

PRINTED: 08/26/2015  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/12/2015
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NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE	STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from August 6, 2015 through August 12, 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 105. The stage two survey sample was thirty-four (34).</p> <p>Abbreviations/Definitions used in this 2367 are as follows:                  NHA - Nursing Home Administrator;                  DON - Director of Nursing;                  ADON - Assistant Director of Nursing;                  RN - Registered Nurse;                  LPN - Licensed Practical Nurse;                  UM - Unit Manager;                  MD - Medical Doctor;                  RNAC - Registered Nurse Assessment Coordinator;                  CNA - Certified Nurse's Aide;                  FSD - Food Service Director;                  RD - Registered Dietitian;                  NP - Nurse Practitioner;                  PA - Physician Assistant;                  ADLs - Activities of Daily Living, such as bathing and dressing;                  PRN - As needed;                  MAR - Medication Administration Record (on paper);                  eMAR - Electronic Medication Administration Record (in the computer);                  MDS - Minimum Data Set (standardized assessment used in nursing homes);                  BM - Bowel movement;                  MOM - Milk of Magnesia, medication to promote a bowel movement;</p>	F 000	<p>Preparation and/or execution of this plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REGISTRANT'S SIGNATURE  <i>Juan P. ...</i>	TITLE  NHA	(X6) DATE  8/31/15
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency for 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.

*Juan P. ...* NHA 9/10/15 (re-submitted)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER'S APPROVAL IDENTIFICATION NUMBER:  085052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/12/2015
NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE		STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966		
(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	Continued From page 1 Enema - Fluid inserted in live rectum to promote a bowel movement; Suppository - Drug given in the rectum to promote a bowel movement; QA - Quality Assurance.	F 000		
F 241 SS-D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to care for residents in a manner that maintained or enhanced dignity for 2 (R34 and R120) out of 34 sampled residents. Findings include:  On 8/6/15 in the Bethany unit's dining room the following were seen during a dining observation: 1. At 8:20 AM E9 (CNA) placed a white terry cloth clothing protector on R34 without first asking permission from this alert resident. 2. At 8:20 AM E10 (CNA) placed a white terry cloth clothing protector on R120 without first asking permission from this alert resident.  These findings were reviewed with E1 (NHA) and E2 (DON) on 8/12/15 at 1:30 PM.	F 241	A. R34 and R120 have severe cognitive impairment and are unable to make appropriate decisions regarding their care. Responsible parties for both have requested clothing protectors be used during meal times in order to assure the residents' dignity with clean clothing following each meal. Clothing protector use has been careplanned for both residents.  B. Clothing protectors are offered to residents who would like to protect their clothing from being soiled during the meal process. Permission is requested from alert and oriented residents prior to placement. In order for those residents whose cognition prevents them from making appropriate decisions, the responsible party is contacted to obtain permission to care plan for clothing protector use in order to preserve their dignity with clean clothing following the meal.  C. Staff Developer/Designee will educate staff to preserve dignity of the residents by asking permission for clothing protector use prior to placement. Permission will be obtained prior to placement for all residents unless a care plan is in place to allow placement.  D. Unit Managers will audit (attachment 1) weekly ensuring permission is obtained prior to clothing protector placement (unless a care plan is in place) until 100% compliance is achieved for 3 consecutive weeks, then monthly until 100% compliance is achieved for 3 consecutive months. At this point this deficient practice will be considered resolved.	10/5/15
F 253 SS-E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and	F 253		

