on [DATE] with subdural hematoma. A craniotomy was performed and R162 had to be intubated (tube inserted inside the windpipe through the mouth or nose). FN3 stated the hospital staff was concerned regarding the delay in sending R162 to the hospital after he started exhibiting signs and symptoms of a change in condition on 10/12/24. FN3 stated when R162 arrived at the hospital, he had obvious signs of injury to his forehead and staff were unable to wake him for more than a few seconds. R162 was unable to communicate verbally and was groaning and coughing when he arrived. FN3 stated R162 was placed onto hospice services while in the hospital. During an interview on 04/17/25 at 1:20 PM, FN4 stated there were three CT scans taken for R162 following his initial fall in 09/10/24. FN4 stated the first CT scan on 09/10/24 showed the hematoma measured 25 mm thickness; the 09/17/24 CT scan was not measured but showed marked improvement; the 10/14/24 CT scan showed a 15 mm thickness with a seven mm shift. FN4 stated the shift was due to the bleeding pushing the left side of the brain to the right-side accounting for the shift from left to right. FN4 stated R162 had a re-injury of the subdural hematoma, based on the CT scan dated 10/14/24 with a craniotomy recommended and performed to relieve the pressure. FN4 stated, due to the previous subdural hematoma in September 2024, R162 was at increased risk and should have been sent to the hospital right away on 10/14/24 after hitting his head when he fell on this date. During an interview on 04/17/25 at 2:38 PM, NP1 reviewed the Emergency department report and the CT scan for R162 both dated 10/14/24. NP1 stated the documentation revealed an intracranial bleed and that an intervention was needed to alleviate the pressure. She stated the midline shift was the concern and indicated that something acute had occurred. NP1 reviewed the Therapy Note dated 10/11/24 showing a decline in R162's cognition the day after the fall and stated if she had known about that, she would have had R162 sent to the hospital at that time. During an interview on 04/15/25 at 1:37 PM, Family Member (F) 5 stated R162 went onto hospice while in the hospital due to his deteriorated condition and was discharged from the hospital to a different nursing facility where he passed away a few months later. Review of the facility's Immediate Jeopardy Removal Plan dated 04/17/25 revealed the facility took the following actions: -RI62 no longer resides in the facility. No immediate actions can be taken for this resident. -The facility Medical Director was made aware of the immediate jeopardy citation on April 17, (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	2025. -All residents who have fallen within the last 72 hours were assessed by a medical provider for changes in condition on April 17, 2025. -All current residents who have fallen within the last 30 days were reviewed to validate that they did not experience an unidentified change in condition on April 17, 2025. -Immediate education of all licensed nurses other than those on leave on identifying and notifying providers of changes in condition after a fall was initiated and completed by the DON/ designee on April 18, 2025. Any staff on leave will be educated prior to their next scheduled shift. -Audits will be conducted by the DON [Director of Nursing]/ designee on residents who sustain a fall to validate that residents are monitored for changes in condition, that changes in condition are identified timely, and the medical provider is notified. The facility QAPI committee through ad hoc will monitor weekly for four weeks to review any trends, findings, issues, or concerns and develop plan of action for follow up or resolution. During an interview on 04/17/25 at 8:16 PM, DON1 stated the training consisted of educating nurses on clinical evaluations, subjective versus objective data, level of consciousness, and provider notification of changes in condition. DON1 stated if the nurses did not agree with the provider, such as whether to send a resident to the hospital, they were to notify the DON, and the DON would notify the Medical Director. The Medical Director will make the final decision for the resident. During an interview on 04/17/25 at 8:19 PM, LPN14 verified she had been trained by DON1 and verbalized understanding of the training when asked specific questions. During an interview on 04/17/25 at 8:21 PM, LPN7 verified she had been trained by the DON and verbalized understanding of the training when asked specific questions. During an interview on 04/17/25 at 8:24 PM, RN7 verified she had been trained by the DON and verbalized understanding of the training when asked specific questions. During an interview on 04/18/25 at 9:11 AM, the Director of Rehabilitation (DOR) and Interim DOR stated they started educating therapy staff last night about change of condition, and how therapy staff should communicate this information to