STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 06/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION SILVERSIDE	3322 SILVERSIDE ROAD WILMINGTON, DE 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
E 000	Initial Comments An unannounced annual, complaint and Emergency Preparedness surveys were conducted at this facility beginning June 13, 2019 through June 25, 2019 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was 108. For the Emergency Preparedness survey, all contracts, operations plan, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from June 13, 2019 through June 25, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 108. The survey sample totaled 40 residents. Abbreviations/Definitions used in this report are as follows: @ - at; & - and; Abscess - accumulation of pus OR a cavity filled with pus that can develop anywhere; ADON - Assistant Director of Nursing; Cellulitis - inflammation of the tissues indicating a local infection; CNA - Certified Nurse's Aide; DON - Director of Nursing;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/18/2019

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.

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F 000	Continued From page 1 Ischium - bony areas on each buttock; IV (Intravenous)- administered into the vein; LPN - Licensed Practical Nurse; MASD (Moisture-Associated Skin Damage)- general term for inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucus; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); Min - minutes; Necrosis / Necrotic - tissue death, usually due to interruption of blood supply or injury OR dead; non-viable tissue; NP-Nurse Practitioner; NHA- Nursing Home Administrator; Osteomyelitis - infection of the bone and bone marrow OR infection and inflammation of the bone; PICC (Peripherally Inserted Central Catheter)- form of intravenous access into a vein in the arm that can be used for a prolonged period of time Pressure Ulcers (PUs) - sore area of skin that develops when the blood supply to it is cut off due to pressure; Purulent - containing pus; thick pus; r/t - related to; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; Sepsis-blood poising; Serous - a thin, clear, light yellow watery fluid found in many body cavities; Subcutaneous - beneath the layers of the skin; SW - Social Worker; Tuberculin disease-respiratory disease; Unstageable pressure ulcer - tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough	F 000		

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F 000	Continued From page 2 (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed); w/c - wheelchair; Wound Vac - negative pressure therapy that applies mechanical forces to the wound to create an environment that promotes wound healing.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that for 1 (R59) out of 40 sampled residents, the facility failed to ensure that R59 received services with reasonable accommodation of his/her needs. Findings include: 6/18/19 at 3:45 PM - An observation revealed that as this surveyor walked past R59's room, the resident began to yell. The surveyor entered R59's room after knocking and asking permission. R59 was pointing to the television. The television was not turned on, nor was it within R59's reach. The surveyor asked R59 if he/she had a call bell. R59 nodded no. The surveyor stepped out to the hallway and asked E4 (LPN) to come into R59's room. R59 immediately showed E4 what he/she wanted by pointing to the television. E4 turned on the television and moved	F 558	1. R59's call bell was put within his reach immediately upon discovery. C.N.A. educated. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected by measures outlined in #3. 3. Staff educator to inservice nursing staff on proper call bell placement to be within residents' reach at all times while in their rooms. 4. DON/Designee to do 10 random observations to determine proper call bell placement. Audits will be conducted daily for 3 consecutive days or until compliance is met for 3 consecutive audits. Then 10 random observations will be conducted 3x weekly or until 3 consecutive audits are 100% compliant. Then audit will be once	9/30/19

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F 558	Continued From page 3 it closer to R59. The surveyor asked E4 to locate R59's call bell. E4 found R59's call bell wrapped around the steel bed frame, which was out of R59's reach. E4 confirmed that R59 can use the call bell and it was out of his/her reach. 6/19/19 at 11:07 AM - A second observation revealed that R59's push button call bell was laying in the top drawer of his/her bedside table, which was out of R59's reach. E4 (LPN) confirmed the finding. 6/25/19 at 12:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 558	weekly for 3 weeks or until 3 consecutive audits are 100% compliant. Then one audit will be done once in one month, if 100% compliance is achieved then problem will be considered resolved. Results of audits will be presented during QAPI.	
F 600 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 interviews and review of the clinical record and facility documentation as indicated, it was determined that for 1 (R91) out of 1 sampled	F 600	1. R91's complaint of abuse was acted upon immediately. C.N.A. removed from schedule and was terminated. Social	9/30/19

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F 600	Continued From page 4 resident, the facility failed to ensure that R91 was free from abuse and neglect. Findings include: The facility's policy entitled, "Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime", last revised on 3/14/19, stated, "...It is the policy...to protect residents and prevent occurrences of abuse, neglect...Definitions: 'Abuse' is the willful infliction of...intimidation, deprivation of goods or services, or...mental anguish...Deprivation of goods or service by staff, Mental and Verbal Abuse is verbal or nonverbal conduct which causes or has the potential to cause humiliation, intimidation, fear, shame, agitation, or degradation...'Neglect' is the failure of the facility, its employees...to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress and includes: Lack of attention to physical needs of the resident;...failure to carry out a prescribed treatment plan for a resident...". Review of R91's clinical record revealed: 2/27/19 - The annual MDS assessment stated that R91 was cognitively intact, exhibited no behaviors or rejection of care, and required extensive assistance of 1 staff person for transfers and toileting care. R91 was not steady and was only able to stabilize with staff assistance when moving on and off the toilet and surface-to-surface transfers. 4/16/19 (untimed) - The facility's Resident Concern Form, written by E8 (RN) based on R91's interview, stated, "...@ 1:30 (am) resident (R91) rang bell. E9 (CNA) came to resident's room. E9 pushed w/c to bed, told resident to 'get	F 600	Services interviewed resident to determine need for further psych services. Psychiatric screen completed. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected by measures outlined in #3. 3. Staff educator to inservice facility staff on abuse and neglect. Cadia Silverside is compliant with all newly hired employees completing education on abuse and neglect. All existing staff are required to complete and are current with annual mandatory requirements (AMR) to complete abuse and neglect training. 4. Social Service to perform 3 random resident interviews and or observations for residents who are not interviewable to audit for presence of abuse/neglect. Three random interviews/observations will be conducted daily for 3 consecutive days or until compliance is met for 3 consecutive audits. Then 3 random resident interviews/observations will be conducted 3x weekly or until 3 audits are 100% compliant. Then three random resident interviews/observations will be done once weekly for 3 weeks or until 3 consecutive audits are 100% compliant. Then one random resident interview/observation will be done once in one month, if 100% compliance is achieved then problem will be considered resolved. Results of audits will be presented during QAPI.	

