

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

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 11/05/2015
--	---	--	---

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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000

INITIAL COMMENTS

F000
 An unannounced complaint survey was conducted at this facility from October 23, 2015 through November 5, 2015. The deficiencies cited in this report are based on record reviews, staff interviews, family interviews, and review of other facility documentation as indicated. The census the first day of the survey was 112. The sample size included two (2) active and two (2) closed records.

F 000

Abbreviations used in this report are as follows:
 -DON - Director of Nursing;
 -ADON - Assistant Director of Nursing;
 -NHA- Nursing Home Administrator;
 -LPN- Licensed Practical Nurse;
 -RN- Registered Nurse;
 -UM- RN Unit Manager;
 -RNAC- Registered Nurse Assessment Coordinator;
 -BiPAP- a machine that helps keep the airway open by providing a flow of pressurized air through a face mask attached to a long plastic hose and used for treatment of chronic obstructive lung disease and sleep apnea (episodes where breathing stops during sleep)

F157 (Cross-refer to F309)- 1A. R1 was adversely affected by the deficient practice. Resident sent to hospital for evaluation, resident did not return to facility. Facility did not have opportunity to correct deficient practice for R1.
 1B. All residents who exhibit a significant change in condition have the potential to be affected by the deficient practice of failing to consult immediately with the physician related to the change in the residents condition. The facility will conduct a focus audit of nursing documentation to identify potential like residents with a significant change in condltion related to respiratory and/or neurological status changes.
 1C. The facility conducted a root cause analysis and it was determined that the facility failed to notify the physician of the change in condition for R1. The Staff Developer/Designee will re-inservice all RN and LPN staff on all shifts on the need for immediate physician notification when a resident is noted with a significant change in condition.

January 3, 2016

F 157
 SS=D

483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a

F 157

Continued

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>12/23/15</i>
--	-------------------------------	------------------------------

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

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 11/05/2015
--	---	--	---

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 157	<p>Continued From page 1</p> <p>deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and other interviews as indicated, it was determined that for one (1) of four (4) residents reviewed (R1) the facility failed to immediately consult with the physician and a known and involved family member when there was a significant change in the resident's physical status and a need to alter treatment significantly. R1 was a newly admitted resident who had respiratory distress and decreased alertness identified by facility staff approximately 12 hours after admission. The facility failed to immediately consult with the physician about the respiratory distress and</p>	F 157	<p>1D. DON/designee will conduct random audits of nursing documentation to help identify residents with a significant change of status with focus directly related to respiratory and/or neurological changes in status to ensure immediate physician notification was completed and is timely (see attachment #1). This audit will be conducted daily until 100% compliance achieved over three consecutive evaluations. Then will be monitored three times per week until 100% compliance is achieved over three consecutive evaluations, then once per week until 100% compliance is achieved over 3 consecutive evaluations. Finally, one more evaluation until 100% compliance is maintained. Finding will be reviewed and monitored by the Quality assurance committee.</p> <p>F157 (Cross-refer to F309) - 2A. R1 was adversely affected by the deficient practice. Resident sent to hospital for evaluation, resident did not return to facility. Facility did not have opportunity to correct deficient practice for R1.</p> <p>2B. All residents who exhibit a significant change in condition have the potential to be affected by the deficient practice of failing to consult immediately with an involved responsible party/emergency contact related to a residents change in condition. The facility will conduct a focus audit of nursing documentation to identify potential like residents with a significant change in condition related to respiratory and/or neurological status changes. The facility conducted a focus audit to ensure that involved responsible party/emergency contact information is up to date. Continued</p>	January 3, 2016
-------	--	-------	--	-----------------

