

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Oakton Place Health and Rehabilitation at the Arli		STREET ADDRESS, CITY, STATE, ZIP CODE 8000 Arlington Circle Naples, FL 34113	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</b></p> <p>Based on observation, review of facility policy and procedure, clinical record review, resident representative and staff interviews, the facility failed to provide the necessary care and services to maintain personal hygiene for 4 (Resident #20, #21, #25 and #35) of 5 residents reviewed for activities of daily living.</p> <p>The findings included:</p> <p>The facility policy Activities of Daily Living (ADL), Supporting implemented 2002 (revised 2018) documented, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good, nutrition, grooming and personal hygiene and oral care . Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care.</p> <p>1. Review of the clinical record revealed Resident #20 had an admitted [DATE] with diagnoses including dementia with mood disturbance, depression and muscle weakness.</p> <p>The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 4/7/24 documented Resident #20 was dependent on staff for personal hygiene and bathing.</p> <p>The MDS noted Resident #20's cognitive skills for daily decision making were severely impaired.</p> <p>On 6/10/24 at 10:50 a.m., Resident #20 was observed in her room in bed. Her hair was uncombed, and her fingernails extended approximately 1/4 inch in length with a brown substance under the nails.</p> <p>In an interview, Resident #20's spouse who was at her bedside said, My wife does not make sense because of her dementia, and she fights with the staff because she doesn't understand. I think they are afraid because they don't want to do anything with her. No one comes into the room unless I ask for them to come.</p> <p>Resident #20's spouse said he visited his spouse every day from 8:00 a.m., until 10:00 p.m. Some days he takes her outside or around the facility in a wheelchair.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Oakton Place Health and Rehabilitation at the Arli		STREET ADDRESS, CITY, STATE, ZIP CODE  8000 Arlington Circle Naples, FL 34113	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>When he leaves, he asks staff to put her to bed but they won't do it and he tells the nurse. He said, They act like they don't want to be bothered with her because she fights them. I feed her all three meals, they don't ask me if I want them to feed her, they assume because I'm here I should do everything but I'm [AGE] years old and she is [AGE] years.</p> <p>The spouse said Resident #20 has been at the facility for nine months because he could no longer take care of her but, but here I am, still doing it. I have never seen them give her a shower. I would like for her to get showered. There is a shower right there in the bathroom.</p> <p>On 6/11/24 at 8:03 a.m., Resident #20 was observed in a wheelchair in her room with her spouse. Her fingernails remained with a brown substance under the nails. Resident #20's spouse said staff got her up before he arrived and he fed her breakfast. He said the staff did not come in to see if she needed anything. The spouse said, I feel like I'm one of the staff and they should be paying me for providing all of the care. No one even comes to check on her unless I ask them to come.</p> <p>Review of the CNA (Certified Nursing Assistant) task list showed Resident #20 preferred Bath schedule was Mondays, Wednesdays, and Fridays, on the 7:00 p.m., to 7:00 a.m., shift.</p> <p>Review of the CNA Plan of Care Response History from 5/14/24 to 6/10/24 failed to show documentation Resident #20 received her showers as scheduled. The documentation showed the resident received a bed bath on 5/24/24, 5/27/24, 6/4/24, 6/5/24 and 6/10/24. On 5/29/24 the documentation noted, Resident refused.</p> <p>2. Review of the clinical record revealed Resident #21 had an admitted [DATE] with diagnoses including hemiplegia (paralysis) of the right side, seizures, and Alzheimer's disease.</p> <p>The Quarterly MDS assessment with a target date of 5/20/24 documented Resident #22 was dependent on staff for personal hygiene. The MDS noted Resident #21's cognitive skills for daily decision making were severely impaired.</p> <p>On 6/10/24 at 2:22 p.m., Resident # 21 was observed in his room in bed, dressed in a hospital gown with approximately three days of facial hair growth. The resident appeared disheveled. His mouth and lips were dry.</p> <p>On 6/11/24 at 10:03 a.m., Resident # 21 was observed in bed. CNA Staff M was assisting him with the morning meal.</p> <p>In an interview, Staff M said Resident #21 likes to be clean. She said she tries to shave him every day but she was off for two days and the day before (6/10/24) she did not have time to get to him to shave him.</p> <p>3. Review of the clinical record revealed Resident #25 had an admitted [DATE] with diagnoses including current COVID infection requiring in room isolation, hemiplegia of the left side and frequent falls.</p> <p>Review of the admission MDS with a target date of 5/24/24 revealed Resident #25 required substantial to moderate assistance with showers and was frequently incontinent of bladder. The MDS noted Resident #25's cognitive skills for daily decision making were moderately impaired.