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 Rehabilitation Silverside

DATE SURVEY COMPLETED: March 07, 2024

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.		
	A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the Delaware Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.		
	Survey Dates: 03/04/24 to 03/07/24		
	Survey Census: 100		
	Sample Size: 33		
	Supplemental Residents: 0		
3201	**Regulations for Skilled and Intermediate Care Nursing 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:		

Provider's Signature Brandi Wilson Title NHA Date 7/2/2024

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	Cross Refer to the CMS 2567-L survey completed March 7, 2024: F580, F584, F600, F609, F610, F689 and F847. **F760 §483.45(f)(2) Residents are free of any significant medication errors.** Based on interview, observations, record review, and review of facility policy, the facility failed to ensure one of six residents (Resident (R) 366) reviewed during medication pass observations was free from a significant medication error. The resident's insulin (a medication used to control blood sugar) pen was not primed prior to the administration of the medication, creating the potential for the resident to receive an inaccurate dose. A total of 33 residents were reviewed in the sample. Findings include: Review of the facility's undated "Administering Subcutaneous Insulin Using an Insulin Pen Procedure" read, in pertinent part, "Prime the needle by dialing up the insulin pen to 2 (units) and push button to remove air from the needle into biohazard container. Repeat until a drop of medication is visible at tip of the needle;" and "Using nondominant hand, grasp a fold of cleansed skin. Do not touch where needle is to be injected. Using nondominant hand, hold the pen in a fist and inject at a 90 degree angle. Hold down the button at the end of the needle and count to 10 seconds before removing the needle (from the resident's skin)." Review of R366's "Admission Record," dated 03/07/24 and found in the EMR under the "Profile" tab, indicated the resident was admitted to the facility on 02/06/24 with a diagnosis of type 2 diabetes. R366's "Minimum	Cross refer to CMS 2567-L survey completed March 7, 2024: F580, F584, F600, F609, F610, F689, F847. **F760** A.) The facility was unable to correct the deficient practice. B.) All residents who require insulin injections have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in Section C. C.) A review of all residents who require insulin injections was conducted, and no other residents were affected by this deficient practice. The facility had recently converted to insulin pens from multidose vials, and a root cause analysis revealed that the licensed nursing staff needed additional training. During new hire orientation, the Staff Developer/designee will educate the licensed nursing staff on priming the insulin pen prior to administration and leaving the needle in the subcutaneous tissue for at least ten seconds after administration to assure absorption of the medication. The education will consist of both verbal and hands on education techniques with return demonstration.	

Provider's Signature Brandi Wilson Title NHA Date 7/2/24

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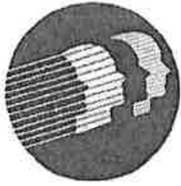
	Data Set (MDS)" assessment was not available to the survey team. Review of R366's "Order Summary Report," dated 03/07/24 and found in the EMR under the "Orders" tab, indicated an order for Insulin Lispro 75-25 inject 18 units subcutaneously every morning. Review of R366's "Medication Administration Record (MAR)," dated 03/01/24 through 03/07/24 and found in the EMR under the "Orders" tab, indicated the insulin was being administered routinely per physician's orders. During an observation of Licensed Practical Nurse (LPN2) on 03/06/24 at 9:16 AM revealed LPN2 was observed administering R366's's medication and dialed up 18 units of insulin and then injected the insulin into the resident's left arm., holding the needle into the resident's subcutaneous tissue for approximately three seconds before removing the needle. LPN2 did not prime the insulin pen prior to administration of R366's medication to ensure there was no air in the needle. During an interview with LPN2 on 03/06/24 at 9:57 AM, she stated she did not routinely prime the resident's insulin pen prior to dialing up the ordered dose of insulin and administering it. She stated she was not aware the needle of the insulin pen needed to remain in the resident's subcutaneous tissue for at least 10 seconds to ensure absorption of the medication. She stated, "I try to leave the needle (in the resident's subcutaneous tissue) for at least three seconds." During an interview with the Director of Nursing (DON) and Administrator on 03/06/24 at 12:21 PM, the DON stated she	D.) The Staff Developer/designee will monitor the administration of insulin to ensure proper administration of insulin to three residents on each floor. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	4/22/2024

