DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Encore at Wilmington

DATE SURVEY COMPLETED: June 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from June 8, 2026, through June 15, 2026. The deficiencies contained in this report are based on interviews, observations, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was sixty-three (63). The sample size was thirty-six (36).	**Corrective Action:** Boiler has been installed. Leadership has been re-educated to ensure the facility reports utility interruption as required. No residents were affected. **Systemic Changes:** Executive Director or Designee will report if there will be a utility interruption of eight hours or more **Monitoring:** Executive Director will complete a weekly audit until 100% compliance for four weeks, then monthly until 100% for two months. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will be addressed and corrected to ensure compliance.	July 31, 2026
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement was not met as evidenced by: Cross Refer to the CMS 2567 - L survey completed June 15, 2026: F600, F609, F628, F644, F645, F655, F656, F657, F658, F677, F679, F684, F685, F689, F726, F732, F745, F812, F842, F880, F881 and F943.		

Provider's Signature _____ Title Executive Director Date 7/10/26

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3225.9.8 3225.9.8.9 S/S – D	**Reportable incidents are as follows:** **Utility interruption lasting more than eight hours in one or more major service including electricity, water supply, plumbing, heating or air conditioning, fire alarm, sprinkler system or telephones.** **This requirement was not met as evidenced by:** Based on interviews and review of facility documentation, it was determined that the facility failed to report a hot water utility interruption to the State Agency (SA) as required. Findings include: 6/11/26 10:23 AM – In response to the surveyor's request regarding the loss of hot water, a corporate email was provided with the following written response: "Effective Dates April 27th – 30th [2026]. The facility notified families of the hot water disruption and provided them notification that bed baths would be given in place of showers beginning on Monday, April 27th. This notification was provided verbally and via signage. Service resolved on April 30th." 6/12/26 11:15 AM – During an interview, E2 (DON) stated that the E1 (ED) asked him to tell me that the facility did not report the loss of hot water to the SA as required. Also stated that E1 is waiting for a copy of the boiler replacement documentation from corporate per the surveyor request. 6/12/26 3:09 PM – Surveyor received a copy of the boiler room repairs estimate for the hot water supply in healthcare documenting "job is complete and paid".		

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	6/15/26 4:15 PM - Finding was reviewed with E1, E2 and E3 (ADON) during the exit conference.		

Provider's Signature _____ Title Executive Director Date 7/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WILMINGTON	**2723 SHIPLEY ROAD , WILMINGTON, Delaware, 19810**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments In accordance with 42 CFR 483.73, an Emergency Preparedness survey was conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility from June 8, 2026 through June 15, 2026. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		07/01/2026
F0000	INITIAL COMMENTS An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from June 8, 2026, through June 15, 2026. The deficiencies contained in this report are based on interviews, observations, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was sixty-three (63). The sample size was thirty-six (36). Abbreviations and Definitions: ADLs - Activities of daily living/tasks needed for daily living, e.g dressing, hygiene, eating, toileting, bathing; ADON - Assistant Director of Nursing; ASW/DSS - Associate Social Worker/Director of Social Services; Asymptomatic - No signs of symptoms; Bipolar Disorder - a mental condition characterized by significant mood swings including manic and depressive episodes; BIMS - Basic Inventory of Mental status, a structured assessment tool aimed at evaluating cognition in the elderly. BIMS score of 0-7 is reflective of severe cognition deficit, 8-12 reflects moderate cognition deficit and 13-15 score is reflective of normal cognition; Cardiology - branch of medicine that deals with diseases and abnormalities of the heart;	F0000		07/01/2026

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 reverse for further 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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F0000	Continued from page 1 cm - centimeters/unit of length; CNA - Certified Nurse's Aide; Congestive heart failure - CHF/heart unable to pump enough blood to meet the body's needs; Diuretics - medications used to help remove excess fluid from the body; DON - Director of Nursing; Dorsal - back side of the hand; ED - Executive Director; eMAR - electronic Medication Administration Record; Extract - remove; Fillings - material used to fill a cavity in a tooth; Hoyer Lift - sling-type hydraulic lift; IP - Infection Preventionist; Income protection - portion of your monthly income that is "protected" from being counted toward your care costs; LPN - Licensed Practical Nurse; MAR - Medication Administration Record; McGreer Criteria - standardized guidelines used to identify and monitor infections in long term care facilities; MD - Medical Director; MDS - Minimum Data Set/a federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; Medicaid - program of medical aid designed for those unable to afford regular medical service and financed by the state and federal governments; Neurocheck - examination that assesses vital signs and oxygen level, level of consciousness, orientation to person, place and time, ability to open eyes, pupil check, speech, strength in upper and lower limbs and motor responses;	F0000		07/01/2026

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F0000	Continued from page 2 NHA - Nursing Home Administrator; NP - Nurse Practitioner; Osteoporosis - weakened bones with increased risk of breaking; OT - Occupational Therapist; Pain Scale – 1-10. The most common scale for pain. The patient to identify their pain between one to ten, with ten being the worst pain imaginable and one being no pain at all; POA - Power of Attorney; Psychotropic - drug that affects behavior, mood, thoughts or perception; PT - Physical Therapist; RD - Registered Dietician; RN - Registered Nurse; State Agency - Division of Health Care Quality/licenses, monitors and inspect health care facilities; TAR - Treatment Administration Record; X - times.	F0000		07/01/2026
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R74) out of two residents reviewed for accidents, the facility failed to ensure R74 received adequate assistance and supervision to	F0689	"Past Noncompliance - no plan of correction required"	07/10/2026

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F0689 SS = G	Continued from page 3 prevent accidents. R74, who required moderate assistance, sustained a facial injury after falling on the floor while receiving care from a staff member. Based review of the facility's evidence to correct the deficient practice and substantial compliance at the time of the current survey, the deficiency was determined to be past non-compliance as of 1/6/26. Findings include: Review of R74's clinical record revealed: 10/20/25 – R74 was admitted to the facility with diagnoses including congestive heart failure and cognitive communication deficit. 10/20/25 – R74's care plan documented that he was at risk for falls due to chronic pain and weakness. 12/24/25 – R74s's medications included Apixaban 5 mg (anticoagulant) twice daily for deep vein thrombosis. 12/30/25 – R74's readmission MDS assessment documented a BIMS score of 5, indicating severely impaired cognition. The assessment also documented that R74 had right and left upper extremity impairments and required partial/maximal assistance to roll left and right. 1/3/26 – A facility incident report documented, "…found [R74] on the floor beside his bed on the window side. [R74] was lying prone [face down] with blood noted to flow from his face…[E27, CNA] and [E28, LPN] were in the room and stated that [R74] fell from the bed to the floor while [E27] was providing care…Skin tear noted to left cheek with bleeding, skin tears also noted on right elbow and bilateral knee…[R74] was sent to ER for evaluation…". 1/3/26 – A general note entered in R74's clinical record documented, "[R74] returned from [hospital]…had 5 stitches on his cheek to be removed in 5 days." 1/5/26 4:11 PM – An IDT (interdisciplinary) Note entered in R74's clinical record documented, "…RCA [root cause analysis]: Positioning near bed edge; bed not wide enough; insufficient guarding; absent floor mat use during care; update care plan and audit compliance." 1/5/26 – R47's fall care plan was updated to include bilateral fall mats while in bed, resident bed in low position, wide bed replacement, and resident safe bed positioning.	F0689		07/10/2026

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F0689 SS = G	Continued from page 4 1/6/26 – A document entitled "Investigation Report Interview", signed by E27 and E3 (DON), documented, "I [E27] walked in around 9 am [9:00 AM] to do morning care to [R47]. The task was changing his brief, I pulled [R47] close to me and assisted [R47] on the right side, [R47] was on the right side. I [E27] was cleaning his brief and the task was done. I told [R47] to roll back and he began to roll the opposite way instead." 1/6/26 2:00 PM – A document entitled "Investigation Report Interview" documented, "Name of Person Interviewed: [E28, LPN]…At around 1000 [10:00 AM] [E27] called and stated [R47] rolled off the bed while being changed. [R47] was found laying on the floor beside his bed on the window side. Blood was flowing from [R47]'s face…". 1/6/26 – A facility document entitled, "Educational Opportunity Notice" signed by E27 and E2 documented, "…[E27] will be conscious of resident positioning when providing care to minimize risk of fall or injury. Verbal education provided. [E27] provide demonstration of what she would do differently and verbalized understanding of education provided…". 1/6/26 11:00 AM – A facility document entitled, "Staff Development Program Attendance Record…Providing Safe Care in Bed" documented a staff training was held and contained the signatures of nursing and CNA staff. A document entitled, "Providing Safe Care While Patient In Bed" dated 1/6/26 stated the contents of the education provided during the training. 6/11/26 12:30 PM - E27 gave the surveyor a documented audit completed for 6 residents monitored for 3 shifts daily for 4 weeks from 1/5/26 to 1/26/26. 6/11/26 1:32 PM – During an interview, E28 stated, "[E27] told the [R47] to roll on his side and he rolled too much. I was not in the room when it happened. There was blood on [R47] and the floor. [R47] was sent out to the hospital." The surveyor asked E27 if had received training after the incident. E27 stated that he received training the next day or so and verbalized the training received. 6/11/26 2:00 PM – Based on the surveyor's review of the facility's investigation, documented response, audit completion, staff interview, and no further resident falls while provided care, the deficiency was considered past non-compliance with a compliance date of 1/6/26.	F0689		07/10/2026

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F0689 SS = G	Continued from page 5 6/15/26 1:15 PM – Findings reviewed with E1 and E2. 6/15/26 4:15 PM - Findings were reviewed with E1, E2 and E3 (ADON) during the Exit Conference.	F0689		07/10/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to store and prepare food in accordance with professional standards for food service safety. Findings include: 1. 6/8/26 9:22 AM – During the initial kitchen tour, the surveyor observed one container of expired liquid thickener and one undated and unlabeled container of liquid thickener in the main kitchen refrigerator. The surveyor also observed three opened undated bags containing hamburger patties, broccoli, and asparagus. Findings were confirmed with E35 (RDD). 2. 6/12/26 9:15 AM – During a food preparation observation, the surveyor observed mechanical soft ham and scrambled eggs being held on a steam	F0812	Corrective Action: Food storage and preparation areas were immediately inspected. Any improperly stored, expired, or potentially unsafe food items were discarded or corrected immediately. Staff were instructed on proper food storage, preparation, labeling, dating, and sanitation practices in accordance with facility policy and applicable food safety regulations. Items were immediately discarded. No residents were affected. Systemic Changes: Root cause analysis is the facility failed to store and prepare food in accordance with professional standards for food service safety. The Dietary Manager or designee will review and reinforce food safety policies with dietary staff, including proper food storage temperatures, labeling and dating procedures, cross-contamination prevention, hand hygiene, and safe food preparation practices. A revised daily and Food Safety and Sanitation Checklist has been implemented. This checklist mandates daily audits of all reach-in, walk-in, and unit nourishment refrigerators by the Culinary team (or designee) to verify compliance with sealing, dating, and labeling. Strict adherence to labeling requirements (item name, preparation/opening date, and expiration/discard date). Routine sanitation procedures will be reviewed by the Director of Dining Services to ensure ongoing compliance to maintain food service safety. Success Evaluation The Dietary Manager or designee will conduct weekly audits until 100% compliance of food storage and preparation practices for four weeks, then monthly audits until 100% compliance for two months. Results will be presented at the facility's Quality Assurance and Performance Improvement (QAPI) meeting to ensure ongoing compliance	07/31/2026