nursing. Therapy was to notify and inform nursing and bring the information to department heads in the morning meetings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to obtain wound treatment orders and provide wound care upon admission to the facility for one of eight residents reviewed for pressure ulcers (Resident (R) 170). Findings include: Review of the facility's policy titled Pressure Ulcer Prevention and Management, revised 01/17/23, provided by the facility revealed Policy: It is the policy of the facility to promote skin integrity through the recognition, treatment and prevention of pressure ulcers. Purpose: To identify residents at risk for skin breakdown and develop an individualized plan of care for prevention, recognition, and treatment of pressure ulcers . Review of R170's undated admission Record located in the electronic medical record (EMR) under the Profile tab revealed she was admitted to the facility on [DATE] with multiple diagnoses which included displaced comminuted fracture of shaft of the left femur, encounter for other orthopedic aftercare, and history of falling. Review of R170's admission Assessment, dated 03/05/25, located in the EMR under the Evaluations tab revealed she was admitted with a stage 2 pressure ulcer on the sacrum and a new dressing was applied. Review of R170's Weekly Skin Check, dated 03/06/25, located in the EMR under the Evaluations tab revealed an existing skin issue on the sacrum. Review of R170's Weekly Skin Check, dated 03/10/25, located in the EMR under the Evaluations tab revealed an existing skin issue wound on sacrum. Review of R170's Encounter Note, dated 03/08/25, located in the EMR under the Prog Notes tab revealed Chief complaint/Nature of presenting problem: pain, wound sacrum History of Present Illness: .Patient was also assessed due to wound to sacrum area that was bleeding and nursing instructed to cleanse and apply dressing. Surrounding areas to wound deep red and nursing instructed to return patient to prevent further breakdown .Sacral Wound start and continue with daily dressing to wound consult wound team per facility schedule continue with q [every] turns . Review of R170's Physician's Orders, dated 03/11/25, located in the EMR under the Orders tab revealed an order to cleanse sacrum with normal saline, apply collagen and cover with a dry dressing one time a day every Monday, Wednesday, and Friday and notify the provider for signs/symptoms of infection and complications. Review of R170's Medication Administration Record (MAR), dated March 2025, located in the EMR under the Orders tab revealed there was no documented treatment provided to the sacral wound until 03/12/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R170's Wound Consult, dated 03/12/25, located in the EMR under the Misc tab revealed an unstageable pressure wound on the sacrum measuring 6 centimeters (cm) length x 8 cm width x undetermined cm depth (48 square cm) and was debrided. Review of R170's Wound Consult, dated 03/19/25, located in the EMR under the Misc tab, revealed an unstageable sacral wound measuring 7 cm length x 9.5 cm width x undetermined cm depth (66.5 square cm) and was debrided. During an interview on 04/16/25 at 2:19 PM, the Assistant Director of Nursing (ADON) confirmed R170 had a sacral wound upon admission and there was no alert charting completed on the wound, or a treatment order obtained for the wound until 03/11/25. The ADON stated the former wound nurse saw R170 when she was admitted to the facility and documented the wound on her sacrum. The ADON also stated she should have seen R170 on 03/06/25 and 03/07/25 but she resigned from the position without obtaining a treatment order. The ADON stated Licensed Practical Nurse (LPN) 12 notified her of the sacral wound without a treatment order on 03/10/25 after she completed R170's skin check. The ADON indicated she interviewed the nurses that were assigned to R170 over the weekend (03/08/25 and 03/09/25) and they stated they provided treatments to the wound on the sacrum without an order but did not document it and did not notify the provider. During an interview on 04/16/25 at 2:43 PM, LPN8 stated he was assigned to R170 on 03/06/25 and performed a skin check on her legs so he did not know she had a sacral wound. During an interview on 04/16/25 at 3:36 PM, LPN12 verified she was assigned to R170 and observed the sacral wound when she completed the skin assessment on 03/10/25. LPN12 stated there was no treatment order in place. LPN12 stated she notified the nurse practitioner and informed the ADON. LPN12 also stated the sacral wound was not passed onto her in nursing report and she did not see alert charting on it in the progress notes. LPN12 stated R170 was placed on the wound rounds on 03/12/25. During an interview on 04/16/25 at 3:50 PM, the Wound Physician stated he was not aware that there were no treatments in place for R170's wound on her sacrum until 03/11/25. The Wound Physician confirmed he saw R170 on 03/12/25 and on 03/19/25, the sacral wound was unstageable, and he debrided it. During an interview on 04/17/25 at 5:34 PM, the Director of Nursing (DON) 1 stated she was informed by the ADON that LPN12 reported to her that R170 had a wound to her sacrum without treatment orders and that LPN12 reported it to the Nurse Practitioner.