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2015
--	---	--	---

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 157	<p>Continued From page 2</p> <p>decreased alertness and also failed to immediately inform R1's family. Findings include:</p> <p>Cross-refer F309.</p> <p>R1 was admitted to the facility from the hospital at approximately 6:30 PM on 9/23/15. On the morning of 9/24/15 (just over 12 hours after admission), the following changes in condition indicating a need to alter treatment significantly were identified by staff: difficulty waking up, rapid respiratory rate, abnormal lung sounds, and gurgling in the throat. There was no evidence that a physician was immediately consulted when this significant change in condition was first identified by the staff at the start of the 7 AM to 3 PM day shift (at approximately 7 AM to 8 AM). Interview with E9 (Medical Director) on 10/26/15 at 2 PM confirmed that he was not consulted by the facility about any changes in R1's condition including rapid breathing.</p> <p>On 10/26/15, the surveyor dialed the emergency contact number in R1's closed clinical record for E14 (brother of R1) and found it to be a wrong number. Interview with E14 on 10/27/15 at 10:20 AM revealed that he had given his correct phone number to a nurse at the time R1 arrived to the facility and the nurse wrote it on a piece of paper but this information did not get entered into R1's clinical record. Consequently when E14 happened to arrive at the facility to visit R1 on the morning of 9/24/15, he (E14) explained to the surveyor that he was told by a nurse that the staff had been trying to call him about R1's deterioration that morning but the number they had was incorrect.</p> <p>These findings were confirmed with E1 (NHA), E2 (DON), E3 (ADON), and E5 (UM) at the exit</p>	F 157	<p>ZC. The facility conducted a root cause analysis and it was determined that the facility failed to notify the involved responsible party /emergency contact of the change in condition for R1. The Staff Developer/Designee will re-inservice all RN and LPN staff on all shifts, Admission Coordinators, and Social Service Coordinators on the need for immediate responsible party /emergency contact notification when a resident is noted with a significant change in condition, for the importance to maintain up to date responsible party /emergency contact phone numbers, to verify resident responsible party/emergency contact phone numbers upon admission/readmission and during resident quarterly care plan meetings, and to enter responsible party/emergency contact phone numbers directly into the computer system upon receiving the information.</p> <p>2D. DON/designee will conduct random audits of nursing documentation to help identify residents with a significant change of status with focus directly related to respiratory and/or neurological changes in status to ensure immediate responsible party /emergency contact notification was completed and is timely (see attachment #2). This audit will be conducted daily until 100% compliance achieved over three consecutive evaluations. Then will be monitored three times per week until 100% compliance is achieved over three consecutive evaluations, then once per week until 100% compliance is achieved over 3 consecutive evaluations. Finally, one more evaluation until 100% compliance is maintained. Finding will be reviewed and monitored by the Quality assurance committee.</p>	
-------	---	-------	---	--

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

PRINTED: 11/24/2015
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 C 11/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 WALKER ROAD DOVER, DE 19801
---	--

(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
<p>F 157</p> <p>F 309</p> <p>SS=G</p>	<p>Continued From page 3 conference on 11/5/15 at 2 PM.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, family interview, physician interviews, and review of facility investigation documentation, it was determined that for one (1) of four (4) residents reviewed (R1), the resident failed to receive and the facility failed to provide the necessary care and services to attain the highest practicable level of physical well-being in accordance with the comprehensive assessment and plan of care. R1 was a resident of the facility from the evening of 9/23/15 (approximately 7 PM) until the morning of 9/24/15 (approximately 10 AM). During that time, R1 failed to receive oxygen with his BiPAP through the night as required by physician orders. Then, R1 failed to receive a thorough assessment and immediate nursing intervention the following morning when he was hard to wake up and had a rapid respiratory rate (visibly breathing fast). The facility staff failed to seek consultation with the physician after staff identified signs and symptoms that R1 required medical intervention (complained of not feeling well, difficulty waking up and rapid breathing).</p>	<p>F 157</p> <p>F 309</p>	<p>F309- 1A. R1 was adversely affected by the deficient practice. Resident sent to hospital for evaluation, resident did not return to facility. Facility did not have opportunity to correct deficient practice for R1.</p> <p>1B. All residents who receive Bipap and Cpap therapy which require the use of an O2 bleed in have the potential to be affected by the deficient practice. The facility conducted a focus audit of resident's receiving Bipap and Cpap therapy to identify potential like residents and facility will adjust bipap/cpap removal order to accommodate for proper removal technique.</p> <p>1C. The facility conducted a root cause analysis and it was determined that the facility failed to provide R1 with his oxygen bleed in to his Bipap and failed to maintain the use of the Bipap until resident was fully awake or per residents choice of removal or per set physician order. The Staff Developer/Designee will re-in-service all RN and LPN staff on all shifts on the proper procedures to adhere to the plan of care as ordered for Bipap/Cpap administration with O2 bleed in, notification to oncoming shift-RN/LPN staff of Bipap/Cpap use and order/administration requirements, oxygen use, oral suctioning, documentation of therapy in EMAR/ETAR, protocol that no resident is to use home equipment for Bipap/Cpap administration and the proper protocol to obtain the equipment from the facility contracted supply company, and that Bipap/Cpap shall not be removed until resident is fully awake or per the resident request of removal or per set physician order.</p> <p>Continued</p>	<p>January 3, 2016</p>