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F 600	Continued From page 5 up'. R91 asked her to remove (sic) covers but was told he/she could do it himself/herself. Stood behind w/c. R91 asked for assistance getting up but was told 'you can do it yourself'. E9 (CNA) did not help R91 after R91 was in w/c. E9 pushed her into bathroom. R91 stood using grab bar. E9 moved w/c from behind R91. R91 used toilet & pulled up brief. E9 had left when R91 sat on the commode. R91 put herself back to bed. E9 came back at least 35 to 40 min. later to cover R91 & left." 4/16/19 (untimed) - The facility's social worker (E14) interviewed R91. The interview statement was: "Resident (R91) reported the CNA (E9) assigned to him/her came to answer his/her light around 1:30 AM on 4/16/19 when resident needed assist to the bathroom. R91 reports that this CNA came in to the room and brought the wheelchair to the side of the bed and stood behind the wheelchair without offering to assist the resident out of bed. The resident then asked for help with removing his/her covers so he/she can get up to sit on the side of the bed and the CNA aggressive (sic) stated to him/her 'do it yourself, you can do it yourself!' the resident reported that he/she had to repeatedly kick the blankets off in order to sit at the side of the bed. Once seated he/she attempted to reach for his/her slippers - one was close by and he/she was able to get the slipper on while the CNA stood behind the wheelchair. The resident was not able to reach the other slipper and requested a hand to stand and transfer to the chair - the resident extended his/her hand to CNA and he/she reported the (sic) he/she told him/her again with an aggressive tone 'you can do it yourself, I'm not going to help you'. The resident then assisted himself/herself to the wheelchair	F 600		

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F 600	Continued From page 6 with only one slipper on and once in the chair moved himself/herself closer to the other slipper on the floor and reached down to grab the slipper off the floor. He/She stated the CNA wheeled him/her into the bathroom, however again refused to transfer to the toilet nor assist...him/her with his/her clothing and hygiene. The Resident then reports that the CNA left the bathroom. The resident put the light back on and waited 45 minutes and decided to transfer himself/herself back to the wheelchair and back to bed. Once he/she was in bed the CNA finally returned. The resident asked the CNA to help him/her pull her blankets up and he/she reports the CNA threw the blankets over him/her and left the room. The resident requests that the CNA never return to his/her room nor be assigned to him/her...". 4/16/19 at 4:50 PM - The facility's Progressive Discipline Form stated that E9 (CNA) was "suspended pending the internal investigation." 4/17/19 at 10:05 AM - E2 (DON) and E11 (Clinical Consultant) interviewed E9 (CNA) by telephone. E9 stated, "...acknowledged caring for R91 on the 11-7 shift beginning on 4-15-19 into the morning of 4-16-19...stated that he/she assisted R91 to the bathroom at approximately 1:15 AM. He/She was with the resident until approximately 1:35 AM. He/She stated he/she assisted the resident with the transfer from bed to wheelchair and from wheelchair to toilet. He/She stated that he/she doesn't 'pull on' the resident's arms during the transfer, as the resident asks him/her to but has R91 use the grab bars to assist with the transfer. E9 stated that R91 is a 'limited assist' with transfers. E9 stated upon completion of toileting he/she assisted the resident off of the toilet and into his/her wheelchair. The resident self-propels	F 600		

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F 600	Continued From page 7 his/her wheelchair back to his/her bed. He/She was assisted back into bed...Upon questioning about assisting with covering the resident with his/her blanket stated R91 doesn't like the blanket on his/her feet but the blanket was covering him/her. E9 was unaware of any care issues or concerns related to this shift. He/She stated that she/he did not have any exchange of words with the resident during the provision of care." 4/17/19 at 12:15 PM - The facility reported the allegation of abuse from 4/16/19 at 1:30 AM to the State Survey Agency and stated, "Resident reported CNA was verbally abusive to him/her and refused to assist with care. CNA suspended pending investigation." 4/17/19 (untimed) - The facility's follow-up information submitted to the State Survey Agency stated, "Investigation conducted. Statements obtained from resident and involved aide. The resident who is alert and oriented is consistent in his/her details of the event. The resident contends that the aide did not provide the requested assistance with transfers from bed to wheelchair to toilet and back to bed. The resident's plan of care notes extensive assistance of 1 for transfers. Also, the resident reported that the aide allegedly stated that he/she (the resident) could 'do it yourself' and 'I'm not going to help you'. The aide acknowledges caring for the resident and denies the allegation. The facility has decided to terminate the aide's employment as of 4-17-19." 4/17/19 at 12:45 PM - The facility's Resident Concern Form stated the following: - E9 (CNA) was "suspended from work from 4-16-19 to 4-17-19 at which time he/she was	F 600		

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F 600	Continued From page 8	F 600		

terminated;
- The resident was interviewed by E14 (SW) and his/her allegation of abuse remained consistent with his/her original concern. The aide failed to follow the resident's plan of care r/t transfer assistance and made statements to the resident that are abusive in nature."
- R91 was notified by E11 (Clinical Consultant) of the action taken by the facility.

