

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

PRINTED: 06/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2015
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NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 WALKER ROAD DOVER, DE 19901
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from May 12, 2015 through May 19, 2015. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 118. The survey sample totaled twenty seven (27).</p> <p>Abbreviations used in this 2567 are as follows: NHA- Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); CNA - Certified Nurse's Aide; ADL - Activities of Daily Living, such as bathing and dressing; mg- milligrams, a unit of weight; ml-milliliter, a unit of volume; Aspiration - breathing in a foreign object like food or fluid into the lungs; Dysphagia - trouble with swallowing.</p>	F 000		
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation it was determined that for 2 (R156 and R27) out of 27 sampled residents</p>	F 241	<p>A. No resident was adversely affected by this deficient practice.</p> <p>B. All residents who require feeding assistance have the potential to be affected by this deficient practice</p> <p>C. The root cause was determined that R27 was not fed at the same time as her roommate R156. The facility failed to ensure that these residents were set up for their breakfast at the same time. A focus audit was conducted to identify like residents. The facility will in-service the nursing assistants on serving meals r/t meal distribution, set-up and proper feeding techniques for all meals. Continued</p>	July 20, 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>6/30/15</i>
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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 241	Continued From page 1 the facility failed to promote care and services in a manner that promoted dignity. Findings include: 1. On 5/12/15 at 8:19 AM R156 was observed in her room eating breakfast. She had consumed about half of her meal. Her roommate R27 was in bed with no breakfast. Staff came in at 8:28 AM and started to feed R27. 2. On 5/12/15 at 8:28 AM E12 was observed feeding R27 while standing up over the resident. About half-way through the meal observation E12, pulled up the resident's wheelchair and sat down to continue feeding. 3. On 5/15/15 at 8:19 AM R156 was observed eating breakfast in her room while R27 was in bed with no breakfast. At 8:40 AM E11, CNA started to feed R27. These observations were reviewed with E1, NHA and E2, DON on 5/19/15 at 2 PM.	F 241	D. DON/designee will audit residents requiring feeding assistance (see attachment #1A and 1B). This audit will be conducted daily until 100% compliance is achieved over 3 consecutive evaluations. Then will be monitored three times a week until 100% compliance is reached over 3 consecutive evaluations then, once a week until 100 % compliance is reached over 3 consecutive evaluations. Finally, one more evaluation until 100 % compliance is maintained		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to consistently	F246	A. R33 was not adversely affected by this deficient practice. B. All residents have the potential to be affected by this deficient practice. C. The facility conducted a root cause analysis and it was determined that the facility failed to provide a reasonable accommodation for the needs/preferences for R33. R33's care plan was reviewed with resident. The facility will conduct an initial sweep for like residents to determine if needs/preferences are followed by the nursing staff. Nursing staff will be educated on resident preferences and the review of the care plan related to preferences. Preferences will be noted on the CNA Assignment Sheets.	7-20-15	

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F 246	Continued From page 2 provide reasonable accommodation for the needs/preferences for one (R33) out of 27 sampled residents. Findings include: As of 12/5/14 R33's care plan included approaches to involve the resident in decisions regarding care, ADL schedules, etc. and that the resident required a hooyer lift with assistance of two for safe transfers. On 5/12/15 at 11:45 AM the resident stated she prefers to be up and dressed by breakfast but was gotten up at 11:30 AM today. R33 said for the past "several days" she was up out of bed late since "they were missing people". On 5/15/15 at 8:28 AM R33 was observed eating breakfast while sitting upright in bed. At 11:00 AM, the resident remained in bed, When E7, LPN was asked if the resident was not feeling well, the nurse indicated R33 was fine but the resident was "perturbed with us that she is not up yet". At 11:05 AM E11, CNA was observed pushing the hooyer lift to R33's room. At 12:30 PM the resident was in the wheelchair in her room and informed the surveyor she did not get up until noon today and added "they know I like to get up early".	F 246	D. DON/designee will audit identified (see attachment #2) resident needs/preferences. This audit will be conducted daily until 100% compliance is achieved over 3 consecutive evaluations. Then, will be monitored three times a week until 100% compliance is reached over 3 consecutive evaluations then, once a week until 100 % compliance is reached over 3 consecutive evaluations. Finally, one more evaluation until 100 % compliance is maintained.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280	1. A. R87 was not adversely affected by this deficient practice. B. All residents with decreased functional mobility, strength, balance and endurance have the potential to be affected by this deficient practice. Continued	July 20, 2015	

