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

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

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Healthcare Renaissance

DATE SURVEY COMPLETED: August 07, 2023

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 and Complaint Survey was conducted at this facility from August 1, 2023 through August 7, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census on the first day of the survey was 106. The survey sample totaled 22 residents.	1. No resident was affected by this deficient practice. 2. All residents have the potential to be affect by deficient practice. Future residents will be protected by the action plan outlined below.	10.9.23
3201	**Regulations for Skilled and Intermediate Care Facilities**	3. Daily staffing will be reviewed by NHA/designee, both projected for current day and actual PPD for previous day, to ensure adequate staffing and compliance with Delaware Nursing Home Staffing Laws. On Fridays, projected staffing and PPD will be reviewed for the upcoming weekend and on Mondays the actual PPD for Friday, Saturday and Sunday will be reviewed. Additionally, we will continue to attempt to acquire new agency contracts, offer incentives to all staff, including PRN staff to pick up open shifts and ensure competitive rates to help recruitment for vacant positions.	
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 the CMS 2567-L survey completed 8/7/23: F577, F585, F656, F686, F695 and F908.		
16 Del., Chapter 11, Subchapter VII	**Minimum Staffing Levels for Residential Health Facilities**	4. Daily staffing will be reviewed by NHA/designee for three consecutive weeks or until 100% compliance is achieved;	

Provider's Signature [signature] Title NHA Date 8.31.23

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1162 Nursing Staffing	**(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.** **Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:** RN/LPN — CNA* Day — 1 nurse per 15 res. — 1 aide per 8 res. Evening — 1:23 — 1:10 Night — 1:40 — 1:20 * or RN, LPN, or NAIT serving as a CNA. (g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week. A desk review staffing audit was conducted by the State of Delaware, Division of Health Care Quality, Office of Long Term Care Residents Protection on 8/7/23. The facility was found to be out of compliance with 16 Delaware Code, Chapter 11 Nursing Facilities and Similar Facilities. Based on review of facility documentation, it was determined that for seven days out of twenty-one days reviewed, the facility failed to provide staffing at a level of at least 3.28 hours of direct care per resident per day (PPD). Findings include:	then three times per week for three weeks or until 100% compliance; then weekly for three weeks or until 100% compliance; finally in one month, an audit will be conducted, if at that time compliance is 100% then deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.	10.9.23

Provider's Signature [signature] Title NHA Date 8.31.23

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	Review of facility staffing worksheets, completed and signed by E1 (Nursing Home Administrator), revealed the following: Review of facility staffing worksheets, completed and signed by the Nursing Home Administrator, revealed the following: 6/4/23 PPD =3.00 6/10/23 PPD =3.21 6/18/23 PPD =2.90 6/24/23 PPD =3.13 7/15/2023 PPD = 3.09 7/16/23 PPD= 3.12 7/22/23 PPD=2.99 8/7/23 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate) during the exit conference. The facility failed to maintain the minimum PPD staffing requirement of 3.28.		

Provider's Signature _____ Title NHA Date 8.31.23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085052	A. BUILDING _____ B. WING _____	C 08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION RENAISSANCE	26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966

(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 and complaint survey was conducted at this facility from August 1, 2023 through August 7, 2023. The facility census was 106 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were found.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from August 1, 2023 through August 7, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census on the first day of the survey was 106. The survey sample totaled 22 residents. Abbreviations/definitions used in this report are as follows: CNA - Certified Nursing Assistant; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RN - Registered Nurse; UM - Unit manager ADL's - Activities of daily living; BIMS - (Brief Interview for Mental Status) -	F 000		

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

Electronically Signed | 08/31/2023

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 assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions) 08-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); Cognition - mental process; thinking; Hypercapnia - condition when there is too much carbon dioxide (CO2) in the patient's blood; Medication Administration Record (MAR) - list of daily medications to be administered; Multiple Sclerosis - nervous system disease that affects the brain and spinal cord; Nasal cannula - tube placed into nostrils to deliver oxygen; Oxygen concentrator - device that provides oxygen to people who need it for medical reasons, such as lung diseases or low blood oxygen levels; Peripherally Inserted Central Catheter - (PICC) form of intravenous access into a vein in the arm that can be used for a prolonged period of time; Quadriplegia - paralysis of arms and legs; Treatment Administration Record (TAR) - list of daily/weekly/monthly treatments to be performed.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity	F 577		10/9/23