4/17/19 at 12:55 PM - The facility's Progressive Discipline Form stated that E9 (CNA) was terminated for violation of work rule from the employee handbook: "...Never verbally, psychologically, physically or sexually abuse a resident."

6/18/19 at 4:50 PM - During an interview, R91 recalled the incident with E9 (CNA) and his/her details remained consistent with the facility's investigation. R91 stated that E9 (CNA) did not provide toileting assistance during the night shift, and it bothered him/her because he/she didn't want to fall.

6/20/19 at 3:46 PM - During an interview, E8 (RN) stated that R91 reported the night shift incident to him/her when he/she arrived for work the morning of 4/16/19. E8 confirmed that R91 was "upset" when telling him/her about what happened. E8 stated that R91 said he/she felt mistreated and did not receive the help he/she needed. When asked if he/she noticed any changes in R91's behavior after the incident, E8 stated no.

6/24/19 at 12:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON). The facility failed to ensure that R91 was free from abuse and neglect when E9 (CNA)

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F 600	Continued From page 9 emotionally abused and refused to assist R91 with toileting care.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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 action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility documentation as indicated, the facility failed to ensure that an allegation involving abuse for 1	F 609	1. R91 was not impacted by this deficient practice. 2. All residents have the potential to be	9/30/19

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F 609	Continued From page 10 (R91) out of 1 resident, was reported to the State Survey Agency (also known as the State of Delaware's Office of Long Term Care Residents Protection) not later than 2 hours after the allegation was made on 4/16/19. Findings include: Cross refer to F600 The facility's policy entitled, "Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime", last revised on 3/14/19, stated, "...Guidelines:...Reporting and Response...Allegations of resident abuse shall be reported to the appropriate state regulatory authority within 2 hours...". Review of the State of Delaware's Office of Long Term Care Residents Protection Web Intake Report stated that an alleged incident involving abuse between R91 and E9 (CNA) occurred on 4/16/19 at 1:30 AM, but was not reported until 4/17/19 at 12:15 PM. 6/20/19 at 3:46 PM - During an interview, E8 (RN) stated that R91 reported the incident to him/her directly when she arrived to work on day shift (7 to 3 PM) on 4/16/19. 6/24/19 at 12:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON). The facility failed to report an allegation of abuse to the State Survey Agency not later than 2 hours after the allegation was made on 4/16/17.	F 609	impacted by this deficient practice. Future residents will be protected by measures outlined in #3. 3. DON/Designee to educate nursing management and supervisory staff regarding the 2 hour mandate to report allegations of abuse and neglect. 4. Investigation Team (DON/ADON and NHA) to meet daily on all allegations of abuse for 3 consecutive days to ensure compliance of reporting regulations or until 100% compliance is achieved. Investigation Team will meet 3x weekly on all allegations of abuse to ensure 100% compliance is reached for three consecutive times. Investigation Team will meet one time per week on allegations of abuse for three consecutive weeks or until 100% compliant with reporting in 2 hours. All allegations of abuse will continue to be audited that they are reported within the 2 hour reporting time. Results of investigations will be presented at QAPI meeting.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		9/30/19

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F 657	Continued From page 11 §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 record review and interviews, it was determined that the facility failed to revise the care plan for one (R73) out of 40 sampled residents. Findings include: Cross refer to F689 Review of R73's clinical record revealed the following: 8/21/14 - R73 was admitted to the facility.	F 657	1. R73 was not negatively impacted by this deficient practice. R73's care plans have since been revised to include all current interventions. 2. All smoking residents have the potential to be affected by this deficient practice. Future smoking residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 3. Corporate Informatics Nurse to update	

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F 657	Continued From page 12 12/28/17 - A care plan for potential for injury related to tobacco use, last edited 6/12/19, stated that R73 declined smoking cessation measures and continued to smoke. The care plan's goal was that R73 will have no significant injury related to smoking. The care plan included the following interventions: educate/remind (R73) that the facility campus is smoke free and he/she has been a nonsmoker since 2014; (R73) will be educated/reminded of safety while smoking; Smoking apron given to R73. R73 verbalized understanding of purpose of smoking apron (safety). He/she is able to apply apron independently; Smoking cessation information will be offered/provided PRN (as needed). 5/22/19 - A significant change in status MDS assessment stated R73 was cognitively intact (able to make decisions independently), required supervision of one (1) staff for transfers to and from bed to wheelchair, and was independent with set up help only for locomotion while in a wheelchair (how resident moves to and returns from off-unit locations). The MDS assessment identified R73 as a current smoker. Review of the clinical record and interviews with R73 on 6/14/19 at approximately 9:50 AM revealed that R73 left facility property to smoke without supervision, held onto his/her own smoking materials, did not wear a smoking apron, and did not inform staff when leaving the property to smoke. The facility failed to revise R73's smoking care plan to include these issues. 6/20/19 3:45 PM - During an interview, findings were reviewed with E2 (DON). E2 acknowledged the care plan did not include the identified	F 657	the "Safe Smoking Evaluation" in EHR. Staff Educator/Designee to in-service nursing staff on the new "Safe Smoking Evaluation" and report that they actively smoke. The assessment will also be completed with all significant changes. Smoking care plans will be updated upon admission, quarterly, and with significant change as needed. 4. Unit Manager/Designee to audit one random resident's smoking care plan each day to ensure compliance with accurate interventions. Audits will be daily or until 100% compliance is reached for 3 consecutive days. Audits will then be three times weekly or until 100% compliance is reached for three consecutive times. Audits will continue at once per week until three consecutive weeks are 100% compliant. If a random sample of three resident audits are 100% complaint in one month, the deficiency will be considered resolved. Results of interviews will be presented at QAPI meeting.	

