

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/16/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Delaney Park Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 215 Annie Street Orlando, FL 32806	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to notify the physician of a change in resident condition to ensure prompt diagnosis and treatment for 1 of 1 resident reviewed for patient rights, out of a total sample of 34 residents, (#61). Finding: Resident #61 was admitted to the facility from an acute care hospital on 6/28/25 for short term rehabilitation. She had diagnoses that included encounter for orthopedic aftercare, displaced condyle fracture of lower end of right femur, shortness of breath, and interstitial pulmonary disease. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed resident #61 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which was cognitively intact. Resident #61's medical record revealed that on 7/06/25 a daily skilled note was entered by the nurse documenting the resident's complaint of pain and warmth to the right leg, which was her surgical leg. The nurse noted that the resident's legs were swollen, especially the right leg and it was red and warm to the touch. The nurse also completed an assessment of the surgical dressing which was dry and intact, and she administered medication for pain. There was no documentation indicating that the MD was notified. Review of previous assessments revealed that on 6/28/25 an admission baseline care plan noted no edema observed to lower extremities. A Daily skilled note on 7/03/25 noted the resident complained of pain, lower extremities were warm, generalized edema was present, and resident was experiencing a cough while lying flat. The nurse administered pain medication and made MD aware of the findings. Review of progress notes for resident #61, revealed on 7/08/25 the nurse became aware of the resident's transfer to the hospital due to positive findings of deep vein thrombosis (DVT) to the right leg. A nursing note on 7/10/25 stated the resident returned to the facility from the hospital with a new diagnosis of DVT and her anticoagulant medication dose was increased. A DVT is a blood clot in one of the deep veins of the body, often the legs. It can be a life-threatening situation if the clot breaks free and travel to the lungs causing a blockage in the artery of the lung. If you have symptoms of a DVT you should contact your physician, (retrieved on 8/03/25 from www.mayoclinic.org). On 7/14/25 at 12:29 PM, resident #61 stated she complained to the nurse on 7/06/25 about the swelling, pain, and warmth to her right lower extremity, but the nurse did nothing. She said nothing was done for the symptoms until she saw the cardiologist at an appointment on 7/08/25 and was sent to the hospital. Review of facility policy titled Notification of Resident/Patient Change in Condition, effective October 2021, revealed nurses would notify the resident/resident representative if there was a crucial/significant change in the resident condition. If the change in resident condition was not crucial or significant, the resident's physician, resident representative or legal representative would be notified at the earliest convenient time. Part of the procedure was for the nurse to document the time notification was made and the names of the person to whom they spoke. On 7/17/25 at 1:46 PM, the Director of Nursing stated that a change in condition should be documented when there was a change in the resident's status. Her expectation was for staff to follow the policy and notify the physician when the resident complained of new symptoms.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 105791	Facility ID: 105791 If continuation sheet Page 1 of 17

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, and interview, the facility failed to maintain a homelike environment in 30 resident rooms on one of two floors, (100 wing) by failing to maintain ceiling vent covers with a clean and sanitary surface. Findings: Observations of resident rooms on the first floor on 7/14/25 at 2:10 PM, revealed ceiling vent covers with a variance in color over the entire surface area from black to white. The surface also had rust-colored substance around the edges. (photographic evidence obtained) In an interview with the resident representative for resident # 85, she stated she has asked staff to address the unsanitary appearance of the vents because they did not look clean and appeared as if they have a mold-like substance or accumulation of debris on the surface. On 7/15/25 at 10:30 AM, the Maintenance Director stated all the vent covers were the same on the first floor and showed signs of wear and tear from years of use. He stated the vents had been painted black, but the white color and rust color was still visible. Later that same day at 11:07 AM, the Maintenance Director was observed just outside the door at the end of the hallway as he scraped the rust-colored substance from the surface and edges of a vent. On 7/18/25 at 12:40 AM, the Maintenance Director stated he thought a family member may have recently complained about the condition of the vent covers. He acknowledged the black color could be interpreted by some as mold, but he said it was not mold. He stated the vents were old, so scraping off the rust and repainting them was how the maintenance staff was able to keep them in use versus replacing them. The floor plan indicated the first floor had 30 resident rooms.