STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A020	A. Building B. Wing	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newark Manor Nursing Home	254 West Main Street Newark, DE 19711

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 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. Based on interview and review of clinical record, it was determined that for one (R1) out of three residents reviewed for accidents, the facility failed to notify the on-call provider of R1's delayed STAT x-ray results ordered 7/18/25. Findings include:Cross refer to F689, example 1 Review of R1's clinical record revealed: 7/18/25 - A physician's order stated to obtain a STAT elbow x-ray for R1's increased pain and decreased movement of left arm. A nursing note, at 5:49 PM, documented that the x-ray was completed in the facility. 7/20/25 8:20 PM - R1's mobile STAT x-ray results were finally read and faxed to the facility revealing a left humeral neck fracture. 10/23/25 11:00 AM - During an interview, E6 (RN) stated that she called the mobile x-ray company on 7/19/25 and was told they were running behind. E6 stated that she did not notify the on-call provider. E6 stated that when she returned to work on 7/20/25 evening shift and found out the results were still not received. E6 stated R1's POA was very upset and requested R1 to be sent to the ER. E6 stated that the on-call provider was notified and an order to send R1 to the ER (emergency room) for an x-ray was obtained. R1 was sent to the ER at 5:10 PM. The facility lacked evidence that R1's physician or an on-call provider was notified that the physician ordered STAT x-ray results were not received until approximately 48 hours later. 10/24/25 2:30 PM - Finding was reviewed during the exit conference with E1 (NHA) and E2 (DON).

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview, record review and other facility documentation, it was determined that for one (R2) out of three residents sampled for falls, the facility failed to thoroughly investigate an allegation of neglect when R2 was left unattended in the bathroom and had a fall. Findings include: An undated facility document entitled, Falls included, . The nurse and charge nurse are to be notified immediately, and the resident is not to be moved until assessed by a nurse unless otherwise directed.2/28/22 - R2 was admitted to facility with diagnoses including but not limited to dementia, left eye absolute glaucoma (permanent vision loss), and difficulty walking.1/16/24 - R2's fall care plan documented, Resident with poor safety awareness and impulse control.8/30/25 2:41 PM - R2's clinical record documented, .S/P [status post] fall hit head, has a superficial laceration to the back of the right side of head that is 0.5cm.8/30/25 7:40 PM - A facility reported incident submitted to the Division documented, Resident found on the floor in the bathroom of the third-floor day room.8/30/25 7:47 PM - E8 (LPN) documented in R2's clinical record, At approximately 1400 [2:00 PM], staff reported an unwitnessed fall in the dining room immediately after lunch. Resident was noted on the floor in a seated/side-lying position with active bleeding from the head.10/21/25 1:30 PM - A review of the facility's post-fall investigative record revealed, During the multidisciplinary care conference for [R2] on 9/11/25, it was brought to the attention of staff that the fall occurred in the bathroom after the resident was left unattended by the CNA [E7.] The CNA misrepresented the location and details of the incident. The facility's new investigation revealed that R2 was left unattended in the bathroom while the CNA went down the hall to obtain an incontinent brief. When she returned, R2 had fallen to the floor. E7 put R2 into the wheelchair and told the supervisor that [R2] had fallen in the dining room.10/21/25 2:30 PM - During an interview, the Surveyor asked E8 (LPN) if she had seen or assessed R2 post fall, E8 stated, No, I was on break, and I did not see her on the floor after the fall. The RN supervisor [E5] told me that she had fallen.10/22/25 2:45 PM - During an interview, the Surveyor asked E6 (3-11RN supervisor) how she became aware of the location of R2's fall. E6 stated, The day shift supervisor [E5] told me that the aide said that the resident had fallen in the bathroom. The location was on the report that I submitted to the state.The facility failed to thoroughly investigate the location of the fall until 12 days after the event. 