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that two of 10 residents reviewed for accidents (Resident (R) 114 and R90) were provided supervision to prevent accidents. Both residents were planned for two staff for bed mobility and transfer but only one staff provided care. R114 was harmed when injuries from the all required emergecy room treatment with stitches to a laceration to the skull. R90 sustained minimal injuries. Verification of training and binder review confirmed the incident with R114 was corrected 12/3/24 and determined to be past-non compliance. The citation for R90 was a D level finding was verified as corrected on 3/21/24. Findings include: 1. Review of the facility's policy titled, Care Planning revised on 01/12/23 revealed that The services provided or arranged by the facility, as outlined by the comprehensive care plan, must: Be provided by qualified persons in accordance with each resident's written plan of care. Review of R114's admission Record located in the Profile tab of the EMR revealed he was admitted to the facility on [DATE] with diagnoses which included anoxic brain damage and persistent vegetative state. Review of R114's Care Plan located in the resident's EMR under the Care Plan tab revealed an intervention dated 10/13/23 to: Assist with transfers and repositioning in bed as ordered. Review of R114's Order Summary Report located in the resident's EMR under the Orders tab revealed an order dated 04/05/24 for Bed Mobility [side to side]: assist of two. Review of R114's Transfer Status Sheet dated 04/05/24 and located in the Misc tab of the EMR revealed R114 required assist of two with rolling side to side. Review of R114's Fall Risk Evaluation, dated 10/14/24 and located in the Evaluations tab of the EMR revealed R114 was not at risk of falling. Review of R114's annual MDS assessment with an ARD (assessment reference date) of 10/16/24 and located in the MDS tab of the EMR revealed R114 was in a persistent vegetative state with no discernible consciousness. R114 had functional limitation in range of motion to both upper and lower extremities and was dependent on staff for rolling side to side. Review of a facility provided Incident Report, dated 11/28/24 and completed by LPN11 revealed CNA14 reported R114 fell out of bed during care. R114 was observed lying on the floor next to the bed, bleeding from the left side of his head. R114 went out to the emergency room for evaluation. Review of R114's Progress Notes, located in the Progress Notes, tab of the EMR revealed: A Nurses Note dated 11/28/24 at 2:42 PM which documented R114 fell onto the floor during care around 12:55 PM. R114 was assessed and an injury to the left side of his head was cleaned and a pressure dressing placed. 911 was called, and R114 left for the hospital at 1:27 PM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An Orders - General Note from eRecord dated 11/29/24 at 12:04 PM which documented R114 returned to the facility at 8:55 AM. R114 had a laceration with stitches on the back left side of his head from the 11/28/24 fall. During an interview on 04/15/25 at 11:53 AM, CNA14 reported she had rolled R114 by herself on 11/28/24 when providing incontinence care. CNA14 had raised the bed to working height, rolled R114 away from her, and reached to grab wipes and a clean brief when R114 slowly fell out of bed. CNA14 reported R114 was supposed to be assisted by two staff to roll but that when she was unable to find someone to assist, she had provided care alone. During a concurrent observation and interview on 04/15/25 at 3:26 PM, CNA13 and CNA19 repositioned R114 in bed. R114 was observed to be totally dependent on staff for mobility with no discernible response to verbalizations. CNA13 reported R114 had little movement, but residents in his state coughed or spasmed at times with rolling, which could cause them to move. When asked how staff knew how to transfer or position residents, CNA13 opened R114's closet door to reveal his Transfer Status Sheet which showed R114 required two staff for rolling side to side. During an interview on 04/16/25 at 12:14 PM, LPN11 stated she was notified by a CNA on 11/28/24 that R114 had fallen from the bed. When LPN11 lifted R114's head, she felt blood on her glove and got another nurse to further assist with assessing. CNA14 reported to LPN11 that when R114 was rolled on his side for incontinence care, he jerked and fell off the bed. He likely coughed or something. CNA14 was the only staff in the room providing care when R114 fell. R114 was supposed to have two staff when rolling. During an interview