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F0812 SS = F	Continued from page 6 table. The surveyor requested the holding temperatures for the ham and eggs. The holding temperature for the ham was approximately 130 degrees Fahrenheit. The holding temperature of the eggs was 126 degrees Fahrenheit. The temperatures did not meet the hot holding temperature requirement of 135 degrees Fahrenheit. Findings were confirmed with E36 (Cook). 6/12/26 2:00 PM – Findings were reviewed with E35 and E37 (DD). 6/15/26 4:15 PM - Findings were reviewed with E1 (ED), E2 (DON) and E3 (ADON) during the Exit Conference.	F0812		07/31/2026
F0655 SS = E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F0655	Corrective Action: Unable to correct for the residents identified due to time of baseline care plan. New admit residents were reviewed to ensure the baseline care plan was development and resident or resident representative received the baseline care plan summary. Systemic Changes: Root cause analysis is the facility failed to ensure a summary of each residents' baseline care plan were developed and/or provided to the resident or resident representative. The facility revised its admission and care planning process to include a standardized admission checklist to verify completion of the baseline care plan, to ensure baseline care plan summaries are developed and provided to residents or their representatives within the required timeframe. Staff Development Nurse or designee will re-educate the Licensed nurses and the interdisciplinary on the regulatory requirements, facility policy, documentation expectations, and the process for providing and documenting receipt of the baseline care plan summary. Success Evaluation: The Director of Nursing or designee will audit new admissions and readmissions weekly until 100% compliance for four weeks, then monthly until 100% compliance for two months, to verify that baseline care plan summaries are completed, provided to the resident and/or representative, and appropriately documented. Audit results will be reviewed through	07/31/2026

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F0655 SS = E	Continued from page 7 (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for four (R1, R3, R18 and R68) out of 36 sampled residents, the facility failed to ensure a summary of each residents' baseline care plan were developed and/or provided to the resident or resident representative. Findings include: The facility's policy and procedure entitled Care Plans – Baseline, last revised December 2016, revealed, "A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission… 4. The resident and their representative will be provided a summary of the baseline care plan that includes, but is not limited to the following: a. The initial goals of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary." 1. Review of R68's record revealed: 3/13/26 – R68 was admitted to the facility.	F0655	Continued from page 7 the facility's Quality Assurance and Performance Improvement (QAPI) process to ensure sustained compliance.	07/31/2026

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F0655 SS = E	Continued from page 8 3/13/26 – The facility's document entitled Baseline Care Plan for R68 was created by E6 (ASW/DSS). The document was missing the following: -Under section F. Allergies / Diagnosis, there was no documentation under 2. Active diagnosis contributing to admission. -There were no documented initial admission goals. -Under Section D. Medications, there was no documentation of the medications the resident is taking, noting the specific classification (i.e. Psychotropic, Diuretics, Insulin). -Under Section G. Physician Orders, the care plan summary lacked specific details and only documented to "See current MAR and TAR orders… Therapy Orders…". Although under Section D. Medications, there was a checkmark that a medication list was provided to the resident/representative, there was no evidence on page 12 that the baseline care plan summary was provided to the resident and resident representative with signatures and dates. 6/11/26 9:16 AM – During an interview, finding was reviewed and confirmed with E6. 2. Review of R1's record revealed: 5/13/26 – R1 was admitted to the facility with diagnoses including Methicillin Resistant Staphylococcus Aureus Infection, peripheral vascular disease, sepsis, stroke, coronary artery disease, osteomyelitis, right partial foot amputation. A care plan was initiated on day of admission. 5/15/25 – R1's care plan was reviewed and updated after R1 was evaluated by P1 (NP). 6/10/26 approximately 10:00 AM – During an interview, FM7 confirmed that the facility did not review a care plan or provide a copy of a baseline or comprehensive care plan to R1 or FM7. FM1 asked how R1 or FM1could get a copy of the care plan. A review of R1's EHR lacked evidence that R1 or FM7 received a copy or summary of the care plan.	F0655		07/31/2026

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F0655 SS = E	Continued from page 9 6/15/26 2:00 PM – Findings reviewed and confirmed during an interview with E1 (ED) 3. Review of R3's record revealed: 4/1/26- R3 was admitted to the facility with diagnoses including infection of the skin and tissue, contusion of the left lower leg, obesity, diabetes. A care plan was initiated on the day of admission. 4/3/26 – R3's care plan was reviewed and revised after R3 was evaluated by P1. 6/8/26 approximately 12:00 PM – During an interview, R3 stated that the facility did not provide a copy of a baseline or comprehensive care plan since the day of admission (4/1/26). A review of R3's EHR lacked evidence that R3 received a copy or summary of the care plan. 6/15/26 2:00 PM – Findings reviewed and confirmed during an interview with E1 4. Review of R18's record revealed: 5/12/26 – R18 was admitted to the facility with diagnoses including Staphylococcal arthritis of the right shoulder and elbow, and left hip, sepsis, failure to thrive. 5/13/26 - R18's care plan was initiated. 5/14/26 – R18's care plan was reviewed and revised after R18 was evaluated by P1. 6/9/26 11:21 AM – R18 reported that the facility did not provide a copy of a baseline or comprehensive care plan since the day of admission (5/12/26). A review of R18's EHR lacked evidence that R18 received a copy or summary of the care plan. 6/15/26 2:00 PM – Findings reviewed and confirmed during an interview with E1 (ED).	F0655		07/31/2026

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F0655 SS = E	Continued from page 10 6/15/26 4:15 PM - Findings were reviewed with E1, E2 (DON) and E3 (ADON) during the Exit Conference.	F0655		07/31/2026
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for six (R1, R3, R18, R25, R39 and R68) out of 36 sampled residents, the facility failed to revise a resident's care plan or lacked evidence of participation of the residents' attending physician and/or nurse aide in the interdisciplinary team care plan review. Findings include: 2. Review of R25' s clinical record revealed: 11/30/23 – R25 was admitted to the facility.	F0657	The care plans for Residents R1, R3, R18, R25, R39, and R68 were reviewed and updated on 7/8/2026 as appropriate to accurately reflect each resident's current needs. Documentation of interdisciplinary team participation, including the attending physician and nurse aide, will be completed, as appropriate, to ensure regulatory requirements. Systemic Changes: Root Cause analysis is the facility failed to ensure revision of a resident's care plan or lacked evidence of participation of the residents' attending physician and/or nurse aide in the interdisciplinary team care plan review. Staff development nurse will re-educate licensed nursing staff, social service director, and IDT regarding timely care plan revisions, required interdisciplinary participation, and documentation expectations. A standardized process and tracking mechanism will be used to ensure all required disciplines are invited to participate, and their involvement is documented during care plan reviews. Success Evaluation: The Director of Nursing or designee will complete a random audit of three resident care plans each week until 100% compliance for four weeks, then three resident care plans monthly until 100% for two months, to verify that: Care plans are revised to reflect changes in residents' conditions and needs. Required interdisciplinary team members, including the attending physician and nurse aide, have participated or their participation has been documented in accordance with facility policy and regulatory requirements. Documentation is complete and accurate. Audit results will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) Committee to ensure sustained compliance.	07/31/2026

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F0657 SS = E	Continued from page 11 3/12/26 – A quarterly MDS assessment documented that R25 had a BIMS score of 14, indicating an intact cognition. 6/8/26 12:47 PM – During an interview, R25 stated, "I only attended one care plan meeting. I have not been to a care plan meeting in over a year." 6/10/26 12:45 PM – During an interview, E6 stated, "R25 is invited to the care plan meetings and refuses to attend." The surveyor asked E6 (SS) to see documentation of R25's care plan meetings. 6/10/26 1:15 PM - E6 gave the surveyor a document entitled, "Care Plan Report", dated 3/5/26, that documented, "Signature below indicates participation in care conference review…". The document contained the signatures of E6 (SS), E4 (RD) and E24 (MDS). There was no evidence of attending physician or nurse aide participation. E6 also gave the surveyor a document entitled, "Care Conference Meeting Notes" that documented that a care plan meeting for R25 was held on 6/9/26. The document lacked evidence of an attending physician or nurse aide participation in R25's care plan meeting. 3. Review of R39's clinical record revealed: 9/1/24 – R39 was admitted to the facility. 6/8/26 11:08 AM – During an interview, FM6 stated, "No one showed up for the last care plan meeting. I only met with E6." 6/10/26 12:45 PM – The surveyor asked E6 to see documentation of R39's care plan meetings. 6/10/26 1:15 PM – E6 gave the surveyor a document entitled, "Care Plan Report", dated 3/10/26, that documented, "Signature below indicates participation in care conference review…". The document contained the signatures of E6, E4, E24 and FM6. There was no evidence of attending physician or nurse aide participation. E6 also gave the surveyor a document entitled, "Care Conference Meeting Notes" that documented that a care plan meeting for R39 was held on 6/9/26. The document lacked evidence of an attending physician or nurse aide participation in R39's care plan meeting. 6/11/26 10:15 AM – During an interview, E6 stated, "The providers and CNAs have never been at a care plan meeting since I have been here. I have been here just over a year." 6/15/26 1:15 PM – Findings were reviewed with	F0657		07/31/2026

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F0657 SS = E	Continued from page 12 E1(ED) and E2 (DON). 1. Review of R68's record revealed: 3/13/26 – R68 was admitted to the facility. 3/16/26 – R68's care plan created by E4 (RD) for nutrition/hydration listed an intervention that included a fluid restriction. 3/16/26 5:33 PM – A physician's order for a fluid restriction was discontinued by P3 (Medical Provider). 6/15/26 11:43 AM – During an interview, finding was reviewed and confirmed with E4 that R68's nutrition care plan was not reviewed and revised to reflect the discontinuation of the fluid restriction. 4. Review of R1's record revealed: 5/13/26 – R1 was admitted to the facility. 6/11/26 3:00 PM – E6 (Social Worker) provided a paper form titled Encore at Wilmington Care Conference Meeting Notes dated 6/3/26 with R1's name. Review of the note revealed the following participants: Social Services, Therapy, Dietary, Life Enrichment and Nursing. Provider participation was not included on the Care Conference Form. Additionally, review of R1's EHR lacked evidence of documentation of provider participation in IDT meetings. 6/11/26 4:00 PM – An interview with E6 revealed that providers do not attend IDT meetings; furthermore, the facility does not seek input from the provider prior to the meeting or share feedback after the meeting. E6 reported the "only time" the facility would reach out to the provider regarding an IDT meeting is if a resident or family member reports they are having difficulty contacting the provider. 6/15/26 2:00 PM – Findings reviewed and confirmed during an interview with E1(ED) 5. A review of R3's record revealed: 4/1/26- R3 was admitted to the facility with diagnoses including infection of the skin and tissue, contusion of the left lower leg, obesity, diabetes. A	F0657		07/31/2026

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F0657 SS = E	Continued from page 13 care plan was initiated on the day of admission. 4/9/26 11:42 AM - A Care Conference progress note documented that a "care conference was held with resident in the room along with idt [sic]. Please see summary under documents". 6/9/26 4:00 PM – A review of R3's EHR lacked evidence of a Care Conference Note in the documents folder. 6/11/25 3:00 PM – E6 provided a paper form titled Encore at Wilmington Care Conference Meeting Notes dated 4/9/26 with R3's name. Review of the note revealed the following participants: Social Services, Therapy, Dietary, Life Enrichment and Nursing. Provider participation was not included on the Care Conference Form. Additionally, review of R3's EHR lacked evidence of documentation of provider participation in IDT meetings. 6/11/26 4:00 PM – An interview with E6 revealed that providers do not attend IDT meetings; furthermore, the facility does not seek input from the provider prior to the meeting or share feedback after the meeting. E6 reported the "only time" the facility would reach out to the provider regarding an IDT meeting is if a resident or family member reports they are having difficulty contacting the provider. 6/15/26 2:00 PM – Findings reviewed and confirmed during an interview with E1. 6. Review of R18's record revealed: 5/12/26 – R18 was admitted to the facility with diagnoses including Staphylococcal arthritis of the right shoulder and elbow, and left hip, sepsis, failure to thrive. 6/11/25 3:00 PM – E6 provided a paper form titled Encore at Wilmington Care Conference Meeting Notes dated 5/22/26 with R18's name. Review of the note revealed the following participants: Social Services, Therapy, Dietary, Life Enrichment and Nursing. Provider participation was not included on the Care Conference Form. Additionally, review of R18's EHR lacked evidence of documentation of provider participation in IDT meetings. 6/11/26 4:00 PM – An interview with E6 revealed that providers do not attend IDT meetings; furthermore, the facility does not seek input from the provider prior to the meeting or share feedback after the meeting. E6 reported the "only time" the facility would reach out to the provider regarding an IDT	F0657		07/31/2026

