

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

PRINTED: 04/24/2014
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 C 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 WALKER ROAD DOVER, DE 19901
---	--

(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
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from April 2, 2014 through April 10, 2014. The deficiencies cited in this report are based on record reviews, staff interviews, observations and review of other facility documentation as indicated. The census the first day of the survey was 110. The sample size included three (3) active records and one (1) closed record.	F 000		
F 309 SS=D	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 observations, record review, resident interview, and staff interviews it was determined that the facility failed to provide one (1) of four (4) residents reviewed (R2) with the necessary care and services to attain her highest practicable level of physical and psychosocial well-being in accordance with her comprehensive assessment and plan of care. R2's care plan required staff to keep her call bell accessible to her; reposition her every 2 hours; check her skin every two hours; and check and change her disposable undergarment as appropriate. Observations and interviews revealed that the facility failed to provide the incontinence care, repositioning, and	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **5/13/14**

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.

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

PRINTED: 04/24/2014
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 C 04/10/2014
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION CAPITOL			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 WALKER ROAD DOVER, DE 19901		
(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	
F 309	<p>Continued From page 1</p> <p>skin checks required by R2's care plan on 4/5/14 between 8:30 AM and 2:30 PM (six hours). Findings include:</p> <p>The facility identified in a 4/5/14 risk assessment that R2 was at high risk for developing pressure sores (wounds that develop from excessive or prolonged pressure on the body) due to constant moisture; chairfast status (unable to walk); and very limited mobility. R2's care plan for "Potential for pressure sores" included repositioning her every two hours and checking her skin. The facility identified in a Minimum Data Set (MDS) assessment dated 4/1/14 that R2 was frequently incontinent of urine (urinated in a disposable undergarment at least once a day but also urinated in toilet at times) and developed a care plan to address this which required staff to answer R2's call bell promptly and check / change her disposable undergarments as appropriate.</p> <p>R2 was observed by the surveyor at 2:15 PM on 4/5/14 seated in a wheelchair next to her bed. The call bell (a device on the end of a cord with a button that is pushed to alert staff of the need for assistance) was observed to be on the surface of the bed approximately 3 feet from R2 and beyond her reach. R2 stated that she had last had her disposable undergarment changed at 8:30 AM (nearly 6 hours earlier) and had been seated in her wheelchair since that time. R2 replied yes when asked by the surveyor if her skin felt wet and also replied yes when asked if she would like to be changed.</p> <p>The surveyor activated R2's call bell at 2:26 PM and E4 (Certified Nurse's Aide / CNA) entered the</p>	F 309	<p>R2 had a skin assessment completed on April 10, 2014. No Impaired skin integrity was identified</p> <p>The facility will complete a skin sweep on all residents with urinary incontinence. Any skin integrity issues will be addressed.</p> <p>The DON completed a root cause analysis with the Unit managers to determine how the process of re-distributing unit workload could be improved</p> <p>The process for mid-shift staffing huddles was revised.</p> <p>All nursing supervisors, RN's/LPN's and nursing assistants will be inserviced on the process for distributing assignments of staff that have left early during the shift</p> <p>A quality assurance tool will be developed for use in monitoring facility practices for unit staffing. Staffing will be monitored daily by the DON or designee x 3 weeks to ensure adequate distribution of resident assignments when a staff member leaves early during the shift. If daily audits do not achieve 100% compliance then the daily audits will continue until 100% compliance is achieved. When the daily audits achieve 100% compliance then the DON or designee will complete weekly audits x 3 weeks. If weekly audits do not achieve 100% compliance then the weekly audits will continue until 100% compliance is achieved. The DON or designee will then complete the audits x 2 months.</p>	June 4, 2014	