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F 280	<p>Continued From page 3 changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R87 and R27) out of 27 sampled residents the facility failed to update the care plan to reflect current needs. Findings include:</p> <p>1. R87's care plan dated 12/13/14 for ADL Functional / Rehabilitation Potential; Self care deficit related to decreased functional mobility, strength, balance and endurance included approaches to periodically check and assist resident while eating; staff to set up tray and monitor and record dietary intake; provide assistive adaptive equipment. Although the care plan was reviewed regularly no further revision to this approach was noted.</p> <p>Review of the ADL Tracker, where the aides document the type of care delivered, revealed the</p>	F 280	<p>C. R87 was re-evaluated by Occupational Therapy to assess level of assistance for feeding. A root cause analysis was conducted and it was determined that the facility failed to update the care plan and CNA instructions to reflect R87's level of assistance for feeding. A focus review was conducted to identify like residents who require assistance with feeding and to update the care plan and CNA instructions to reflect the needs of each resident.</p> <p>D. Therapy Director/designee will conduct an audit (see attachment #3) on all residents who require assistance with feeding to ensure that all care plans and CNA instructions are up to date. This audit will be conducted daily until 100% compliance is achieved over 3 consecutive evaluations. Then, will be monitored three times a week until 100% compliance is reached over 3 consecutive evaluations then, once a week until 100 % compliance is reached over 3 consecutive evaluations. Finally, one more evaluation until 100 % compliance is maintained.</p>	

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F 280	<p>Continued From page 4 following in the area of eating:</p> <p>April 2015 7-3 mostly supervision with one person physical assist.</p> <p>May 2015 7-3 dependent one person physical assist.</p> <p>The Occupational Therapy discharge recommendations dated 5/6/15 stated "24 hours assist to continue and now to include feeding for all meals expect for dialysis days with finger foods".</p> <p>The most recent quarterly assessment dated 5/10/15 documented the resident needed limited assistance with one person physical assist with eating.</p> <p>Current instructions in CNA book read; -cut up all food, open all containers/packages -set-up all foods/fluids/utensils in reach of resident (resident is unable to re-arrange items on plate/tray) -elevate head of bed to 90 degrees for appropriate positioning -place pillow at each side of patient under elbows and side of trunk for support -intermittent supervision for patient to access food.</p> <p>The care plan and CNA instructions were not updated to reflect the increased needs with feeding.</p> <p>An interview on 5/19/15 at 10:36 AM with E6, LPN revealed that the resident did need more assistance with eating and that she would update the care plan and CNA information sheet.</p>	F 280	<p>2.</p> <p>A. R27 was not adversely affected by this deficient practice. Care plan was updated to reflect level of feeding assistance and elimination of adaptive equipment immediately.</p> <p>B. All residents who require feeding assistance have the potential to be affected by this deficient practice.</p> <p>C. A root cause analysis was conducted and it was determined that the facility failed to update the care plan to reflect R27's level of assistance for feeding and adaptive equipment. A focus review was conducted to identify like residents who require assistance with feeding and to update the care plan to reflect the needs of each resident.</p> <p>D. Therapy Director/designee will conduct an audit (see attachment #3) on all residents who require assistance with feeding to ensure that all care plans are up to date. This audit will be conducted daily until 100% compliance is achieved over 3 consecutive evaluations. Then, will be monitored three times a week until 100% compliance is reached over 3 consecutive evaluations then, once a week until 100% compliance is reached over 3 consecutive evaluations. Finally, one more evaluation until 100% compliance is maintained.</p>		

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F 280	<p>Continued From page 5</p> <p>2a. R27's care plan dated 8/21/14 for Nutritional Status: Need to maintain good nutrition and hydration related to mechanical soft diet, dysphagia, weight loss, nectar thick liquid (thickness of tomato juice or maple syrup) included the approach to assist with setup/meals as needed, adaptive equipment (scoop plate, 2 handle mug) per Occupational Therapy. Although the care plan was reviewed regularly no further revision to this approach was noted.</p> <p>The care plan dated 8/29/14 for ADL Functional / Rehabilitation Potential: Self care deficit related to decreased mobility (walking) and arthritis included the approach set-up/assist with meals and monitor for adequate dietary intake. Although the care plan was reviewed regularly no further revision to this approach was noted.</p> <p>The resident's quarterly MDS dated 2/15/15 indicated R27 is totally dependent in the area of eating.</p> <p>The care plan was not updated to reflect the resident's need for total assistance with feeding and elimination of adaptive equipment.</p> <p>Interview with E6, LPN on 5/15/15 around 10 am confirmed the resident is totally dependent on staff for feeding.</p> <p>2b. R27's care plan dated 9/2/14, although reviewed regularly no further revision to this approach was noted, for Nutritional Status: Potential for aspiration related to dysphagia included the approach Diet as ordered:</p> <p>- Lemon ice with all meals - pureed soups, fruits,</p>	F 280			