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F0657 SS = E	Continued from page 14 meeting is if a resident or family member reports they are having difficulty contacting the provider. 6/15/26 2:00 PM – Findings reviewed and confirmed during an interview with E1 (ED). 6/15/26 4:15 PM - Findings were reviewed with E1, E2 (DON) and E3 (ADON) during the Exit Conference.	F0657		07/31/2026
F0881 SS = E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that the facility failed to have evidence of implementation of facility antibiotic stewardship protocols to monitor resident antibiotic use. Findings include: CDC (Center for Disease Control and Prevention) guidance dated 2015, entitled, "The Core Elements of Antibiotic Stewardship for Nursing Homes" states, "...Infection prevention coordinators have key expertise and data to inform strategies to improve antibiotic use. This includes...monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections...". The facility's antibiotic stewardship policy dated 2016 and titled, "Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes" included, "…3. Appropriate indications for use of antibiotics include: a. criteria met for definition of active infection…4. All resident antibiotic regimens will be documented on the facility approved antibiotic surveillance tracking form. The information gathered will include:…a. start date of antibiotic…f. pathogen identified…i. stop date…j. total days of therapy…". 6/11/26 3:00 PM – E34 (IP) provided the surveyor with facility resident antibiotics tracking documents entitled, "Infection Surveillance Report" for January	F0881	Corrective Action: Unable to correct due to tracking documents for April 2026 and May 2026 lacked evidence of resident antibiotic start date, stop date and pathogen treated. Facility will begin to maintain logs including start date, stop date, and pathogen treated, along with if it fits McGreer's Criteria. Director of Nursing or designee will educate the Infection control nurse on proper antibiotic log tracking. Systemic Changes: Root cause analysis is the facility failed to have evidence of implementation of facility antibiotic stewardship protocols to monitor resident antibiotic use. The infection control nurse will maintain an organized and precise log of the antibiotic use in the facility. Success Evaluation The DON will audit in conjunction with the ID nurse to ensure proper completion of the logs. Auditing will occur on a weekly until 100% compliance four weeks, then monthly audits until 100% compliance for two months. Results will be presented at the facility's quality and assurance performance improvement meeting to ensure ongoing compliance.	07/31/2026

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F0881 SS = E	Continued from page 15 2026, February 2026, March 2026, April 2026 and May 2026. The tracking documents for April 2026 and May 2026 lacked evidence of resident antibiotic start date, stop date and pathogen treated. 6/15/26 11:54 AM – During an interview, E34 (IP) confirmed that the facility utilizes McGreer Criteria to monitor facility resident antibiotic use. The surveyor asked E34, "How is the duration of antibiotic use, the organism being treated, and whether the resident antibiotic use meets McGreer Criteria is being tracked on the Infection Surveillance Reports?" E34 confirmed that the items were not tracked on the reports. 6/15/26 1:15 PM – Findings were reviewed with E1 (NHA) and E2 (DON). 6/15/26 4:15 PM - Findings were reviewed with E1, E2 and E3 (ADON) during the Exit Conference.	F0881		07/31/2026
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and review of record and facility documentation, it was determined that for one (R40) out of one resident reviewed for abuse, the facility failed to ensure R40 remained free from abuse on 6/7/26. Findings include: Cross refer F609 Review of R40's record and facility documentation revealed:	F0600	Corrective Action: Upon receiving allegation from resident on 06/09, employee was suspended, report to state and investigation immediately followed. All residents were interviewed and evaluated for signs of abuse, with no allegations or findings. Staff received education on when to report and whom to report to when receiving an allegation. System Changes: Root cause analysis was failure to report incident to the supervisor to ensure resident to free of abuse, neglect, or mistreatment. The facility reviewed and reinforced its Abuse Prevention, Reporting, Investigation, and Protection policies with all staff. Agency staff will receive facility abuse policy /education and resident rights prior to start of shift. The Staff Development Nurse/Education Nurse will provide education regarding recognizing, preventing, reporting, and responding to allegations or suspicions of abuse, including the responsibility to immediately protect residents and notify facility leadership. The facility also revised its medication refusal process to reinforce that staff are to discontinue attempts to retrieve medications through physical intervention if a resident refuses to relinquish medications and instead utilize appropriate de-escalation techniques, notify the supervisor, document the occurrence, and follow established medication refusal procedures. Facility leadership will monitor compliance with abuse	07/31/2026

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F0600 SS = D	Continued from page 16 2/22/26 – E20's (agency LPN) staffing agency provided a document entitled Orientation Information for Contracted/ Agency Employees, signed by E20 on 2/22/26. The document stated the following under Abuse/Neglect and Mistreatment, "… Physical abuse. Use of physical force that may result in bodily injury… If you see some (sic) say something. Abuse/Neglect MUST be reported immediately especially by licensed professionals. The failure of a licensed health care personnel to report instances of physical abuse, mistreatment and neglect for Residents in a nursing home is considered professional misconduct… Avoiding allegations of abuse and neglect by: following the plan of care, report abuse or neglect or signs of it immediately, know your limits- talk to your supervisor, if frustrated or losing control step back (sic) breathe take a break, tell your supervisor or nurse of any refusals of care, SEE SOMETHING SAY SOMETHING! If you witness abuse of any form, you must first STOP IT, SEPARATE IT AND REPORT IT IMMEDIATELY. Make sure the patient is safe and report it to the nursing supervisor immediately. It is the supervisor's responsibility to do an immediate investigation…". It should be noted that E19 (agency LPN) signed the same document on 4/2/26. 4/4/26 – The facility's agency staff orientation document signed by E20 (agency LPN) stated, "Abuse and Grievance Coordinators: [Name of E1, ED… Name of E2, DON… Name of E6, ASW/DSS] *Any allegation of abuse (Neglect/ Exploitation/ Abandonment) must be reported to a supervisor IMMEDIATELY. Examples of Abuse: Unknown injury or bruise,… neglect, mistreating Resident, unmet promises, ignoring Resident needs, rudeness to Resident…". 6/7/26 8:52 PM – A managed care progress note by E20 (agency LPN) documented, "… MENTAL STATUS Alert and Oriented X 3: Yes. Makes Self Understood – (Ability to express ideas and wants, consider both verbal and non-verbal expression): Understood. Ability to understand others – (Understanding verbal content, however able – with hearing aid or device if used): Understands... Obeys commands: Yes…". 6/7/26 10:56 PM – A nursing note by E20 (agency LPN) documented, "Resident called out for Tylenol and this nurse went in to administer it as requested. Resident yelled out 'these are two different pills, they aren't the same size'. This nurse called in another nurse to witness and confirm that both pills	F0600	Continued from page 16 prevention practices through routine observations and ongoing review of incident reports. Success Evaluation: Medication refusals will be documented in EMAR. Executive Director or Director of Nursing will audit abuse allegations and medication refusals weekly until 100% compliance is achieved for four consecutive audits, then monthly until 100% compliance is achieved for two months. The results of the audits will; be provided to the QAPI monthly for the next three months to determine if any continued monitoring is indicated to maintain compliance	07/31/2026

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F0600 SS = D	Continued from page 17 were Tylenol. Resident still refused to accept the pills. This nurse asked the resident to return the pills and resident become (sic) verbally aggressive. This nurse let the resident know that it is not safe practice to leave the pills unattended with her and asked again for the medication to be returned. Resident pushed the cup with the pills into this nurse's hand. The CNA [E36] assigned to the resident attempted to talk to the resident and redirect her to be able to accept her medications. Resident proceeded to place allegations against this nurse and other nurse while also accepting the medication. Medication pass was successful after redirection." 6/7/26 11:06 PM – An order-administration note by E20 (agency LPN) documented that Tylenol was administered. 6/8/26 12:16 AM – An order-administration note by E12 (LPN) documented that the Tylenol was effective. 6/9/26 – The facility's incident report by E2 (DON) documented, "Resident reported today 6/9/26 that on 6/7/26 at approximately 2310 (11:10 PM), she had asked her primary care nurse to give her some Tylenol. Per resident the nurse brought in 2 medications in a cup but one is big and the other was small. Resident stated that 'she told the nurse that the medications did not look familiar and requested for the nurse to get the medication card for verification'. Patient stated 'that the nurse asked her to give her back the cup of medication, but she refused'. Resident stated that 'the nurse left the room and was speaking to another nurse', shortly after both nurses came in the room and one nurse held her hand and they pry (sic) the cup of medication off (sic) her hand. Resident stated that she received a bruise on right dorsal hand and a small skin tera (sic) on the left wrist measuring 0.1cmx0.1cm (sic)." The immediate action taken was documented as "Resident assured safety upon reporting the incident. Agency was called and the nurses in question were suspended pending investigation. Assessment was completed. A bruise was noted on right dorsal hand and a small skin tear with flap measuring 0.1cmX0.1cm was noted to be dry and no drainage. NP [name] notified. [Name] POA notified… Mental Status [checked] oriented to person, [checked] oriented to place and [checked] oriented to time.	F0600		07/31/2026

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F0600 SS = D	Continued from page 18 6/9/26 at 10:21 PM – A progress note by E34 (LPN) documented, "... MENTAL STATUS Alert and Oriented X 3: Yes. Makes Self Understood – (Ability to express ideas and wants, consider both verbal and non-verbal expression): Understood. Ability to understand others – (Understanding verbal content, however able – with hearing aid or device if used): Understands. Neurological Obeys commands: Yes...". 6/10/26 – A progress note by P3 (Medical Doctor) documented that R40's "Mental Status: AAOx3" (awake, alert, oriented times 3). Surveyor review of R40's clinical record revealed no documented bruise on the resident's right dorsal hand prior to the 6/7/26 10:50 PM incident. The bruise was not recorded until 6/9/26 after the allegation was reported to and documented by E2 (DON). 6/11/26 11:18 AM – During an interview, R40 stated that she had told this story several times. Surveyor and a State Agency investigator acknowledged and explained who and why we were asking her questions. R40 stated that on the weekends, the staff are different. R40 stated that she requested Tylenol around 10 PM and the nurse came in around 10:50 PM. R40 stated that she always looks at her medications and will ask the nurse if there was an extra one or different one. R40 said that she knew what Tylenol pills look like. R40 stated that one looked smaller than the other. She said that she held the medication cup in her right hand. R40 stated that the nurse twisted her hand to get the medication. R40 stated that she was "shocked and scared" when the nurse did that. R40 stated that she called out to the hallway for help. During the interview, surveyor observed a purple bruise on the right dorsal hand about the size of a half-dollar coin in an oval shape. 6/11/26 12:16 PM – During an interview, E20 (agency LPN) confirmed that she worked on 6/7/26 3 PM to 11 PM shift and was the assigned nurse to R40. E20 stated that she was picking up 1 to 2 shifts for about 3-4 months now at the facility through the staffing agency's APP (computer application). E20 stated that the CNA (E36) told her that R40 asked for Tylenol. E20 stated that she was wrapping up her shift and proceeded to the medication cart. E20 stated that R40 was stating that this was not Tylenol as they were two different sizes. E20 stated that R40 was never irate as she was usually sweet. E20 stated	F0600		07/31/2026

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F0600 SS = D	Continued from page 19 that she stepped out at the doorway and saw E19 (agency LPN) on the split medication cart. E20 stated that E19 looked in and R40 was "going off." E20 stated that she told R40 that under my license, she could not leave the medication with her. E20 stated that R40 said that she wasn't taking it. E20 stated that she was on the right side of the bed and lifted R40's hand and R40 started swinging. E20 stated that she was able to grab the tip of the medication cup. E20 stated that E36 offered to assist with E20 observing the Tylenol administration. After E36 assisted, E20 stated that E36 told her to document because you do not want to mess with R40. E20 stated that she went back into R40's room to talk to her after E43's comments. E20 stated she documented a nurse's note on 6/7/26. E20 stated that R40 was compliant with her 8 PM medication administration earlier in the shift. When asked if she was still on the schedule, E20 confirmed that the facility cancelled all of her scheduled shifts on the APP after this incident. 6/11/26 12:55 PM – During an interview, E32 (LPN) stated that she worked 11 PM to 7 AM starting 6/7/26 into 6/8/26. When asked if E20 reported the 6/7/26 10:50 PM incident to her during shift change report, E32 stated "no", she was not informed. E32 stated that she learned about it on 6/9/26 when she reported to work at 11 PM and was told by the supervisor. 6/11/26 1:06 PM – During an interview, E36 (CNA) stated that R40 was re-assigned to her on 6/7/26 evening shift. E36 stated that R40 rang the call bell and asked for Tylenol and she told E20. E36 stated she was in the hallway and saw two nurses come out of R40's room with the pills. E36 stated that she heard R40 yelling her name. E36 stated that R40 said they snatched them out of her hand as R40 would not give the medication to the nurse. E36 stated that R40 told her that they had to take the medication from her. E36 stated that she assisted E20 in giving R40 the Tylenol. E36 stated that she told both E19 and E20 that "[R40] don't play. Make sure you both document." E36 stated that she did not know about the bruise as R40's skin was fragile. When E36 was asked about the supervisor, E36 responded that she believed she was on a medication cart. 6/12/26 2:58 PM – During an interview, E19 (agency LPN) stated that E20 called her into R40's room because R40 would not take her Tylenol. E19 stated that R40 was upset and agitated and did not believe	F0600		07/31/2026