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F 657	Continued From page 13 concerns. 6/25/19 approximately 4:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 657		
F 689 SS=D	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 observation, resident and staff interview, and review of facility policy, it was determined that the facility failed to ensure the resident environment remained as free of accident hazards as is possible and that each resident received adequate supervision to prevent accidents. Although the facility has a smoke free policy, for one (R73) out of one resident sampled for smoking, the facility knowingly allowed R73 to leave facility property to smoke without having completed a comprehensive assessment to determine R73's ability to smoke independently and safely. Findings include: The facility's policy titled, Smoke-Free Campus, revision date February 27, 2017 stated, "...Smoking is prohibited in all public, private and common area of Cadia Facilities. The Smoke-Free campus Policy is reviewed during	F 689	1. R73 was not negatively impacted by this deficient practice. R73 has since been assessed by nursing staff to ensure safety during smoking activities. 2. All smoking residents have the potential to be affected by this deficient practice. Future smoking residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 3. Corporate Informatics Nurse to update the "Safe Smoking Evaluation" observation in EHR. Staff Educator/Designee to in-service nursing staff on the new "smoking assessment" and "smoking care plan" to be completed in facility's EHR with all new admissions who report that they actively smoke. The assessment will ensure that staff assess actively smoking residents for the	9/30/19

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F 689	Continued From page 14 the admission process and an acknowledgement of the policy is signed by new residents and filed with resident's documents." Review of R73's clinical record revealed the following: 8/21/14 - R73 was admitted to the facility. 8/22/14 - The facility's Admission Agreement stated, "...Smoking Policy Smoking and /or the use of tobacco by residents or visitors is not permitted anywhere on Facility property at any time. The definition of facility property for the purpose of this policy includes all land, buildings, structures, parking lots, sidewalks, and any vehicles owned or leased to the facility. Failure to maintain a smoke-free campus by residents and/or visitors could result in outcomes up to and including discharge." This agreement was signed by R73 on 8/22/14. 12/28/17 - A care plan for potential for injury related to tobacco use, last edited 6/12/19, stated that R73 declined smoking cessation measures and continued to smoke. The care plan's goal was that R73 will have no significant injury related to smoking. Care plan interventions included: educate/remind resident of safety while smoking; smoking apron provided and able to apply independently; smoking cessation information will be offered/provided as needed. 5/22/19 - A significant change in status MDS assessment stated R73 was cognitively intact (able to make decisions independently), required supervision of one (1) staff for transfers to and from bed to wheelchair, and was independent with set up help only for locomotion while in a	F 689	following: safe smoking techniques - holding cigarettes, safe technique lighting a cigarette, putting out the matches or lighter, disposing ashes and extinguishing cigarettes, that the resident remains alert during the course of smoking, and that the resident has no evidence of burns on fingers, clothing, or wheelchair. 4. Unit Manager/Designee to audit one random resident's "Safe Smoking Evaluation" each day to ensure compliance that the resident is able to smoke safety and without staff supervision. Audits will be daily or until 100% compliance is reached for 3 consecutive days. Audits will then be three times weekly or until 100% compliance is reached for three consecutive times. Audits will continue at once per week until three consecutive weeks are 100% compliant. If a random sample of three resident audits are 100% complaint in one month, the deficiency will be considered resolved. Results of interviews will be presented at QAPI meeting.	

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F 689	Continued From page 15 wheelchair (how resident moves to and returns from off-unit locations). The MDS assessment identified R73 as a current smoker. Review of the clinical record lacked evidence of a smoking assessment for R73. Although the facility was smoke free, they were aware that R73 was leaving the facility property to smoke. There was no evidence of any assessments completed from 12/28/17 through 6/25/19 regarding R73's ability to smoke safely and without supervision. 6/14/19 9:47 AM - During an interview, R73 stated that he/she goes out to smoke several times a day whenever he/she wants. R73 stated that he/she does not always tell staff where he/she is going when leaving the unit, and that he/she holds onto his/her own cigarettes and lighter. 6/14/19 10:17 AM - R73 was observed in an electric scooter driving across the facility parking lot to the right of the facility's main entrance. R73 proceeded into the church parking lot, adjacent to the facility, and went to the far end of the parking lot near a row of trees to smoke. 6/20/19 1:50 PM - During an interview, E13 (SW) stated that R73 did not smoke when first admitted to the facility, but then he/she began smoking. E13 stated that R73 was told that he/she could smoke off the facility's property either on the sidewalk or at the church parking lot. E13 stated R73 was given a smoking apron but would not wear it. E13 also stated that R73 was asked to sign out when leaving the facility to go smoke, but doesn't. Review of the nursing unit's sign out book, located at the nurse's station, revealed that the last time R73 signed out when leaving facility	F 689		

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F 689	Continued From page 16 property was on 10/7/18. 6/20/19 3:45 PM - During an interview, E2 (DON) stated that a smoking assessment was started on R73 back in December 2017, but was not completed because it was invalid due to the facility being a smoke free property. During the interview, E2 acknowledged that the facility must ensure that R73 was as free of accident hazards as is possible. Additionally, E2 stated that there had been facility discussion regarding the safety of residents holding onto their own smoking materials. The facility failed to assess R73 for his/her ability to smoke safely and without staff supervision. Although the facility knew that R73 left the property to smoke, there were no assessments ensuring he/she was able to do so safely. 6/25/19 approximately 4:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 689		
F 710 SS=E	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that-	F 710		9/30/19