Provider's Signature Brandi Wilson Title NHA Date 7/2/24



SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	was not sure of the process for priming an insulin pen or how long the insulin needle needed to remain in place when administering insulin. The DON indicated nursing staff was expected to follow the facility's policy and procedure related to the administration of insulin via and insulin pen. **F880 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.** Based on interview, observations, and record review, the facility failed to ensure infection control procedures were followed for one of six residents (Resident (R) R366) reviewed during medication administration. The resident's insulin pen and blood glucose monitor were placed on an overbed table in the resident's room without placing a clean barrier between the items and the un-sanitized overbed table, and then the items were returned to the medication cart without properly sanitizing them first. A total of 33 residents were reviewed in the sample. Findings include: Review of R366's "Admission Record," dated 03/07/24 and found in the EMR under the "Profile" tab, indicated the resident was admitted to the facility on 02/06/24 with diagnoses including type 2 diabetes. Review of R366's "Order Summary Report," dated 03/07/24 and found in the EMR under the "Orders" tab, indicated orders for the resident's blood sugar to be obtained twice daily and for the administration of Insulin Lispro	F880 A.) The facility was unable to correct the deficient practice. B.). All residents who require insulin injections and/or blood glucose monitoring have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in Section C. C.) A review of all residents who Require insulin injections and/or blood glucose monitoring was conducted, and no other residents were affected by this deficient practice. A root cause analysis was completed and identified that the	

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	75-25 inject 18 units subcutaneously every morning. Review of R366's "Medication Administration Record (MAR)," dated 03/01/24 through 03/07/24 and found in the EMR under the "Orders" tab, indicated the blood sugar testing and insulin were being administered routinely per physician's orders. During an observation of Licensed Practical Nurse (LPN2) administering R366's's medication on 03/06/24 at 9:16 AM revealed LPN2 entered the resident's room, placing the insulin pen and the blood sugar monitor on the resident's overbed table without using a clean barrier between the items and the table. LPN2 obtained R366's blood glucose level, leaving the insulin pen on the overbed table, then placed the blood sugar monitor back on the overbed table and administered the resident's insulin. After administering the resident's medication, LPN2 returned to the medication cart, placing the insulin pen into the medication drawer without sanitizing it first and placing the blood glucose monitor on the top of the cart without sanitizing it first. During an interview with LPN2 on 03/06/24 at 9:57 AM, she stated she was not aware a clean barrier should be used when placing any multi-use medication containers or monitoring equipment on a surface in a resident's room. During an interview with the Director of Nursing (DON) and Administrator on 03/06/24 at 12:21 PM, the DON stated her expectation was a clean barrier be used when placing any multi-dose medication or re-usable equipment that was expected to be returned to the medication cart on any surface in a resident's room to prevent potential	licensed nursing staff failed to place a clean barrier between the insulin pen and glucose monitor and the bedside table and failed to sanitize the insulin pen and glucose monitor prior to returning them to the medication cart related to a knowledge deficit. The Staff Developer/designee will educate the licensed nursing staff on placing a clean barrier between the insulin pen and/or glucose monitor and the bedside table and sanitizing the insulin pen and/or glucose monitor prior to returning them to the medication cart. D.) The Staff Developer/designee will monitor the administration of insulin and/or blood glucose monitoring to ensure a clean barrier is placed and that the items are sanitized prior to being placed in the medication cart on three residents on each floor. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	4/22/2024

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	cross contamination (the potential transfer of pathogens from a resident's room to the medication cart). During an interview with the DON on 03/07/24 at 9:30 AM, she stated the facility did not have a policy/procedure related to infection control with medication administration.		

Provider's Signature Brandi Wilson Title NHA Date 7/2/24

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 03/07/2024

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 A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality on 03/04/24 through 03/07/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the Delaware Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 03/04/24 to 03/07/24 Survey Census: 100 Sample Size: 32 Supplemental Residents: 0	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		4/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed — TITLE — (X6) DATE 03/22/2024

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 580	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews, medical record review, and policy review, the facility failed to ensure the responsible party (RP) for one of three residents (Resident(R)214) sampled for pressure ulcers,	F 580	F580 1.) R214 no longer resides in the facility. R214 was not negatively impacted by this deficient practice.	

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F 580	Continued From page 2 were made aware of the resident's change in condition. Findings include: Review of the facility's policy titled "Provider Notification of Resident Change in Medical Condition" dated 01/03/24, documented "staff will notify the provider and applicable POA (power of attorney)/responsible parties of accident with injury, abnormal and critical diagnostic testing results, significant change in condition in physical, mental, or psychosocial status in either life-threatening or clinical components." Review of R214's undated "Admission Record" located in the electronic medical record (EMR), under the "Profile" tab, indicated R214 was admitted on 09/11/23, and discharged on 10/26/23. R214's diagnoses included Parkinson's disease without dyskinesia, without mention of fluctuations, dementia, abnormal posture, muscle weakness, and acute embolism and thrombosis of left iliac vein. Review of R214's quarterly "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab, with an Assessment Reference Date (ARD) of 09/14/23, revealed the "Brief Interview for Mental Status" (BIMS), revealed a score of five out of 15, indicating R214 was severely cognitively impaired. Review of R214's "Skin Alteration" incident report, dated 10/13/23, provided by the facility, documented "ulceration to left shoulder blade noted during care." Further review of the report revealed no documentation pertaining to the notification of R214's responsible party.	F 580	2.) All residents who experience alterations in skin integrity have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in Section C. 3.) A facility wide sweep of all residents with current alterations in skin integrity was completed and no other residents were affected by this deficient practice. A route cause analysis was conducted, and it was determined that the licensed nurse failed to notify the responsible party of R214 when the alteration in skin integrity was identified. The Staff Developer/designee will educate the licensed nursing staff of notifying the responsible party of a resident when an alteration in skin integrity is identified. 4.) The Wound Care Nurse/designee will audit wound incident reports to ensure compliance with family notification. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All	