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

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 11/05/2015
--	--	--	---

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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 309	<p>Continued From page 4</p> <p>There was lack of evidence in the clinical record that the BiPAP remained on R1 until he was fully awake. Staff statements obtained by the facility while investigating R1's care revealed a lack of effective staff communication about R1's respiratory care needs and immediate need for intervention. One staff member (E4, LPN) recognized that R1 required intervention and she considered suctioning (using a catheter to remove secretions from the mouth and airway), however, due to ineffective communication with another staff member (E11, RNAC), no suctioning was provided to R1. R1 then became unresponsive and required cardiopulmonary resuscitation (CPR) in the facility on 9/24/15 approximately 14 - 15 hours after admission to the facility. R1 was then transferred to the hospital for emergency care by paramedics responding to the facility's 911 call. Findings include:</p> <p>R1 was admitted to the facility from the hospital on 9/23/15 at approximately 6:30 pm. Admission orders for R1 required the use of oxygen 3 liters per minute 24 hours a day. In addition, R1 was required to have BiPAP at night with the oxygen use to continue while the BiPAP was being used. Due to staff error, however, the oxygen was not used with the BiPAP on the first and only night R1 was in the facility. A nursing note dated 9/24/15 and timed 12:24 AM documented that the oxygen was turned off when the BiPAP was applied to R1 at bedtime. In a statement dated 9/27/15, E6 (RN) wrote that she did not receive instructions to connect the BiPAP to oxygen. This is contradicted by the fact that there was a physician's admission order to do so and documented discharge instructions from the hospital for oxygen to be used at all times</p>	F 309	<p>1D. DON/designee will conduct audit of all residents who require the use of Bipap or Cpap therapy to ensure that the therapy is being carried out per the residents set plan of care. (see attachment #3). This audit will be conducted daily until 100% compliance achieved over three consecutive evaluations. Then will be monitored three times per week until 100% compliance is achieved over three consecutive evaluations, then once per week until 100% compliance is achieved over 3 consecutive evaluations. Finally, one more evaluation until 100% compliance is maintained. Finding will be reviewed and monitored by the Quality assurance committee.</p> <p>F309- 2A. R1 was adversely affected by the deficient practice. Resident sent to hospital for evaluation, resident did not return to facility. Facility did not have opportunity to correct deficient practice for R1.</p> <p>2B. All residents have the potential to be affected by the deficient practice of lack of immediate thorough nursing assessment / intervention upon noted significant change in resident condition and poor communication of assessment finding.</p> <p>2C. The facility conducted a root cause analysis and it was determined that the facility failed to provide R1 with immediate thorough nursing assessment/intervention upon noted significant change in resident condition related to the residents respiratory and neurological status and poor communication of residents condition. The Staff Developer/Designee will re-inservice all RN and LPN staff on all shifts on the proper techniques of nursing assessment related directly to respiratory and neurological assessments, communication basics/techniques, documentation/notification of assessment, and SBAR/interact guides. Continued</p>	January 3, 2016
-------	--	-------	--	-----------------