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Oakton Place Health and Rehabilitation at the Arli		STREET ADDRESS, CITY, STATE, ZIP CODE  8000 Arlington Circle Naples, FL 34113	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/10/24 at 1:00 p.m., Resident #25 was observed in a wheelchair having lunch in his room. Resident #25 had approximately three days of facial hair growth. His fingernails were dirty with a brown substance underneath the nails. Resident #25 was not able to answer all simple questions appropriately and was not able to say if he received assistance with shaving.</p> <p>On 6/11/24 at 1:01 p.m., Resident #25's spouse, and a private duty sitter were observed in the resident's room.</p> <p>In an interview, Resident #25's spouse said she's either here or has a private duty care giver with him three times a week for four hours.</p> <p>She said, I can tell you no one comes into this room to assist my husband for care because they assume that we will do everything. He fell at home and is here to get therapy. They are not toileting him and there are times I come here, and he is soaked with urine, his clothing the sheets, it is terrible.</p> <p>She said she has not seen him get a shower. He took showers at home. She did not know why, but they told her he couldn't get a shower. She said, Sometimes he has a body odor that is not pleasant.</p> <p>Resident #25's private duty care giver said, I do everything for him because no one comes in here to do anything. I have never seen him take a shower.</p> <p>Review of the CNA Plan of Care Response History from 5/21/24 to 6/10/24 documented the resident's bathing schedule was on Tuesdays, Thursdays and Saturdays during the 7:00 p.m., to 7:00 a.m., shift. The only shower documented was on 6/4/24. Resident #25 received a bed bath on 5/21/24, 5/28/24, 5/31/24, 6/4/24, 6/6/24 and 6/8/24.</p> <p>4. Review of the clinical record revealed Resident #35 had an admitted [DATE]. Diagnoses included current COVID infection requiring in room isolation, type 2 diabetes and urinary retention with indwelling catheter.</p> <p>Review of the Admission MDS with an assessment reference date of 5/26/24 revealed Resident #35 required partial to moderate assistance with showers.</p> <p>Review of Resident #35's care plan initiated 5/29/24 specified shower days were Mondays, Wednesdays and Fridays during the 7:00 a.m., to 7:00 p.m., shift. The care plan documented the resident preferred showers.</p> <p>On 6/10/24 at 10:37 a.m., Resident #35 was observed in bed in a hospital gown. The resident was not able to answer questions appropriately. Her fingernails extended approximately 1/4 inch with a brown substance around and under the fingernails.</p> <p>Resident #35's family member present during the observation said he had not seen anyone shower her.</p> <p>On 6/11/24 at 8:28 a.m., Resident #35 was observed in bed wearing a hospital gown. The resident's fingernails remained with a brown substance around and under the nails which extended approximately 1/4 inch.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Oakton Place Health and Rehabilitation at the Arli		STREET ADDRESS, CITY, STATE, ZIP CODE  8000 Arlington Circle Naples, FL 34113	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #35's representative was at the bedside and said, They told me someone bathed her last night.</p> <p>Review of the CNA Plan of Care Response History from 5/23/24 to 6/10/24 documented Resident #35 received a shower on 5/27/24. No other shower was documented. Resident #35 received a bed bath on 5/24/24, 5/29/24, 5/31/24, 6/3/24, 6/5/24, 6/7/24 and 6/10/24.</p> <p>On 6/12/24 at 8:31 in an interview Licensed Practical Nurse (LPN) Staff A said, Daily shaving, and nail care are considered part of daily personal hygiene.</p> <p>On 6/12/24 at 2:23 p.m., in an interview, CNA Staff F said the shower list was located in each resident room on the white board and there was a shower list at the CNA charting desk. She said all residents get a shower three times a week. The CNA said if a resident refuses a shower, then she offers a bed bath and if they still refuse the shower after three times, she documents the refusal and lets the nurse know. When asked how staff know to give a shower or a bed bath the CNA replied, If they are a two person transfer or use a lift to transfer, then they get a bed bath. When asked to clarify, CNA Staff F said, Correct, if a resident is a two person transfer or requires the use of a mechanical lift for transfer, they get a bed bath.</p> <p>On 6/13/24 at 8:40 a.m., in an interview CNA staff K said, We follow the shower schedule at the desk and it is also on the white board in each resident's room. When asked how she would know if a resident was to receive a shower or a bed bath, Staff K replied, If the resident can't transfer or needs a lift, then they get a bed bath. A bed bath means we use the basin, soap and water and wash the face, hair the body and then we change the whole bed when we are done because it is wet.</p> <p>On 6/13/24 at 8:47 a.m., in an interview CNA Staff B said with showers we have a list here at the desk and it is on the board in the resident rooms. When asked how she knew if a resident required a bed bath or a shower she said, If they refuse a shower, I do a bed bath. They have showers in the rooms, but some don't like it so I take them to the bathroom if they can walk and I put them on the toilet. I was them on the toilet, I do the hair the whole body while they are on the toilet. I fill out the shower sheet and the nurse signs it. Staff B provided a copy of the shower sheet form but the form did not have a place to indicate if a shower or bed bath was provided or if the resident refused. The CNA said, I just write it in. Staff B said, Every day you brush the residents teeth, shave and do nails, but sometimes they don't want it.