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F 577	Continued From page 2 to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the state survey inspection results were available for residents to read. Findings include: The facility bulletin board located in the front lobby indicates that survey results will be located in a black binder in the facility lobby. On 8/3/23 10:51 AM during inspection of the facility binder for survey results the binder contained survey results from the 11/12/20 focused infection control survey, the facility's 10/22/21 annual survey and 7/13/22 complaint survey results were not in the facility's binder. During an interview on 8/3/23 at 10:54 AM E1 (NHA) confirmed the finding.	F 577	a. Missing survey results from the 10/22/21 annual survey and 7/13/22 complaint survey were replaced in survey binder. b. 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 actions outlined below in Section C. c. Upon receiving survey results they will be placed in survey binder in front lobby by NHA or designee. d. The NHA or designee will audit binder to ensure results are placed timely and remain in binder at all times. The audits will be performed daily or until 100%	

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F 577	Continued From page 3	F 577	compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the	F 585		10/9/23

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F 585	Continued From page 4 provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source,	F 585		

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F 585	Continued From page 5 and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that for one (R264) out of one resident reviewed for grievances, the facility failed to ensure that concerns received by the facility were timely and thoroughly investigated to resolve the grievance. Findings include: Review of R264's clinical record revealed: 4/5/23 - Admission to the facility.	F 585	a. Personal effects form will be completed timely upon admission. In the event of a missing item a thorough investigation will take place with timely and thorough follow up with resident and/or responsible party. b. 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	

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F 585	Continued From page 6 4/5/23 - A review of the inventory of personal effects form revealed no evidence it was completed upon admission. 4/9/23 - A review of the inventory of personal effects form revealed "son brought one pair of black pants and one shift labeled with black marker." 4/23/23 - A review of an Employee Concern/ Complaint form revealed that R264 had the following missing items: blue sweatshirt, black sweatpants, pack of ten contact lenses, and dark green blanket. A response noted from the facility, "blue sweatshirt, black sweatpants, and green blanket were found. Son notified and will pick up on Friday." 8/3/23 9:15 AM- An interview with E1 (NHA) confirmed that the contact lenses for R264 were not found and the facility lacked evidence of any follow-up on the missing contact lenses. 8/7/23 - Findings reviewed with E1, E2 (DON), E3 (Corporate) at approximately 2:00 PM.	F 585	actions outlined below in Section C. c. Root cause analysis was conducted and it was determined that the facility failed to ensure that concern regarding missing contact lenses was timely and thoroughly investigated. An in-service will be conducted by Staff Development for staff that are involved in admission assessments to ensure personal effects form is completed timely and accurately. When missing items are identified a concern form will be initiated, a thorough investigation will ensue, and timely and thorough follow up will be provided to resident and/or responsible party. d. The Social Services Director or designee will audit new missing item concerns to ensure that a personal effects form was completed timely upon admission and that a thorough investigation and follow up is completed of missing item. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		10/9/23

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F 656	Continued From page 7 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 8 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, it was determined that for one (R18) out of twenty-two residents reviewed for care plans, the facility failed to develop a care plan for the use of oxygen. Findings include: Cross refer F695 Review of R18's clinical record revealed: 6/6/23 - R18 was re-admitted to the facility with acute respiratory failure with hypercapnia. 6/12/23 - R18 had a documented BIMS score of 15/15, revealing an intact cognitive state. 8/1/23 10:59 AM - An interview with R18 stated she uses oxygen only at night and has been using oxygen for a few weeks. 8/1/23 through 8/4/23 - Random observations of R18's room revealed an oxygen concentrator with nasal cannula oxygen tubing and a zip lock bag taped to the side of the concentrator with R18's name. 8/4/23 10:32 AM - An interview with E5 (LPN) confirmed there were no physician orders or nursing measures for R18 relating to the use of oxygen. A record review lacked evidence of a	F 656	a. Orders were obtained and care plan updated to reflect PRN use of Oxygen for resident R18. b. All residents using Oxygen have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. A root cause analysis was conducted and it was determined that thefAn audit of all residents was completed to identify residents who use Oxygen. An audit was then done to ensure that all residents that use oxygen have a care plan for Oxygen usage as well as orders from the physician. Nurses will be provided with education that in the event they identify a resident is in need of Oxygen to obtain an order from physician and ensure care plan is updated to reflect Oxygen usage. d. The DON or designee will audit all residents who use Oxygen to ensure that appropriate orders and care plan is in place. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive	

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F 656	Continued From page 9 person-centered care plan for R18's oxygen administration. 8/7/23 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate) during the exit conference.	F 656	weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R66) out of one resident reviewed for pressure ulcers the facility failed to ensure that the resident received the necessary treatment and services to promote healing and prevent new pressure ulcers from developing. For R66, a dependent resident with a pressure ulcer the facility failed to ensure that R66 was turned and repositioned every two hours. Findings Include: National Pressure Ulcer Advisory Panel (NPUAP), Prevention and Treatment of Pressure Ulcers:	F 686	a. Care staff for R66 were immediately educated on importance of turning and repositioning as well as skin check intervention every two hours as well as PRN (as needed.) b. All residents who have orders for two hour turning, repositioning and skin checks have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.	10/9/23