10/24/25 12:00 PM - Findings were confirmed with E2 (DON).10/24/25 2:30 PM - Finding was reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and review of clinical record, it was determined that for one (R1) out of three residents reviewed for accidents, the facility failed to ensure a person-centered care plan was initiated and implemented that included measurable objectives and timeframes to meet R1's medical need with respect to the resident's pacemaker. Findings include: Review of R1's clinical record revealed: 1/31/23 - R1 was admitted to the facility with diagnosis that included, but was not limited to, dementia, legal blindness and sick sinus syndrome. 1/31/23 2:15 PM - The Resident Assessment-Data Collection Form documented that R1 had a pacemaker on her left upper chest. 1/31/23 - R1 was care planned for a pacemaker r/t [related to] sick sinus syndrome with goals and interventions that included: Goals:-will remain free from s/sx [signs/symptoms] of pacemaker malfunction or failure through the review date.Interventions:-Monitor vital signs monthly and as needed. Notify MD (medical doctor) of significant abnormalities. Notify MD of significant abnormalities.-Monitor/document/report PRN (as needed) any s/sx of altered cardiac output or pacemaker malfunction: dizziness, syncope (fainting), difficulty breathing (dyspnea), pulse rate lower than programmed rate, lower than baseline B/P (blood pressure). The facility failed to ensure that R1's pacemaker care plan was person-centered. Specifically, the care plan lacked R1's pacemaker's function information (type, settings/rate, battery status); education for the resident/family on the purpose and function of the pacemaker, signs and symptoms of pacemaker complications and the importance of follow-up appointments with R1's Cardiologist; and monitoring of skin integrity at location site. 10/23/25 approximately 3:00 PM - During an interview, surveyor reviewed that R1's pacemaker care plan was not person-centered with E2 (DON). 10/24/25 2:30 PM - Finding was reviewed during the exit conference with E1 (NHA) and E2.

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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. Based on observation, interview and review of clinical record, it was determined that for three (R1, R4 and R5) out of seven residents reviewed for bed rails, the facility failed to review and revise each resident's bed rail care plan to ensure they were person-centered to meet their medical needs and included, but were not limited to, ongoing assessment and monitoring of the bed rail usage. Findings include:1. Review of R1's clinical record revealed: 3/7/23 - R1 was care planned for left bed enabler for assistance to change position while in bed. Interventions included:- Document that the enabler is being used to help assist resident to change position in bed;-Ensure a valid consent is on chart prior to initiating enabler; and-Obtain order for enabler. R1's bed rail care plan lacked evidence of the monitoring and supervision to be provided during the use of the bed rail; ongoing assessment to make sure that the bed rail was used to meet the resident's needs; ongoing evaluation of risks; identification of the person who will determined when the bed rail will be discontinued, and the identification and interventions to address any adverse effects of the bed rail use. 10/23/25 approximately 3:00 PM - During an interview, finding was reviewed with E2 (DON). 2. Review of R4's clinical record revealed: 5/17/24 - R4 was care planned for right side rail enabler to assist with changing position while in bed. Interventions were:- anticipate and meet the resident's needs;-document the rail is being used to help assist the resident in changing position;-ensure a valid consent is in the chart prior to initiating rail;-obtain order for rail enabler; and-PT referral as ordered by MD. R4's bed rail care plan lacked evidence of the monitoring and supervision to be provided during the use of the bed rail; ongoing assessment to make sure that the bed rail was used to meet the resident's needs; ongoing evaluation of risks; identification of the person who will determined when the bed rail will be discontinued, and the identification and interventions to address any adverse effects of the bed rail use. 10/23/25 approximately 3:00 PM - During an interview, finding was reviewed with E2 (DON). 3. Review of R5's clinical record revealed: 7/3/24 (last revised) - R5 was care planned for . right sided bed enabler for assistance to change position while in bed. Interventions were:- anticipate and meet the resident's needs;-document the rail is being used to help assist the resident in changing position while in bed; and-ensure a valid consent is in the chart prior to initiating rail. R5's bed rail care plan lacked evidence of the monitoring and supervision to be provided during the use of the bed rail; ongoing assessment to make sure that the bed rail was used to meet the resident's needs; ongoing evaluation of risks; identification of the person who will determined when the bed rail will be discontinued, and the identification and interventions to address any adverse effects of the bed rail use. 10/23/25 7:20 AM and 11:38 AM - Despite R5's care plan for a right sided bed enabler, observations of R5 in bed revealed that bilateral bed rails in the up position were still being used. 10/23/25 approximately 3:00 PM - During an interview, finding was reviewed with E2 (DON). 