

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

PRINTED: 08/08/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/14/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CADIA REHABILITATION CAPITOL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1225 WALKER ROAD DOVER, DE 19904</b>
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(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
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced annual survey was conducted at this facility from July 8, 2016 through July 14, 2016. 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 one hundred fifteen (115) . The survey sample totaled twenty seven (27).</p> <p>Abbreviations used in this report 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;  RNAC - Registered Nurse Assessment Coordinator;  ADL - Activities of Daily Living, such as bathing and dressing;  mg- milligrams, a unit of weight;  mg/dL - Milligrams per deciliter, a unit of measure that shows the concentration of a substance in a specific amount of fluid;  FSBS; finger stick blood sugar;  PRN - As needed;  eMAR - electronic Medication Administration Record;  Continence - control of bladder and bowel function;  Humalog - insulin-medication used to control blood sugar;  Incontinence - loss of control of bladder and/or bowel function;  Frequently Incontinent [urine]- 7 or more</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>07/27/2016</b>
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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 000	Continued From page 1 episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day period; Occasionally Incontinent [urine] - less than 7 episodes of incontinence during a 7 day period; Straight Cath - tube inserted into the bladder to obtain urine (tube removed afterward); Void - to urinate; Voiding Diary - a record of voiding (urinating) for 72 hours and/or 3 days.	F 000		
F 272 SS=D	<b>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b>  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272		9/12/16

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F 272	<p>Continued From page 2</p> <p>Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record review and interview it was determined that for one (R90) out of 27 sampled residents the facility failed to accurately assess urinary continence status. Findings include:</p> <p>The following was reviewed in R90's clinical record:</p> <p>2/23/16 - Bowel and Bladder Assessment documented the resident was always incontinent. However, supporting CNA data noted the resident had some continent episodes. The assessment was also performed on the day of admission without completion of the required 3 day voiding diary as indicated in the assessment instructions.</p> <p>2/24/16 - 2/26/16 - 3 day voiding diary conducted.</p> <p>3/2/16 - Admission MDS documented R90 was occasionally incontinent of urine. Review of the supporting CNA documentation noted 10 episodes of urinary incontinence. The MDS should have been coded as frequently incontinent</p>	F 272	<ol style="list-style-type: none"> <li>1. R90 was not negatively impacted by this deficient practice. R90 is frequently incontinent of urine.</li> <li>2. All new residents who are noted with episodes of incontinence have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in #3.</li> <li>3. The facility conducted a focus review of all like residents. It was determined that the admitting nurse completed a bowel/ bladder assessment prior to completing a three day voiding diary as stated in the facility policy. No other residents were affected by this deficient practice. The facility will conduct focused education for nurses on assessing urinary continence, voiding diary completion and bowel/ bladder assessment. The Registered Nurse Assessment Coordinator (RNAC) will be educated on accurate coding onto the Minimum Data Set (MDS) and on</li> </ol>		

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F 272	Continued From page 3 based on this data.  During an interview, on 7/12/16 at 2:54 PM, with E4 (RNAC) and E2 (DON) it was confirmed that the MDS was coded incorrectly. It was also revealed that the Admission Bowel and Bladder Assessment was inaccurately completed on the day of admission with information provided by the transferring facility instead of after a full assessment including a 3 day voiding diary in the facility.  These findings were reviewed with E1 (NHA) and E2 on 7/14/16 at 1:40 PM.	F 272	proper extraction of information of Nursing Assistant documentation. 4. The Director of Nursing (DON)/ designee will audit all newly admitted residents with noted episodes of incontinence to ensure proper completion of the three day voiding diary and bowel and bladder assessment. The audit will also include accurate MDS coding. The audit will be conducted daily until 100% compliance is achieved. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by:  Based on clinical record review and interview, it was determined that the facility failed to follow the	F 309	1. R106 was not negatively impacted by this deficient practice. All future blood	9/12/16	

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F 309	<p>Continued From page 4</p> <p>physician's plan of care for medication administration for 1 (R106) out of 27 sampled residents. Findings include:</p> <p>Review of R106's clinical record revealed:</p> <p>R106 had a physician's order dated 5/19/16 for Humalog to be administered three times a day, and hold for FSBS under 120 mg/dL.</p> <p>Humalog was given 6 times over 3 months when this parameter was not met.</p> <p>Review of R106's eMAR from May 2016 - July 2016 revealed the following:</p> <ul style="list-style-type: none"> <li>-On 5/21/16 at 5:00 PM a FSBS of 112mg/dL and Humalog was administered.</li> <li>-On 5/28/16 at 12:00 PM a FSBS of 119mg/dL and Humalog was administered.</li> <li>-On 6/1/16 at 12:00 PM a FSBS of 117mg/dL and Humalog was administered.</li> <li>-On 6/11/16 at 5:00 PM a FSBS of 115mg/dL and Humalog was administered.</li> <li>-On 6/16/16 at 12:00 PM a FSBS of 97mg/dL and Humalog was administered.</li> <li>-On 7/5/16 at 12:00 PM a FSBS of 117mg/dL and Humalog was administered.</li> </ul> <p>An interview with E 6 (LPN) on 7/13/16 at 10:40 AM confirmed the findings.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 7/14/16 at 1:40 PM.</p>	F 309	<p>sugar results will be reviewed daily for this specific resident to monitor compliance with sliding scale parameters for the next 30 days, then weekly x 30 days.</p> <p>2. All residents who are diabetic and have sliding scale insulin coverage have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in #3.</p> <p>3. The facility conducted a focus review of all like residents who are diabetic with ordered insulin sliding scale coverage. It was determined that no other residents were negatively affected by this deficient practice. The DON/designee will educate nurses on the five medication administration rights and proper adherence to ordered medication parameters.</p> <p>4. The DON/designee will audit all diabetic residents with ordered insulin sliding scale coverage with written parameters to hold. The audit will be conducted daily until 100% compliance is achieved. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.</p>		