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F 580	Continued From page 3 Review of the "Skin/Wound Note" dated 10/16/23, located in the EMR under the "Progress Notes" tab, documented abrasion to left posterior shoulder, partial thickness. A physical therapy consult is recommended for the patient to evaluate for wheelchair evaluation-concern about round screws securing high back chair to frame being source of abrasion." Further review of R214's "Progress Notes" revealed there is no documentation related to notification of R214's responsible party. During an interview conducted with the Wound Care Nurse on 03/07/24 at 12:05 PM, the wound care nurse revealed after a new pressure ulcer was identified, an incident report would have been completed, and the family would be notified by the person completing the incident report. The wound was identified as resulting from a screw on the wheelchair and therapy was consulted for cover/pad for wheelchair. On 03/07/24 at 12:12 PM, the Wound Care Nurse confirmed the family was not notified of abrasion on shoulder. During an interview conducted with the Administrator on 03/07/24 at 3:37 PM, the Administrator confirmed the incident report was incomplete and that it was expected for the staff to complete the form and notify the responsible party.	F 580	results will be brought through the QAPI meetings.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		4/22/24

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F 584	Continued From page 4 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of housekeeping procedures, and record review, the	F 584	F584	

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F 584 Continued From page 5

facility failed to ensure one (Resident (R)1) room out of 33 rooms observed was properly cleaned to ensure a homelike environment.

Findings include:

Review of R1's "Profile" in the electronic medical record (EMR) under the "Clinical" tab revealed R1 was admitted on 05/15/23 and had diagnoses that included acute and chronic respiratory failure with hypoxia, acute and chronic respiratory failure with hypercapnia, chronic obstructive pulmonary disease (COPD), and chronic diastolic heart failure.

Review of R1's Quarterly "Minimum Data Set (MDS)" in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) dated 02/19/24 revealed a "Brief Interview for Mental Status (BIMS)" with a score of 15 out of 15 indicating R1 was cognitively intact.

During an observation and interview with R1 on 03/04/23 at 1:18 PM in the resident's room revealed the floor around R1's bed was observed with dirt and debris, the bed frame had a heavy buildup of dust on the headboard and footboard, and the frame holding the air mattress pump located at the end of the bed had a heavy buildup of dirt and debris. The bedside table was observed to have a buildup of dust on the top. In an interview, at the time of the observation, R1 stated, "look at the wardrobe, look at the dust there, they never clean that, they never been taught how to clean." R1 stated, "Why don't they clean my side of the room, just because I'm in bed?"

During an observation on 03/04/24 at 3:28 PM,

F 584

1.) R1 still resides in the facility and her room was thoroughly cleaned by the Housekeeping Director.

2.) All residents have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in Section C.

3.) The housekeeper assigned to R1□s room that day was educated in real time. A facility wide sweep of all resident rooms was conducted, and no other residents were affected by this deficient practice. A route cause analysis was conducted, and it was determined that the housekeeping staff failed to follow their five-step cleaning procedure.
The Housekeeping Director/designee will educate the housekeeping staff on the five-step cleaning procedure.

4.) The Housekeeping Director/designee will randomly audit five resident rooms on each floor to ensure compliance with the cleaning process.
The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective actions will be taken. If

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CADIA REHABILITATION SILVERSIDE	3322 SILVERSIDE ROAD WILMINGTON, DE 19810

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F 584	Continued From page 6 R1's room remained in the same condition. During an observation and interview on 03/05/24 at 11:06 AM, R1 stated "they swept the room, but didn't dust anything, the guy is new, he doesn't know anything." During an observation and interview on 03/06/24 at 10:21 AM, the Housekeeping Director (HKD) was observed dry mopping the hallway outside R1's room. The HKD was asked to describe the expectations of housekeeping staff when cleaning a resident room. HKD stated, "we have a five step process, high dust, wipe high touch areas, empty trash, dry mop the floor, and then damp mop the floor. The HKD confirmed the heavy buildup of dust and dirt on R1's bed, dresser, wardrobe, and frame holding the air mattress pump. The HKD said he did have a new employee and would provide training today, (03/06/24), and would also clean R1's room appropriately. Review of the undated "Procedure" provided by the HKD, revealed step two of the five step cleaning process as "Horizontal Surfaces - disinfected using a solution of properly diluted germicide, sanitize all horizontal surfaces. As you enter the room, work clockwise around the room hitting all surfaces. Use your high duster to dust hard to reach areas, such as the tops of closets, high lights, and ceilings areas as needed. Tabletops, headboards, windowsills, chairs, over bed lights, wall ledges, over bed tables, and the bases of over bed tables should all be done."	F 584	compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and	F 600		4/22/24