10/24/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and review of clinical record and facility documentation, it was determined that for two (R1 and R2) out of three residents reviewed for accidents, the facility failed to ensure each resident received adequate supervision to remain free of accident hazards. For R1, the facility failed to identify that R1's left bed rail was a potential hazard. R1, a dependent resident with dementia, was identified with a change of condition on 7/18/25 and diagnosed with a left upper extremity fracture. The facility's investigation documented that R1 sustained the injury as an accidental contact with the bed enabler during care. As a result, R1 was harmed. R2, a severely cognitively impaired resident and dependent resident sustained a scalp laceration, and a subtle sacral fracture from a fall when she was left in the bathroom unsupervised. Findings include: An undated facility document entitled, Falls included, . The nurse and charge nurse are to be notified immediately, and the resident is not to be moved until assessed by a nurse unless otherwise directed. 2/28/22 - R2 was admitted to facility with diagnoses including but not limited to dementia, left eye absolute glaucoma (permanent vision loss), and difficulty walking. 3/2/22 – R2's fall care plan (revised 7/18/24) included, .At high risk for falls r/t [related to] gait/balance problems/ambulatory dysfunction. The interventions included, Anticipate and meet [R2's] needs. 1/16/24 – R2's fall care plan documented, Resident with poor safety awareness and impulse control. A review of R2's clinical record revealed the following history of falls: 2/24/25 – R2 sustained a fall in her room next to the bed. 3/12/25 – R2 sustained an unwitnessed fall in the lounge. 4/26/25 – R2 was found sitting on the floor of her room. 4/30/25 – R2 was found sitting on the floor next to her bed. 5/16/25 – R2 was found sitting on the floor next to her bed. 6/2/25 – R2 fell while walking unassisted out of the dining room. 6/14/25 – R2's quarterly fall assessment document a score of 80, indicating a high fall risk. R2's fall care plan lacked evidence of a person-centered care plan and interventions for the high fall risk. 8/3/25 – R2's quarterly MDS assessment documented a BIMS score of 00, indicating the inability to complete a cognitive assessment. This assessment also documented that R2 required minimum assistance with eating and was completely dependent on staff for all other activities of daily living. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	8/30/25 2:41 PM – R2's clinical record documented, .S/P [status post] fall hit head, has a superficial laceration to the back of the right side of head that is 0.5cm. 8/30/25 7:40 PM – A facility reported incident submitted to the Division documented, Resident found on the floor in the bathroom of the third-floor day room. 8/30/25 7:47 PM – E8 (LPN) documented in R2's clinical record, At approximately 1400 [2:00 PM], staff reported an unwitnessed fall in the dining room immediately after lunch. Resident was noted on the floor in a seated/side-lying position with active bleeding from the head. This nurse arrived at 1402 [2:02 PM], activated post-fall protocol, and assessed the resident in place. Linear laceration to scalp. approximately 0.5 cm length, bleeding scant. 8/30/25 4:50 PM – R2's clinical record documented, On-call doctor called back, and new order received. Send to ER for evaluation.The resident was sent to the ER [emergency room.] The facility failed to implement appropriate emergency interventions in a timely manner for R2's unwitnessed fall with obvious head injury. R2 fell at approximately 2:00 PM and was sent to the emergency room at 4:50 PM, 2 hours, 50 minutes later. 8/31/25 1:15 AM – R2 returned from the hospital with a diagnosis of a head laceration and a subtle non-displaced vertical fracture to the right of the sacrum. 