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F 280	Continued From page 6 vegetables and mechanical soft entree with extra gravy and sauces, thin liquids. Current diet (physician order dated 4/6/15) puree diet with nectar thickened liquids discontinuing the use of lemon ice. Nectar thickened liquids was originally ordered by the physician on 2/16/15. The care plan was not updated to reflect the change in liquid consistency and elimination of lemon ice. Interview with E6, LPN on 5/15/15 around 10 am confirmed the resident is receiving nectar thickened liquids. These findings were reviewed with E1, NHA and E2, DON on 5/19/15 at 2 PM.	F 280			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to provide assistance with eating based on the plan of care for one (R27) out of 27 sampled residents. Findings include: The resident's care plan dated 9/2/14 and	F312	A. R27 was not adversely affected by this deficient practice. B. All residents who require feeding assistance have the potential to be affected by this deficient practice. C. A root cause analysis was conducted and it was determined that the facility failed to follow the speech language plan of treatment for R27 which includes positioning and verbal prompting. A facility focus review was conducted for like residents who require assistance with feeding. Unit Managers will place information on the CNA Flow Sheet which is kept inside the closet of each resident for purposes of confidentiality. CNA staff were educated on reviewing the CNA Flow Sheet prior to feeding resident.	7-20-15	

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F 312	<p>Continued From page 7</p> <p>reviewed regularly for Nutritional Status: Potential for aspiration related to Dysphagia included the approaches provide verbal cues for resident to swallow as needed; refer to speech care plan for specific instructions.</p> <p>R27's MDS dated 2/15/15 indicated the resident is dependent with eating and transferring (getting out of bed).</p> <p>R27's Speech Language Pathologist Evaluation and Plan of Treatment dated 2/16/15 included the following strategies:</p> <ul style="list-style-type: none"> - lingual sweep (moving tongue around in mouth to remove food between cheek and teeth) - re-swallow (making swallow motion again after swallowing food or liquid) - alternate liquid and solid - chin tuck(keeping chin to chest during swallow) - general swallow techniques/precautions - second dry swallow (swallowing on purpose) and hard throat clear (coughing to clear throat)/ re-swallow - upright posture during meals (up in chair or 90 degrees in bed) and for at least 30 minutes after meals <p>Current instructions on the CNA Flowsheet include: take small bites, alternate solids/liquids, moisten each bite with sauce/gravy, swallow extra times after each bite, remain upright following meals.</p> <p>On 5/15/15 at 8:30 AM the resident was sleeping in bed with the head of the bed raised to around 45-50 degrees. At 8:40 AM E11 CNA (seated in a chair facing the resident) was feeding R27 small bites of pureed breakfast food in an</p>	F 312	<p>D. DON/designee will conduct audits (see attachment #3) on all residents who require assistance with feeding to ensure that all care plans are up to date and followed. This audit will be conducted daily until 100% compliance is achieved over 3 consecutive evaluations, then once a week until 100% compliance is reached over 3 consecutive evaluations. Finally, one move evaluation until 100% compliance is maintained.</p>		

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F 312	Continued From page 8 unhurried manner. The resident remained in bed with the head of the bed unchanged. E11 did ask the resident about her preference about what she wanted to eat/drink next. No verbal prompting was observed by E11 for re-swallows throughout the meal which ended at 9:03 AM. During an interview with E6, LPN at 10:57 AM on 5/15/15 verified the definition of upright posture for meals to be either up in a chair or positioned in bed at 90 degrees (E6 held her right hand up with fingers pointing toward ceiling). E6 also informed the surveyor that R27 needs to be prompted to complete her re-swallows. Observations were reviewed with E6 on 5/15/15 at 10:59 AM. These findings were reviewed with E1, NHA and E2, DON on 5/19/15 at 2 PM.	F 312			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation during the initial tour it was determined that the facility failed to ensure that the resident environment remained as free from accident hazards as is possible on two out of three units of the facility. Findings include:	F 323	A. No resident was adversely affected by the deficient practice. B. All residents have the potential to be affected by this deficient practice. C. A root cause analysis was conducted and it was determined that the facility failed to identify that bolts securing toilets in rooms 102, 200, 201, 203, and 205 were exposed, rusty and protruding above the base of the toilet. Furthermore, there were no caps and only one bolt present in room 229. In room 233, there were no caps and the toilet was moveable and unsteady. The maintenance director conducted a focus audit on all toilets to assess for repairs and it was determined that all other toilets were in satisfactory condition.	7-20-15	