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 03/07/2024

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F 600	Continued From page 7 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 facility policy review, record review, resident and staff interviews, the facility failed to ensure two Residents of six residents (Resident (R) 62 and R86) reviewed for abuse remained free from physical abuse. A total of 33 residents were reviewed in the sample. Findings include: Review of the facility's "Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime Policy" most recently reviewed 01/03/24 read, in pertinent part, "It is the policy of Cadia Healthcare to protect residents and prevent occurrences of abuse, neglect, mistreatment, misappropriation of resident property, exploitation, and crime." 1.Review of R86's "Admission Record," found in the electronic medical record (EMR) under the "Profile" tab, indicated the resident was admitted on 11/04/22 with diagnoses including dementia with mood and behavior disturbance.	F 600	F600 1.) R86 still resides in the facility. The facility identified the abuse and took the appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. 2.) All residents have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in Section C. 3.) A review of all residents with current allegations of abuse was completed and no other residents were affected by this deficient practice. A route cause analysis was conducted, and it was determined that the certified nursing staff involved failed to follow the facility policy on abuse. The Staff Developer/designee will educate	

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F 600	Continued From page 8 Review of R86's Quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/09/24, revealed a "Brief Interview for Mental Status (BIMS)" assessment could not be done due to the resident's poor cognition. The assessment indicated the resident had both short and long-term memory deficits. The assessment indicated R86 required substantial assistance from staff to complete his Activities of Daily Living (ADLs), including bed mobility and transfers. The resident did not exhibit any behaviors during the assessment reference period according to the assessment. Review of R86's "Care Plan," dated 05/2023 and found in the EMR under the Care Plan Tab," indicated the resident was resistive to care at times, including refusing to take his medication, refusing to have his blood sugar checked, and refusing to get out of bed. Interventions included leaving the resident if he refused cares and reapproaching in 10 to 15 minutes and allowing the resident to make decisions about his own treatment to give him a sense of control. Review of an "Incident Report" related to R86, dated 06/21/23 and provided to the survey team, read, in pertinent part, "at 1515 (3:15 PM) today, resident stated that he was picked up and swung into bed last night. Assigned CNA (Certified Nursing Assistant) suspended (during) investigation." Further review of the report revealed a staff member who was interviewed during the investigation stated she witnessed another staff member (CNA2) handling R86 roughly while helping him to sit down in his wheelchair. In addition, the report indicated a resident who was interviewed during the	F 600	the Certified Nursing Assistants on Cadia□s abuse policy. 4.) The ADON/designee will randomly interview five residents on each floor to ensure they have not experienced abuse. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. F600 1.) R62 still resides in the facility. The facility identified the abuse and took the appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. 2.) All residents have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in Section C. 3.) A review of all residents with current allegations of abuse was completed and	

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F 600	Continued From page 9 investigation of the incident reported she witnessed two staff members (CNA1 and CNA2) being rough with R86. Both CNA1 and CNA2 were suspended during the investigation and were terminated for rough handling of R86. The document indicated the allegation of CNA1 and CNA2 rough handling R86 was substantiated. During an interview with the Administrator and the Director of Nursing (DON) on 03/06/24 at 12:15 PM, both indicated they were not employed at the facility at the time of the investigation into R86's allegation of abuse. Both confirmed the investigation report revealed substantiated staff to resident abuse. Both stated their expectation was residents residing in the facility were to be free from all types of abuse. 2. Review of R62's undated "Admissions Record" located in the EMR under the "Profile" tab, indicated R62 was admitted to the facility initially on 08/06/20, with a readmission of 02/21/24, with diagnoses including functional quadriplegia, adjustment disorder with depressed mood, and cognitive communication deficit. Review of R62's quarterly "MDS" located in the EMR under the "MDS" tab, with an ARD of 12/06/23 revealed a BIMS score of 13 out of 15, indicating R62's cognition was intact. R62 was assessed as not displaying any behavioral indicators. Review of R62's "Care Plan" located in the EMR under "Care Plan" tab, revision date of 03/05/24, revealed R62 had an activities of daily living (ADLs) self-care performance due to deconditioning and impaired mobility-has history of decline from fractures, and most recently PNA	F 600	no other residents were affected by this deficient practice. A route cause analysis was conducted, and it was determined that the certified nursing staff involved failed to follow the facility policy on abuse. The Staff Developer/designee will educate the Certified Nursing Assistants on Cadia□s abuse policy. 4.) The ADON/designee will randomly interview five residents on each floor to ensure they have not experienced abuse. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	