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of five residents reviewed for unnecessary drugs did not receive an unnecessary antipsychotic medication with subsequent increase in dose and a diagnosis of schizophrenia without clear documentation to support the indication for use and diagnosis in the medical record, of a total sample of 34 residents, (#68). [NAME], [NAME] (68) Findings: Resident #68 was admitted from an acute care facility on 2/21/25 with diagnoses of hypertension, type 2 diabetes mellitus, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The admission Minimum Data Set assessment dated [DATE] indicated the resident had no potential indicators of psychosis and no behavioral symptoms. The same assessment found the resident did not have any psychotic disorders or schizophrenia. The resident was assessed with severe cognitive impairment. The quarterly assessment dated [DATE] also indicated the resident had no indication of psychosis, no behavioral symptoms, and no psychotic disorders or schizophrenia. Behavioral notes dated 3/11/25 documented no psychiatric history, no further need for psychologist, resident now adjusting to facility placement. On 7/09/25 the resident had new orders for an antipsychotic drug, Risperdal 0.25 milligrams (mg) with the reason listed as psychosis with paranoia/auditory hallucinations. A behavioral care plan was initiated on 7/08/25 when the resident was noted to scratch himself. The goal was will not harm self and will honor resident rights. The first intervention was to administer psychotropic medication as ordered. Other interventions were to document episodes of behavior and review to document effectiveness of medication. The care plan did not include any interventions to address the circumstances surrounding the resident scratching self nor any resident-centered interventions specific to that behavior. Risperdal is an antipsychotic medicine that works by changing the effects of chemicals in the brain. Risperdal is used to treat schizophrenia in adults and children who are at least [AGE] years old. Risperdal is also used to treat symptoms of bipolar disorder (manic depression) in adults and children who are at least [AGE] years old. Warnings: Risperdal is not approved for use in older adults with dementia-related psychosis. Risperdal is a High-risk drug with a Black Box Warning - Increased mortality in elderly patients with dementia-related psychosis, (retrieved from www.drugs.com on 7/29/25 at 5:27 PM). A review of the behavior monitoring record from 7/05/25 at 6:59 AM to 7/18.25 at 1:13 AM, indicated no behaviors were observed. On 7/17/25 at 11:00 AM, nurse D, who was familiar with the resident, revealed the resident was generally happy with a good appetite. She said she heard he expressed worries at night about law enforcement coming for him a little over a week ago, but explained he was doing much better this week. After a visit from the Mental Health Nurse Practitioner on 7/17/25, the resident received an order to increase the antipsychotic medication to Risperdal 0.5mg for schizophrenia. The review of systems documented no psychotic symptoms noted or reported. The mental status examination documented hallucinations: auditory but did not note any other specific details about the resident to possible direct non-pharmacologic intervention. On 7/18/25 at 12:00 PM, the Director of Nursing (DON) and Regional Nurse were asked in a joint interview why the antipsychotic medication was increased and why the resident was given a new diagnosis of schizophrenia for that medication when the behavior documentation record indicated that the resident has not had any behaviors. The Regional Nurse provided a written statement from the President of the Behavioral Services group who employed the Mental Health Nurse Practitioner. The statement stressed the importance of having at least 10 years of appropriate documentation for a schizophrenia diagnosis and must include conversations with staff and primary physicians. The statement continued that any increase in medication must be preceded by documentation of noticeable symptoms as the reason for the increase. Neither the DON nor the Regional Nurse provided a verbal explanation to the above question and the information provided by the facility did not answer the question. No further documentation was provided.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to document/investigate residents who discharged Against Medical Advice (AMA) to ensure the residents were not forced to leave the facility and to provide a safe discharge to the extent possible for 1 out 3 residents sampled for discharge, of a total sample of 34 residents, (#96). Findings: Resident #96 admitted to the facility on [DATE] and her diagnoses included clavicle fracture, abnormal gait, morbid obesity and malaise. Review of the resident's medical record revealed resident #96 had a daughter but the resident was responsible for herself. Review of discharge summaries for both Physical Therapy and Occupational Therapy noted the resident discharged home on 6/16/25. The resident Discharge Summary, nor the Physician's Discharge order was not in the medical record. The medical record did not provide evidence resident #96 safely discharged from the facility. On 7/17/25 at 10:53 AM, the Rehabilitation Director said the resident started therapy on 5/28/25 and the physician had ordered six weeks of therapy. The Rehabilitation Director could not explain why resident #96 did not complete her therapy. On 7/18/25 the Social Worker (SW) said she could not find the physician's order for discharge, and she could not provide the reason why the resident left the facility. The next day, on 7/19/25 at 10:48 AM, the SW said resident #96 discharged AMA on 6/16/25. She could not provide an AMA form or evidence the physician was notified of the AMA. The SW added nursing should have provided a medication list and informed the resident to follow up with her provider regardless of whether the discharge was AMA or voluntary. The SW was not able to provide any evidence the resident was provided with a medication list and instructed to contact her physician. The SW stated she was not at the facility when the resident left AMA, nor did she investigate the resident's AMA to ensure the discharge was safe to the extent possible. On 7/18/25 at 11:08 PM, the Business Office Manager (BOM) confirmed resident #96 was admitted to the