10/21/25 1:30 PM – A review of the facility's post-fall investigative record revealed, During the multidisciplinary care conference for [R2] on 9/11/25, it was brought to the attention of staff that the fall occurred in the bathroom after the resident was left unattended by the CNA [E7.] The CNA misrepresented the location and details of the incident. The facility's new investigation revealed that R1 was left unattended in the bathroom while the CNA went down the hall to obtain an incontinent brief. When she returned, R2 had fallen to the floor. E7 put R2 into the wheelchair and told the supervisor that [R2] had fallen in the dining room. The facility failed to thoroughly investigate the location of the fall until 12 days after the event. 10/21/25 12:30 PM – During an interview, the Surveyor asked E8 (LPN) if she had seen or assessed R2 post fall, E8 stated, No, I was on break, and I did not see her on the floor after the fall. The RN supervisor [E5] told me that she had fallen. 10/21/25 1:00 PM – During an interview, the Surveyor asked E5 (RN supervisor) how she was she became aware that R2 had sustained a fall. E5 stated, The aide [E7] came to the second floor and told me that the resident had fallen. I went up to the third floor and saw [R2] sitting in the wheelchair in the common area. The Surveyor asked E5 about emergency intentions for R2's obvious head injury, E5 stated, I started neuro checks and waited for the on-call doctor to call back. The facility failed to have R2 assessed by a registered nurse after the unwitnessed fall prior to getting back into the wheelchair (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	10/21/25 2:00 PM – During an interview E3 (ADON) stated, All of the aides know that any resident who is an assist of one with transfers should not be left alone in the bathroom. It's documented on the care plan and on the resident's care sheet in the closet. The Surveyor asked E3 if the aides had access to the residents' care plans in the electronic records, E3 stated, No, but they can ask the nurse. A review of R2's care plan and care sheet lacked evidence of documentation for staff to remain the bathroom with her to prevent falls. The facility failed to ensure that R2 had adequate supervisor to prevent falls with injuries despite the extensive history of falls. 10/24/25 12:00 PM - Findings were confirmed with E2 (DON). 10/24/25 2:30 PM – Finding was reviewed during the exit conference with E1 (NHA) and E2 (DON). 1. Cross refer to F580, F657 example 1, F700 example 1, and F776 Review of R1's clinical record revealed: 3/7/23 – R1 was care planned for left bed enabler for assistance to change position while in bed. Interventions included: -Document that the enabler is being used to help assist resident to change position in bed; -Ensure a valid consent is on chart prior to initiating enabler; and -Obtain order for enabler. 10/26/23 – A physician's order stated, TRANSFER STATUS: resident is a Hoyer lift with 2 staff assist with transfers BED MOBILITY: resident is a 1 assist with bed mobility. 7/3/24 – A physician's order stated, May use a left sided bed enabler to assist with turn and repositioning. 5/1/25 3:19 PM – R1's side rail assessment documented by C1 (contracted PT): 1. Has Resident expressed a desire to have side rails raised while in bed for their own safety and/or comfort? Yes. rolling and positioning. 2. Does the resident have fluctuations in levels of consciousness or a cognitive deficit? Yes. dementia. 3. Does the resident have any visual deficits? Yes. glaucoma, legally blind. 4. Is the resident able to get in/out of bed safely? Yes. 7. Is the resident having problems with balance or poor trunk control? Yes. enabler for sitting balance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	7/18/25 5:49 PM – A nursing note documented, X-ray of left arm completed. Awaiting results to come back. The following nursing notes revealed: 7/19/25 3:32 AM - No complaints of pain this shift. Still waiting for xray (sic) results of left arm. 7/19/25 10:05 AM - LATE ENTRY. This RN called [name of x-ray company] at 1000 [10 AM], and was told that the X-ray results still pending. They stated that they are running late, once they get the results, and they'll fax the results to the facility. Family made aware. 7/19/25 3:48 PM - PRN Tylenol administered for pain level of 10/10. 7/19/25 8:57 PM - Resident still continues with pain to L arm, slightly swollen. Pain relieved with Tylenol, given around 1545 [3:45 PM] and 2045 [8:45 PM]. Xray results still pending as of this time. 7/20/25 1:34 AM - . Xray of left arm results still pending. 7/20/25 9:45 AM - The nurse called [name of x-ray company] at 0945 [9:45 AM], and they stated that the X-ray result is not available yet. They will let us know in 2 to 3 hours. 7/20/25 4:22 PM - This RN got a phone call from [name of x-ray company] at 1610 [4:10 PM], and was told that the X-ray results are still not available. They stated that they hoped to get the result by 9 PM today. 