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F 323	Continued From page 9 1. Bolts securing the toilets in rooms 102, 200, 201, 203, and 205 were exposed and rusty, with each protruding approximately 3-4 inches in length above the base of the toilet, creating a hazard for the residents sharing these bathrooms. 2. There were no caps and only one bolt present on the toilet in room 229 causing the toilet to be moveable unsteady and creating a hazard to residents. There were no caps, or bolts present on the toilet in room 233 causing it to be moveable and unsteady. These observations were reviewed with E1, NHA and E2, DON on 5/19/15 at 2 PM.	F 323	D. Maintenance Director/designee will conduct an audit (see attachment #4) on all toilets to assess for repair and working order. This audit will be conducted daily until 100% compliance is achieved over 3 consecutive evaluations. Then, will be monitored three times a week until 100% compliance is reached over 3 consecutive evaluations then, once a week until 100% compliance is reached over 3 consecutive evaluations. Finally, one more evaluation until 100% compliance is maintained.		
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to dispose of garbage and refuse properly. Findings include: On 5/12/15 at 9:00 AM, observations were made by a State Public Health inspector and an Environmental Health Specialist surveyor of the compactor and the surrounding area which revealed the following: - There was an observation of refuse at the outdoor waste receptacle and surrounding areas.	F 372	A. Area cited during the survey was corrected immediately by maintenance. B. No residents were affected by the deficient practice. C. The root cause of the deficient practice was that the dumpster area was not properly assessed for cleanliness and refuse was not disposed of correctly D. The ensure we are 100% compliant with dumpster area cleanliness; the dietary supervisor will audit using a monitoring form. Also, housekeeping, maintenance and dietary staff will be in serviced on proper refuse disposal. The audit (attachment #5) will be completed daily x 30 days or until 100% compliance is achieved for 2 consecutive weeks. The audit will then be done once a week x 4 weeks until 100% compliance is achieved. To maintain compliance, 2 random audits will be done per month until 100% compliance is achieved for 2 months	July 20, 2015	

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F 428	Continued From page 11 3. Review of R44's clinical record revealed that the Consultant Pharmacist Review was missing documentation for October and November 2014. 4. Review of R130's clinical record revealed that the Consultant Pharmacist Review was missing documentation for October and November 2014. 5. Review of R145's clinical record revealed that the Consultant Pharmacist Review was missing documentation for October and November 2014. During an interview on 5/14/15 at 2:24 PM with E2 DON it was confirmed that the facility pharmacist did not conduct pharmacy reviews facility wide for the months of October and November 2014. These observations were reviewed with E1, NHA and E2 on 5/19/15 at 2 PM.	F 428			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431	A. No resident was adversely affected by this deficient practice. All expired medications were destroyed when found. B. All residents have the potential to be affected by this deficient practice. C. A root cause analysis was conducted and it was determined that the facility failed to have a system in place for checking expired/undated/opened medications. An initial focus audit was conducted and no other medications were found to be expired. The facility has implemented a systemic change for reviewing all medication carts/medication rooms weekly to ensure expired medications are destroyed and medications are dated. Continued	July 20, 2015	

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F 431	<p>Continued From page 12 applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that for 3 out of 3 resident units the facility failed to ensure that expired medications were removed. Findings include:</p> <p>1. Observation on 5/14/15 at 11:00 AM of the Scott Unit medication Cart 1 of three revealed the following medications were expired. Tramadol (pain medication) 50 mg with 14 pills remaining, expired 4/2015 and Oxycodone with Tylenol (pain medication) 5-325 with 15 pills remaining expired on 2/15; for Cart 2 on the same unit, Zofran (nausea and vomiting medication) 4 mg with 4 pills remaining expired 11/2014. Metaxalone (pain/muscle relaxer medication) 800 mg with 22 pills remaining expired on 3/2014, Naproxen (pain medication) 375 mg with 6 pills remaining expired</p>	F 431	<p>D. The Unit Manager/designee will conduct daily audits (see attachment # 7) until 100% compliance is achieved over 3 consecutive evaluations. Then, will be monitored three times a week until 100% compliance is reached over 3 consecutive evaluations then, once a week until 100 % compliance is reached over 3 consecutive evaluations. The facility will maintain a weekly audit going forward.</p>		