facility on [DATE], under Medicare and the resident discharged AMA on 6/16/25 at approximately 7:36 PM. The BOM said Medicare may deny payment for residents that discharge AMA, and the resident would be responsible for any charges incurred during their stay at the facility. The BOM stated she was not at the facility when the resident discharged AMA and confirmed that staff should have informed resident #96 about the potential Medicare non-payment for leaving AMA. The BOM could not provide any documented evidence the resident was informed. On 7/18/25 at 3:53 PM, the Unit two Manager (UM) said the reports indicated resident #96 left the facility AMA. The Unit Manager said he did not remember who the nurse was when the resident discharged AMA. The UM indicated at a minimum the resident should have been given her medication list, and the attending physician should have been notified. The UM could not provide any documented evidence that facility staff provided a safe discharge, to the extent possible, for a resident that left the facility AMA.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident at risk for Deep Vein Thrombosis (DVT) formation was appropriately monitored and treated in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 1 resident reviewed for edema care, of a total sample of 34 residents, (#61). Findings: Resident #61 was admitted to the facility from an acute care hospital on 6/28/25, for short term rehabilitation. She had diagnoses that included encounter for orthopedic aftercare, right leg fracture, shortness of breath, and interstitial pulmonary disease. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed resident #61 had a Brief Interview for Mental Status score of 15 out of 15, which meant she was cognitively intact. The assessment indicated she had a history of hip fracture, a lower extremity impairment on one side, utilized a walker or wheelchair for mobility, and was taking anticoagulants. Resident #61's physician orders included monitoring for signs and symptoms (s/s) of bleeding and thromboembolism during each nursing shift. The s/s of thromboembolism were listed to include pain or tenderness, swelling of lower extremity, increased warmth, and unexplained shortness of breath. The order detailed if any of the s/s were present the nurse was to notify the physician. Resident #61 also had an order for an anticoagulant, Eliquis Oral Tablet 2.5 milligram (mg) twice a day for Atrial Fibrillation (A-Fib). Review of resident #61's medical record revealed a care plan was initiated on 7/8/25, for anticoagulant therapy related to A-Fib, and post-surgical care. The goal was to minimize the risk of complications, and the interventions included daily skin inspection, reporting of abnormalities to the nurse, and observation for changes to extremities. On 7/14/25 at 12:29 PM, resident #61 was observed in her room sitting in a wheelchair and was well groomed. Her husband was at the bedside. Her legs were swollen from the knee down and she said she had surgery on her right leg prior to the admission. The resident said her legs started to swell a few days after her admission to the facility and a couple days later she was hospitalized due to a blood clot in her right calf. She recalled that a few days prior to the hospitalization, she told the facility nurse she was feeling pain, and warmth on her right leg. The resident stated the nurse gave her some pain medication but nothing else was done. She continued that a few days later while at a cardiology appointment, she told the Cardiologist about her symptoms, and they performed a doppler study in the office. Resident #61 said she had a blood clot in the right leg, and she was transferred to the hospital right away. She recalled that at the hospital they diagnosed her with DVT. She recalled she was admitted to the hospital for two days and the clot was treated with intravenous anticoagulants. She said her Eliquis dose was increased upon her discharge from the hospital. Review of a nursing note dated 7/06/25, read the resident's bilateral lower extremities were swollen, especially the right one. The nurse noted resident #61's right leg was red and warm to the touch. The note indicated the resident said her leg had been normal a few days prior. The nurse documented she removed the resident's sock and assessed the area including the bandages on the knee and upper thigh, but the dressing was clean and intact. She noted that the resident complained of pain to the leg and so she administered pain medication as ordered. Review of the medical record revealed no other notes showing the nurse reported her findings to a physician or supervisor, or any other follow up. On 7/08/25, a nurse documented she called the Cardiologist's office when resident #61 did not return from her appointment and was told by the receptionist that the resident had been transferred to the hospital due to positive findings of DVT to the right leg. On 7/10/25, the resident returned from the hospital and the anticoagulant medication was increased. The Agency for Healthcare Administration (AHCA) transfer form 3008 dated 7/09/25 for resident #61, revealed she had a primary diagnosis of acute deep vein thrombosis of the right lower extremity. The accompanying history and physical (H&P) dated 7/08/25, noted resident #61 had right lower extremity swelling, pain, and erythema (redness of the skin). A DVT in the leg was the most common cause of pulmonary embolism (blood clot of artery in lung). If the clot became loose from the vein, it could travel through the bloodstream ending up in the lungs and causing a blockage that could be potentially fatal. This could happen immediately after clot formation, or it could happen later. The risk factors for DVT formation include trauma and surgery, (retrieved on 7/19/25 from www.WebMD.com) On 7/17/2025 at 11:57 AM, Registered Nurse (RN) A confirmed they often got post-surgical residents, specifically from orthopedic surgery. She explained that surgical residents needed to be monitored for bleeding, pain, infection to the site, edema, and cellulitis. The nurse conveyed if a resident complained of pain, swelling, and/or heat to the extremities, she should communicate this to the doctor. She stated that		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)		