on 04/16/25 at 6:00 PM, DON1 stated she expected staff to follow the plan of care for rolling, transferring, and ambulation. Nursing staff were educated to look for the plan of care inside the resident's closet doors. If the plan of care stated to roll with the assist of two staff, she expected two staff to be utilized. Review of a facility provided binder revealed the facility started a Quality Assurance and Performance Improvement (QAPI) plan following the 11/28/24 fall. An Action Plan titled Resident Staff Assisted Bed Mobility was initiated on 11/29/24. Certified staff received re-education on utilizing the ordered amount of staff assistance with bed mobility from 11/29/24 to 12/03/24. Audits were completed on utilizing the required staff assistance with bed mobility three times weekly until compliance was consistent at 100% for three consecutive audits. Following this, audits were completed weekly until consistent compliance was achieved over three consecutive weeks. Finally, monthly audits were performed, which began in January 2025. The last audit form in the binder was dated 01/10/25. 2. Review of R90's undated admission Record located in the EMR under the Profile tab revealed he was admitted on [DATE] with multiple diagnoses which included vegetative state, acute respiratory failure, tracheostomy, contractures, gastrotomy, and nontraumatic intracerebral hemorrhage. Review of R90's annual MDS assessment with an ARD of 10/18/24, located in the EMR under the MDS tab revealed R90 was not interviewable and could not be assessed for mental status. The MDS indicated that R90 was dependent on staff for eating, oral hygiene, toileting, shower, upper and lower body dressing, personal hygiene, rolling, and transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R90's Care Plan, dated 02/24/23, located in the EMR under the Care Plan tab revealed a focus of ADL self-care performance deficit r/t [related to] vegetative state with interventions of Picture in closet for positioning dated 01/18/24, and Transfer: The resident requires Mechanical Lift (Hoyer) with 2 staff assistance for transfers (dated 02/24/23). Review of R90's Nurses Note, dated 02/22/25, located in the EMR under the Prog Note tab revealed Charge nurse came in to the Unit and reported to the nursing supervisor that resident has a fall during provision of care. Nursing supervisor ran to resident's room. Resident has contractures of the upper limbs and very limited movement in lower extremities. No evidence of bones fracture. Resident presented: excoriations of the right side of forehead, small hematoma/elevation of the middle of the forehead, scant amount of dry blood on the inferior lip, small skin tear on right shoulder. Resident was resistant to mouth evaluation. Review of R90's Nurses Note, dated 02/22/25, located in the EMR under the Prog Note tab revealed . Resident was assessed by NPs [nurse practitioners] and new order received to send resident to the Hospital for evaluation and treatment . Review of R90's Nurses Note, dated 02/22/25, located in the EMR under the Prog Note tab revealed pt [patient] returned from hospital s/p [status post] fall. no new orders received. pt vitals are stable. no signs of distress noted. no signs of pain or discomfort. call bell within reach . Review of R90's Facility Reported Incident (FRI), dated 02/22/25, provided by the facility revealed the five-day report was sent to the State Survey Agency (SSA) on 02/28/25 which documented CNA10 stated she was cleaning the resident and went to turn him, and he rolled off the bed. During an interview on 04/14/25 at 8:50 PM, Family Member (F) 9 stated there was an incident on 02/22/25 when two staff were not present when turning R90 in bed during care. F9 also stated the CNA told him that she was giving a bath to R90, then she turned him away from her and he fell off the bed onto the floor. F9 stated the CNA stated R90 had a few scraps on him but no injuries. During an interview on 04/17/25 at 3:33 PM, DON1 confirmed she completed R90's fall investigation and concluded CNA10 did not wait for another nursing assistant to assist her in providing care to the resident on 02/22/25, which was the required level of assistance per the care plan. DON1 also stated the care plan was posted in each resident's armoire. DON1 indicated R90 returned from the hospital with no injuries. DON1 also indicated CNA10 was suspended during the investigation and terminated after the investigation was concluded. DON1 stated training was provided to all staff on 02/24/25 then auditing was conducted which included observations of the nursing assistants providing care to the residents. Training was provided to all nursing staff on 02/24/25 on patient transfer status and bed mobility by the DON. Audits were conducted three times weekly by the Staffing Coordinator from 02/24/25 to 03/21/25 through observations on each floor of assistance required with bed mobility per the QAPI Plan.