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

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 11/05/2015
--	---	--	---

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 5 including with the BiPAP at night. E6 signed off the order for BiPAP with oxygen at 3 liters per minute starting at 10:11 PM but confirmed in an interview with a State survey agency investigator on 10/7/15 at 2:05 PM that no oxygen was used with the BiPAP.</p> <p>During the night shift (11 PM to 7 AM), E8 (LPN) failed to identify that oxygen use was ordered but not being used with the BiPAP. In an interview with a State agency investigator on 10/9/15 at 2:07 PM, E8 explained that she administered two nebulizer treatments (medication inhaled through a tube in a vapor mist form) to R1 during her shift and applied oxygen to R1 via nasal cannula (prongs inserted into the nasal openings) during the treatments but did not know the oxygen was to be used with the BiPAP until after the fact. E8 wrote in a statement dated 9/25/15 that after the second nebulizer treatment was given at about 5:30 AM, she did not reapply the BiPAP to R1 and instead applied the oxygen without the BiPAP. The treatment record for R1 indicated that the BiPAP was signed off as discontinued by E8 at 6:54 AM. There was no evidence found that R1 was fully awake, up for the day, and alert at the time the BiPAP use was discontinued.</p> <p>The day shift (7 AM to 3 PM) staff making initial rounds identified that R1 did not feel well on the morning of 9/24/15. E12 (CNA) reported to a facility nurse (as documented in a statement dated 10/2/15) who was investigating R1's care that R1 initially did not respond when E12 asked his name and then stated to E12 that he was hungry and did not feel well. E12 stated that he notified E4 (LPN) of this and then took breakfast to R1 but R1 did not want to eat. E7 (CNA) wrote in a statement dated 9/24/15 that</p>	F 309	<p>2D. DON/designee will conduct random unannounced audits of RN/LPN staff to observe assessment techniques related to respiratory and neurological assessments and to assess for knowledge of communication standards. (see attachment #4). This audit will be conducted daily until 100% compliance achieved over three consecutive evaluations. Then will be monitored three times per week until 100% compliance is achieved over three consecutive evaluations, then once per week until 100% compliance is achieved over 3 consecutive evaluations. Finally, one more evaluation until 100% compliance is maintained. Finding will be reviewed and monitored by the Quality assurance committee.</p> <p>F309 (Cross-refer to F157)- 3A. R1 was adversely affected by the deficient practice. Resident sent to hospital for evaluation, resident did not return to facility. Facility did not have opportunity to correct deficient practice for R1. 3B. All residents who exhibit a significant change in condition have the potential to be affected by the deficient practice of failing to consult immediately with the physician related to the change in the residents condition. The facility will conduct a focus audit of nursing documentation to identify potential like residents with a significant change in condition related to respiratory and/or neurological status changes. 3C. The facility conducted a root cause analysis and it was determined that the facility failed to notify the physician of the change in condition for R1. The Staff Developer/Designee will re-inserve all RN and LPN staff on all shifts on the need for immediate physician notification when a resident is noted with a significant change in condition. Continued</p>	January 3, 2016

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

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 11/05/2015
--	--	--	---

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 6</p> <p>R1 appeared very tired when she asked him what he wanted for breakfast and she had to wake him up two or three times to get a response from him. E7 wrote that R1 stated that he did not want anything to eat.</p> <p>E4, who was the nurse assigned to R1 for the day shift on 9/24/15, wrote in a statement dated 9/25/15 that on the morning of 9/24/15 she observed R1 in bed breathing rapidly with his eyes closed and mouth open with his oxygen on. E4 wrote that she asked R1 why he didn't feel well and he replied that he hadn't had breakfast yet. E4 further wrote the following facts about R1's condition that morning:</p> <ul style="list-style-type: none"> -that she (E4) heard rales (an abnormal sound in the lungs) and heard gurgling in R1's throat so she asked him to cough which he did weakly; -that she had R1 spit out the coughed up secretions from his mouth and then left R1 and went to the nursing station and told E11 (RNAC) and E13 (LPN, acting UM that shift) that R1 didn't look good and asked E11 about the policy for suctioning; -that E11 told her (E4) that a doctor's order was needed for suctioning; -that she (E4) told E13 about R1's condition and that the physician's assistant would be arriving at the facility shortly; -that she (E4) went to give medicine to another resident and planned to go complete her assessment of R1 after that; -that after giving medication to another resident she went back to R1's room and observed him to be pale in bed (raised up at an 80 degree angle) and she (E4) tried to gently shake R1 but could not wake him up; -that R1's lips were purple in color and she (E4) left R1 to go down the hallway to request that an 	F 309	<p>3D. DON/designee will conduct random audits of nursing documentation to help identify residents with a significant change of status with focus directly related to respiratory and/or neurological changes in status to ensure immediate physician notification was completed and is timely (see attachment #1). This audit will be conducted daily until 100% compliance achieved over three consecutive evaluations. Then will be monitored three times per week until 100% compliance is achieved over three consecutive evaluations, then once per week until 100% compliance is achieved over 3 consecutive evaluations. Finally, one more evaluation until 100% compliance is maintained. Finding will be reviewed and monitored by the Quality assurance committee.</p> <p>F309 (Cross-refer to F157) - 4A. R1 was adversely affected by the deficient practice. Resident sent to hospital for evaluation, resident did not return to facility. Facility did not have opportunity to correct deficient practice for R1.</p> <p>4B. All residents who exhibit a significant change in condition have the potential to be affected by the deficient practice of failing to consult immediately with an involved responsible party/emergency contact related to a residents change in condition. The facility will conduct a focus audit of nursing documentation to identify potential like residents with a significant change in condition related to respiratory and/or neurological status changes. The facility conducted a focus audit to ensure that involved responsible party/emergency contact information is up to date.</p> <p>Continued</p>	January 3, 2016
-------	--	-------	--	-----------------