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F0600 SS = D	Continued from page 20 that she was administered Tylenol. E19 stated that she confirmed it was Tylenol. E19 also stated that the R40 was swinging her right arm and saying "Get out." E19 stated that she did not see any bruises on R40's right hand at the time or if R40 bumped her hand. E19 stated that she never saw R40 before as she was usually in a different hallway. E19 stated that R40 was covering the medication cup in her right hand and E20 was able to grab the tip of the medication cup from R40's hand. E19 stated after the incident with R40 that she went back to her assigned residents. E19 confirmed that she did not tell the supervisor. When asked if the facility obtained a statement from her, E19 stated no one has called her about this incident. E19 stated that she had not returned to work at the facility since this incident. 6/15/26 4:15 PM - Findings were reviewed with E1 (ED), E2 (DON) and E3 (ADON) during the exit conference.	F0600		07/31/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective	F0609	Corrective Action: Upon receiving allegation from resident on 06/09, employee was suspended, report to state and investigation immediately followed. All residents were interviewed and evaluated for signs of abuse, with no allegations or findings. Staff received education on when to report and whom to report to when receiving an allegation. System Changes: Root cause analysis was the facility failed to identify and report the allegation of abuse that occurred between a staff to resident within two hours. The facility reviewed and reinforced its Abuse Prevention, Reporting, Investigation, and Protection policies with all staff. Agency staff will receive facility abuse policy /education and resident rights prior to start of shift. The Staff Development Nurse/Education Nurse will provide education regarding recognizing, preventing, reporting, and responding to allegations or suspicions of abuse, including the responsibility to immediately protect residents and notify facility leadership. Licensed nurses, certified nursing assistants, agency personnel, and supervisory staff will be re-educated regarding the facility's Abuse Prevention and Reporting Policy, emphasizing that any allegation, suspicion, observation, or resident statement involving potential abuse, neglect, exploitation, or mistreatment must be reported	07/31/2026

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F0609 SS = D	Continued from page 21 action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R40) out of one resident reviewed for abuse, the facility failed to identify and report the allegation of abuse that occurred between a staff to resident on 6/7/26 at 10:50 PM. Findings include: The facility's policy and procedure entitled Abuse, Neglect, Exploitation or Misappropriation – Reporting and Investigating, last revised September 2022, revealed, "… Reporting Allegations to the Administrator and Authorities… The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility… 3. 'Immediately' is defined as: a. within two hours of an allegation involving abuse…". Cross refer F600 Review of R40's record and facility documentation revealed: 6/7/26 10:56 PM – A nursing note by E20 (agency LPN) documented, "Resident called out for Tylenol and this nurse went in to administer it as requested... Resident proceeded to place allegations against this nurse and other nurse while also accepting the medication...". Despite staff directly involved and aware of the 6/7/26 incident with R40, the facility staff failed to notify the supervisor at the time and report the 6/7/26 incident as required. 6/9/26 12:15 PM - Approximately 37 hours later, the facility reported the 6/7/26 staff-to-resident incident to the State Agency only after R40 notified them. 6/12/26 10:32 AM – During an interview, finding was reviewed with E2 (DON). 6/15/26 4:15 PM - Finding was reviewed with E1 (ED), E2 and E3 (ADON) during the exit conference.	F0609	Continued from page 21 immediately to the nursing supervisor regardless of the staff member's personal assessment of the allegation. Facility leadership will monitor compliance with reporting abuse timely through routine observations and ongoing review of incident reports. Success Evaluation: Executive Director or Director of Nursing will audit abuse allegations and timely reporting weekly until 100% compliance is achieved for four consecutive audits, then monthly until 100% compliance is achieved for two months. The results of the audits will; be provided to the QAPI monthly for the next three months to determine if any continued monitoring is indicated to maintain compliance.	07/31/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is	F0628	Corrective Action: Additional bed hold notices were provided to the resident representative of R11 from the dates of residents hospitalization. Resident hospitalizations moving forward from annual survey will receive bed hold notices with required regulatory information, appeal rights and bed payment policy on required per diem rates.	07/31/2026

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F0628 SS = D	Continued from page 22 documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F0628	Continued from page 22 Systemic Changes: Root cause analysis is the facility failed to provide written notifications containing the required information to resident's Responsible Party (RP) when transferred and hospitalized on 3/9/26, 4/3/26, 5/3/26 and 5/8/26. The failure had the potential to affect the resident and or/ her RP concerning resident's appeal rights. In addition, the facility failed to provide bed hold notices upon resident's hospital transfers with information on the facility's reserved bed payment policy on the required per diem rates. Bed Hold policy and form reviewed for compliance. Staff Development coordinator/Nurse Educator will re-educate the Licensed Nursing staff and IDT on providing the bed hold notice to resident and/or resident representative will the appropriate appeal information and the per diem rate following hospitalization. Succes Evaluation: The Director of Nursing or designee will complete a random audit of three resident transfers to the hospital each week until 100% compliance for four weeks, then three resident transfers monthly until 100% compliance for two months, to verify that: Bed holds are being provided to resident/resident representative Proper documentation indicating this is in the chart.	07/31/2026

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F0628 SS = D	Continued from page 23 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental	F0628		07/31/2026

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F0628 SS = D	Continued from page 24 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or	F0628		07/31/2026

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F0628 SS = D	Continued from page 25 therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, it was determined that for one (R11) out of two residents reviewed for hospitalization, the facility failed to provide written notifications containing the required information to R11's Responsible Party (RP) when R11 was transferred and hospitalized on 3/9/26, 4/3/26, 5/3/26 and 5/8/26. The failure had the potential to affect R11 and or/ her RP concerning R11's appeal rights. In addition, the facility failed to provide bed hold notices upon R11's hospital transfers with information on the facility's reserved bed payment policy on the required per diem rates. Findings include: Review of R11's clinical record revealed: 1. 12/19/25 - R11's initially admitted to the facility. Contents of the Written Notice a. 3/9/26 10:59 AM - A nurse progress note documented that R11 had an angiogram appointment on 3/9/26. 3/9/26 4:13 PM - A nurse progress note documented that R11 was still at the hospital for angiogram appointment.	F0628		07/31/2026

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F0628 SS = D	Continued from page 26 3/18/26 6:59 PM - A nurse progress note documented that R11 was re-admitted to the facility. 6/11/26 3:00 PM - Further review of R11's transfer record revealed: no documentation that written notification containing the required information including the location to which R11 was transferred; a statement of R11's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; information on how to obtain an appeal form and assistance in completing the form; submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State Long - Term Care Ombudsman. 6/12/26 9:00 AM - Finding was discussed with E2 (DON). b. 4/3/26 1:02 PM - A nurse progress note documented that R11 was transferred to the hospital for evaluation and treatment of right groin hematoma. 4/10/26 10:59 PM - A nurse progress note documented that R11 was re-admitted to the facility. 6/11/26 3:05 PM - Further review of R11's transfer record revealed: no documentation that written notification containing the required information including the location to which R11 was transferred; a statement of R11's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; information on how to obtain an appeal form and assistance in completing the form; submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State Long - Term Care Ombudsman. 6/12/26 9:05 AM - Finding was discussed with E2	F0628		07/31/2026

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F0628 SS = D	Continued from page 27 (DON). c. 5/3/26 1:5 PM - A nurse progress note documented that R11 was transferred to the hospital for shortness of breath. 5/6/26 8:57 PM - A nurse progress note documented that R11 was re - admitted to the facility. 6/11/26 3:10 PM - Further review of R11's transfer record revealed: no documentation that written notification containing the required information including the location to which R11 was transferred; a statement of R11's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; information on how to obtain an appeal form and assistance in completing the form; submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State Long - Term Care Ombudsman. 6/12/26 9:10 AM - Finding was discussed with E2 (DON). d. 5/8/26 8:13 AM - A nurse progress note documented that R11 was transferred to the hospital for a change in condition and "seizure like" activity. 5/20/26 11:06 PM - A nurse progress note documented that R11 was re-admitted to the facility. 6/11/26 3:15 PM - Further review of R11's transfer record revealed: no documentation that written notification containing the required information including the location to which R11 was transferred; a statement of R11's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; information on how to obtain an appeal form and assistance in completing the form; submitting the appeal hearing request;	F0628		07/31/2026

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F0628 SS = D	Continued from page 28 the name, address (mailing and email) and telephone number of the Office of the State Long - Term Care Ombudsman. 6/12/26 9:15 AM - Finding was discussed with E2 (DON). 2. Bed - hold Notice Upon Transfer An undated facility bed hold policy statement indicated, "Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed - hold policies... Policy Interpretation and Implementation ... 3. The written information regarding bed - holds provided to the residents/representatives explains in detail: ... the facility per diem rate required to hold a bed (for non - Medicaid residents), or to hold a bed beyond the state bed - hold period (for Medicaid residents) ... " 6/15/26 - A review of R11's transfer record on her 3/9/26 hospitalization revealed no documentation of the per diem rates as indicated in the facility's reserve bed payment policy. 6/15/26 10:30 AM - Finding was discussed with E2 (DON). 6/15/26 4:15 PM - Findings were reviewed with E1 (ED), E2 and E3 (ADON) during the Exit Conference.	F0628		07/31/2026
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.	F0644	Corrective action: R74 was submitted for a PASSAR resident review. Social Services Director reviewed current residents with Level II PASRR determinations and residents who experienced a significant change in condition within the previous 90 days to verify that required PASRR referrals were completed timely. No additional residents were impacted. Systemic Changes: Root cause analysis was facility failed to ensure a resident was submitted for a PASSAR review after a change in condition. Social Services will monitor change in condition or new mental health diagnosis to ensure a new PASSAR evaluation is completed to verify is new PASSAR is required. The Staff Development nurse or designee will re-educate Social Services, and the interdisciplinary team regarding PASRR requirements, including identifying a significant change in condition that requires a PASRR Level II Resident	07/31/2026

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F0644 SS = D	Continued from page 29 This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R74) out of five residents reviewed for Unnecessary Medications review, the facility failed to ensure R47 was submitted for a PASSAR resident review after a change in condition. Findings include: Review of R47's clinical record revealed: 11/15/2023 – R47 was admitted to the facility with diagnoses including bipolar disorder with psychotic features and Alzheimer's Disease. 2/29/24 – R7's PASSAR Level II screening documented diagnoses of bipolar with severe manic psychotic features, anxiety disorder and dementia. R47 had no manic episodes and was able to be redirected as needed. R47's medications included Trazodone and Zoloft for depression and melatonin for insomnia. 11/21/25 – R47's annual MDS assessment documented depression and bipolar disorder among her active psychiatric/mood disorder diagnoses. 12/2/25 – An order placed in R47's clinical record documented, "send [sic] [R47] to hosp [hospital] for eval [evaluation] due to change in MS [mental status]." 12/12/25 – A hospital "Discharge Summary" documented, "…restraints were required during her second inpatient day due to uncontrolled aggression…there was a concern [R47] was becoming a danger to herself. [R47] required two doses of 2.5 IM [intramuscular] olanzapine [antipsychotic medication]…[R47] was medically stable to transfer to the inpatient psychiatric unit…continue with olanzapine 5 mg once in morning and olanzapine 10 mg once at night…". 12/12/25 – R47 was readmitted to the facility with new diagnoses of psychotic disorder with hallucinations due to known physiological condition and major depressive disorder. 12/18/25 – Orders were entered in R47's clinical record for olanzapine 5 mg to be administered in the morning and olanzapine 10 mg to be administered at bedtime. 12/29/25 12:00 AM – An "Encounter Note" entered in R47's clinical record documented, "…[R47] continues to be with delusions and psychosis as	F0644	Continued from page 29 Review and the process for timely referral and documentation. The facility implemented a standardized review process to ensure PASRR requirements are evaluated during significant change assessments, care plan meetings, and interdisciplinary team reviews. Success Evaluation The Social Services Director or designee will audit all residents identified with a significant change in condition and applicable PASRR referrals weekly until 100% compliance consecutively for four weeks, then monthly until 100% compliance for two months to verify changes in mental health diagnoses and compliance with PASRR requirements. Audit results will be reviewed during the Quality Assurance and Performance Improvement (QAPI) Committee meetings, and corrective actions will be implemented as needed to ensure ongoing compliance.	07/31/2026