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F 315 F 315 SS=D	Continued From page 5 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by : Based on record review and interview it was determined that for one (R81) out of 27 sampled residents the facility failed to thoroughly assess a decline in urinary continence. Findings include:  The facility's policy for Continence Management effective 8/28/13 and last revised 4/29/16 documented that a Bowel and Bladder Assessment should be completed when there is a change of continence status identified on the MDS. The RNAC should complete the MDS Decline Notification Form and forward it to the DON or designee. The DON then notifies the Unit Manager of the decline and a voiding diary is initiated. Based on the results of the voiding diary a toileting program may be developed and the care plan updated.  The following was reviewed in R81's clinical record:  11/25/14 (last reviewed/revised 6/7/16) - Care	F 315 F 315	1. R 81 was a hospice resident who expired while in the facility. 2. All residents have the potential to be affected by the deficient practice. The RNAC was provided with a copy of the MDS Decline Notification Form. Current residents will be re-assessed for a decline on the MDS /section H-300 within for the past 30 days. If a decline is noted, a voiding diary will be initiated. Future residents will be assessed as outlined in Cadia's Continence Management policy and procedural guideline. Measures to promote improvement and continued compliance in following this guideline will be addressed through re-instruction of the licensed nursing staff which includes the RNAC/LNAC. The DON/Designee will also conduct audits of Section H of the MDS to note declines in urinary continence to determine compliance with the guideline	9/12/16	

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F 315	<p>Continued From page 6</p> <p>plan for urinary incontinence with approaches that included: -toileting plan as indicated. -complete voiding diary on admission and as needed for changes in condition.</p> <p>1/17/16 - Annual MDS documented the resident was frequently incontinent of urine.</p> <p>3/16/16 - Readmission Bowel and Bladder Assessment was left blank for the area of urinary incontinence but documented the resident was alert and aware of bladder urges.</p> <p>3/16/16 - Physician's order to straight cath every eight hours PRN if no void.</p> <p>3/23/16 - Re-admission 5 day MDS documented the resident was frequently incontinent of urine.</p> <p>4/12/16 - Significant change MDS documented the resident was always incontinent of urine. This was a change in urinary continence.</p> <p>4/18/16 - Significant Change Bowel and Bladder Assessment documented that R81 was frequently incontinent of urine. However, the CNA data indicated the resident was always incontinent of urine. The assessment indicated that it should be completed after a 3 day voiding diary was completed. There was no evidence that a 3 day voiding diary was completed.</p> <p>6/1/16 - 6/3/16 - 3 day voiding diary conducted.</p> <p>6/11/16 - Nurse's note documented resident died in the facility.</p> <p>An interview on 7/13/16 at 10:45 AM with E4 (</p>	F 315	<p>3. An in-service will be provided for licensed nursing staff to review Cadia's Continenence Management policy and procedure guidelines. Based on the root-cause-analysis of this deficient practice conducted during the survey, it was determined that the LNAC was not following the guideline for completion of the MDS Decline Notification Form. The form has been provided to the RNACs with instructions of when to use the form and the submission process to the DON.</p> <p>4. The DON/designee will audit all declines in urinary incontinence and compliance with Cadia's Continenence Management Policy. The audit will be conducted daily until 100% compliance is achieved. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.</p>	

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F 315	<p>Continued From page 7</p> <p>RNAC) revealed that when the MDS showed a decline in urinary continence a form should be used to communicate the decline to the DON and the unit manager. E4 also confirmed that there was no 3 day voiding diary associated with the significant change Bowel and Bladder assessment.</p> <p>An interview on 7/13/16 at 3:47 PM with E2 (DON ) revealed that she did not have a copy of the MDS Decline Notification Form and was not sure whether she ever got one. E2 had no evidence that the decline form was initiated nor evidence that the decline in urinary continence was fully assessed.</p> <p>These findings were reviewed with E1 (NHA) and E2 on 7/14/16 at 1:40 PM.</p>	F 315			



**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:** July 14, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b> An unannounced annual survey was conducted at this facility from July 8, 2016 through July 14, 2016. 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 one hundred fifteen (115). The survey sample totaled twenty seven (27).</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>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.</b></p> <p><b>This requirement is not met as evidenced by:</b> Cross Refer to the CMS 2567-L survey completed July 14, 2016: F272, F309, and F315.</p>	<p>Cross refer to CMS 2567-L F272, F309 and F315</p>	<p>9/12/16</p>

DHSS/DLTCRP  
JUL 28 2016

Provider's Signature  Title NHA Date 7/27/16