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F 600	Continued From page 10 (pneumonia). Interventions included R62 states that it is important to her to choose what type of bath she receives, she is scheduled for hair care/nail care and shower/bed bath weekly on Tuesday and Friday, 7-3 shift, avoid scrubbing & pat dry sensitive skin, provide a sponge bath when a full bath or shower cannot be tolerated. During an interview with R62 on 03/04/24 at 1:15 PM, R62 stated that she had been abused, and mistreated in the past. R62 stated that in the past year there was a CNA that had been rough with her while providing her care and turning her in the bed. R62 stated she had reported it to the Administration. Review of the "Facility Reported Incident (FRI)" provided by the facility, documented R62 was "admitted to facility with rheumatoid arthritis, resident is an assist with all ADLs. On 11/08/23, R62 stated to social services that her assigned CNA (CNA7) for 7-3 [first shift] was rough with her during care. Resident has a BIMs of 11 ...while speaking to the resident, the resident informed us (administration) that another CNA(CNA3) had overheard the accused CNA's interaction with the resident. Second CNA3 was interviewed, and resident's statements, and accusations were confirmed. CNA7 was terminated." Review of a "Witness" statement provided by the facility dated 11/13/23, documented by CNA3, revealed that "on 11/08/23, around lunch time, (CNA3) witnessed (CNA7) storm out of (R62's) room. CNA3 went into R62's room to check on the resident. CNA3 observed that R62's bed was raised to about waist level, and the resident's lower body was exposed, R62 told CNA3 that CNA7 had been rough with her, pushing her	F 600		

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F 600	Continued From page 11 around, and roughly turning her. R62 told CNA3 that she (R62) had told CNA7, can you be nice to me like you were this morning. CNA3 documented that she went to speak with CNA7, and CNA7 told CNA3 the same things as R62. Review of CNA7's written statement dated 11/13/23, CNA7 documented "incident never occurred because the resident does not eat and only drinks coffee so she would not have to choose between the two." CNA7 refused to give further statements to Director of Nursing (DON) when requested by the DON on 11/14/23. During an interview on 03/05/24 at 1:57 PM with CNA3, CNA3 confirmed the witness statement she had written about the incident between CNA7 and R62. CNA3 reiterated that she had witnessed CNA7 storm out of R62's room, and she appeared mad. CNA3 stated she did not recall the verbal exchange between CNA7 and R62. However, R62 was visibly upset and crying when she went into the resident's room. During an interview with Unit Manager (UM)2 on 03/05/24 at 1:59 PM, the UM stated that CNA7 had told her she was not taking care of R62 anymore. UM2 went and spoke with R62, who informed her that CNA7 had been rough with her. During an interview with the DON on 03/05/24 at 2:04 PM, the DON stated she had spoken with R62, and both the CNAs (3 and 7) that were involved as part of her investigation. After interviewing both CNAs and the resident the DON substantiated the incident and terminated CNA7. During an interview with the Administrator on 03/05/24 at 2:12 PM, the Administrator was	F 600		

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F 600	Continued From page 12 questioned about what she recalled about the incident. The Administrator stated she had spoken to R62 while doing rounds, resident reported to her she was very upset, that CNA7 had exposed her. The Administrator spoke with CNA3, who wrote her witness statement. After speaking with CNA7, CNA7 was terminated.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		4/22/24

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F 609	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview, record review, document review, and facility policy review, the facility failed to ensure that an allegation of staff to resident abuse was reported timely to the State Agency for one of six residents (Resident(R)62) sampled for allegations of abuse. This had the potential to place the resident at risk for further abuse. Findings include: Review of the facility's policy titled "Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime" review date 01/03/24, documented "Reporting and Response: Witnessed or suspected incidents of abuse or reasonable suspicions of crime are to be reported immediately. A witness who fails to report abuse, neglect, mistreatment, misappropriation of resident property, exploitation, or suspicions of crime is considered to be as culpable as the accused. Their name will also be reported to the appropriate regulatory agency and/or law enforcement for further investigation. The Director of Nursing (DON) or designee is responsible for conducting the abuse investigation. The Nursing Home Administrator (NHA) serves as the abuse coordinator. Allegations of resident abuse shall be reported to the appropriate state regulatory within 2 hours." Review of R62's undated "Admissions Record" located in the electronic medical record (EMR) under the "Profile" tab, indicated R62 was admitted to the facility initially on 08/06/20, with a readmission of 02/21/24, with diagnoses including functional quadriplegia, adjustment disorder with	F 609	F609 1.) R62 still resides in the facility and was not negatively impacted by this deficient practice. 2.) All residents who express an allegation of abuse have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in Section C. 3.) A review of all residents with current allegations of abuse was completed and no other residents were affected by this deficient practice. A route cause analysis was conducted, and it was determined that the nursing management team failed to report the allegation in the regulatory allotted time frame. The Staff Developer/designee will educate the nursing management team on the time requirements of reporting abuse. 4.) The DON/designee will review all allegations of abuse to ensure they have been reported within the regulatory timeframe. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks.	