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F 710	Continued From page 17 §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on interview and clinical record review, it was determined that for one (R16) out of three sampled residents, the facility failed to ensure the attending physician supervised R16's medical care, specifically medical issues related to the resident's skin status. There was no evidence in the clinical record from 3/10/19 to 5/16/19 that R16's left ischial wound was assessed, including visualization, by E10 (R16's Attending Physician/Medical Director) in the nursing facility prior to R16 being hospitalized. Findings include: Review of R16's clinical record revealed: 6/30/15- R16 was admitted to the facility. 3/10/19- An event report evaluation note documented that R16 had MASD to his/her left ischium and treatment was ordered by E10 (R16's attending physician). 3/13/19-3/29/19- Treatments were ordered by E10 for R16's left ischium, however, there was no evidence that E10 examined R16's left ischium during this time. 3/29/19- A consult was done by a wound NP (Nurse Practitioner) at the request of the attending provider (E10). The consult documentation noted that the wound NP would give recommendations and approval by the	F 710	1. R16 was not impacted by this deficient practice. R16's wound was assessed weekly by Wound Healing Solutions Nurse Practitioner and treated appropriately. 2. All residents with wounds have the potential to be impacted by this deficient practice. Future residents will be protected by measures outlined in #3. 3. Cadia Silverside will implement a weekly High Risk Meeting to review all residents at risk of decline including those with significant and/or worsening wounds. Medical Director will participate in weekly meetings to assure appropriate supervision of resident care. Medical Director will visualize and assess any worsening wounds presented at High Risk Meeting and advise on care needed. A note will be placed in each residents' medical record who is reviewed during High Risk Meeting. Weekly sign in sheets will be required and maintained to include that of the Medical Director. 4. DON/Designee to audit physician documentation that all residents requiring her supervision were seen and assessed. Audits will be conducted weekly for 90 days. If 100% compliance is achieved then problem will be considered resolved. Results of audits will be presented during	

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F 710	Continued From page 18 attending provider (E10) was to be obtained prior to carrying out the plan. The NP's examination noted that R16 had a subcutaneous abscess to his/her left buttock. Treatment recommendations were made and E10 (R16's attending physician) placed the orders. 3/30/19-4/15/19- R16 was examined weekly by the wound NP and was noted to still have a subcutaneous abscess to his/her left ischium (previously called left buttock). Treatments were recommended by the wound NP, approved and then ordered by E10 for R16's left ischium, however, there was no evidence that E10 assessed R16's left ischium during this time. 4/24/19- A practitioner progress note by E10 (R16's attending physician) stated that R16 was examined. Under the skin section, E10 checked the box stating that R16's skin was clean, dry, and intact, however, R16 still had a subcutaneous abscess to his/her left ischium at the time of this assessment. There was no evidence that E10 assessed R16's left ischium. 4/29/19- R16 was examined by the wound NP and was noted to still have a left ischium subcutaneous abscess that was not improving. Treatment was recommended to be changed and new orders were approved and placed by E10, however, there was no evidence that E10 assessed R16's left ischium. 5/6/19- R16 was examined by the wound NP and R16's left ischium subcutaneous abscess was reclassified as an unstageable pressure ulcer. It was documented that the wound was not improving; however, treatment remained the same. There was no evidence that E10 (R16's	F 710	QAPI.	

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F 710	Continued From page 19 attending physician) assessed R16's left ischial wound after it was reclassified as a pressure ulcer. 5/15/19- A progress note documented that R16's wound had a large amount of serous/purulent drainage from the wound bed. It was noted that there was a "possible underlying abscess" and E10 was made aware. New orders were placed by E10 to treat R16's wound for infection, however, there was no evidence that E10 assessed R16's left ischial wound at that time. 5/16/19 4:21 PM- A progress note documented that R16 was sent to the hospital. 5/17/2019 9:05 AM- A progress note documented that R16 was admitted to the hospital with a diagnosis of left buttock cellulitis. 5/25/2019 2:57 AM- A progress note documented that R16 returned from the hospital with admitting diagnoses of sepsis due to a left necrotic ischium wound and osteomyelitis. R16 had a PICC line with orders to receive IV antibiotics and it was noted that a wound vac was to be placed on the left ischial wound in the morning. 6/24/19 2:31 PM- During a telephone interview with E10 (R16's attending physician), it was confirmed that E10 never visualized or assessed R16's wound from 3/10/19 through 5/15/19. E10 stated the first time she visualized the wound was in a picture she was sent by the facility on 5/16/19, and from that picture, she ordered R16 to be sent to the hospital. E10 stated that she relied on the expertise of the wound care NP and the wound nurse at the facility to assess the wound, and typically only looked at wounds if it	F 710		

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F 710	Continued From page 20 was requested. E10 stated that the wound NP and facility staff updated her on the wound and she placed orders accordingly. The physician failed to supervise and assess R16's left ischial skin alteration from 3/10/19 to 5/16/19. On 5/16/19 R16 was sent to the hospital due the wound becoming infected. 6/25/19 approximately 12:00 PM- Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 710		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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 §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		9/30/19