7/20/25 6:40 PM – A nursing note documented, The resident's [name of POA] came in to see the resident this afternoon. was very upset to know the X-ray results still pending. was so concerned. asked to send the resident to ER to get the X-ray. MD made aware. New MD order received at 1650 [4:50 PM]. Send to ER for evaluation and treatment for left elbow pain and decreased range of motion to LUE [left upper extremity]. The resident was sent to ER by ambulance at 1710 [5:10 PM]. 7/20/25 8:20 PM – While R1 was in the ER, the mobile x-ray results were faxed to the facility and documented acute nondisplaced fracture of the left humeral neck and no acute abnormality at the elbow. According to the facility's investigation, when the ER called to report that R1 was going to return and there was no elbow fracture, the facility informed the ER about the fracture identified in the mobile x-ray results. The ER cancelled R1's transfer back to the facility and conducted further x-rays, which revealed a fracture. 7/21/25 12:20 AM – The ER's x-ray of R1's left humerus revealed that there was an impacted fracture of the surgical neck of the humerus. 7/25/25 – The facility's five-day follow-up to the State Agency documented that .based on the review of staff statements, timing, and the location/pattern of the injury, it is feasible that the resident sustained the injury as an accidental contact with the bed enabler during care. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	10/22/25 12:58 PM – During an interview, E9 (LPN) stated that staff have to move/roll the resident in bed. E9 stated that R1 would always have her left elbow bent and would rest her left hand on her stomach. E9 stated that R1 would ask for Tylenol for knee pain or body aches and never complained about her left arm before the fracture. E9 confirmed that R1 was unable to get out of bed independently. 10/22/25 3:30 PM – During an interview, E10 (CNA) stated that she was assigned to provide care for R1 on 7/18/25 day shift. E10 stated that when she touched R1's left arm, the resident screamed and told her that it hurts. E10 stated that she immediately knew something was wrong as this was an unusual response of R1. E10 stated that she immediately reported this complaint of pain to the assigned nurse. 10/24/25 11:00 AM – During an interview, E11 (CNA) stated that R1 could not turn in bed. E11 stated that R1 always kept her hands together and left elbow bent. The facility failed to identify R1's right sided bed rail as a potential accident hazard. 10/24/25 2:30 PM – Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newark Manor Nursing Home	254 West Main Street Newark, DE 19711

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and review of clinical records and facility documentation, it was determined that for three (R1, R4 and R5) out of seven residents reviewed for bed rails, the facility failed to ensure that each residents' bed rail was used appropriately with ongoing monitoring. Additionally, the facility lacked evidence that preventive maintenance/safety checks were being done for bed rails being used in the facility. Findings include: The facility's policy and procedure entitled Bed Enabler, last updated 10/28/23, stated, Objective: 1. To assist with bed mobility. 2. To assist with transfer from bed to chair. Procedure:1. Physical therapy will determine the potential benefit of bed enabler use for bed mobility and/or transfers.2. Obtain an order for bed enablers from the physician.3. Obtain informed consent from the resident and/or resident representative.4. The Maintenance Department will be asked to install a bed enabler on the side/sides of the bed as specified by the physician order in Point Click Care.5. Update the care plan.6. The resident will be reassessed at least every six months for continued bed enabler use by physical therapy.7. If the bed enabler is discontinued, the bed enabler will be removed from the bed, cleaned with disinfectant, dry thoroughly and placed in a designated storage area by the Maintenance department. 1. Cross refer to F689, example 1 Review of R1's clinical record revealed: 3/7/23 - R1 was care planned for left bed enabler for assistance to change position while in bed. Interventions included:- Document that the enabler is being used to help assist resident to change position in bed;-Ensure a valid consent is on chart prior to initiating enabler; and-Obtain order for enabler. 7/3/24 - A physician's order stated, May use a left sided bed enabler to assist with turn and repositioning. 