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Revision of the Quarterly Minimum Data Set (MDS) dated [DATE] for resident #90, revealed she had a Brief Interview for Mental Status score of 10 out of 15, which indicated moderate cognition. She had no rejection of care behaviors noted and no mood changes. The assessment indicated she had upper extremity impairments bilaterally and lower extremity impairment on one side. The assessment described for her activities of daily living (ADLs), she was dependent for toileting, showering, dressing, personal hygiene, transfers, and mobility. On 7/14/25 at 2:30 PM, resident #90 was in her room sitting in a wheelchair with her eyes closed. Her right arm was bent at the elbow and her right hand was in a fist. She was holding her right hand with her left and was leaning off the wheelchair to the right. She opened her eyes briefly but did not respond when asked how she was doing. The Occupational Therapy (OT) Evaluation and Plan of Treatment report for resident #90 dated 4/28/25, revealed she was referred for OT due to a decline in all areas, prevention of further decline, ADL training, and neuromuscular education. The report also noted that resident #90 verbalized pain to the right shoulder, elbow, and wrist, which she described as discomforting and chronic. Review of resident #90's Order Summary Report dated 7/18/25, revealed a physician's order dated 10/25/24 for right elbow splint to be worn in the daytime for four to six hours per day. A further review of the Medication and Treatment Administration Record revealed staff applied the elbow splint daily. On 7/15/25 at 10:30 AM, resident #90 was in the dining room during an activity. She was not wearing the elbow splint. Resident #90 explained the staff did not put the splint on her during morning care. She was unable to recall the last time she wore the splint but said she had asked one of her aides to apply it, but they did not know where it was. Resident #90 was observed again without the elbow splint on 7/16/25, and 7/17/25. On 7/17/25 at 3:50 PM, Certified Nursing Assistant (CNA) E stated she had cared for resident #90 many times and was familiar with her care. She explained she mainly worked the 3-11 PM shift, and the resident would already have the splint on when she arrived for her shift. The CNA confirmed she had not seen the resident wearing the splint today but said she was not surprised because staff would sometimes remove the splint during lunch to give her a break. She confirmed resident #90 had no behaviors, and no rejection of care. Review of resident #90's care plan revealed she had an ADL care plan initiated 6/29/24, revised 5/18/25. The focus was on ADL selfcare performance deficit related to several diagnoses including hemiparesis affecting the right dominant side. Interventions included applying a right-hand splint as tolerated, initiated on 7/18/25 but there was no intervention for applying the right elbow splint. On 7/17/25 at 4:05 PM, the Director of Rehabilitation (DOR) confirmed resident #90 was ordered the right elbow splint in October 2024. She said it was the responsibility of the nurses and CNAs to apply the splint as ordered. On 7/18/25 at 1:00 PM, CNA B confirmed she worked the 7-3 PM shift and was assigned resident #90. She said the resident had not been wearing the elbow splint because it was lost. She said, they looked in the room and found the elbow splint in the top drawer of a tall dresser next to the resident's bed. On 7/18/25 at 1:04 PM, assigned Licensed Practical Nurse (LPN) C reviewed the resident's active orders and saw she the order for a splint for her right elbow starting October of 2024. She said she did not remember seeing the resident with the splint that morning and could not recall the last time she saw her wearing it. LPN C said CNAs were mainly responsible for applying splints, but the nurse would verify that it was done. She stated she had not received any education on how to apply the splint for resident #90 and therapy was responsible for providing training to staff on splints. On 7/18/25 at 1:16 PM, the 100-unit Unit Manager (UM) explained when a resident had an order for a splint, therapy would come down to the floor and provide training to staff on how to apply it, but she was unsure if therapy had come to train staff for resident #90's elbow splint. She said that not knowing how to apply the splint was not a reason for not following physician orders and staff needed to ensure they asked for training. The UM said she could not recall the last time she saw resident #90 with the elbow splint. On 7/18/25 at 1:24 PM the DOR confirmed		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to maintain medical records that were accurately documented in accordance with professional standards of practice for 1 of 1 resident reviewed for splint care and limited range of motion, of a total of 34 residents, (#90). Findings: Resident #90 was admitted to the facility on [DATE] with diagnoses that included stroke, abnormality of gait and mobility, need for assistance with personal care, cognitive communication deficit, vascular dementia, muscle wasting and atrophy, acquired absence of right leg below the knee, and hemiplegia/hemiparesis (one sided paralysis/weakness) affecting the right dominant side. Revision of the Quarterly Minimum Data Set (MDS) dated [DATE] for resident #90, revealed she had a Brief Interview for Mental Status score of 10 out of 15, which indicated moderate cognition. She had no rejection of care behaviors noted and no mood changes. The assessment indicated the resident had upper extremity impairments