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F 725	Continued From page 21 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interviews and review of clinical records, it was determined that the facility failed to have sufficient nursing staff allocated to ensure medications were administered to residents timely on 6/24/19 during the 7 AM to 3 PM shift on 1 out of 2 nursing floors. The facility's failure affected 4 residents (R10, R19, R30 and R71). Findings include: 6/24/19 at 12:12 PM - During an interview, the surveyor asked E15 (RN) to inspect her medication cart on the first floor South hallway. Immediately, E15 stated that she was still passing medications. The surveyor asked her if she was passing lunch medications. E15 stated, "no, 10 AM scheduled medications". The surveyor asked E15 for the names of the residents that have not received their medications yet. The four (4) residents were: R10, R19, R30 and R71. E15 directed the surveyor to the medication cart for the back hall, which was positioned next to her, to inspect and where E18 (RN) was standing. At 12:16 PM, the surveyor asked E18 (RN) to inspect the back hall medication cart. During the inspection, the surveyor asked E18 if this was her medication cart. E18 stated that she hasn't taken responsibility of the medication cart. E18 stated that she arrived at the facility at 11 AM as there was a nurse call off. The surveyor asked if she passed medications this morning. E18 stated no. E18 stated that she was helping out in other areas where the facility needed assistance.	F 725	1. R71, R19, R10 and R30 were impacted by this deficient practice by receiving their medications late. 2. All residents have the potential to be impacted by the deficient practice. Future residents will be protected by measures outlined in #3. 3. Unit Manager/Designee will assume cart nurse position in the event of a nurse call out, that can not be replaced, to assure timely medication pass of all residents. 4. DON/Designee to audit all nurse call outs daily to ensure cart nurse positions are covered and adequate for timely medication passes. Audits will be conducted daily for 3 consecutive days or until compliance is met for 3 consecutive audits. Then 10 call out audits will be conducted 3x weekly or until 3 consecutive audits are 100% compliant. Then call out audit will be done once weekly for 3 weeks or until 3 consecutive audits are 100% compliant. Then one call out audit will be done once in one month, if 100% compliance is achieved then problem will be considered resolved. Results of audits will be presented during QAPI.	

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F 725	Continued From page 22 Review of the clinical records of the affected 4 residents revealed the following: 1. R71's eMAR on 6/24/19 revealed the following scheduled 10 AM medications were administered at 12:27 PM: - Amlodipine (used to lower blood pressure); - Ascorbic Acid (Vitamin C supplement); - Benazepril (used to lower blood pressure); - Colace (used to help pass bowel movements); - Hydralazine (used to lower blood pressure); - Ferrous Sulfate (used to treat a reduced production of red blood cells); - Isosorbide Mononitrate (used to lower blood pressure); - Lasix (used to help the heart pump enough blood to meet body's needs); - Lyrica (used to treat pain); - Metoprolol Tartrate (used to lower blood pressure); - Morphine (used to treat chronic pain); - Miralax (used to help pass bowel movements); - Pramipexole (used to treat the symptoms of Parkinson's disease: difficulties with movement, muscle control, and balance); and - Senna (used to help pass bowel movements). In addition, R71's scheduled 8 AM Ensure Clear supplement was administered at 12:27 PM. 2. R19's eMAR on 6/24/19 revealed the following scheduled 8 AM and 10 AM medications were administered at 12:35 PM: - 8 AM - Lactulose (used to help pass bowel movements); - 10 AM - Tylenol (used to treat pain); - 10 AM - Aspirin (used to treat narrowing or blockage of the arteries that supply blood to the heart); - 10 AM - Lisinopril (used to treat high blood	F 725		

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	085056	A. BUILDING _____ B. WING _____	C 06/25/2019

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F 725	Continued From page 23 pressure); and - 10 AM - Tramadol (used to treat pain). In addition, R19's scheduled 8 AM Med Pass supplement was administered at 12:35 PM. 3. R10's eMAR on 6/24/19 revealed the following scheduled 10 AM medications were administered at 12:41 PM: - Bumetanide (used to help the heart pump enough blood to meet body's needs); - Colace (used to help pass bowel movements); - Metoprolol Tartrate (used to treat high blood pressure); - Omeprazole (used to treat stomach acid that flows back into your food pipe); - Senna (used to help pass bowel movements); and - Spironolactone (used to lower blood pressure). In addition, R10's scheduled 8 AM Med Pass supplement was administered at 12:41 PM. 4. R30's eMAR on 6/24/19 revealed the following scheduled 8 AM medications were administered at 12:46 PM: - Aspirin (used to treat narrowing or blockage of the arteries that supply blood to the heart); - Finasteride (used to treat the blockage of urine flow out of the bladder); - Losartan (used to treat high blood pressure); - Metformin (used to treat high blood sugars); - Norvasc (used to treat high blood pressure); - Tamsulosin (used to treat the blockage of urine flow out of the bladder); and - Trazodone (used to treat depression). In addition, R19's scheduled 8 AM Med Pass supplement was administered at 12:46 PM. 6/24/19 - Review of the facility's Staff Posting for the 1st floor on 7 AM to 3 PM shift revealed the	F 725		

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F 725	Continued From page 24 following nurses present: - E17 (RN, Unit Manager); - E5 (RN, Desk Nurse on South Hallway); - E15 (RN, assigned Medication Nurse on South Hallway); and - E16 (LPN, assigned Medication Nurse on West Hallway). 6/24/19 at 2:07 PM - During an interview, E15 (RN) stated that he/she normally worked on the second floor. E15 stated that he/she just picked up an extra shift today. When E15 arrived this morning, he/she was assigned rooms 162 to 179B. When the surveyor asked about the medication cart assignments, E15 stated that there were 3: - back hall medication cart covered rooms 169 to 179B; - split medication cart covered rooms 102 to 168; and - short hall medication cart covered rooms 103 to 114. E15 stated that E5 (RN, Desk Nurse on South Hallway) assisted him/her with checking residents blood sugars and transporting residents from activities back to their rooms for their medications. E15 stated that E18 (RN) assumed responsibility of the split medication cart at 12:45 PM. 6/24/19 at 2:19 PM - During an interview, E16 (LPN) stated that he/she normally worked on the 1st floor and knows the residents well. E16 stated her assignment was rooms 100 to 114 and 160 and 161. E16 stated that the facility typically has 3 nurses passing medications on the first floor, but a nurse called out this morning. 6/24/19 at 2:29 PM - During an interview, E5 (RN)	F 725		