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F0644 SS = D	Continued from page 30 well as mania...". 12/30/25 10:20 PM – A Behavior Note entered in R47's clinical record documented, "[R47] was very combative, cursing, [sic] foul language at staff. Redirection not effective, it just fuels combativeness...[R47] also swung her hands to hit and punch...". 1/1/26 9:55 PM – A "Behavior Note" entered in R47's clinical record documented that R47 was using vulgar language toward the staff and could not be redirected. 2/26/26 – R47's quarterly MDS assessment documented depression, bipolar disorder and psychotic disorder among her active psychiatric/mood disorder diagnoses. 5/27/26 5:55 PM – An IDT (interdisciplinary team) note was entered in R47's clinical record documented, "...Staff observed [R47] crawling on the floor on at least one occasion... When questioned [R47] unable to provide reason for crawling...". 6/12/26 12:30 PM – During an interview, E7 (SS) stated, "I submitted a PASSAR request to [PASSAR State Authority] yesterday. They said a resident does not need a new PASSAR if the diagnosis never changed." 6/15/26 8:50 AM – During an interview, S1 (State PASSAR Authority) confirmed that R47 should have been submitted for resident review when treated in hospital inpatient psychiatric unit and had a change in diagnosis. 6/15/26 1:15 PM – Findings reviewed with E1 (NHA) and E2 (DON). 6/15/26 4:15 PM - Findings were reviewed with E1, E2 and E3 (ADON) during the Exit Conference.	F0644		07/31/2026
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of	F0645	Corrective action: R8 received a rescreening. The Social Services Director or designee completed an audit of current residents with PASRR Level II determinations or residents requiring follow-up PASRR evaluations to verify that all required reviews were completed within the required timeframes. Any overdue or missing PASRR referrals identified during the audit were submitted immediately.	07/31/2026

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F0645 SS = D	Continued from page 31 this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility	F0645	Continued from page 31 Systemic Changes: Root cause analysis is the facility failed to ensure a required follow-up PASARR was completed within the required timeframe. Staff Development Nurse will re-educate the Social Services Director, MDS Coordinator, Admissions Director, and licensed nursing staff regarding PASRR requirements, including the identification of residents requiring follow-up PASRR reviews, required timelines, documentation, and referral procedures. If facility admits any residents with a PASARR with a rescreening requirement, facility will complete rescreening prior to the end of the given time period. Social Services and Admissions received education on monitoring the PASARR screening process. Success Evaluation: Social Services Director or designee will complete a PASSAR audit weekly to ensure reviews are completed within required time until 100% compliance is achieved for four consecutive audits, then monthly until 100% compliance is achieved for two months. The results of the audits will; be provided to the QAPI monthly for the next three months to determine if any continued monitoring is indicated to maintain compliance.	07/31/2026

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F0645 SS = D	Continued from page 32 services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Number of residents sampled: Number of residents cited: Based on record review, interviews, and review of facility documentation, it was determined that for one (R8) out of one resident reviewed for PASSAR (Preadmission Screening and Resident Review), the facility failed to ensure a required follow-up PASARR was completed for R8 within the required timeframe. Findings include: Review of R8's record revealed: 11/10/25 – A PASARR Level I screening was completed. The results noted that R8 met the criteria for Convalescent Care and was approved to stay in the facility up to 60 calendar days. Re-screening was required "by or before the 60th day" if R6 was expected to remain in the facility "beyond the authorized timeframe." 11/10/25 – R8 was admitted to the facility with diagnoses including respiratory failure, hypertension, bipolar disorder, depression, and ambulatory dysfunction. 6/9/26 10:00 AM – A review of R6's EHR (Electronic Health Record) revealed the PASSAR was completed on 11/10/25; however, the record lacked evidence of additional follow-up PASSAR assessments. 6/10/26 10:35 AM -During an interview, E6 (SW, Social Worker) confirmed that a follow-up PASARR was not in R8's EHR. E6 reviewed her emails and stated that she did not "have any emails from [State PASARR	F0645		07/31/2026

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F0645 SS = D	Continued from page 33 Contractor] with [R8's follow-up assessment]." E6 further stated that "[State PASARR Contractor] usually contacts us when one [an assessment] is due. I can go ahead and submit a request now to get it done." 6/10/26 3:34 PM – An email from S1 (RN Supervisor, State PASARR Authority) confirmed that the 60- day Convalescent Care period approved in the initial PASRR ended 1/9/26. R8 was required to have a follow-up evaluation completed before the end of the convalescent period. The facility was responsible for submitting the referral for the follow-up evaluation before 1/9/26. S1 indicated that "[State PASRR Contractor] received the request for the follow-up evaluation on 2/2/26. The evaluation was completed on 2/4/26. 6/15/26 2:00 PM – Findings reviewed and confirmed during an interview with E1 (ED) 6/15/26 4:15 PM - Findings were reviewed with E1, E2 (DON) and E3 (ADON) during the Exit Conference.	F0645		07/31/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical	F0656	Corrective Action: R31's careplan has been updated to reflect refusal of medications. IDT received education on care planning for behaviors when behaviors are observed, reported, or documented. The Director of Nursing or designee conducted an audit of residents who routinely refuse medications to verify that individualized care plans addressing medication refusals were developed, implemented, and reflected current interventions. Any identified deficiencies were corrected immediately. Systemic Changes: Root cause analysis is the facility failed to develop and implement a comprehensive care plan to address refusal of medications. Staff Development nurse will educate licensed nursing staff, the MDS Coordinator, and the interdisciplinary team regarding the requirement to develop and maintain comprehensive, individualized care plans that address medication refusals. The facility implemented a process requiring interdisciplinary review and care plan updates whenever recurring medication refusals are identified. When residents refuse medications, or similar behaviors, facility will implement a care plan reflecting this immediately.	07/31/2026

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F0656 SS = D	Continued from page 34 record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R31) of five residents reviewed for unnecessary medications, the facility failed to develop and implement a comprehensive care plan to address R31's refusal of medications. Findings include: Review of R31's record revealed: A review of an undated, unsigned facility policy titled "Medication and Treatment Refusal" included "Policy: Resident's refusal of medication and/or treatment must be recorded in resident's medical record. Procedure: 1. Should a resident refuse his or her medication and/or treatment, documentation must be recorded regarding the refusal; education provided to resident, any discussions of risks vs,[versus] benefit attempts to reapproach etc. 2. Documentation pertaining to a resident's refusal will include as a minimum: ,,,c. The resident's response and reason(s) for refusal…f. The date and time the physician was notified as well as the physician's response. I If resident continually refuses medication and/or treatment, i.e. two (2) or more consecutive times for three (3) days, the Director of Nurses, the resident's representative and the attending physician are notified….**NOTE: Cardiac, psychotropics, oral glycemic, and/or insulin refusal must be reported to physician each time refused..." 3/19/25 – R31 was admitted to the facility with	F0656	Continued from page 34 Success Evaluation: The Director of Nursing or designee will review the 24-hour report on a M-F basis for progress notes indicating refusal of medications or similar behaviors. When such notes are discovered, the DON or designee will check to ensure that the care plan is updated and correctly reflects this behavior. This will continue regularly as part of the DONs daily responsibilities. The Director of Nursing or designee will audit residents with documented medication refusals weekly until 100% compliance is met for four weeks and then monthly until 100% compliant for two months. The results of the audits will; be provided to the QAPI monthly for the next three months to determine if any continued monitoring is indicated to maintain compliance.	07/31/2026

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F0656 SS = D	Continued from page 35 diagnoses including major depression, right above the knee amputation, peripheral vascular disease, chronic heart failure, atrial fibrillation, chronic kidney disease. 3/20/25 – R31 was care planned for receiving "anticoagulation therapy for atrial fibrillation." Interventions did not include addressing instances of refusal of medication. Additionally, R31 was care planned for "...altered cardiovascular status r/t [related to]...HTN [hypertension], CHF [congestive heart failure], A-fib [atrial fibrillation], on diuretic and anticoagulant." Interventions included "...Administer medications as ordered by physician." Additional interventions included monitoring for symptoms for complications related to medications. Interventions did not include addressing instances of refusal of medication. Both care plans were reviewed by the facility 9/2/25. 8/31/25 – An order for Apixaban (an anticoagulant/blood thinner) 5 mg twice a day was entered into R31's medication profile. 10/20/25 – A potassium lab value of 2.7 (normal 3.5 -5.5) was reported for R31. P1(NP) ordered for R31 to receive a one-time dose of 40 mEq [milliequivalents]of Potassium by mouth on 10/20/25 and 20 mEq of Potassium by mouth daily starting 10/21/25. 11/3/25 - R31'2 MAR [Medication Administration Record] documented that R31 refused the daily dose of Potassium. R31's EHR [Electronic Health Record] lacked evidence that the provider was notified or that R31 received education regarding the risks/benefits of refusing the medication. 11/5/25 - R31'2 MAR documented that R31 refused the daily dose of Potassium. R31's EHR lacked evidence that the provider was notified or that R31 received education regarding the risks/benefits of refusing the medication. 11/6/25 - R31'2 MAR documented that R31 refused the daily dose of Potassium. R31's EHR lacked evidence that R31 received education regarding the risks/benefits of refusing the medication. 11/7/25 - R31'2 MAR documented that R31 refused the daily dose of Potassium. R31's EHR lacked evidence that the provider was notified or that R31 received education regarding the risks/benefits of refusing the medication. 11/10/25 - A potassium lab value of 2.8 (normal 3.5	F0656		07/31/2026

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F0656 SS = D	Continued from page 36 -5.5) was reported for R31. A progress note by P1 documented R31 "has a history of hypokalemia [low potassium] though he has been refusing potassium supplement…seen today and discussed with [R31] about lab results. [R31] is agreeable to take potassium as liquid…" 2/17/26 – R31's MAR documented that R31 refused the 9:00 AM and 8:00 PM doses of Apixaban. Review of R31's EHR lacked evidence that the provider was notified of R31's refusal or that R31 received education regarding the risks and benefits of refusing Apixaban. 2/19/26 – R31's MAR documented that R31 refused the 9:00 AM dose of Apixaban. Review of R31's EHR lacked evidence that the provider was notified of R31's refusal or that R31 received education regarding the risks and benefits of refusing Apixaban. 6/15/26 2:00 PM – Findings reviewed and confirmed during an interview with E1(ED) 6/15/26 4:15 PM - Findings were reviewed with E1, E2 (DON) and E3 (ADON) during the Exit Conference	F0656		07/31/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R73) out of three residents reviewed for falls, the facility failed to meet professional standards of the Delaware Board of Nursing Scope of Practice by failing to have a registered nurse (RN) complete and document a RN post-fall assessment. Findings include: "Delaware State Board of Nursing – RN, LPN... Duties 2024… RN… Post Fall Assessment & Documentation… RN must do initial fall assessment; LPN can do subsequent assessments... updated 10/11/24." Review of R73's record revealed:	F0658	Corrective Action: Unable to correct R73. Reviewed fall incidents within the past 90 days and no additional residents were affected. Systemic Changes: Root cause analysis the facility failed to meet professional standards of the Delaware Board of Nursing Scope of Practice by failing to have a registered nurse (RN) complete and document a RN post-fall assessment. Staff Development nurse will re-educate the licensed nursing staff on the professional standards of practice with additional emphasis on the fact that RNs must complete and document an initial and post fall assessment. RNs are only to complete the initial and post fall assessments and document in the chart. Upon notification of fall, the RN will be immediately notified to complete to initial post fall assessment and document in the chart. Success Evaluation: The Director of Nursing or designee will complete a random audit of three resident falls each week until 100% compliance for four weeks, then monthly until 100% compliance for two months, to verify that:	07/31/2026