bilaterally and lower extremity impairment on one side. She was dependent for toileting, showering, dressing, personal hygiene, transfers, and mobility but was able to eat independently. On 7/14/25 at 2:30 PM, resident #90 was in her room, sitting in a wheelchair with her eyes closed. She had her right arm bent at the elbow and her right hand was in a fist. She was holding her right hand with her left and was leaning off the wheelchair to the right. She opened her eyes briefly but did not respond when asked how she was doing. Review of resident #90's Order Summary Report dated 7/18/25, revealed she had an order dated 10/25/24 for a right elbow splint to be worn in the daytime for four to six hours per day. On 7/15/25 at 10:30 AM, resident #90 was in the dining room during an activity. She was not wearing the elbow splint. Resident #90 explained the staff did not put the splint on her during morning care. She was unable to recall the last time she wore the splint, but she said she had asked one of her aids to put it on, but they did not know where it was. Resident #90 was observed without the elbow splint again on 7/16/25, 7/17/25, and 7/18/25. Review of the Medication Administration Record for resident #90, revealed the nurse had documented that the splint had been applied to resident on 7/14/25, 7/15/25, 7/16/25, 7/17/25, and 7/18/25. On 7/18/25 at 1:04 PM, Licensed Practical Nurse (LPN) C reviewed resident #90's orders and confirmed the physician's order for a right elbow splint. She was not sure if the resident was wearing the splint today or when the last time she had seen her with the splint. The conversation was moved to the dining room where resident #90 was involved in an activity and LPN C confirmed the resident was not wearing the splint. LPN C explained it was the CNA's responsibility to ensure the splint was applied and they should inform the nurse if there were any issues or the resident refused. She confirmed she had not received any communication from the CNA about the resident refusing to wear the splint. The Medication Administration Record for July 2025 was reviewed and LPN C confirmed she had documented the resident was wearing the splint both on 7/15/25 and today. She said she did not communicate with the CNA or actually verify if the resident was wearing the splint prior to documenting on it. During the month of July, there were five other occasions when LPN C documented the splint was applied but she was unable to recall if she had actually seen the resident wearing the splint. The nurse confirmed the documentation was inaccurate and said it was important to ensure orders were being followed prior to documenting. On 7/18/25 at 1:16 PM, the 100- Unit Manager confirmed CNAs were responsible for applying splints and the nurses were to ensure the resident was wearing the splint as ordered. It was her expectation to provide accurate documentation on all resident charts. The DON was interviewed a short time later at 2:00 PM and agreed the expectation was for staff to follow orders and ensure documentation was accurate.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observation, interview, and record review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify an area of systemic non-compliance with the Infection Prevention & Control Program identified by the survey team. Findings: Review of the facility's survey history revealed repeat deficiency concerns for infection prevention and control over the past year. The survey history revealed the facility had a deficiency in infection prevention and control during the 6/05/24 annual survey and again during the current annual survey. On 7/18/25 at 3:14 PM, a joint interview was conducted with the facility's Administrator and Director of Nursing (DON) to discuss the facility's QAPI program. The facility could not show documented evidence they had a Process Improvement Plan (PIP) or current audits in effect for infection prevention and control. The Administrator acknowledged the facility completed a plan of correction for infection prevention based on last year's annual survey results but closed out monitoring of it in January of 2025. Review of the facility policy for Quality Assessment, Assurance, and Compliance (QAA&C) effective January 2025 read, The facility will form a QAA&C Committee, designed to review and analyze facility-based evidence data, develop and implement process improvement plans, monitor effectiveness of plans, and ensure resources are allocated to ensure improvements. It is the responsibility of the QAA&C Committee to consider data presented by the members and process improvement team(s) then direct the team(s) to continue, change, or conclude the assignment. The QAA&C will assign improvement tasks to Committee(s), Quality Assurance Performance Improvement (QAPI)/ Process Improvement Plan (PIP) Teams, or individuals.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control policies and procedures were followed to implement the infection prevention and control plan by failing to initiate enhanced barrier precautions for 24 residents on one of two floors (100 unit), failed to ensure transmission-based isolation was the least restrictive for one of two residents reviewed for transmission-based precautions, (#30); failed to document process surveillance, including identification of pertinent process surveillance from the infection control risk assessment, and failed to follow transmission-based precautions to help prevent the spread of infection on one of two wings, (100 wing) for 2 of 2 residents reviewed for transmission-based precautions (#82, and #30), of a total sample of 34 residents. Findings: 1. On 7/14/25 at 1:00 PM, observations on the second floor (200 wing) revealed approximately 12 residents on enhanced barrier precautions. Personal protective equipment (PPE) was readily available in a caddy on the door and a sign for enhanced barrier precautions was located prominently on the outside of the