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F 725	Continued From page 25 stated that he/she was assigned as the Desk Nurse for South Hallway. When the surveyor asked what duties he/she performed this morning, E5 stated that he/she assisted with checking residents blood sugars, transporting residents back to their rooms for medications, passing out meal trays and answering call lights. E5 stated that the 1st floor census today was 64 residents. 6/24/19 at 2:40 PM - During an interview, E17 (RN, UM) stated that 3 nurses usually pass out medications during the day shift. On 6/24/17, E17 remained as the desk nurse, assisted in the dining room for breakfast, answered calls and requests from family members. There was no evidence that she assisted with medication administration on the morning of 6/24/19. 6/24/19 at 2:48 PM - During an interview with E2 (DON), findings were reviewed and acknowledged. 6/25/19 at 12:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON). The facility failed to have sufficient nursing staff allocated to ensure medications were administered to residents timely on the 7 AM to 3 PM shift on 6/24/19. The facility's failure affected 4 residents (R10, R19, R30 and R71).	F 725		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		9/30/19

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F 761	Continued From page 26 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility documentation as indicated, it was determined that for 1 out 2 medication storage rooms, the facility failed to discard R85's medication and a multi-use vial of Tuberculin (used to test for tuberculin disease) that had expired. Findings include: The facility's "Dating of Multi-Use Containers", last revised on 8/14/18, stated, "...Tuberculin... (Period Open before Discarding) 28 days...All products must be dated when opened and discarded according to these guidelines or expiration on packaging (whichever occurs first)." 6/24/19 at 11:17 AM - An observation of the 1st floor medication storage refrigerator revealed the	F 761	1. No residents were negatively impacted by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 3. Facility will develop medication room audit tool to be used daily to ensure accurate dating and disposal of all expired/discontinued medications. 4. Night Shift Supervisor/Designee to audit/reconcile the 1st Floor Medication Room/fridge and the 2nd Floor Medication Room/fridge on the 11-7 shift every night. Audit of the 1st Floor Medication Room/fridge and 2nd Floor Medication	

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F 761	Continued From page 27 following: - a Vancomycin (antibiotic) oral solution medication container for R85 with a date opened on 5/15/19 and a discard date after 5/29/19; and - an opened multi-use vial of Tuberculin that had 2 handwritten dates of "5/1" and "5/21". It was unclear which handwritten date was the "open" date. E5 (RN) was asked when the multi-dose vial should be discarded after it was opened. E5 stated that he/she would let this surveyor know. 6/24/19 at 11:52 AM - During a follow-up interview, E5 (RN) stated that the Tuberculin multi-use vial was to be discarded 28 days after it was opened. E5 confirmed the findings. 6/24/19 at 12:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON). The facility failed to discard R85's medication and a multi-use vial of Tuberculin that had expired.	F 761	Room/fridge will be completed daily or until 100% compliance is reached for 3 consecutive days. Audit of the 1st Floor Medication Room/fridge and 2nd Floor Medication Room/fridge will then be three times weekly or until 100% compliance is reached for three consecutive times. Audit of the 1st Floor Medication Room/fridge and 2nd Floor Medication Room/fridge will continue at once per week until three consecutive weeks are 100% compliant. If audit of the 1st Floor Medication Room/fridge and 2nd Floor Medication Room/fridge are 100% complaint in one month, the deficiency will be considered resolved. Results of interviews will be presented at QAPI meeting.	
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and interview, it was determined that for 1 (R23) out of 5 sampled residents, the facility failed to consistently provide R23 with an adaptive device, a weighted blue cup with a lid, to use during meals as per the plan of care. Findings include:	F 810	1. R23 was not negatively impacted by this deficient practice. 2. All residents requiring adaptic equipment during meals have the potential to be impacted by the deficient practice. Future residents will be	9/30/19

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F 810	Continued From page 28 Review of R23's clinical record revealed: 11/5/18 - R23 was care planned to have a weighted blue mug with a lid at every meal. 6/13/19 at 12:25 PM - An observation in the first floor dining room during lunch revealed that R23 drank thickened apple juice from a clear glass with no lid. At 12:38 PM, E20 (CNA) was observed mixing cranberry juice with thickener in the same clear glass used earlier and gave it to R23. R23 drank some of the thickened cranberry juice from the clear glass with no lid. At 12:46 PM, R23 was observed knocking over the clear glass with the thickened cranberry juice. At 12:48 PM, E17 (RN, UM) was observed placing a pureed lunch and a clear plastic sipping cup with a lid in front of R23. E17 proceeded to mix cranberry juice and thickener and gave it to R23. The facility failed to provide R23 with a weighted blue cup with a lid during lunch. 6/18/19 from 8:38 AM to 8:43 AM - An observation of R23 in her room during breakfast revealed that R23 had a brown plastic "coffee" cup with no lid on her meal tray, which contained thickened apple juice. The facility failed to provide R23 with a weighted blue cup with a lid during breakfast. 6/20/18 at 4:53 PM - During an interview, findings were reviewed with E2 (DON). 6/24/19 at approximately 8:45 AM - An observation of R23 in her room during breakfast revealed that R23 had a weighted blue cup with a lid on her meal tray.	F 810	protected by measures outlined in #3. 3. Food Service Director/Designee to educate all dietary staff on tray accuracy including adaptic equipment. The need for adaptic equipment appears on the residents' meal ticket. 4. Food Service Director/Designee to audit tray line for adaptic equipment accuracy daily for 3 consecutive days or until compliance is met for 3 consecutive audits. Then 10 audits will be conducted 3x weekly or until 3 consecutive audits are 100% compliant. Then audit will be once weekly for 3 weeks or until 3 consecutive audits are 100% compliant. Then one audit will be done once in one month, if 100% compliance is achieved then problem will be considered resolved. Results of audits will be presented during QAPI.	