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F0658 SS = D	Continued from page 37 10/16/25 – R45 had a physician's order for Eliquis (blood thinner) tablet twice a day for a diagnosis of aFib (irregular heart rhythm). 12/16/25 2:45 PM – The facility's incident report by E29 (LPN) documented that R45 was "found on his knees with left arm inside the drawer of the bedside table. Head resting on bedside table… Sent to ER [emergency room]." 12/16/25 2:45 PM – The facility's baseline and subsequent neurological check evaluations were documented by E29. 12/16/25 4:44 PM – A nursing note by E29 documented, "S/p [Status post] fall with no injuries. Pulse ox [vital sign that measures oxygen saturation/normal levels 92% to 100%] at 70% on continuous oxygen. Oxygen increased and pulse ox at 88%. Orders given to send resident to hospital for further eval [evaluation]…". Review of R45's clinical record lacked evidence that an RN performed the post-fall assessment and documentation on 12/16/25. 6/12/26 10:20 AM – During an interview, E29 recalled R45's 12/16/25 fall after reviewing the documentation. Despite remembering the details of the resident's fall, E29 stated that she could not tell the surveyor if an RN assessed R45 after the unwitnessed fall. E29 confirmed that she performed the baseline and subsequent neurocheck assessments. 6/12/26 10:32 AM – During an interview, finding was reviewed with E2 (DON). 6/15/26 4:15 PM - Findings were reviewed with E1 (ED), E2 and E3 (ADON) during the exit conference.	F0658	Continued from page 37 An RN completed the initial and post fall eval with documentation in the chart	07/31/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F0677	Corrective Action: Facility reviewed all resident charts to ensure bathing/shower schedules were ordered and tasked properly. Facility ensure R71 received two baths/showers a week with proper documentation.	07/31/2026

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F0677 SS = D	Continued from page 38 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R71) out of four residents reviewed for ADLs, the facility failed to ensure that R71, a dependent resident, was showered/bathed at least two times a week. Findings include: Review of R71's record revealed: 10/16/25 – R71 was admitted to the facility. 1/22/26 – R71 had a physician's order for a shower day every Wednesday and Saturday day shift and to notify the POA of refusal then enter a progress note. 4/24/26 11:54 AM – R71's physician order for a shower on Wednesday and Saturday day shift was discontinued because the resident was discharged to the hospital. 4/24/26 3:35 PM – R71 was readmitted to the facility. Review of the record revealed that R71's physician order for a shower or bathing on Wednesday and Saturday was never re-entered upon re-admission to the facility. The facility failed to ensure that R71 was showered/bathed at least two times a week upon readmission to the facility. 6/15/26 12:45 PM – During an interview, finding was reviewed and discussed with E2 (DON). 6/15/26 4:15 PM - Findings were reviewed with E1 (ED), E2 and E3 (ADON) during the exit conference.	F0677	Continued from page 38 Systemic Changes: Root cause analysis is the facility failed to ensure that a resident, a dependent resident, was showered/bathed at least two times a week. Staff Development Nurse will re-educate nurses on entering bath/shower orders and tasks. CNAs will be re-educated on documenting the completion of the task in POC. Nursing staff will enter bath schedule order upon resident admission or re-admission and to ensure the schedule coordinates with CNA tasks. Nursing staff must sign off the bath was completed. Success Evaluation: The Director of Nursing or designee will complete a random audit of three new or readmissions each week until 100 % compliance for four weeks, then three resident every month until 100 % compliance for two months, to verify that: Bath/shower schedule is in orders Bath/shower schedule is in tasks Bath/shower is being properly documented in POC by the CNAs	07/31/2026
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to	F0679	Corrective Action: R24 is receiving 1:1 activities as care plan instructs. Staff Development Nurse or designee will re-educate Activity staff on the providing 1:1 activities as scheduled to dependent residents and ensuring documentation is completed.	07/31/2026

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F0679 SS = D	Continued from page 39 support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R24) out of one resident reviewed for activities, the facility failed to ensure R24 was provided with an ongoing activity program based on identified interests. Findings include Review of R24's record revealed: 2/27/25 – R24 was admitted to the facility with diagnoses including peripheral vascular disease, failure to thrive, hypertension, adjustment disorder 3/18/25 – R24 was care planned for being "dependent on staff for meeting emotional, intellectual, physical, spiritual and social needs." Goals included "[R24] will attend programs of choice at least 2-3x per week." Care plan was created by E25 (Director of Life Enrichment) 6/25/25 – R24's care plan was revised by E25 to include "…[R24] will accept 1:1 visits at least 3 times per week…" 6/09/26 11:27 – During an interview, R24 reported being unable to attend group activities due to limited mobility and severe back pain with movement. R24 stated "Once in a while they come in, it would be nice if they could come visit more often." 6/12/25 – A review of R24's EHR revealed two 1:1 activity visits documented for January 2026; one 1:1 activity visit documented for February 2026; no 1:1 activity visits documented between 3/1/26 and 3/11/26; four 1:1 activity visits documented between 3/12/26 and 3/13/26; no 1:1 activity visits documented between 3/14/26 and 3/27/26; one 1:1 activity visit documented 3/28/26 and 3/31/26. Between 4/1/26 and 4/30/26, no 1:1 visit was documented; one 1:1 activity visit was documented between 5/1/26 and 5/31/26; no activity visits were documented between 6/1/26 and 6/11/26. 6/12/26 approximately 11:00 AM – During an interview, E25 confirmed that R24 does not attend group activities; 1:1 activities and visits are provided by activities staff in R24's room. Activities	F0679	Continued from page 39 Systemic Changes: Root cause analysis is the facility failed to ensure a resident was provided with an ongoing activity program based on identified interests. All dependent residents were reviewed for 1:1 activity programming. A schedule with required documentation will be completed at least weekly to ensure 1:1 activity is received. Care plan and documentation were audited to ensure compliance in providing activities. Success Evaluation: Activity Director or designee will complete a random audit of three 1:1 activity residents each week until 100% compliance for four weeks, then three 1:1 activity residents monthly until 100% compliance for two months, to verify that 1:1 activities are being provided and documented appropriately.	07/31/2026

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F0679 SS = D	Continued from page 40 log in R24's EHR reviewed with E25. E25 stated that activity visits provided by CNAs (certified nursing assistants) were documented on a paper log. Review of paper activity visit logs revealed 1:1 activity visit documented on 5/4/26 and 5/12/26. R24 was noted as "sleeping" on 5/5/26 and 5/20/26. 6/15/26 2:00 PM – Findings reviewed and confirmed during an interview with E1 (ED) 6/15/26 4:15 PM - Findings were reviewed with E1, E2 (DON) and E3 (ADON) during the Exit Conference.	F0679		07/31/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R68) out of two residents reviewed for hospitalization, the facility failed to ensure R68's physician order for trending weights was followed. Findings include: The facility's policy and procedure for weights, dated 9/2020, revealed, "Residents will be weighed to establish baseline weights and identify trends of weight loss or weight gain… 5. Consistent weighing process and technique is used to determine accurate body weight measurement. This includes weighing the resident at approximately the same time of day and using the same scale." Review of R68's record revealed: 3/13/26 – R68 was admitted to the facility with a diagnosis of congestive heart failure. 3/16/26 – R68's care plan created by E4 (RD) for nutrition/hydration listed an intervention that included to monitor weights.	F0684	Corrective Action: Resident received weights as ordered and has been discharge since. Systemic Changes: Root cause analysis is the facility failed to ensure a resident's physician order for trending weights was followed. All residents with weight orders were audited and evaluated for weights being completed as ordered. Staff Development nurse will re-educate Nurses and CNAs on following physician orders with emphasis on obtaining weights as ordered and reporting to the physician as ordered. Residents with ordered weights will be completed per physician's order and reported to the Dietician and physician if there are weight changes for evaluation. Licensed Nurses will document weights per order. Success Evaluation: The Director of Nursing or designee will complete a random audit of three residents with weight orders each week until 100% compliance for four weeks, then three residents with weight orders monthly until 100% compliance for two months, to verify that: Weights are being completed as ordered Communication to physician is occurring and documented if order instructs this.	07/31/2026

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F0684 SS = D	Continued from page 41 3/23/26 - A cardiology consult note by P4 (Medical Provider) stated, "... I will ask nursing to trend weights...". 3/23/26 – A physician's order by P4 stated to weigh R68 every Monday and Thursday. Review of the dates and times of R68's documented weights according to the physician's order revealed: -Thursday, 3/26/26 at 11:04 AM; -Monday, 3/30/26, no weight obtained; -Thursday, 4/2/26 at 1:15 PM; -Monday, 4/6/26 at 11:55 AM; -Thursday, 4/9/26 at 1:43 PM; -Monday, 4/13/26 at 10:07 AM; -Thursday, 4/16/26, no weight obtained; -Monday, 4/20/26, no weight obtained; and -Thursday, 4/23/26, no weight obtained. 6/15/26 11:43 AM – During an interview, finding was reviewed and confirmed with E4. The facility failed to follow a physician's order to trend R68's weights. 6/15/26 4:15 PM - Findings were reviewed with E1 (ED), E2 (DON) and E3 (ADON) during the exit conference.	F0684		07/31/2026
F0685 SS = D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and	F0685	Corrective Action: Resident was informed she will be getting her new Hearing aids in July, facility still awaiting delivery at this time. Social Services director and Director of nursing have been in communication with the provider Systemic Changes:	07/31/2026

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F0685 SS = D	Continued from page 42 §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is NOT MET as evidenced by: Number of residents sampled: Number of residents cited: Based on record review and interview, it was determined that for one (R64) out of one resident reviewed for hearing the facility failed to assist in obtaining hearing aids as recommended by a licensed audiologist. Findings include: Review of R64's revealed: 9/8/23 – R64 was admitted to the facility with diagnoses including anxiety, depression, diabetes, degenerative joint disease. 4/21/25 – R64 was care planned for "My hearing ability needs are: I have a hearing loss and I wear 1 hearing aid in Right ear." Interventions included: "…Check that my hearing aid(s) is in place daily, when I am attempting to interact with others and/or interact with others and /or interface with my environment …" Care plan was created by E24 (MDS Coordinator, LPN). 9/2/25 1:00 AM – A progress note by P1 who documented "Hearing impairment Assessment: Patient reports hearing difficulties." 1/9/26 11:45 AM – A progress note by P2 who documented "…Very focused on hearing issues and needing to see hearing doctor to have ears cleaned and upgrade of hearing aid. Difficult to move on from this issue and the more she discussed it the more anxious she became". 1/20/26 – R64's care plan was revised by E24 to include "Nursing to reach out to ENT or hearing center as directed to have screened for new hearing aids." 1/22/26 00:00 AM – A progress note by P1 who documented "… asked to evaluate [R64] as [R64] was very upset that [R64] is not able to hear well and [R64] thinks it is because of the earwax	F0685	Continued from page 42 Root cause analysis is the facility failed to assist in obtaining hearing aids as recommended by a licensed audiologist. Facility will continue to support residents within the facility's control for hearing aid appointments, ordering, delivery, and replacement. The Social Services director will complete tracking process to monitor audiology referrals and recommendation, and completion of recommended hearing devices. Care plans will be updated to reflect hearing needs and interventions as appropriate. Success Evaluation: The Social Service Director will monitor residents that are hard of hearing or utilizing hearing aids for changes in status that require new or different equipment. The Social Services Director or designee will complete a random audit of three residents with hard of hearing/hearing aids each week until 100% compliance for four weeks, then three resident with hard of hearing/hearing aids monthly until 100% compliance for two months, to verify that they have hearing aids, they do not require hearing aids, and that if they require replacement the facility will coordinate in a timely manner.	07/31/2026