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F 686	Continued From page 10 Quick Reference Guide, second edition, published 2014, stated "Do not position an individual directly on a pressure ulcer...Continue to turn and reposition the individual regardless of the support surface in use...No support surface provides complete pressure relief." A facility policy (last revised 1/17/2023) "Pressure Ulcer prevention and Management" included: Interventions for dependent residents may include, but are not limited to: Turning and repositioning every two hours; Use of pillows to aid in positioning. Review of R66's clinical record revealed: 10/21/19 - R66 was admitted to the facility with diagnoses that included quadriplegia and multiple sclerosis. 10/27/19 - Admission MDS assessment documented R66 was dependent for all ADL's and care, high risk for developing pressure ulcers and no pressure ulcers were identified. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage) was identified. 4/15/23 - A care plan intervention included, assist/encourage the resident for turning and repositioning every 2 hours for pressure relief (May use pillows to offload pressure areas). 4/18/23 - A quarterly MDS assessment documented R66 had one unstageable pressure ulcer. (tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, grey, green or brown dead tissue) and/or eschar (dead tissue	F 686	c. A root cause analysis was conducted and it was determined that the facility failed to turn and reposition resident every two hours. All direct care staff will be in-serviced by Staff Development on the importance of and expectation that all residents who have orders for the two hour turning, repositioning and skin checks are receiving this intervention as ordered. d. The Director of Nursing or designee will select 3 residents who are care planned for the two hour turning, repositioning and skin check program and observe to ensure they receive this care consistently and timely. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 686	Continued From page 11 that is tan, brown or black and tissue damage more severe than slough in the wound bed). 6/22/23 - An annual MDS assessment documented one unstageable pressure ulcer with slough or eschar. 7/27/23 - R66's Braden scale (tool used to determine risk for development of pressure ulcers) score was 12 (10 - 12 is considered high risk). 7/1/23 through 8/6/23 - CNA "Documentation Survey Report" revealed that turning and repositioning was being signed off across all shifts. On the following dates and times, R66 was observed in bed laying on his back: 8/2/23 8:30 AM, 8/2/23 11:05 AM, 8/2/23 1:25 PM, 8/3/23 7:50 AM; 8/3/23 10:00 AM; 8/3/23 12:02 PM; 8/3/23 3:55 PM; 8/7/23 10:20 AM; 8/7/23 12:10 PM. 8/7/23 10:15 AM - During an interview E7 (UM) revealed R66 has a pressure relieving mattress on his bed and R66 is turned and repositioned every two hours. E7 confirmed R66 has an unstageable pressure ulcer to the right ischium (bony areas on each buttock). 8/7/23 10:40 AM - Observation and interview with E8 (assigned CNA) in the presence of E7 (UM) in R66's room. R66 observed on his back with a pillow under his right shoulder, not close to the lower back/ buttocks (correct position). E7 and E8 both confirmed R66 was not in a position to promote healing. E8 confirmed the last time R66 was turned and repositioned was at the beginning	F 686		

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F 686	Continued From page 12 of her shift at approximately 7:30 AM. Following the interview E7 stated that turning and repositioning was being signed off on the CNA "Documentation Survey Report". The documentation was not consistent with the observations. 8/3/23 11:50 AM - During an interview FM1 (family member) stated that both herself and her husband visit every day and they are concerned that staff are not turning and repositioning R66 every two hours. She proceeded to tell Surveyor that "last Sunday night we waited 3 hours and R66 had not been turned so we put the light on. When his aide appeared I mentioned he was a 2 hour rotation - she said nothing. At times they haven't come in at all and it's been 4 hours or more." FM1 stated she had spoken with E2 (DON) about their concerns, in addition, a grievance had been filed. The facility failed to ensure that R66, a dependent resident with a pressure ulcer, was turned and repositioned every two hours. 8/7/23 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (Corporate) during the exit conference.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		10/9/23