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

PRINTED: 04/24/2014
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 C 04/10/2014
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION CAPITOL			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 WALKER ROAD DOVER, DE 19901		
(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	
F 309	Continued From page 2 room within a few minutes. E4 was observed by the surveyor to tell R2 that she would return to assist her. At 2:39 PM after E4 and E5 (CNA) had provided assistance to R2, E5 stated to the surveyor that R2 was a "heavy wetter" (urinated large amounts). E5 explained that E6 (CNA) had R2 on her assignment that morning but E6 was sent home at 11 AM due to the census on the unit being low. E4 further explained that she (E5) and E4 "picked up" E6's assignment. At 2:45 PM, E4 stated to the surveyor that R2 was soaked (very wet with urine) when changed at about 2:30 PM. E4 further stated that she and E5 had not formally divided E6's assignment when E6 left but together had "picked up" the care of those residents. E7 (Nursing Supervisor) confirmed at 2:50 PM on 4/5/14 that E6 had left at 11 AM due to the unit census being 22, not at the capacity of 30. R2 failed to receive necessary care and services in accordance with her care plan on 4/5/14 for approximately 6 hours after a staffing assignment change was made without clarifying who would be responsible for each individual resident. Findings were confirmed with E1 (Administrator) and E2 (Director of Nursing) on 4/10/14 at 2 PM.	F 309			
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 333			

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

PRINTED: 04/24/2014
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 C 04/10/2014
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION CAPITOL			STREET ADDRESS, CITY, STATE, ZIP CODE 1226 WALKER ROAD DOVER, DE 19901	
(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
F 333	<p>Continued From page 3</p> <p>Based on record review, staff interviews, and review of other documentation as indicated it was determined that the facility failed to ensure that one (1) of four (4) residents reviewed (R1) was free of significant medication errors. R1 received six (6) doses of Lovenox, a blood-thinning medication, after this medication should have been discontinued according to physician orders. Subsequent to the six erroneously administered doses, R1 experienced extensive superficial bruising of the abdomen, right side, and right leg after she (R1) was found lying across her roommate's legs on her (R1's) abdominal area and right side. Findings include:</p> <p>R1 was admitted to the facility on 3/25/14 with a physician's order for the blood-thinning medication Lovenox 60 milligram (mg) (0.6 milliliter dose) to be administered subcutaneously (injected into the skin with a small needle) [given in the abdomen] every 12 hours until R1's INR (a blood test which measures the time it takes for a person's blood to clot) was greater than 2 (seconds). The hospital discharge instructions called for staff to "continue (Lovenox) until INR greater than 2 (seconds)". This hospital discharge instruction was correctly copied onto the Medication Administration Record (MAR) in the area where the nurses were to sign off administration of this medication. In addition to Lovenox, R1's admission orders also included the blood thinning medication Coumadin 5 mg by mouth once a day.</p> <p>A laboratory report dated 3/26/14 indicated that R1's INR was 2.59 seconds which meant that the Lovenox should have been discontinued since R1's INR was "greater than 2 (seconds)". The facility nurses, however, failed to discontinue the</p>	F 333	<p>R1 is no longer receiving lovenox injections. PT/INR was therapeutic as of March 29, 2014</p> <p>A focused review was completed on April 2, 2014 of all residents on dual therapy anticoagulants. Any identified issues were addressed with the attending physician.</p> <p>A Root cause analysis of this medication error was completed by the D.O.N./ADON and reviewed with the Medical Director.</p> <p>As a result of the Root Cause analysis a systemic change from paper records to a new electronic medical record system has been implemented. The process of documenting physician orders for dual therapy anti-coagulants and lab results of PT/INR has been changed facility wide. Licensed nurses will review all PT/INR parameters as ordered with diagnosis / indication for use. The PT/INR section of the emar will be selected for daily task completion on all dual ordered anticoagulant. Nursing will record the PT/INR results in the allotted section daily for the most recent lab results prior to medication administration.</p>	