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F0685 SS = D	Continued from page 43 buildup…[R64] is tearful during the exam as she is not able to hear well and looking forward to have an appointment to see an ENT (Ear, Nose and Throat provider)." P1's note further documented that on exam, both of R64's ears were clogged with earwax; P1 prescribed drops to help remove the wax. In addition, P1 wrote "…if not improving, may consult ENT…" 1/22/26 11:46 PM - A progress note by E31 (medical records clerk) who documented that E31 reached out to [hearing aid company] about R64's hearing aids. E31 was informed by [hearing aid company] representative that they were "going to an administrator to look into why [R64's] hearing aids hasn't [sic] been replaced yet." E31 documented that if [hearing aid company] did not follow up "by the beginning of next month, [E31] will call [hearing aid company] again to follow up." 1/23/26 12:43 PM – A progress note by E31 who documented that E31received a call from [hearing aid company] and "…there is no record of any hearing aids for [R64], however, [E31] did put in a request to have the resident evaluated by [hearing aid company] doctor to start the process of hearing aids for the resident." 1/30/26 12:12 PM – A progress note by P2 who documented "…[R64] also hyper focused on hearing aids and staff are attempting to connect with hearing aid company. Now on drops for wax and fixated on this…" 2/3/26 00:00 AM – A progress note by P3 (DO, Doctor of Osteopathy) who documented "…[R64] reports decreased vision as well as decreased hearing. 2/6/26 3:41 PM – a progress note by P2 who documented "…[R64] also hyper focused on hearing aids and staff are attempting to connect with hearing aid company…" 3/6/26 12:04 PM – A progress note by P2 who documented "…[R6] also hyper focused on hearing aids and again discussed seeing hearing doctor who flushed [R64's] ears. Reminded [R64] that staff are attempting to connect with hearing aid company." 3/13/26 11:55 AM – A progress note by P2 who documented "…[R64] also hyper focused on hearing aids and again discussed seeing hearing doctor who flushed [R64's] ears. Reminded [R64] that staff are attempting to connect with hearing aid	F0685		07/31/2026

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F0685 SS = D	Continued from page 44 company…" 3/27/26 1:00 AM – A progress note by P3 (DO) who documented "…[R64] is hard of hearing at baseline." 3/27/25 4:41 PM – A progress note by P4 documented that R64 was "hyper focused on hearing aids and not being able to 'see or hear.'" P4 reminded R64 that staff "are attempting to connect with hearing aid company." 4/3/26 2:02 PM – A progress note by E31 who documented "Attempted to contact [hearing aid company] for a consult. The office is closed. A voice message was left. [E31] will do a follow up call on Monday…" 4/3/26 2:29 PM – A progress note by P2 who documented that "…[R64] also hyper focused on hearing aids and not being able to 'hear or see…'" 4/7/26 12:31 PM - A progress note by E16 (Medical Records) who documented that P4 (CEO of [hearing aid company]) "advised [R64] was seen on 2/24/26 and also on 2/26/25." P4 reported that [R64's] ears were cleaned and the "possibility of getting hearing aids was discussed". P4 requested confirmation that R64 had a POA (Power of Attorney) or that R64 could make own decisions. P4 provided company's email address for further communication. 4/10/26 3:11 PM – A progress note by P2 who documented "…[R64] also hyper focused on hearing aids and not being able to 'hear or see'" 4/17/26 2:24 PM – A progress note by P2 who documented that R64 continued to be "hyper focused on hearing aids and not being able to 'hear or see.'" 4/29/26 10:41 AM – A nursing progress documented that R64 was seen by ENT and had ear wax removed from both ears. 5/8/26 3:39 PM – A progress note by P2 who documented "…[R6] discussing have ears cleaned but still perseverates on hearing deficits." 5/15/26 11:31 AM A progress note by P2 who documented "…[R64] also perseverates on hearing deficits…also hyper focused on hearing aids and not being able to 'hear or see.'" 5/22/26 2:55 PM – A progress note by	F0685		07/31/2026

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F0685 SS = D	Continued from page 45 P2 who documented that R64 continued to be focused on "hearing deficits." 6/8/26 12:10 PM – During an interview, R64 stated, "I've been wearing hearing aids for years." Prior to being admitted to the facility, the cost for R64's hearing aids was covered under R64's medical insurance. R64 was seen by two hearing aid companies in 2025; R64 stated that one company "turned me away because of my insurance" but the other company "made the molds and gave me the hearing aids." R64 was unable to recall the names of the companies. R64 reported that three months after receiving the hearing aids, "[FM1] got a call from the company saying they were coming to take them back because my insurance didn't cover them." R64 was unsure when this occurred but stated it was "several months ago." R64 has a hearing aid for the right ear which R64 described as being "really old and broken." R64 became very teary eyed and began crying, stating, "I can't enjoy TV which is something I love. I don't have $6000 to pay for them…I'm so depressed, I just want to be able to hear...I've been waiting, and I keep asking, but no one will tell me what's going on." 6/8/26 2:30 PM – An interview with E6 revealed that R64 was eligible to receive new hearing aids. E6 confirmed that R64 had received new hearing aids which were "taken back by the company" three months after R64 received them. E6 was unsure of the time frame but reported it occurred "within the past year." Per E6, R64's new insurance plan was effective 2/1/26 and covered hearing aids. E6 stated that the paperwork [hearing aid company] had at the time their provider evaluated R64 "probably had [R64's] old insurance, which did not cover hearing aids." E6 stated she was going to call [hearing aid company]. 6/8/26 3:30 PM – A review of E64's EHR revealed an ENT consult dated 4/29/26 that included an order for an Audiology consult. The EHR also contained an audiology consult however, it was not clear enough to be read. Additionally, the record lacked evidence of documentation regarding R64 receiving hearing aids in 2025 which then had to be returned. 6/9/26 10:30 AM – During an interview, E1 (ED) confirmed that R64 had received new hearing aids within the last year, and approximately three months after receiving them, the hearing aid company required R64 return them since they were not covered by R64's insurance. E1 was unsure of the date this occurred, but reported it was within the past year. E1provdided the following documents:	F0685		07/31/2026

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F0685 SS = D	Continued from page 46 ENT consults dated 2/19/25 and 4/29/26; emails from the facility to [hearing aid company] dated 4/7/26 and 6/8/26. Review of the email dated 4/7/26 revealed the facility notified [hearing aid company] that R64 was "capable of making [R64's] decisions, however [R64] does have [FM5] who is POA (power of attorney)." Review of email dated 6/8/26 revealed the facility requested "updates regarding [R64's] hearing aids". 6/09/26 3:15 PM – During an interview, E6 stated that [hearing aid company] confirmed that R64 was "seen in February, and at that time, the paperwork still showed [R64's] private insurance." E6 provided R64's new insurance information and was told [hearing aid company] would "notify their business office." It should be noted that ENT consult was dated 2/19/25. 6/10/26 approximately 1:30 PM –During a joint interview, E24 (MDS Coordinator, LPN) confirmed [hearing aid company] was sending facility the required documents to process request for hearing aids through R64's insurance. E6 explained that the facility's Business Office would submit the documents to [State Agency] for approval. During the interview, E6, E24 and E26 (MDS Coordinator, RN) confirmed that R64 was currently using an older, broken hearing aid in her right ear. E24 reported that R64 was able to hear "as long as there wasn't any other noise around." 6/10/26 5:22 PM – A progress note by E6 documented that R64 was told "[R64] will be getting new hearing aids in about a little over a month. [R64] was extremely happy with the news." 6/11/26 3:50 PM – A review of R64's EHR lacked evidence of documentation that the facility worked with R64 to identify and implement alternative methods to support hearing and participation in preferred activities, including the ability to hear and enjoy television programs. 6/12/26 12:23 – A progress note by P2 documented "…Discussed issues with hearing aids and social service has worked out insurance info and [R64] to get new hearing aides within a month or so. This made her very happy…" 6/15/26 9:14 AM– During a phone interview, P4 stated that [hearing aid company] initially saw R64 on 2/19/25. An audiology consult was recommended at that time. [Hearing aid company] was told that R64 was "going to another provider." [Hearing aid company] followed up with R64 on	F0685		07/31/2026

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F0685 SS = D	Continued from page 47 10/25/25; at that time, R64 was being seen "by an outside provider." On 4/29/26, R64 was seen by [hearing aid company] ENT who cleaned out [R64's] ears and recommended [R64] be seen by audiologist for hearing aids. R64 was seen by [hearing aid company] audiologist on 5/19/26 and fitted for nearing aids. P4 reported hearing aids are available; once approval received from [State Agency], audiologist will see R64 to fit and adjust hearing aids. The facility failed to assist R64 in replacing her hearing aides in a reasonable amount of times and lacked efforts to provided alternative hearing assistance in the absence of hearing aids. 6/15/26 2:00 PM – Findings reviewed and confirmed during an interview with E1 (ED) 6/15/26 4:15 PM - Findings were reviewed with E1, E2 (DON) and E3 (ADON) during the Exit Conference.	F0685		07/31/2026
F0726 SS = D	Competent Nursing Staff CFR(s): §483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides.	F0726	Corrective Action: Resident medical record was reviewed to ensure the attending provider was notified of the resident's reported ankle pain. The resident was assessed, and appropriate medical evaluation and treatment were obtained. Staff Development nurse will re-educate Licensed nurses on assessment and reporting requirements if there are changes in resident condition. Systemic Changes: Root cause analysis is the facility failed to timely notify the provider when resident's ankle pain was reported to staff. Staff Development Nurse will re-educate the Nurses and CNAs assessment and reporting requirements if there are changes in resident condition. Nursing staff will report a change in resident's condition to nursing supervisor or physician upon notification of change. DON/ADON will also receive report from the nurses M-F during standup and discuss resident changes in condition to ensure required follow-up was completed. Success Evaluation: The Director of Nursing or designee will complete audit of three residents with new complaints of pain	07/31/2026

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F0726 SS = D	Continued from page 48 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R38) out of two residents reviewed for accidents, the facility failed to timely notify the provider when R38's ankle pain was reported to staff. Findings include: Review of R38's clinical record revealed: 3/25/24 – R38 was admitted to the facility with diagnoses including age-related osteoporosis and left lower leg amputation. 4/5/24 – R38's care plan documented dependence on two staff persons with mechanical lift for sit to stand transfers. 10/2/25 – A quarterly assessment documented R38 had a BIMS of 10, indicating moderately impaired cognition. The assessment also documented that R38 had right and left lower extremity impairments and was dependent for assistance to stand and to transfer from bed to chair. 10/24/25 – A Physical therapy Treatment Encounter Note signed by E30 (PT) documented, "…Transfer: bed to chair via sit pivot in small increments and max A [assist] of 2. R [right ankle] appeared to have slightly more eversion [pointing outward]…No swelling or redness noted. Nurse made aware and came to [R38]'s room." 10/24/25 – An Occupational Encounter Note documented, "[R38] required max A [assistance] x2 for squat pivot transfer from bed to wheelchair and reported no pain with transfer. [R38] reported 5/10 pain in R [right] ankle upon attempted PROM [passive range of motion]…mobility stopped immediately d/t reported pain. [R38] further reported small cut on middle R [right] toe. Nursing notified of both cut and pain immediately…". 10/24/25 1:27 PM – An Administration Note entered by E29 (LPN) documented that Tylenol was given to R38 for a complaint of right ankle pain. 10/25/26 8:27 AM – An Administration Note documented entered by E31(LPN) documented,	F0726	Continued from page 48 each week until 100% compliance for four weeks, then three residents every month until 100% for two months to verify the following: Did resident have a change in condition (i.e. new reports of pain, change in functional status) Was the provider promptly notified, and was it documented.	07/31/2026