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F 695	Continued From page 13 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R18) out of one resident reviewed for respiratory care, the facility failed to provide professional standards of practice by ensuring the oxygen tubing was changed weekly. Findings include: Cross refer F656 Review of R18's clinical record revealed: 6/6/23 - R18 was re-admitted to the facility with acute respiratory failure with hypercapnia. 6/12/23 - R18 had a documented BIMS score of 15/15, revealing an intact cognitive state. 8/1/23 10:59 AM - An interview with R18 stated she uses oxygen only at night and has been using oxygen for a few weeks. 8/1/23 through 8/4/23 - Random observations of R18's oxygen tubing revealed no label with a date. 8/4/23 1:05 PM - During a joint observation and interview, E4 (CNA) stated she was not sure when the tubing was changed last and confirmed the oxygen tubing was not labeled for R18. A review of the Treatment Administration Record (TAR) indicated no documentation of oxygen tubing being changed. A review of R18's Physician orders revealed no	F 695	a. Orders were obtained and care plan updated to reflect PRN use of Oxygen for resident R18. Orders were put in place for resident R18 to change oxygen tubing weekly and Treatment Administration Record was updated to reflect this weekly task. Tubing was labeled with date. b. All residents using Oxygen have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. A root cause analysis was conducted and it was determined that the facility failed to ensure O2 tubing was changed weekly. Orders and care plan were not initiated due to the nurse who placed Oxygen on patient not notifying provider or Interdisciplinary Care Team when applying the oxygen. An audit of all residents who use Oxygen was completed to ensure orders are in place to change Oxygen tubing weekly, Treatment Administration Record reflects same and that all Oxygen tubing labeled with date. Nurses will be provided with education regarding the need to ensure orders and Treatment Administration Record reflect the need to change Oxygen tubing weekly and tubing is dated. d. The DON or designee will audit all	

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F 695	Continued From page 14 orders to change oxygen tubing. 8/7/23 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate) during the exit conference.	F 695	residents who use Oxygen to ensure that tubing is changed weekly and that all tubing is dated. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		10/9/23

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F 842	Continued From page 15 all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 842		

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F 842	Continued From page 16 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of facility documentation, it was determined that for one (R262) out of twenty-one (21) sampled residents, the facility failed to ensure accurate and complete records. 1. Review of R262's clinical record revealed: 3/6/23 - Admission to facility. 8/7/23 - 9:03 AM- A review of R262's Medication Administration Record (MAR) lacked documentaion of the administration of Zosyn (antibiotic medication) on 3/16/23 and 3/23/23. R262 was receiving his antibiotic through a PICC (peripheral inserted central catheter) line. 8/7/23 10:01 AM - An interview with E4 (LPN) revealed that if a medication is unavailable, staff would notify the pharmacy and the on-call provider to get a hold order. Also, if there is an issue with the PICC line staff would notify the IV team. 8/7/23 10:22 AM - An interview with E5 (UM) confirmed that the MAR lacked a signature for the administration of Zosyn. E2 (DON) was present and confirmed there was no medication variance noted for the dates 3/16 and 3/23/23. There was a lack of evidence of complete and accurate documentation regarding medication administration for R262.	F 842	a. R262 was discharged from facility prior to this survey. No corrective action taken. b. All residents receiving antibiotic through a PICC line have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. A root cause analysis was conducted and it was determined that the facility failed to document medication administration through PICC. An audit of all residents receiving antibiotics through PICC line was done to ensure that administration of antibiotic is documented as ordered. Staff will be educated on the importance of accurate documentation during medication administration and that every administration must be captured in the Medication Administration Record. d. The DON or designee will audit all residents who receive antibiotics through PICC ensuring there is a documented medication administration for every dose ordered on the Medication Administration Record. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits	

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F 842	Continued From page 17 8/7/23 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate) during the exit conference.	F 842	will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee	
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain essential kitchen equipment in safe operating condition. Findings include: 8/1/23 10:24 AM - During a tour of the kitchen, the surveyor observed three areas of ice build-up in the walk-in freezer on the floor below the fans, behind the fans, and under a black pipe that runs from the fan area to the wall. An interview with E6 (Dietary Director) revealed the ice build-up had been ongoing for the last two months. 8/1/23 10:37 AM - Findings were confirmed with E6 (Dietary Director). 8/7/23 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (Corporate) during the exit conference.	F 908	a. The ice buildup was immediately thawed by Food Services Director. b. No resident was affected by this deficient practice. All residents have the potential to be affected by this deficient practice. Future residents will be protected from his deficient practice by the corrective actions outlined below in section C. c. A root cause analysis wad conducted and it was determined that the facility failed to take action once identifying there was ice build up in walk in freezer. The fan was replaced and is now functioning properly, preventing ice buildup. Kitchen staff will be educated on the importance of monitoring for ice buildup in the walk-in freezer and alerting maintenance immediately if identified.	10/9/23

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F 908	Continued From page 18	F 908	d. The food services director will audit walk in freezer for ice buildup. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	