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F 431	Continued From page 13 on 3/2015 and Benzonatate (cough medication) 100 mg with 12 pills remaining expired on 4/2015. 2. Observation on 5/14/15 at 11:30 AM of the Magnolia Unit storage refrigerator in the medication storage room revealed one bottle of Tubersol (tuberculosis testing) solution was opened and undated. Manufacturer recommendation is the bottle of tubersol solution has a duration of thirty days once opened. 3. Observation on 5/14/15 at 1:30 PM of the Holly Unit medication cart revealed the following four medications were expired: 4 mg of Zofran with 15 pills remaining that expired on 2/2015. Oxycodone 5 mg with 7 pills remaining expired 5/5/2015. Mirtazapine (depression medication) 7.5 mg with 13 pills remaining expired on 4/2015 and Simvastatin (cholesterol lowering medication) 20 mg with one pill left expired on 9/17/2014. Six pills found in the bottom of the drawers that were not identifiable. These observations were reviewed with E1, NHA and E2, DON on 5/19/15 at 2 PM.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	A. R111 was not adversely affected by this deficient practice. E10 was educated on infection control techniques immediately. B. All residents have the potential to be affected by this deficient practice. Continued	July 20, 2015

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F 441	<p>Continued From page 14 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to maintain infection control technique designed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection. The facility failed to ensure proper infection control techniques were used during a medication administration for one (R111) out of 27 sampled residents. Findings include:</p>	F 441	<p>C. A root cause was conducted and it was determined that the facility failed to maintain proper infection control techniques during a medication pass. E10 mistakenly touched a pill with her ungloved hand during a medication pass. Nursing staff will be in-serviced on proper infection control procedures during a medication pass. An initial focus review was conducted and no further issues were identified.</p> <p>D. DON/designee will conduct random unannounced medication passes to ensure compliance (see attachment # 8) with this deficient practice. This audit will be conduct with a sample of 3 nurses weekly until 100% compliance is achieved over 3 consecutive evaluations. Then, will be audited monthly until 100% compliance is reached over 3 consecutive evaluations then one more time until 100 % compliance is maintained.</p>		

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F 441	Continued From page 15 During a medication administration observation on 5/12/15 at 8:14 AM E10, LPN was observed inserting her ungloved finger in the medicine cup to separate the capsule from the other medications so that she could place it into the bag to crush with the other medications. E10 then picked up the capsule with her bare hands to pour out the capsule's content's into a different cup. This was done after E10 was observed having had already touched the computer, the mouse by the computer, touched the drawers of the medication cart and handed off keys to another co-worker. During an interview with E10 on 5/12/15 at approximately 10:50 AM, E10 confirmed that all the above events happened during the medication observation. On 5/12/15 at approximately 12:00 PM, findings were reviewed with E2 (DON). These observations were reviewed with E1, NHA and E2 on 5/19/15 at 2 PM. 483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 441			
F 514 SS=E		F 514	1. A. R7 was not adversely affected by this deficient practice. B. All residents have the potential to be affected by this deficient practice. C. A root cause analysis was conducted and it was determined that R7's bowel movements were not recorded in the clinical record and did not match a separate laxative list that was generated. It was also noted that the lactulose was not recorded in the MAR on 4/10/15. A focus review was conducted on like residents and no other residents were identified. Nurses and CNA's will be educated on the facility policy for documenting and implementing the bowel protocol. Continued	July 20, 2015	