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F0726 SS = D	Continued from page 49 "...[R38] c/o [complained of] right ankle pain. Supervisor and MD notified..." The provider was notified of R38's change in condition 8 hours after it was reported to staff. 10/25/25 12:46 PM – A General Note entered documented, "[R38] reported pain on right ankle. [P1, NP] made aware. New order received for STAT right ankle x-ray two view x-ray…". 10/25/25 10:53 PM – A facility incident report documented, "[R38] reported pain on right ankle. [R38] stated pain increases with movement, right ankle noted with swelling. [P1, NP] made aware. New order received for STAT right ankle x-ray…At 2151 [9:51 PM] x-ray results received…acute fracture in distal shaft of the right fibula…[R38] left facility at 2252 [10:52 PM] for ER…". 10/26/25 1:05 AM – A hospital radiology report documented that [R38] had an acute distal fibular fracture. 10/29/25 – A facility document entitled, "Investigation Report Interview", documented, "Name of Person Interviewed: [E29]…Alerted by therapy that [R38]'s ankle appeared to be turned outward. PRN [as needed] Tylenol given. Cause unknown. [R38] stated she doesn't remember hitting her leg on anything. This was during 10/24/25 day shift". 6/10/26 – During an interview R38 stated, "I did not have PT on that Thursday. That Friday when PT came, my leg looked funny. I don't know how it happened.". 6/11/26 10:53 AM – During a joint interview with E30 (PT) and E33 (OT), E33 stated, "[R38] always had right ankle eversion, but it was more everted than baseline. We did a squat pivot from the chair to the wheelchair. When I started the PROM, [R38] complained of pain. I stopped and we immediately let [E29] know." The surveyor asked what time this occurred. E30 stated, "[R38]'s session was between 1:00 PM and 3:00 PM. We continued to work on upper body strength exercises. I did not notice any redness or swelling. E30 stated, "[R38] has been transferred by stand pivot on the right leg previously with no issues." 6/11/26 2:16 PM – During an interview, E29 stated that she was informed by PT and OT that R38 had ankle pain and gave her Tylenol. The surveyor asked E29, "Did you assess R38's ankle pain or notify the	F0726		07/31/2026

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F0726 SS = D	Continued from page 50 provider?" E29 stated, "No, I didn't." 6/15/26 1:15 PM – Findings reviewed with E1 (NHA) and E2 (DON). 6/15/26 4:15 PM - Findings were reviewed with E1, E2 and E3 (ADON) during the Exit Conference.	F0726		07/31/2026
F0732 SS = D	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F0732	Corrective Action: Staffing posting was corrected immediately on 6/11/2026 and included the missing information, total hours worked for CNAs , LPNs, and RNs. Systemic Changes: Root Cause analysis is the facility failed to post the required federal staffing information. Staffing coordinator has updated scheduling reported to include total hours worked per shift for each discipline which includes RN, LPN, and CNAs. Staffing coordinator received education to post these items on her daily posting, including weekends and holidays. The weekend and holiday schedules will be prepared prior to the weekend or holiday for the nurse supervisor to post with the required total hours for CNAs, LPN, and RNs. The DON or ADON will oversee staffing posts has the appropriate information included. Success Evaluation: The ED or Director of Nursing will randomly audit the staffing postings weekly until 100% compliance for four weeks and then monthly until 100% compliance for two months to ensure the postings have all information required by the regulation.	07/31/2026

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F0732 SS = D	Continued from page 51 (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of facility documentation and staff interviews, it was determined that the facility failed to post the required federal staffing information. Findings include: 6/11/26 12:00 PM - An observation in the healthcare's nursing station revealed that the staffing posting did not contain the total worked hours per shift for each discipline, Registered Nurse (RN), Licensed Practical Nurse (LPN) and Certified Nursing Assistants (CNA). 6/11/26 12:16 PM - In an interview, E23 (Scheduler) stated that ever since she joined the company under the previous ownership, the staffing postings did not contain the hours worked by the nurses and the nursing aides (CNAs). 6/15/26 2:00 PM - Finding was discussed with E1 (ED) and E2 (DON). 6/15/26 4:15 PM - Finding was reviewed with E1, E2 and E3 (ADON) during the Exit Conference.	F0732		07/31/2026
F0745 SS = D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R45) out of one resident reviewed for dental care, the facility failed to ensure that the resident received medically related social services for a dental care need. Findings include:	F0745	Corrective Action: Resident's dental services were reviewed by the interdisciplinary team. The resident received the necessary dental extractions and remains under the care of the dental provider for completion of the recommended upper partial denture. Social Services reviewed the resident's record to ensure all communications regarding coordination of dental services and financial resources are documented. Systemic Changes: Root cause analysis is the facility failed to ensure	07/31/2026

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F0745 SS = D	Continued from page 52 Review of R45's record revealed: 9/19/25 – A dental consult documented, "… Continue doing… fillings. May need to send income protection for those and future extraction of #8 and removable upper partial denture." 12/21/25 – A dental consult documented, "Pt does want an upper partial denture but would need to have #8 extracted prior to fabrication of the denture. Facility has not given us approval to make upper partial denture according to income protection which was sent." 2/7/26 – A dental consult documented, "… will place fillings in some of the cavity areas due to poor oral hygiene. If hygiene does not improve then cavities will fail… We have sent income protection for her upper partial denture. Will need to extract #8 & [and] 9 in the future." 5/19/26 – A dental consult documented, "… extracted teeth #8+9… return to take impression for upper partial denture." 6/11/26 8:45 AM – During an interview, E6 (ASW/DSS) stated that social work will find resources, i.e. money to obtain services. E6 stated that she spoke with R45's resident representative but did not document a note about it. E6 stated that R45's resident representative requested for the resident to be seen by the dentist and thought this occurred about March or April 2026. Review of R45's record lacked evidence of medically related social services for a dental care need from September 2025 until May 2026. 6/12/26 2:11 PM – During an interview, R45 was asked if she had any difficulty chewing or mouth pain and she replied "not now." Surveyor asked if she had tooth pain before and R45 said, "yes." 6/15/26 4:15 PM - Findings were reviewed with E1 (ED), E2 (DON) and E3 (ADON) during the exit conference.	F0745	Continued from page 52 that the resident received medically related social services for a dental care need. The Director of Social Services (or designee) completed an audit of all residents with active dental treatment recommendations, pending dental procedures, or outstanding dental referrals to verify appropriate follow-up, coordination of services, and documentation of Social Services involvement when indicated. Any identified concerns were addressed promptly. Social Services Director will complete tracking process to monitor dental referrals and recommendation, and completion of recommended dental services. Success Evaluation: The Director of Social Services, or designee, will audit three residents each week with active dental or other medically related specialty service needs until 100 % compliance for four weeks, then five residents monthly until 100% compliance for two months to verify: Appropriate follow-up has occurred; Social Services involvement is documented when indicated; Resident and/or representative communication is documented; Outstanding needs are tracked through completion.	07/31/2026

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F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F0842	Corrective Action: Bed hold form was update immediately on 6/15/2026 to ensures the names are pre-filled. Systemic Changes: The root cause analysis is the facility failed to ensure that resident's notice of bed hold records were complete and accurate. The Staff Development Nurse will educate the Admissions Coordinator, Social Services Director, and Nursing staff on the facility's Bed Hold Policy to ensure it's prefilled with the resident name on the form. The bed hold forms has been updated to ensure the names are included. The Director of Nursing or ADON will monitor to ensure compliance. Success Evaluation: The Social Services Director (or designee) will audit 100% of hospital transfers weekly until 100% compliance for four weeks, then monthly until 100% compliance for two months, to verify complete and accurate bed hold documentation. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will be addressed promptly, and additional education or corrective action will be implemented	07/31/2026

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F0842 SS = D	Continued from page 54 §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R11) out of two residents reviewed for hospitalization, the facility failed to ensure that R11's notice of bed hold records were complete and accurate. Findings include: Review of R11's clinical record revealed: 4/3/26 - R11 was hospitalized. 4/6/26 - The facility's notice of bed hold sent to FM1 (POA) via electronic mail revealed a blank form and a lack of R11's pre - filled name in the form to identify R11. 5/3/26 - R11 was hospitalized. 5/4/26 - The facility's notice of bed hold sent to FM1 via electronic mail revealed a blank form and a lack of R11's pre - filled name in the form to identify R11. 5/8/26 - R11 was hospitalized. 5/12/26 - The facility's notice of bed hold sent to FM1 via electronic mail revealed a blank form and a lack of R11's pre - filled name in the form to identify R11. 5/15/26 2:00 PM - Findings	F0842		07/31/2026

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F0842 SS = D	Continued from page 55 were discussed with E1 (ED) and E2 (DON). 6/15/26 4:15 PM - Findings were reviewed with E1, E2 and E3 (ADON) during the Exit Conference.	F0842		07/31/2026
F0943 SS = D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility documentation, it was determined that for two (E21 and E22) out of four agency staff sampled, the facility failed to provide abuse, neglect, exploitation, and dementia training. Findings include: The facility was provided a list of four agency staff names selected randomly and instructed to provide documentation of in - service training for abuse, neglect, exploitation, and dementia training for new and existing agency staff. 6/12/26 9:49 AM - During an interview and record review with E7 (HRD) it was confirmed: E21's (CNA) first day of work in the facility was 6/9/26. E21's record review lacked evidence of abuse and dementia training. E22's (CNA) first day of work in the facility was 3/20/26. E22's record review lacked evidence of abuse and dementia training. 6/15/26 2:00 PM - Findings were discussed with E1 (ED) and E2 (DON). 6/15/26 4:15 PM - Findings were reviewed with E1, E2 and E3 (ADON) during the	F0943	Corrective Action Regional scheduling coordinator communicated on 6/15/2026 to the staffing agency of the facility's orientation and training requirements for all agency personnel prior to providing resident care. Systemic Changes Root cause analysis is the facility failed to provide abuse, neglect, exploitation, and dementia training to agency staff. The facility revised its onboarding process for agency staff to include a standardized orientation and training checklist. Human Resources will verify and document completion required orientation and mandatory training, including abuse, neglect, exploitation, misappropriation of resident property, and dementia training, before any agency staff member is scheduled to work independently. The facility will communicate these requirements to contracted staffing agencies to ensure compliance prior to staff placement. Success Evaluation: The Human Resources Director or designee will audit 100% of newly assigned agency staff personnel files prior to their first shift for 90 days to verify completion and documentation of all required training. A monthly audit of all active agency personnel files will be conducted until 100% compliance for three months. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months. The QAPI Committee will review results, identify trends, and implement additional corrective actions as indicated.	07/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WILMINGTON	2723 SHIPLEY ROAD , WILMINGTON, Delaware, 19810

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F0943 SS = D	Continued from page 56 Exit Conference.	F0943		07/31/2026
F0880 SS = C	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F0880	Corrective Action The Infection Preventionist (IP), in collaboration with the facility Medical Director, Director of Nursing, and Administrator, reviewed all infection prevention and control policies and procedures, including but not limited to hand hygiene, standard precautions, transmission-based precautions, enhanced barrier precautions, droplet precautions, airborne precautions, antibiotic stewardship, and infection surveillance. Infection prevention and control policies and procedures were reviewed updated as appropriate to reflect current evidence-based practice and regulatory requirements. Systemic Changes Root cause analysis is the facility failed to have evidence of annually reviewed and updated infection prevention and control policies and procedures. The facility implemented an annual policy review schedule to ensure infection prevention and control policies and procedures are reviewed at least annually and revised as necessary. The Executive Director or Director of Nursing will maintain a tracking log to document the review date, approval date, and responsible reviewer for each infection prevention and control policy. Success Evaluation The Infection Preventionist or designee will conduct a quarterly audit of the infection prevention and control policy review log to ensure policies remain current and that annual reviews are completed as scheduled. The Infection Control nurse (or designee) will audit the infection control policies and procedures monthly until 100% compliance for three months, then quarterly until 100 % compliance for three quarters. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will be addressed promptly, and additional education or corrective action will be implemented.	07/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

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F0880 SS = C	Continued from page 57 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that the facility failed to have evidence of annually reviewed and updated infection prevention and control policies and procedures. Findings include: 6/11/26 2:00 PM – During an interview, the surveyor requested that E34 (IP) provide all facility infection prevention and control policies and procedures. 6/11/26 3:00 PM – E34 provided the surveyor with the facility infection prevention and control policies and procedures. The facility policies for hand hygiene, standard precautions, transmission-based precautions, enhanced barrier precautions, droplet precautions and airborne precautions were dated 10/2024. Facility antibiotic stewardship policies were dated 12/2016 and infection surveillance policy was dated 9/2017. 6/15/26 11:54 AM – During an interview E34 confirmed that the facility infection prevention and control policies had not been reviewed in the last year. E34 stated, "We use the policies and procedures that are given by corporate."	F0880		07/31/2026

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F0880 SS = C	Continued from page 58 6/15/26 1:15 PM – Findings were reviewed with E1 (NHA) and E2 (DON). 6/15/26 4:15 PM - Findings were reviewed with E1, E2 and E3 (ADON) during the Exit Conference.	F0880		07/31/2026