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F 609	Continued From page 14 depressed mood, and cognitive communication deficit. Review of R62's quarterly "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab, with an assessment reference date (ARD) of 12/06/23,erevealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R62's cognition was intact. R62 was assessed as not displaying any behavioral indicators. During an interview conducted with R62 on 03/04/24 at 1:15 PM, R62 stated that she had been abused, and mistreated in the past. R62 stated that she couldn't remember the exact date, but in the past year there was a Certified Nursing Assistant (CNA) that had been rough with her while providing her care and turning her in the bed. R62 stated she had reported it to the Administration the same day it occurred. Review of the "Facility Reported Incident (FRI)" provided by the facility, revealed the "FRI" was submitted on 11/13/23 at 3:21 PM. The incident description was documented as "resident stated CNA was ruff (sic) with her during care. Investigation on-going. Incident date/time: 11/13/23 at 12:00 PM. Upon further review of the "FRI" it was documented the incident occurred on 11/08/23, five days prior to the incident being reported. During an interview with the Administrator on 03/04/24 at 3:58 PM, the Administrator confirmed the incident was on 11/08/23, and the facility was aware of the allegations on 11/08/23. When questioned why the incident was not reported until 11/13/23, the Administrator stated the Director of Nursing (DON) thought it was more of	F 609	Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 609	Continued From page 15 a customer service issue at first.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 facility policy review, record review, and resident and staff interviews, the facility failed to ensure a thorough investigation was completed related to allegations of potential abuse for two Residents of six residents (Resident (R)59 and R62) reviewed for abuse. A total of 33 residents were reviewed in the sample. Findings include: Review of the "Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime Policy" most recently reviewed 01/03/24 read, in pertinent part, "It is the	F 610	F610 1.) R59 still resides in the facility and was not negatively impacted by this deficient practice. 2.) All residents who experience or are alleged to have experienced abuse have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in Section C. 3.) A review of all residents with current	4/22/24

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F 610	Continued From page 16 policy of Cadia Healthcare to protect residents and prevent occurrences of abuse, neglect, mistreatment, misappropriation of resident property, exploitation, and crime;" and "Investigation: The NHA (Nursing Home Administrator) or designee shall investigate allegations and report to appropriate regulatory agencies and/or law enforcement. All persons identified as involved in or with knowledge of the occurrence will be interviewed." 1.Review of R59's "Admission Record," found in the electronic medical record (EMR) under the "Profile" tab, indicated the resident was admitted on 05/14/20 with diagnoses including rheumatoid arthritis and unsteadiness on her feet. Review of R59's Quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/16/24, revealed a "Brief Interview for Mental Status (BIMS)" assessment score of 10 out of 15, indicating the resident was moderately cognitively impaired. The assessment indicated R59 used a wheelchair for mobility. The resident did not exhibit any behaviors during the assessment reference period according to the assessment. Review of the "Progress Notes" located in the EMR under the "Notes" Tab, read, "Resident (R59) reported that she had a wheelchair leg rest thrown on her right foot after resident (R51) was shouting at her. Right foot assessed, blanching erythema to 4th digit noted. Resident states it "hurts just a little." Resident offered an ice pack and PRN (as needed) Tylenol (a medication used to control pain), resident refused both stating, "it's not that bad it will be fine." This nurse told resident (R59) to let me know if she changed her	F 610	allegations of abuse was completed and no other residents were affected by this deficient practice. A route cause analysis was conducted, and it was determined that the Administrator and DON failed to thoroughly investigate the allegations of abuse by interviewing all persons identified as involved in or with knowledge of the occurrence. The Chief Nursing Officer/designee will educate the Administrator and DON on the steps in completing a thorough investigation. 4.) The Chief Nursing Officer/designee will review all allegations of abuse to ensure they have been investigated thoroughly. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. F610 1.) R62 still resides in the facility and was not negatively impacted by this deficient	