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F 810	Continued From page 29 6/25/19 at 12:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference. The facility failed to consistently provide R23 with an adaptive device, a weighted blue cup with a lid, to use during meals as per the plan of care.	F 810		
F 812 SS=E	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 observations and interview, it was determined that the facility failed to ensure sanitary practices in the kitchen to prevent cross-contamination. Findings include: During the tour of the kitchen on 6/13/19 at 11:00 AM, E3 (Dietary Aide) was observed in the dish room retrieving newly washed dishes, bowls,	F 812	1. No resident was negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by the deficient practice. Future residents will be protected by measures outlined in #3. 3. Staff educator to re-educate all dietary staff on Infection Control Policy and	9/30/19

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F 812	Continued From page 30 beverage cups and eating utensils as they came out of the dishwasher. Bare-handed, E3 removed these articles from the racks, touching food-contact surfaces in the process, and placed them on top of utility carts in the dish room which E3 then pushed out of the area in order to bring empty carts in. While waiting for the next racks with newly washed items to come out of the dishwasher, E3 was observed touching the left side of his/her face. Between transfers of clean items to the empty carts, E3 was also observed reaching for the back of his/her pants to pull them up. No handwashing was noted throughout the activities observed in the dish room. At 11:38 AM, E3 moved from the dish room to the tray line area to place plates, bowls, beverage cups and flatware on resident trays with tray tickets in preparation for lunch. In the middle of the activity, E3 took out a Sharpie pen to write on tray tickets. E3 was also observed reaching for the back side of his/her pants to pull them up. E3 then reached for a cloth kitchen towel and began wiping the eating utensils. No handwashing was observed being done by E3 after the dish room tasks ended and during the tray line activities, nor was E3 observed wearing disposable gloves. In an interview at 4:15 PM on 6/13/19, E7 (Food Service Manager) stated that E3 previously worked at an upscale facility, where polishing the silverware was a part of the foodservice activities and where staff did not wear disposable gloves around the residents. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 6/25/19 at approximately 12:00 PM.	F 812	Procedures and proper handwashing technique. Food Service Director educated to observe dietary staffs' handwashing techniques in one month to ensure compliance to previous in-servicing. 4. Staff educator to perform Infection Control rounds daily daily for 3 consecutive days or until compliance is met for 3 consecutive audits. Then Infection Control rounds will be conducted 3x weekly or until 3 consecutive audits are 100% compliant. Then Infection Control rounds will be once weekly for 3 weeks or until 3 consecutive audits are 100% compliant. If a random sample of three infection control rounds are 100% compliant in one month the then deficiency will be considered resolved. Results of audits will be presented during QAPI.	

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F 881	Continued From page 31	F 881		
F 881 SS=F	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 review of facility documentation and interview it was determined that the facility failed to develop antibiotic use protocols as part of the facility antibiotic stewardship program. Findings include: Review of facility documentation revealed the following: The facility's antibiotic stewardship program included antibiotic surveillance tools, however, there were no written protocols. On 6/24/19 at 3:30 PM, during an interview, E6 (Staff Developer) stated that there were no written antibiotic protocols. E6 stated that residents attending physicians ordered antibiotics as needed. E6 stated that different physicians had different antibiotic ordering practices, some ordered antibiotics based on symptoms, while some physicians waited for lab results before prescribing an antibiotic. The facility failed to develop an antibiotic stewardship program which included the	F 881	1. No residents were negatively impacted by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 3. Facility will develop and implement "Facility Use Protocols" for the Antibiotic Stewardship Program. Physicians' orders for antibiotics that don't comply with antibiotic protocols will be reviewed by the Medical Director and addressed as appropriate. DON/Designee will in-service Nursing Supervisors and facility providers on the new "Facility Use Protocols" for appropriate antibiotic use. 4. Pharmacist/Designee to audit facility antibiotic use to ensure that antibiotics were ordered according to the "Facility Use Protocols". Audits of three random residents presently on antibiotics will be completed daily or until 100% compliance is reached for 3 consecutive days. Audits will then be three times weekly or until	9/30/19

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F 881	Continued From page 32 development of protocols. Findings were reviewed with E2 (DON) on 6/25/19 at 9:30 AM and with E1, and E2 on 6/25/19 at 12:00 PM during the exit conference.	F 881	100% compliance is reached for three consecutive times. Audits will continue at once per week until three consecutive weeks are 100% compliant. If a random sample of three resident audits are 100% complaint in one month, the deficiency will be considered resolved. Results of interviews will be presented at QAPI meeting.	

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

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Silverside

DATE SURVEY COMPLETED: June 25, 2019

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 13, 2019 through June 25, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 108. The survey sample totaled 40 residents.		
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 is not met as evidenced by:** Cross refer to CMS 2567-L survey completed June 25, 2019: F558, F600, F609, F657, F689, F710, F725, F761, F810, F812, and F881.	Cross refer to CMS 2567-L survey completed June 25, 2019: F558, F600, F609, F657, F689, F710, F725, F761, F810, F812 and F881.	9/15/19

Provider's Signature Laurie P. Dittner Title NHA Date 8/13/19

DELAWARE HEALTH AND SOCIAL SERVICES
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STATE SURVEY REPORT

NAME OF FACILITY: Cadia Silverside

DATE SURVEY COMPLETED: June 25, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE

Provider's Signature Laura L Ottmer Title NHA Date 8/13/19