door. On 7/14/25 at 2:30 PM, observations on the first floor of the facility (100 unit) revealed no evidence of implementation of enhanced barrier precautions (EBP). None of the resident rooms had PPE readily available on the door and no enhanced barrier signs or other enhanced barrier precaution indicators were present. Review of the resident matrix provided by the facility indicated 14 residents on the 100 unit with one or more of the following: pressure ulcers, tube feeding, indwelling catheters, or tracheostomies. Review of the Policy and Procedure titled "Barrier Precautions" effective April 2024, included EBP. The Policy listed EBP as an infection control intervention designed to reduce transmission or multi drug-resistant organisms (MDROs) that employed targeted gown and glove use during high-contact resident care activities. EBP were used in conjunction with Standard Precautions and expanded the use of PPE to donning of gown and gloves during high-contact resident care activities that provided opportunities for transfer of Multi Drug Resistant Organisms (MDROs) to staff hands and clothing. EBP was indicated for residents with any of the following: Infection or colonization with a Centers for Disease Control and Prevention (CDC) targeted MDRO when contact precautions did not otherwise apply or, wounds and/or indwelling medical devices even if the resident was not known to be infected or colonized with a MDRO. The procedure listed the following: Staff will be routinely trained in infection control practices to include when to use Standard Precautions, Contact Precautions, Enhanced Barrier Precautions, and Droplet Precautions. A grid was provided (appendix A) for staff reference which outlined the differences between Contact Precautions and Enhanced Barrier Precautions. The Director of Nursing/Designee will track resident infections and ensure staff was notified of resident-specific precautions. Signage was used, as appropriate. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Appendix A revealed a portion of the verbiage from the guidance for EBP from Appendix PP Guidance to Surveyors for Long-Term Care Facilities was missing related to implementation of contact versus EBP regarding language for secretions or excretions that were unable to be contained. The policy and procedure did not contain any other details regarding the implementation and use of EBP as listed in the regulatory guidance or from the nationally recognized and accepted standards (Center for Disease Control and Prevention). On 7/16/25 at 8:30 AM, the 100 wing Unit Manager stated EBP were used for residents who have tracheostomies. She confirmed resident #85 had a tracheostomy and confirmed PPE was not readily available for use with EBP. On 7/14/25 at 3:40 PM, the Director of Nursing (DON) said the Infection Preventionist (IP) position had been vacant for over three weeks. She stated she was acting as the IP in the interim. On 7/16/25 at 4:00 PM, the DON explained the facility was in the process of implementing EBP on the first floor as to why enhanced barrier precautions were not implemented on the 100 wing. She did not have a reply for whether she was aware of the regulatory guidance that became effective more than a year ago on April 1, 2024. The DON stated she was not aware of the missing language in appendix A of the EBP procedure. On 7/17/25 at 11:30 AM, the Administrator and the DON confirmed the lists provided to the survey team for residents on transmission-based precautions and enhanced barrier precautions was inaccurate. The DON provided a new list of residents now on EBP on 7/18/25, and 24 residents were listed on the first floor. The reasons listed were as follows: Foley (urinary catheter), wound, gastrostomy tube (tube to stomach), tracheostomy (breathing tube in throat), other tube. Two residents were listed with onset for the indication for EBP in 2024 and the others ranged from 1/13/25 to 7/18/25. 2. Resident #30 was admitted from an acute care facility on 2/05/25. He had diagnoses of cerebral palsy with a history of head injury, aspiration pneumonia, sepsis, tracheostomy and gastrostomy tube. Progress notes dated 2/05/25 indicated the hospital called to notify the facility the resident was colonized with the MDRO (Candida auris). The progress note indicated the resident was moved to a private room and placed on contact isolation at that time. Colonized refers to the presence of micro-organisms on the surface of or in the tissue of a wound without the signs and symptoms of infection (fever, redness, purulent exudates) or without detectable immune response, cellular damage, or clinical expression, (retrieved on 8/03/25 from the Centers for Medicare and Medicaid Services State Operations Manual Appendix PP Guidance to Surveyors for Long Term Care Facilities). Policy and Procedure for the Infection Prevention and Control Program effective October 2021 and approved by the Administrator, Medical Director, and DON in January 2025 revealed one of the goals was to identify and correct problems relating to infection control and prevention practices. A major activity listed included implementation of infection control and prevention measures. The policy indicated the prevention of the spread of infections was accomplished by use of Standard Precautions, organism specific precautions, and other barriers&hellip; (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Policy and Procedure titled "Barrier Precautions" effective April 2024 revealed EBP was indicated for residents with infection or colonization with a Centers for Disease Control and Prevention (CDC) targeted MDRO when contact precautions did not otherwise apply. The current CDC list of targeted MDROs included Candida auris. On 7/14/25 at 3:30 PM, an observation of resident #30's room showed a receptacle hanging on his door that contained PPE (gowns, gloves, and masks) and a sign that indicated the resident required contact precautions. The door