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

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 11/05/2015
--	---	--	---

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 7</p> <p>RN come to R1's room; -that another nurse followed her back to R1's room and they began CPR and tried to suction R1 although the suction equipment did not initially work; and -that when a second suction machine was obtained white foam was suctioned from R1's mouth and at this point R1's face was purple in color.</p> <p>In an interview with a State agency investigator on 9/30/15 at 12:35 PM, E4 explained that she first saw R1 at about 7:30 AM and that his breathing was rapid at that time. E4 stated that she heard gurgling and told R1 to cough which he did. E4 stated that the BiPAP had been removed by the previous shift (11 PM to 7 AM). E4 stated that she next saw R1 when she returned to his room after 9 AM and at that time she observed his lips to be purple and CPR was initiated a short time later (after E4 left the room to get another nurse and returned to R1's room with the other nurse). Prior to and after finding R1 with purple lips, E4 failed to identify that putting the BiPAP back on R4 was an immediately available intervention to help R1.</p> <p>Although E4 wrote that she told E11 about R1's condition and asked about suctioning, surveyor interview with E11 on 10/28/15 at approximately 12 noon in the presence of E2 (DON) revealed that she (E11) thought E4 was asking a general question about suctioning and did not process or understand that E4 was specifically asking about whether R1 could be suctioned at that time. E11 stated that if she thought there was an urgent problem or current need for suctioning, she would have gone right to R1's room to assess him. E2 confirmed to the surveyor, and E11</p>	F 309	<p>4C. The facility conducted a root cause analysis and it was determined that the facility failed to notify the involved responsible party /emergency contact of the change in condition for R1. The Staff Developer/Designee will re-in-service all RN and LPN staff on all shifts, Admission Coordinators, and Social Service Coordinators on the need for immediate responsible party /emergency contact notification when a resident is noted with a significant change in condition, for the importance to maintain up to date responsible party /emergency contact phone numbers, to verify resident responsible party/emergency contact phone numbers upon admission/readmission and during resident quarterly care plan meetings, and to enter responsible party/emergency contact phone numbers directly into the computer system upon receiving the information.</p> <p>4D. DON/designee will conduct random audits of nursing documentation to help identify residents with a significant change of status with focus directly related to respiratory and/or neurological changes in status to ensure immediate responsible party /emergency contact notification was completed and is timely (see attachment #2). This audit will be conducted daily until 100% compliance achieved over three consecutive evaluations. Then will be monitored three times per week until 100% compliance is achieved over three consecutive evaluations, then once per week until 100% compliance is achieved over 3 consecutive evaluations. Finally, one more evaluation until 100% compliance is maintained. Finding will be reviewed and monitored by the Quality assurance committee.</p>	
-------	---	-------	--	--