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F 514	<p>Continued From page 16 services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the other facility documentation it was determined that the facility failed to maintain accurate and complete clinical records for two (R7 and R51) out of 27 sampled residents. For R7 there were multiple opportunities when bowel movements (BM) were not recorded correctly. Findings include:</p> <p>1. Bowel Protocol policy (dated 4/2013) Any resident who is identified as having gone 9 shifts without a BM should have the bowel protocol implemented. The resident's name is placed on the laxative list for that day. Protocol consists of the following: 7-3 shift give Milk of Magnesia (medication to promote a BM) 30 ml to be administered on the day shift following discovery that 9 shifts have passed without a BM. If the resident is receiving dialysis, Lactulose (another medication to promote a BM) 30ml should be substituted for the Milk of Magnesia.</p> <p>Review of R7's CNA Flowsheet from February, 2015 revealed that the bowel protocol should have been initiated and the resident should have received lactulose on February 19th since the prior 9 shifts had no bowel movements recorded. The medication was not recorded as given on the MAR (Medication Administration Record). There were 24 shifts in a row (February 20-28) without a BM documented on the CNA Flowsheet along with two evening shift documentation that were</p>	F 514	<p>D. DON/designee will conduct random bowel protocol audits (see attachment # 9) on 10 sampled residents daily until 100% compliance is achieved over 3 consecutive evaluations. Then, will be monitored three times a week until 100% compliance is reached over 3 consecutive evaluations then, once a week until 100 % compliance is reached over 3 consecutive evaluations. Finally, one more evaluation until 100 % compliance is maintained.</p> <p>2. A. R51 was not adversely affected by this deficient practice. B. All residents have the potential to be affected by this deficient practice. C. A root cause analysis was conducted and it was determined that E14 did not document R51's assessment in clinical record after complaints of pain. E14 was educated on proper documentation after assessing a resident. Education will be conducted with nursing staff on documenting assessments in resident progress note D. DON/designee will audit (see attachment # 10) 10 sampled residents to ensure proper assessment and pain management are documented in the clinical record. Daily audits will be conducted until 100% compliance is achieved over 3 consecutive evaluations. Then, will be monitored three times a week until 100% compliance is reached over 3 consecutive evaluations then, once a week until 100 % compliance is reached over 3 consecutive evaluations</p>		

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F 514	<p>Continued From page 17 missing on February 18 and 20 of 2015.</p> <p>Review of the CNA Flowsheet for April, 2015 showed, R7 should have received lactulose on April 10. The medication was not recorded on the Medication Administration Record as being given on 4/10/15. Two evening shift documentation's were missing on April 16 and 17.</p> <p>During an interview with E6, LPN on 5/14/15 around 2:00 PM confirmed the missing entries and found the laxative list (stored in a binder at the nurses station) documented that R7:</p> <ul style="list-style-type: none"> - had a BM on 2/18 which was not recorded on the CNA Flowsheet. Canceling the need for lactulose on 2/19. - had a BM on 2/22, 2/23 and 2/27 which were not recorded on the CNA Flowsheet. - had a BM on 3/11/15 which was not recorded on the CNA Flowsheet. - received lactulose on 4/10/15 which was not recorded on the MAR. - had a BM on 4/10/15 which was not recorded on the CNA Flowsheet. <p>These observations were reviewed with E1, (NHA) and E2, (DON) on 5/19/15 at 2 PM.</p> <p>2. Review of employee statements from an investigation of an injury documented;</p> <p>E14 (RN) was told by E13 (CNA) that R51 was complaining of pain but that he sometimes has arthritis (typically joint pain, swelling or stiffness) or cellulitis (bacterial skin infection). Observed: leg looked a little inflamed but he was not complaining of pain; told next nurse E16.</p>	F 514		

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F 514	Continued From page 18 Review of the progress notes lacked evidence that E14 documented her assessment of R51 in the clinical record. These observations were reviewed with E1 and E2 on 5/19/15 at 2 PM.	F 514			



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Capitol

DATE SURVEY COMPLETED: May 19, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from May 12, 2015 through May 19, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 118. The survey sample totaled twenty seven (27).</p> <p>Abbreviations used in this 2567 are as follows: NHA- Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); CNA - Certified Nurse's Aide; ADL - Activities of Daily Living, such as bathing and dressing; mg- milligrams, a unit of weight; ml-milliliter, a unit of volume; Aspiration - breathing in a foreign object like food or fluid into the lungs; Dysphagia - trouble with swallowing.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p>		

Provider's Signature  Title Administrator Date 6/19/15



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AND SOCIAL SERVICES**

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3201.1.0	Scope		
3201.1.2	<p>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.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed May 19, 2015 F241, F246, F280, F312, F323, F372, F428, F431, F441, and F514.</p>	<p>Cross Refer F 241, F 246 F 280, F 312, F 441, F 323 F 431, F 514, F 372, F428</p>	<p>July 20, 2015</p>

Provider's Signature  Title Administrator Date 6/24/15