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F 610	Continued From page 17 mind and wanted any of those interventions offered or if the pain had gotten any worse at all, resident agreed. Resident (R59) asked this nurse what she should have done, resident educated that if she encounters an aggressive/angry resident to back away from them or the situation for her safety and to come find a staff member immediately and to never try to intervene herself. Resident shook her head in agreement. Resident returned to her room. This nurse will continue to monitor. Supervisor and Assistant Director of Nursing (ADON) aware." Review of R51's "Admission Record," found in the electronic medical record (EMR) under the "Profile" tab, indicated the resident was admitted on 11/20/17 with diagnoses including congestive heart failure and dementia. Review of R51's Quarterly "MDS" with an ARD of 01/30/24, revealed a "BIMS" score of three out of 15, indicating the resident was severely cognitively impaired. The resident exhibited verbal behaviors toward others on one to three days during the assessment reference period according to the assessment. R51 did not exhibit any physical behaviors toward others during the assessment reference period. Review of an "Incident Report" related to R51 and R59, dated 01/08/24 and provided by the facility to the survey team, read, in pertinent part, "Resident (R51) was in the hallway shouting at (R59) holding wheelchair leg. This nurse intervened. (R59) reports that (R51) hurt her foot with the wheelchair leg." Review of the facility's Investigation File related to the above incident report, dated 01/08/24 through	F 610	practice. 2.) All residents who experience or are alleged to have experienced abuse have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in Section C. 3.) A review of all residents with current allegations of abuse was completed and no other residents were affected by this deficient practice. A route cause analysis was conducted, and it was determined that the Administrator and DON failed to thoroughly investigate the allegations of abuse by interviewing all persons identified as involved in or with knowledge of the occurrence. The Chief Nursing Officer/designee will educate the Administrator and DON on the steps in completing a thorough investigation. 4.) The Chief Nursing Officer/designee will review all allegations of abuse to ensure they have been investigated thoroughly. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and	

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	085056	A. BUILDING ______ B. WING ______	C 03/07/2024

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F 610	Continued From page 18 01/10/24 and provided by the facility to the survey team, revealed no interviews were conducted with statements by staff or residents, other than R51 and R59 related to the incident during the investigation. The allegation of potential abuse was not substantiated by the facility based solely on interviews with R51 and R59 and a physical assessment of R59 immediately after the incident (which was negative for any physical signs or symptoms of abuse). During an interview with the Administrator and the Director of Nursing (DON) on 03/06/24 at 11:33 AM, both confirmed no additional resident interviews were conducted and no staff interviews were conducted during the investigation into the above incident between R51 and R59. The DON indicated she had been responsible for conducting the investigation and stated, "I spoke with the UM (Unit Manager) and she saw the episode. If there isn't a statement in the record I didn't get one. I did not talk to any other staff members or get any statements. I did not speak to any residents or get statements from them." The DON stated, "In this situation I spoke to the UM who told me what happened, so I just went with that." The Administrator stated her expectation was staff and residents were to be interviewed during an investigation of potential abuse. 2. Review of R62's undated "Admissions Record" located in the EMR under the "Profile" tab, indicated R62 was admitted to the facility initially on 08/06/20, with a readmission of 02/21/24, with diagnoses including functional quadriplegia, adjustment disorder with depressed mood, and cognitive communication deficit.	F 610	corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 610	Continued From page 19 Review of R62's quarterly "MDS" located in the EMR under the "MDS" tab, with an ARD of 12/06/23, revealed a BIMS score of 13 out of 15, indicating R62's cognition was intact. . Review of the "Facility Reported Incident (FRI)" provided by the facility, documented R62 was admitted to facility with rheumatoid arthritis, resident is an assist with all Activities of Daily Living (ADLs). On 11/08/23, R62 stated to social services that her assigned Certified Nursing Assistant (CNA)7 for was rough with her during care. Further review of the "FRI" indicated that additional residents and staff were not interviewed concerning the incident between CNA7 and R62. During an interview conducted with the Administrator on 03/05/24 at 4:14 PM, the Administrator revealed since the resident was alert and oriented, she didn't feel it was necessary to conduct official resident interviews. Upon further review of the "FRI" the Administrator confirmed the incident was incomplete.	F 610		
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:	F 689		4/22/24