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

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 11/05/2015
--	---	--	---

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 309	<p>Continued From page 8</p> <p>acknowledged, that suctioning could have been performed if needed based on nursing judgement without a physician's order and that the required equipment for suctioning was available on each of the facility's three units. As a result of poor communication between E4 and E11, facility staff failed to identify that suctioning was an immediately available intervention to help R1.</p> <p>The 911 dispatch center advised the surveyor on 11/3/15 at 1:22 PM that 911 calls were received from the facility on 9/24/15 at 9:35 AM, 9:36 AM, and 9:41 AM with the Basic Life Support team arriving at the facility at 9:42 AM and the Advanced Life Support team arriving at 9:45 AM. This indicates that from the time the day shift staff first identified that R1 did not feel well, did not look good, was hard to wake up, and was breathing rapidly, one to two hours passed before any medical assistance was sought. During that time span, there was no thorough assessment of R1 by any nurse along with a failure of facility staff to identify immediate nursing interventions available to help R1 breathe easier. R1 was transported to the hospital via ambulance with CPR in progress.</p> <p>A cardiologist (heart specialist) consultation report dated 9/24/15 indicated that R1 likely experienced acute respiratory failure from his underlying chronic lung disease and sleep apnea and that there was no evidence that a cardiac issue was the source of R1's change in condition in the facility. A pulmonologist (lung specialist) consultation report dated 9/24/15 indicated that R1 likely experienced respiratory arrest (stopped breathing) which then caused cardiac arrest (heart stopped beating).</p>	F 309		

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

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 11/05/2015
--	---	--	---

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 9
 Interview with E9 [Medical Director] on 10/26/15 at 2 PM revealed that while the failure of the facility to use oxygen for R1 as ordered was sub-optimal, he did not believe it was the cause of R1's cessation of breathing and need for CPR. Interview with E10 (R1's family physician) on 10/30/15 at 1:50 PM revealed that the lack of oxygen use was very significant for R1 and E10 further questioned why staff did not reapply the BiPAP when R1 was difficult to wake up and was breathing rapidly on the morning of 9/24/15.

 In summary, the facility failed to provide ordered oxygen to R1 overnight with his BiPAP. Then the facility failed to monitor R1's respiratory status after rapid breathing was identified and re-assess R1 to identify what immediate interventions were needed to help R1 breathe easier. The facility's failure to monitor and re-assess R1 spanned a time frame of one to two hours during which multiple staff members were aware that R1 said he did not feel good, did not want to eat, did not look good, was breathing rapidly, had a weak cough, and gurgling in his throat. The facility also failed to immediately consult with R1's physician and notify R1's family when R1 experienced a significant change in condition that indicated a need for medical treatment.

F 309

F 328
 SS=E

483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS

 The facility must ensure that residents receive proper treatment and care for the following special services:

F 328

F328 (Cross-refer F309)- 1A. R1 was adversely affected by the deficient practice. Resident sent to hospital for evaluation, resident did not return to facility. Facility did not have opportunity to correct deficient practice for R1. 1B. All residents who receive Bipap and Cpap therapy which require the use of an O2 bleed in have the potential to be affected by the deficient practice. The facility conducted a focus audit of resident's receiving Bipap and Cpap therapy to identify potential like residents and facility will adjust bipap/cpap removal order to accommodate for proper removal technique.
 Continued

January 3, 2016

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

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 11/05/2015
--	--	--	---

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 328	<p>Continued From page 10</p> <p>Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prosthesis.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that for one (1) of four (4) residents reviewed (R1) and one (1) of one (1) sub-sample residents reviewed (SS1), it was determined that the facility failed to ensure that the residents received proper treatment and care related to respiratory needs. R1 and SS1 had BIPAP treatments ordered by the physician to be used at night, however, the BiPAP was routinely discontinued at the end of the 11 PM to 7 AM shift rather than at the time the residents were fully awake and alert and no longer asleep. Findings include:</p> <p>1. Cross refer F309. R1 had a physician order, dated 9/23/15, for BiPAP at night with oxygen. Treatment record documentation indicated that the BiPAP was discontinued prior to 7 AM on 9/24/15 although there was no evidence that R1 was fully awake, alert, and no longer sleeping. The treatment record contained a pre-printed prompt for staff on the night shift (11 PM to 7 AM) to remove the BiPAP.</p>	F 328	<p>1C. The facility conducted a root cause analysis and it was determined that the facility failed to provide R1 with his oxygen bleed in to his Bipap and failed to maintain the use of the Bipap for R1 until resident was noted as fully awake or per residents choice of removal. The Staff Developer/Designee will re-inservice all RN and LPN staff on the proper procedures to adhere to the plan of care as ordered for Bipap/Cpap administration with O2 bleed in, notification to oncoming shift-RN/LPN staff of Bipap/Cpap use and order/administration requirements, oxygen use, oral suctioning, documentation of therapy in EMAR/ETAR, protocol that no resident is to use home equipment for Bipap/Cpap administration and the proper protocol to obtain the equipment from the facility contracted supply company, and that Bipap/Cpap shall not be removed until resident is fully awake or per the resident request of removal or per set physician order.</p> <p>1D. DON/designee will conduct audit of all residents who require the use of Bipap or Cpap therapy to ensure that the therapy is being carried out per the residents set plan of care. (see attachment #3). This audit will be conducted daily until 100% compliance achieved over three consecutive evaluations. Then will be monitored three times per week until 100% compliance is achieved over three consecutive evaluations, then once per week until 100% compliance is achieved over 3 consecutive evaluations. Finally, one more evaluation until 100% compliance is maintained. Finding will be reviewed and monitored by the Quality assurance committee.</p>	<p>January 3, 2016</p>
			<p>F328 (Cros-refer F309)- 2A. SS1 was not adversely affected by the deficient practice. Resident still resides in facility. Facility has adjusted resident plan of care to meet residents needs.</p> <p>Continued</p>	