to the room was open (photographic evidence obtained) and the resident was observed inside the room. On 7/14/25 at 3:20 PM, Licensed Practical Nurse (LPN) D was observed inside the resident's room near the bed, and she was not wearing any PPE. LPN D stated the resident has C. auris and staff only needed to wear PPE in the room if they touched the resident or items in the room. She said she did not know about enhanced barrier precautions and did not know who the current infection preventionist was after the previous one left. On 7/15/25 at 11:37 AM, the Unit Manager (UM) confirmed resident #30 was on contact precautions for C. auris. She stated the resident was not receiving treatment for an infection and she did not know how long he had been isolated in his room. The care plan for fungal infection, C. auris was initiated on 2/06/25 and revised on 5/22/25. One of the goals of the plan was the resident's infection will resolve without complications by the next review date. Contact precautions were listed as an intervention. The Minimum Data Set assessment with a review date of 2/12/25 and 5/08/25 indicated the resident was not on isolation. A physician's order for Contact isolation for C. auris was dated 4/09/25. The end date for the isolation was listed as "indefinite." "Using the least restrictive isolation was not included in the care plan. On 7/17/25, the DON was asked for the line listing of infections from February 2025 to July 2025. Resident #30 was not listed as having an active infection. The DON was asked to explain why the resident was on isolation for colonization of an organism and without any indication for a need for contact isolation for the past five months. She confirmed the resident did not have an active infection or any other reason to require contact precautions. The DON stated she would need to ask the Department of Health to ascertain if the resident could have been on enhanced barrier precautions that would allow him to leave his room during that time. 3. On 7/16/24 at 3:30 PM, the DON was asked to provide evidence of process surveillance of infection control practices. The Policy and Procedure for the Infection Prevention and Control Program effective October 2021 and approved by the Administrator, Medical Director, and DON in January 2025 included a section for duties and responsibilities. The policy indicated the objectives of the Infection Control committee included: "Implement isolation precaution protocols when control of an infectious or communicable disease" and "Implement policies and procedures for the surveillance and monitoring of infection control practices." The procedure included: "review isolation precaution techniques and procedures and help ensure that personnel, residents, and visitors follow established procedures/precautions" and maintain "Process surveillance of the workplace to ensure that required work practices are observed and that protective clothing and equipment are provided and properly used." At that time the DON could not provide documentation of any process surveillance. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/25 at 11:30 AM, the Administrator stated he conducted the Infection Control risk assessment in January of 2025. The assessment included several areas for process surveillance events including: staff non-compliance with hand hygiene, staff non-compliance with EBP, staff non-compliance with TBP. The part of the assessment that identified the risk score for those measures was not documented. When the Administrator and DON were asked what data or observations were used to complete the risk assessment, they did not reply. The administrator stated enhanced barrier precautions including surveillance of donning/doffing/hand washing is on the agenda for the monthly infection control meeting but when asked for any routine documentation of EBP or Transmission Based Precautions (TBP) surveillance, none was provided. The DON stated TBP and EBP topics were on the annual education calendar in February and confirmed she did not have documentation of any routine process surveillance. Evidence of any documentation of routine process surveillance was requested again and was not provided at the time of exit. 4. Review of the Resident Matrix provided by the facility on 7/14/25 revealed no residents were on transmission-based precautions. On 7/14/25 at 3:30 PM, resident #30's room had a receptacle hanging on his door that contained PPE and a sign that indicated the resident required contact precautions. The sign provided instructions including but not limited to, everyone must: clean their hands, including before entering and when leaving the room. Providers and Staff must also put on gloves before entry, put on gown before room entry. The door to the room was open (photographic evidence obtained) and the resident was observed inside the room. On 7/14/25 at 3:20 PM, Licensed Practical Nurse (LPN) D confirmed the resident was on contact precautions for C. auris after she was observed inside the resident's room near the bed, not wearing gloves or a gown. She explained staff only needed to wear a gown and gloves in the room if they touched the resident or items in the room. On 7/16/25 at 3:30 PM, the DON acknowledged the interview and observation with LPN D on 7/14/25. The DON stated contact precautions required all who entered to wear gown and gloves and confirmed the door should remain closed. 5. Resident #82 was admitted to the facility from acute care hospital on [DATE] with diagnosis that included encephalopathy (brain disorder), sepsis, enterocolitis due to clostridium difficile (C.diff), need for assistance with personal care, immunodeficiency (deficient immune system), and dementia. Review of the Agency for Healthcare Administration hospital transfer form 3008 dated 7/10/25, revealed resident #82 required a surrogate for decision making and had a primary diagnosis of sepsis and urinary tract infection. He was on contact precautions for C.diff and was being treated with antibiotics. Resident #82 was incontinent of bowel and bladder. According to the Mayo Clinic C.diff was a bacterium that caused an infection of the colon, the longest part of the large intestine. Symptoms could range from diarrhea to life-threatening damage to the colon, (retrieved on 7/18/25 at www.Mayoclinic.org). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/14/25 at 12:59 PM, on the hallway of the 100-unit, resident #82's door was closed and there was Personal Protective Equipment (PPE) hanging from the door. The PPE included gloves, masks, and gowns, however there was no signage at the door that listed the type of isolation precautions resident #82 was on or an alert to speak to the nurse prior to entering. An article on the CDC website explained that C.diff could live on people's skin and people who touch an infected person's skin could pick up the germs on their hands. If those people did not perform hand hygiene, they could spread the germs to other people and things they touched. Furthermore, staff caring for patients in a healthcare setting should use certain precautions like wearing gowns and gloves to prevent the spread of C.diff to themselves and other residents, (retrieved on 7/28/25 at www.cdc.gov). On 7/14/25 at 1:00 PM, The 100-unit UM confirmed resident #82 had been admitted on [DATE] and was on TBP for C. diff. She acknowledged there was no sign on the door that described the isolation precautions, but said she was on her way to put the sign up. She was unable to provide a reason why the sign had not been added to the door upon the resident's admission. The UM did not say how anyone entering resident #82's room would know to take precautions such as wearing a gown, or gloves since there was no sign in place. On 7/18/25 at 1:00 PM, Certified Nursing Assistant (CNA) E said she was aware resident #82 was on TBP but she was not sure for what. She said the sign at the door was important because it let staff know what PPE was required before entering the room to provide care to the resident. According to the Minesota Department of Health, TBP door signage should be part of the infection control guidelines for long term care facilities. Signage was an important communication tool to alert staff and other visitors to take additional precautions when entering a room and the sign should remain in place until terminal disinfection of the room occurred, (retrieved on 7/28/25 at www.health.state.mn.us/). On 7/14/25 at 4:45 PM, a contact precaution sign had still not been placed on resident #82's door prior to the survey team's exit for the day. On 7/17/25 at 3:27 PM, the DON stated that she was the interim IP because the previous one left and they were in the process of hiring. She said she was responsible for ensuring TBP was being followed by staff members and visitors. She explained when a resident was admitted on TBP the Admissions Coordinator would be made aware by the hospital, and she would then share that information with the DON and the IP who at the time of resident #82's admission was the DON. The DON conveyed that the IP/DON would communicate the resident's status to the staff, and the UM and all staff were responsible for ensuring the room was ready for the resident's arrival, including adding the appropriate signage to the door. She recalled that on 7/10/25 she was at the facility when resident #82 was admitted but said she was not feeling well which was why she missed the signage on the door. She stated that the 100-unit UM should have ensured the sign was at the door as soon as she was made aware it was missing. The DON said her expectation was for all staff to work as a team and not wait for the IP or UM to ensure TBP was being followed.		

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview, and record review, facility failed to ensure the facility had an Infection Preventionist responsible for the facility's Infection Prevention and Control Program (IPCP) with qualifications and current specialized training to ensure implementation, monitoring and managing the IPCP. Findings: On 7/14/25 at 3:40 PM, the Director of Nursing (DON) stated the Assistant Director of Nursing (ADON) was responsible for overseeing the IPCP. She said the position had been vacant for 3 weeks and she was designated by the Administrator as the Infection Preventionist required to work at least part-time in addition to working full-time as the DON. Review of the Job Description for the ADON included the summary of position as responsible for assisting with developing, organizing, evaluating, and administering of the patient care programs and services of the center; provides staff development education, training, and completes nursing competencies; oversees the IPCP and the Antibiotic Stewardship Program. Essential duties and responsibilities included must maintain Infection Preventionist Certification. On 7/16/25 at 3:30 PM, the DON was asked for her qualifications as the Infection Preventionist. She indicated she had professional training in nursing and had maintained her license as a Registered Nurse. The DON was asked for her current qualifications as an IP and evidence of certification as required in the facility job description for the IP. She provided a paper that indicated she participated in an educational activity over 4.5 years ago on 11/24/20 titled Nursing Home Infection Preventionist Training Course. She confirmed she had not worked as an Infection Preventionist since completing that educational activity. A certificate of continuing education for 2.5 education units was dated 2/17/23 for Universal Infection Prevention and Control. The DON confirmed she was not certified in Infection Prevention and control from the Certification Board of Infection Control and Epidemiology (CIBCE). She did not provide any other evidence of any other qualifications or specialized training beyond the educational activity prior to assuming the role.		