5/1/25 3:19 PM - R1's side rail assessment documented by C1 (contracted PT):1. Has Resident expressed a desire to have side rails raised while in bed for their own safety and/or comfort? Yes. rolling and positioning.2. Does the resident have fluctuations in levels of consciousness or a cognitive deficit? Yes. dementia.3. Does the resident have any visual deficits? Yes. glaucoma, legally blind.4. Is the resident able to get in/out of bed safely? Yes.7. Is the resident having problems with balance or poor trunk control? Yes. enabler for sitting balance.8. Does the resident use the side rails for positioning or support? Yes9. Does the side rail help the resident rise from a supine position to a sitting/standing position? Yes.14. Is there a risk to the resident if side rails are used? No16. Is the resident alert and oriented? Yes17. Is the resident currently using a side rail for positioning or support? Yes18. Would a side rail improve independence for transfers in/out of bed? Yes18b. Side Rail Type and Location: Left side enabler. Despite the 5/1/25 Side Rail Assessment, R1's 5/17/25 quarterly MDS assessment documented that R1 was dependent for toileting hygiene/rolling left and right/sitting to lying/lying to sitting on side bed/chair to bed transfers. 7/16/25 11:00 AM - The Multidisciplinary Care Conference form documented that R1 was dependent on staff for all ADLs and required a Hoyer lift for transfers. There was no evidence that R1's bed rail was reviewed to ensure it was still appropriate for the resident. 2. Review of R4's clinical record revealed: 8/19/24 - A physician's order stated, May use right side bed enabler to assist with turn and repositioning. 8/23/24 - A physician's order stated, . Bed Mobility: resident is an assist of 1 with bed mobility. 9/21/25 - The quarterly MDS assessment documented that R4 had a BIMS of 15/15 (cognitively intact); was dependent for toileting hygiene/upper body dressing/roll left and right/sit to lying/lying to sitting on side of the bed/sit to stand/chair to bed transfer/shower transfer; and daily use of bed rail. Review of the October 1-21, 2025 CNA Documentation Survey Report revealed that for 56 out 63 shifts, staff documented that R4 was dependent for rolling left and right in bed. 10/23/25 1:15 PM - An observation during care revealed that R4 had a right sided bed rail in the up position. E10 (CNA) was observed removing the therapy carrot device from R4's left contracted hand. During incontinent care, R4 required two staff assist for rolling left and right in bed. R4 was observed and the resident stated that he was not able to grab the right bed rail with his left contracted hand to roll in bed. Immediately after the observation, E10 confirmed that R4 required staff assistance for turning in bed. 3. Review of R5's clinical record revealed: 7/3/24 - A physician's order stated, May use right side bed enabler to assist with turn and repositioning. 10/23/25 7:20 AM - Despite having a physician's order for only one bed rail, an observation of R5 in bed revealed bilateral bed rails in the up position and head of bed elevated approximately 30 degrees. R5 was sleeping with the right elbow bent and laying on top of the right sided bed rail and right hand under his head. The left hand was in a fist and laying on his chest. 10/23/25 11:05 AM - During an interview, E12 (ES) confirmed that the facility did not have evidence of preventive maintenance/safety checks of the bed rails that are currently being used in the facility. E12 provided the manufacturer's guidelines for the bed rails being used. 10/23/25 11:38 AM - An observation during

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on interview and review of clinical records and facility documentation, it was determined that for one (R1) out of three residents reviewed for accidents, the facility failed to meet the acute medical needs of R1 with regard to obtaining the timeliness of STAT x-ray results on 7/18/25. Findings include: Review of R1's clinical record revealed: 7/18/25 - A physician's order stated, Elbow X-ray: Including the humerus, radius, and ulna, for fractures, dislocations, or deformities R/T [related to] increased pain and decreased movement. STAT for Increased pain and decreased movement of LEFT arm. 7/20/25 8:20 PM - Approximately 48 hours later, R1's mobile x-ray results were faxed to the facility and documented an acute nondisplaced fracture of the left humeral neck. 10/23/25 12:18 PM - During an interview, C2 (Representative with X-ray company) stated that STAT x-ray results are usually completed in two hours on the same day ordered. C2 confirmed that on the weekend of 7/18/25 through 7/20/25, the company had limited staff coverage for reading x-rays. C2 stated that the x-ray company notified the facility on 7/20/25 at 2:28 PM that the next available reading would be on 7/20/25 approximately 8:30 PM. 10/24/25 2:30 PM - Finding was reviewed during the exit conference with E1 (NHA) and E2 (DON).