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

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 11/05/2015
--	---	--	---

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 328	<p>Continued From page 11</p> <p>2. SS1 had a physician order, dated 10/13/15, for BIPAP every night at bedtime and as needed with the instruction to "remove in AM". The treatment records for September and October of 2015 contained a pre-printed prompt for the night shift (11 PM to 7 AM) shift to remove the BIPAP. In an interview on 11/3/15 at 10:05 AM, E2 [DON] explained that the prompt was entered by the nursing staff who entered the order and that a time had to be entered. E2 acknowledged that residents wake up at different times on different days and that the BIPAP should consequently be coming off at different times (e.g. sometimes before 7 AM and sometimes after 7 AM) and should not be routinely removed at the end of the night shift if a resident was not yet fully awake. E2 stated that she would address this issue so that BiPAP use was discontinued upon waking, not routinely at the end of the 11 PM to 7 AM shift.</p> <p>These findings were confirmed with E1[NHA], E2, E3[ADON], and E5[UM] at the exit conference on 11/5/15 at 2 PM.</p>	F 328	<p>2B. All residents who receive Bipap and Cpap therapy which require the use of an O2 bleed in have the potential to be affected by the deficient practice. The facility conducted a focus audit of resident's receiving Bipap and Cpap therapy to identify potential like residents and facility will adjust bipap/cpap removal order to accommodate for proper removal technique.</p> <p>2C. The facility conducted a root cause analysis and it was determined that the facility failed to maintain the use of the Bipap for SS1 until resident was noted as fully awake or per residents choice of removal. The Staff Developer/Designee will re-inservice all RN and LPN staff on the proper procedures to adhere to the plan of care as ordered for Bipap/Cpap administration with O2 bleed in, notification to oncoming shift-RN/LPN staff of Bipap/Cpap use and order/administration requirements, oxygen use, oral suctioning, documentation of therapy in EMAR/ETAR, protocol that no resident is to use home equipment for Bipap/Cpap administration and the proper protocol to obtain the equipment from the facility contracted supply company, and that Bipap/Cpap shall not be removed until resident is fully awake or per the resident request of removal or per set physician order.</p> <p>2D. DON/designee will conduct audit of all residents who require the use of Bipap or Cpap therapy to ensure that the therapy is being carried out per the residents set plan of care. (see attachment #3). This audit will be conducted daily until 100% compliance achieved over three consecutive evaluations. Then will be monitored three times per week until 100% compliance is achieved over three consecutive evaluations, then once per week until 100% compliance is achieved over 3 consecutive evaluations. Finally, one more evaluation until 100% compliance is maintained. Finding will be reviewed and monitored by the Quality assurance committee.</p>	



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

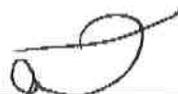
DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Capitol

DATE SURVEY COMPLETED: November 05, 2015

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>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 October 23, 2015 through November 5, 2015. The deficiencies cited in this report are based on record reviews, staff interviews, family interviews, and review of other facility documentation as indicated. The census the first day of the survey was 112. The sample size included two (2) active and two (2) closed records.</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 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 November 05, 2015 F157, F309 and F328.</p>	<p>Cross reference F 157,F 309 and F 328</p>	<p>Jan 3 2016</p>

Provider's Signature  Title Administrator Date 12/4/15