

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

PRINTED: 01/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/05/2015
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION BROADMEADOW			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH BROAD STREET MIDDLETOWN, DE 19709	
(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 beginning December 18, 2014 and ending January 5, 2015. The facility census on the entrance day of the survey was 106. The survey sample was composed of 9 residents. The survey process included observations, interviews and review of resident charts, facility documents and facility policies and procedures. Abbreviations used in this report are as follows: ED - Executive Director DON - Director of Nursing ADON - Assistant Director of Nursing RN - Registered Nurse	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 clinical record review, review of facility documents and staff interviews it was determined that the facility failed to provide care and services to maintain the highest practicable physical,	F 309	A) R2 without adverse reaction related to medication error. Resident placed on alert charting with routine assessments without deviation from norm. B) No other residents were adversely affected by deficient practice. E4 was educated on 6 rights of medication administration. Facility Licensed nurses educated on 6 rights to medication administration.	2/19/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE _____
Carol Humbold, MHA Administrator 1-27-15

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 309	<p>Continued From page 1</p> <p>mental and psychosocial well-being for one resident (R2) out of nine sampled. The facility failed to follow the plan of care and administered a medication to R2 that was not prescribed by the resident's physician. Findings include:</p> <p>Review of a facility incident report dated 11/13/2014 and timed 9:00 AM revealed discovery of a medication error that occurred after administration of the wrong medication to R2 on 11/11/2014 at 8:00 PM. In an interview conducted with E3 (ADON) on 1/5/2014 at approximately 4:15 PM It was confirmed that the pharmacy reported this medication error to the facility on 11/13/2014 at 9:00 AM after checking the contents of the emergency medication box that was returned to the pharmacy. Further review of the same incident report revealed that R2 received an incorrect medication that was removed from a drawer of the emergency box that stored two different medications. According to the above referenced incident report E4 (RN) removed 4 tablets of Glyburide (antidiabetic) 2.5 mg [milligrams] each from the emergency box. The count of all Coumadin (blood thinner) 2.5 mg tablets stored in the same drawer of the emergency box as the Glyburide tablets remained the same.</p> <p>The incident report dated 11/13/2014 and timed 9:00 AM also revealed that R2 was administered "Glyburide 2.5 mg" instead of Coumadin 2.5 mg" as ordered by the physician. Review of the "Physician Order Report" dated 11/01/2014 through 11/30/2014, revealed R2 was prescribed "Coumadin tablet, 2.5 mg, one tablet by mouth once a day at 8:00 PM. Review of the facility "Medication Administration History" (medication record) dated 11/01/2014 through 11/13/2014</p>	F 309	<p>Emergency box medication audit conducted and changes were made to the location of medications related to appearance, size and dosage by pharmacy. C) Monthly review of emergency box contents to assess medication disposition and medication locations in box. Unannounced monthly medications pass review of licensed nurses with concentration on the 6 rights of medications will be conducted D) DON/Designee will review 3 residents daily during a random medication pass until consistent achievement of 100% is obtained over 3 consecutive evaluations, then monitor a sample of 3 residents three times a week until 100% is consistently achieved over three consecutive evaluations, then measure once a week until consistently reach 100% success over three consecutive evaluations. Finally, measure one more time one month later, if 100%, problem has successfully been addressed. If not, review the process currently being used for changes needed to achieve the goal. Repeat the auditing process timeline until the</p>	2/19/15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/05/2015
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION BROADMEADOW			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH BROAD STREET MIDDLETOWN, DE 19709		
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F 309	<p>Continued From page 2</p> <p>also revealed documentation of the administration of "Coumadin 2.5mg, one tablet by mouth at 8:00 PM".</p> <p>However review of the facility incident report dated 11/13/2014 with attached investigation revealed that E4 removed a medication from the emergency medication box, prepared the medication for administration and administered the medication to R2 without verification of the right medication for the right resident. E4 received disciplinary action (11/13/14 at 3:00 PM) for failure to verify the right medication and right dose prior to the administration of the right medication to the right resident on 11/11/2014 at 3:00 PM. The facility failed to ensure that R2 received a medication as prescribed by her physician. The facility policy "Specific Medication Administration Procedures" states "...F. Read medication label three (3) times before pouring...".</p> <p>These findings were reviewed with E1 (ED), E2 (DON) and E3 on 1/5/2014 at 4:00 PM.</p>	F 309	measures implemented have consistently met the goal set. Report results to the facility QA committee quarterly.	2/19/15	



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 Broadmeadow

DATE SURVEY COMPLETED: January 5, 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 December 18, 2014 through January 5, 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 106. The survey sample totaled nine (9)</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 complaint survey ending January 5, 2015, F309.</p>	<p>Cross Reference F-309</p>	<p>2/19/15</p>

Provider's Signature *Charles J. Rummel* NHA Title Administrator Date 1-27-15