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F 689	Continued From page 20 Based on observation, interview, record review, and review of facility policy, the facility failed to complete a smoking assessment and secure smoking materials for one (Resident (R)61) out of one resident who the facility identified as a smokier out of a sample of 33 residents. This had the potential for an accident/hazard related to smoking. Findings include: Review of the facility's "Smoking Policy," located in the "Admission Packet," dated 08/21, revealed "Smoking and/or the use of tobacco, tobacco products or electronic cigarettes 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." During the entrance conference on 03/04/24 the Administrator identified that the facility was a non-smoking facility and that there was only one resident (R61) who smoked. The expectation was that R61 was to smoke off the facility premises and all smoking materials were kept locked at the nurses' station. R61 was identified as a smoker and that numerous vapes had been repeatedly removed from R61's room. Review of R61's "Profile" located in the "Clinical" tab in the electronic medical record (EMR) revealed R61 was admitted on 06/03/22 and had diagnoses that included paralytic syndrome following nontraumatic intracerebral hemorrhage	F 689	F689 1.) R61 still resides in the facility and was not negatively impacted by this deficient practice. 2.) All residents who smoke have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in Section C. 3.) R61□s care plan has been updated to reflect his smoking status and he has been educated on maintaining his smoking materials at the nurse□s station. A review of all residents who smoke was conducted, and no other residents were affected by this deficient practice. A root cause analysis was completed and identified that licensed nursing staff did not complete the smoking assessment and secure residents □smoking materials. The Staff Developer/designee will educate the licensed nursing staff on completing smoking assessments on all residents who smoke, including securing their smoking materials. Education will also be provided to both the licensed nursing staff and the certified nursing staff to notify the nursing supervisor if they see or become aware of residents who smoke. 4.) The Unit Managers/designee will review all currently identified smokers and all new admissions to assure that the smoking assessments are completed (as appropriate) and all smoking materials are secured (if resident is identified as a	

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F 689	Continued From page 21 affecting left nondominant side, seizures, unspecified lack of coordination, and muscle spasm. Review of R61's quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 12/08/23 revealed R61 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 indicating R61 was cognitively intact. There was no evidence of a smoking assessment in R61's EMR. During an interview on 03/05/24 at 2:30 PM, R61 said "I smoke some. I buy them from my friend two doors down. We have to go to the church parking lot, smoke, and throw the butts in the dumpster. I have no idea if I'm supposed to tell anyone that I'm going outside to smoke or that they have to lock up my lighters." During the interview, R61 placed his cell phone over a lighter he had on top of his electric wheelchair. During an interview with the Administrator and the Director of Nursing (DON) on 03/06/24 at 9:40 AM, the Administrator and the DON each confirmed that they were unaware of R61 smoking or having smoking materials in his room. The DON stated, "the expectation is that smoking materials are kept locked at the nurses' station." Review of the "Nurses Progress Notes" located in the EMR, dated 03/06/24 at 10:35 AM, revealed a notation by the DON that read, "Met with resident who acknowledge that he understood the facility is smoke free. Discussed with resident the expectation is that we hold onto any smoking material such as cigarettes and lighters. Resident denied smoking daily and stated he only occasionally smoked and does not currently have	F 689	smoker). The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	

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F 689	Continued From page 22 any cigarette or lighters however 2 lighters were taken from resident's room. Also discussed with resident and offered smoking apron to which he refused. Offered smoking cessation program to resident who refused and stated he only smokes every once in a while, and has no cravings for cigarettes. This writer asked resident to inform me if/when he does obtain cigarettes so that a smoking assessment can be completed at that time." During an interview on 03/06/24 at 10:20 AM, Certified Nursing Assistant (CNA)4 stated, "yes, I'm aware R61 smokes, at least since last summer, I thought everyone knew." During an interview with the Unit Manager (UM)1 on 03/07/24 at 9:51 AM, the UM1 stated, "I know the social service staff have taken vapes out of R61's room before. The night shift gave me a lighter from his room this morning and I gave it to the social service staff." During an interview with the Social Service Director (SSD)1 and the SSD2on 03/07/24 at 12:19 PM, both the SSD1 and SSD2 confirmed they had been given lighters confiscated from R61.	F 689		
F 847 SS=D	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any	F 847		4/22/24

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F 847 Continued From page 23 F 847

resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(n)(2) The facility must ensure that:
(i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands;
(ii) The resident or his or her representative acknowledges that he or she understands the agreement;

§483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.

§483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State

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F 847	Continued From page 24 Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to allow 30 days for a resident or their responsible party to rescind the voluntary "Attachment #3: Binding Arbitration Agreement" after it was signed. This failure would take the right to rescind the agreement away. Findings include: Review of the facility "Attachment #3: Binding Arbitration Agreement revealed it stated ". . . (3) this Agreement may be rescinded by written notice sent to the other party via Certified Mail, return receipt requested, within twenty-one (21) days of the date upon which it is signed. . ." Interview with the Admission Coordinator on 03/07/24 at 10:33 AM confirmed the form allowed for only 21 days to rescind the Arbitration Agreement. She stated no one has pursued arbitration.	F 847	F847 1.) No resident was negatively impacted by this deficient practice. 2.) All residents have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in Section C. 3.) It was identified during survey that the Binding Arbitration Agreement provided to all residents upon admission contained verbiage of 21 days to rescind vs. the required 30 days. Corporate Compliance revised the agreement to be in compliance with the required 30-day time period to rescind. 4.) The Admissions Director/designee will ensure all new admissions are updated with the required 30-day period to rescind arbitrations. Since facility staff cannot access, change, nor amend admission packets, the problem will be considered resolved.	