</p> <p>On 6/13/24 at 9:00 a.m., in an interview Licensed Practical Nurse (LPN) Staff L said there was a shower list at the desk and showers were written on the boards in the residents' rooms. The CNA task sheet lets the CNA know if the resident is to receive a shower or a bed bath. Staff L said personal hygiene, shaving, nail care and oral care is done daily.</p> <p>On 6/13/24 at 10:19 a.m., in an interview the Director of Nursing (DON) said she would expect the resident to get a shower on their scheduled shower day. The DON said she did not know why a resident would get a bed bath in place of a shower unless they wanted it, and it would be documented on the CNA task sheet. The DON said she did not know why the CNAs would say if a resident was a two person transfer or a required a lift they were given a bed bath.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Oakton Place Health and Rehabilitation at the Arli		STREET ADDRESS, CITY, STATE, ZIP CODE  8000 Arlington Circle Naples, FL 34113	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/13/24 at 11:56 a.m., in an interview the DON said she spoke with the staff and the staff are to follow the resident's preference for showers. The expectation is for showers unless the resident wants a bed bath. The DON said the resident preference was located on the care plan or the CNA task list.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Oakton Place Health and Rehabilitation at the Arli		STREET ADDRESS, CITY, STATE, ZIP CODE  8000 Arlington Circle Naples, FL 34113	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30599</p> <p>Based on observations, record review, resident and staff interviews the facility failed to implement measures to prevent the development and/or worsening of a pressure ulcer for 1 (Resident #34) of 2 residents reviewed for pressure ulcers.</p> <p>The findings included:</p> <p>Review of the clinical record revealed Resident #34 was admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Review of the 5-day Minimum Data Set (MDS) assessment with a target date of 5/30/24 noted Resident #34's cognition was moderately impaired with a Brief Interview for Mental Status score of 08. The resident had a stage 4 pressure ulcer (Full thickness tissue loss) of the sacral region and a pressure-induced deep tissue damage of the right heel.</p> <p>Resident #34 used a manual wheelchair and required substantial/maximal assistance for mobility once seated in the wheelchair to wheel 50 feet and make two turns.</p> <p>The physician's orders dated 5/29/24 included, Offloading boots [redistribute pressure from vulnerable areas of the sole of the foot] to be worn at all times; except when ambulating and transferring.</p> <p>The care plan initiated on 5/6/24 noted the resident had an actual impairment to the skin, including a stage 4 pressure ulcer to the sacrum and a deep tissue injury to the right heel. The interventions included as of 5/30/24, Offloading boots to be worn at all times except when walking and transferring.</p> <p>The Certified Nursing Assistant Kardex (Provides instructions for care) specified offloading boots to be worn at all times except when walking or transferring.</p> <p>On 6/11/24 at 11:33 a.m., and 2:26 p.m., Resident #34 was observed in her wheelchair in her room watching television. She had no sock on and was wearing slip-on loafers. Resident #34 was not wearing the offloading boots as per the physician's orders, and the care plan.</p> <p>On 6/11/24 at 2:30 p.m., in an interview Resident #34 said she did not have any boots for her feet.</p> <p>On 6/12/24 at 9:10 a.m., at 2:49 p.m., and on 6/13/24 at 8:31 a.m., Resident #34 was observed in her wheelchair in her room watching television. She did not have the offloading boots on. Resident #34 had no sock on and was wearing slip-on loafers.</p> <p>Review of the Treatment Administration Record (TAR) showed on 6/11/24, and 6/12/24, the nurse placed her initials for the day shift indicating the resident was wearing the offloading boots at all times, except when ambulating and transferring.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Oakton Place Health and Rehabilitation at the Arli		STREET ADDRESS, CITY, STATE, ZIP CODE  8000 Arlington Circle Naples, FL 34113	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/13/24 at 9:25 a.m., Certified Nursing Assistant (CNA) Staff B said this was her first day caring for Resident #34. Staff B said she was not aware the resident was to wear offloading boots. She searched the resident's closet and drawers and said she was not able to find offloading boots.</p> <p>On 6/13/24 at approximately 9:40 a.m., Licensed Practical Nurse Staff A verified Resident #34 was in her wheelchair and not wearing the offloading boots as ordered. Staff A verified the resident should be wearing the offloading boots except when transferring or ambulating. She said, I will fix it.</p> <p>On 6/13/24 at 11:48 a.m., in an interview the Director of Nursing (DON) verified the physician's order specified for Resident #34 to have the offloading boots on except when ambulating or transferring. The DON verified the nurses signed the TAR indicating the resident was wearing the offloading boots when she was not.