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

PRINTED: 04/24/2014
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 C 04/10/2014	
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION CAPITOL		STREET ADDRESS, CITY, STATE, ZIP CODE 1225 WALKER ROAD DOVER, DE 19901		
(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
F 333	<p>Continued From page 4</p> <p>medication and administered Lovenox 60 mg subcutaneously to R1 on the following dates / times documented on the MAR:</p> <p>-3/26/14 8 PM -3/27/14 8 AM -3/27/14 8 PM -3/28/14 8 AM -3/28/14 8 PM -3/29/14 8 AM</p> <p>On 3/28/14, a laboratory report indicated that R1's INR had increased to 3:39 seconds. When notified of this result, R1's physician (E3) ordered R1's Coumadin (a different blood thinning medication taken in pill form) to be held for the next 4 days.</p> <p>According to an incident report, dated 3/29/14 timed 6:30 PM, R1 was observed to have bruising of the abdomen and right side and was sent to the hospital for evaluation. R1's INR was tested on that date in the hospital and revealed a result of 2.41 seconds (within the therapeutic range of 2 - 3 seconds printed on the laboratory report). E8 (hospital physician) examined R1 upon admission to the hospital and documented that her abdomen was soft and non-tender with extensive bruising towards the right side of R1's abdomen and flank. The discharge summary for this hospitalization following diagnostic tests and evaluation dated 4/5/14 indicated that R1 had "abdominal bruising secondary to Lovenox injection" which was much improved.</p> <p>The facility reported the six (6) medication errors involving Lovenox erroneously administered to R1 to the State survey agency and conducted an internal investigation. After obtaining written</p>	F 333	<p>All nurses will be Inserviced by Staff Development or designee on the proper way to communicate PT/INR results to the physician. This would include a review of all current orders for dual therapy anti-coagulants.</p> <p>DON or designee will complete weekly audits x 4 weeks to ensure residents on dual therapy anticoagulants are receiving the medications as ordered by the physician. If audits are not 100% compliant than the audits will continue weekly until 100% compliance is achieved. When the weekly audits are at 100% compliance then the DON or designee will complete monthly audits x 3 months.</p>	June 4, 2014

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

PRINTED: 04/24/2014
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 C 04/10/2014
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION CAPITOL		STREET ADDRESS, CITY, STATE, ZIP CODE 1226 WALKER ROAD DOVER, DE 19901		
(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
F 333	<p>Continued From page 5</p> <p>statements and interviewing the nurses involved, E2 (Director of Nursing) stated to the surveyor on 4/2/14 at approximately 1:50 PM that the five (5) nurses involved had acknowledged that the instruction to discontinue the Lovenox when R1's INR was greater than 2 seconds was written on the MAR, however, they (nurses) failed to read it.</p> <p>During their investigation of the medication error, the facility identified that on the morning of 3/29/14, R1 had been found lying on the legs of her roommate (R4) while R4 was in her own bed. The surveyor interviewed R4 on 4/7/14 at 6 PM and R4 confirmed that she had awakened that morning (on 3/29/14) and was alarmed because she (R4) could not move her legs. R4 stated that she then opened her eyes and saw R1 lying on top of her (R4's) legs. R4 stated that she was unsure how long R1 had been there". R4 confirmed that R1's right side and abdominal area were leaning against R4's legs.</p> <p>Findings were confirmed with E1 (Administrator) and E2 on 4/10/14 at 2 PM.</p>	F 333		



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care Res-
idents Protection

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

STATE SURVEY REPORT

Page 1 of 2

NAME OF FACILITY: Cadia Rehabilitation Capitol

DATE SURVEY COMPLETED: April 10, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	--	--

<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced complaint survey was conducted at this facility from April 2, 2014 through April 10, 2014. The deficiencies cited in this report are based on record reviews, staff interviews, observations and review of other facility documentation as indicated. The census the first day of the survey was 110. The sample size included three (3) active records and one (1) closed record.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <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</p>	<p>Cross reference plan of correction for CMS-2567 dated April 10, 2014 for Tag F309 and F333</p>
---	--	---

Provider's Signature [Signature] Title Administrator Date 5/15/14