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Oakton Place Health and Rehabilitation at the Arli		STREET ADDRESS, CITY, STATE, ZIP CODE  8000 Arlington Circle Naples, FL 34113	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38570</p> <p>Based on observation, policy review, and staff interview the facility failed to store food in a manner that complies with safe food handling practices.</p> <p>The findings included:</p> <p>Review of the facility policy titled Food Receiving and Storage last revised November 2022, revealed procedures for Refrigerated/Frozen Storage read,</p> <p>All foods stored in the refrigerator or freezer are covered, labeled and dated .</p> <p>Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen or discarded .</p> <p>On 6/10/24 at 9:35 a.m., during the initial tour of the kitchen with the Dietitian, Kitchen Supervisor Staff H, and Sous Chef Staff I the following were observed:</p> <p>A pan of gravy, and a pan of oatmeal stored in the walk-in refrigerator were not labeled with the date of preparation.</p> <p>A large, uncovered bucket of water containing peeled and diced potatoes and carrots was not dated.</p> <p>On 6/10/24 at 9:40 a.m., the Dietitian, Sous Chef Staff I and the Kitchen Supervisor Staff H said food items should have been labeled with the preparation, cooked or opened date. They also said the bucket of potatoes and carrots should not have been stored uncovered.</p> <p>On 6/10/24 at 9:50 a.m., in an interview Staff H said the pan of gravy and oatmeal were prepared the previous night and should have been labeled. Staff H said dietary staff are supposed to cover and label food items with the date prepared or opened before placing them in the walk-in refrigerator.</p> <p>On 6/12/24 at 9:32 a.m., during a second kitchen tour a large, opened Caesar salad dressing was observed in the walk-in refrigerator. The opened container was not labeled with the date opened.</p> <p>On 6/12/24 at 9:35 a.m., Sous chef Staff I, and the Dietitian verified the large Caesar salad dressing container was opened, had been used but was not labeled with the date opened.</p> <p>On 6/13/24 at 9:16 a.m., in an interview the Dietitian said food stored in the refrigerator must be dated at the time it is prepped or at the time the container is opened. She said the container of Caesar Salad dressing was opened and served the previous night. She said it should have been labeled with the date opened. She said all food items observed on 6/10/23 stored in the walk-in refrigerator should have been covered and/or labeled with the date prepared or the date the container was opened.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Oakton Place Health and Rehabilitation at the Arli		STREET ADDRESS, CITY, STATE, ZIP CODE  8000 Arlington Circle Naples, FL 34113	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>30599</p> <p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>Based on record review and staff interview, the facility failed to ensure the binding arbitration agreement explicitly informed the residents of their right to rescind the agreement within 30 calendar days of signing it for three (Residents #1, #26, and #97) of three residents reviewed.</p> <p>The findings included:</p> <p>On 6/13/24 review of the clinical records revealed Residents #1, #26, and #97 signed an arbitration agreement respectively on 5/14/24, 5/31/24, and 6/5/24.</p> <p>Review of the Resident and community arbitration agreement signed by Residents #1, #26, and #97 read, This arbitration clause binds all parties to this Agreement, their spouses, parents, heirs, legal representatives, executors, administrators, successors, as applicable, whether existing now or in the future. If this Agreement is cancelled in compliance with the terms of paragraph ten (10) of this Agreement, this Arbitration Agreement shall remain in effect for the resolution of all claims or disputes that arose prior to that date.</p> <p>Paragraph 10 of the arbitration agreement read, The arbitrator shall have the exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability, or formation of this Agreement, including, but not limited to, any claim that all or any part of this Agreement is void or voidable. The Parties agree that all of the provisions contained in this Agreement are severable. If any provision of the agreement, or portion thereof, is held to be void, voidable or otherwise invalid, this Agreement shall be interpreted as if the invalid provision or portion was not contained herein, and the remaining provisions of the Agreement will remain in full force and effect in order to effectuate the paramount intent of the Parties to resolve any disputes between them via binding arbitration. This Agreement to arbitrate will not fail because any part, clause or provision hereof is held to be indefinite or invalid.</p> <p>The signed arbitration agreement did not explicitly grant the residents or representatives the right to rescind the agreement within 30 calendar days of signing the document.</p> <p>On 6/13/24 at 12:05 p.m., in an interview the Administrator verified the arbitration agreement signed by Residents #1, #26, and #97 did not clearly explain Residents #1, #26 and #97's right to withdraw from or terminate the agreement within 30 calendar days of signing the document if they changed their mind.</p> <p>The Administrator said the arbitration agreement form was the one currently signed by residents upon admission to the facility.</p>		