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NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE	STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966
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F 253	<p>Continued From page 2</p> <p>maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview it was determined that the facility failed to maintain housekeeping and maintenance services for 18 (108, 202, 205, 214, 220, 221, 222, 224, 227, 228, 230, 301, 302, 303, 307, 308, 313, 315) out of 32 resident rooms and 2 out of 3 bathing rooms reviewed. Findings include:</p> <ul style="list-style-type: none"> <li>• During initial stage one observation on 8/8 and 8/7/15, approximately 8:00 AM-10:00 AM both days, and follow-up observations on 8/11 (8:00 - 2:45 PM) and 8/12/15 (9:00 - 5:00 AM) the following were observed:</li> <li>• Dry wall damage and wall scuffs - 108, 202, 205, 214, 220, 221, 222, 224, 227, 228, 230, 302, 303, 307, 309, 313, 315.</li> <li>• Floor dirty - 220, 222, 301, 307</li> <li>• Towel bar loose - 302</li> <li>• Dirty grout / caulking around shower - Bathery spa</li> <li>• Broken tile - Fenwick spa.</li> </ul> <p>An interview on 8/12/15 at 10:15 AM with E3, Maintenance Director revealed that the facility was aware of the dry wall damage and wall scuffs. They are working on installing a cleanable product over the painted drywall. The rest of the observations were reviewed with E3.</p>	F 253	<p>A. Dry wall damage, wall scuffs, dirty floors, dirty grout/caulking and broken tile are being addressed. Towel bar in room 302 was repaired immediately. No residents were directly affected by these practices.</p> <p>B. All residents have the potential to be affected.</p> <p>C. The Director of Housekeeping Services/designee will conduct daily quality control inspections (attachment 2) and Housekeeping District Manager will monitor monthly for compliance. Housekeeping staff will be educated to communicate to their department Director the environmental concerns that reach beyond their housekeeping abilities (attachment 2A). The Director of Housekeeping will communicate these needs to the Director of Maintenance for further review and attention. The Director of Maintenance will communicate the completion of these needs to the NHA (attachment 2A).</p> <p>D. The NHA/designee will conduct weekly audits (attachment 2) until 100% compliance is achieved for 3 consecutive weeks, then audit bi-weekly until 100% compliance is achieved for 3 consecutive evaluations, then audit monthly until 100% compliance is achieved for 3 consecutive months.</p>	10/5/15
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NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 28002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966		
(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 253	Continued From page 3	F 253			
F 272 SS=D	<p>These findings were reviewed with E1, MHA and E2, DON on 8/12/15 at 1:30 PM.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. This assessment must include at least the following:</p> <ul style="list-style-type: none"> <li>• Identification and demographic information;</li> <li>• Customary routine;</li> <li>• Cognitive patterns;</li> <li>• Communication;</li> <li>• Vision;</li> <li>• Mood and behavior patterns;</li> <li>• Psychosocial well-being;</li> <li>• Physical functioning and structural problems;</li> <li>• Continence;</li> <li>• Disease diagnosis and health conditions;</li> <li>• Dental and nutritional status;</li> <li>• Skin conditions;</li> <li>• Activity pursuit;</li> <li>• Medications;</li> <li>• Special treatments and procedures;</li> <li>• Discharge potential;</li> <li>• Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and</li> <li>• Documentation of participation in assessment.</li> </ul>	F 272	<p>A. R90 was not impacted by the deficient practice. Resident and responsible party are now aware of the availability of dental services. Arrangements have been made by the facility for a dental evaluation for this resident.</p> <p>B. All residents that have dental issues are at risk for this practice. RNAC will complete the CiraI assessment utilizing a penlight to identify missing, chipped and discolored teeth. Any areas of concern by resident or RNAC will be communicated immediately to the Nursing Staff for further evaluation, including dental consult if necessary.</p> <p>C. Lead RNAC educated RNAC staff on necessity of accurate dental assessments. A focused review was conducted on all like residents. No further issues identified.</p> <p>D. Lead RNAC/Designee will audit 4 (attachment 3) Annual VIOS's monthly until 100% compliance is achieved during 3 consecutive evaluations, then will be audited quarterly until 100% compliance is achieved.</p>	10/5/15	

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NAME OF PROVIDER OR SUPPLIER  GADIA REHABILITATION RENAISSANCE	STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (3) (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 272	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to accurately assess the dental status for one (R90) out of 34 sampled residents. Findings include:</p> <p>R90 was admitted 7/27/12. Annual MDG's dated 7/20/14 and 8/3/15 stated 'None Present' referring to problems with the resident's teeth.</p> <p>Upon interview and observation of R90 on 8/10/16 at 1:40 PM, the resident stated she had not seen a dentist since she was admitted and did not know that the service was offered through the facility. R90 pointed out that she only had two teeth on the bottom and was missing a few teeth on top. The surveyor noted her teeth were discolored and chipped. R90 stated, "They break off when you get old."</p> <p>During an interview on 8/10/15 at 2:00 PM E4 (Social Services) revealed there was no documentation that a dental consult was performed. E4 stated the resident's daughter was very active in the resident's care and attended care plan meetings often along with the resident. R90's dental status had never come up during care plan meetings.</p> <p>The facility failed to accurately assess the resident's dental status.</p>	F 272		
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NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 20002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966	
(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 279	Continued From page 6  On 7/20/15 the physician ordered MOM concentrated, stronger than regular MOM, to be given once a day as needed. The regular strength MOM order remained active.  On 8/10/15 review of the resident's care plan dated 6/11/14 (last edited 7/14/15) found no problem about constipation was included.  During an interview on 8/11/15 at 10:00 AM E5 (UM) was asked to clarify when to use the two different MOM strengths. E5 stated the concentrated MOM order was obtained since the resident did not want the suppository and desired additional MOM instead. E5 was informed R84's care plan did not address constipation or the MOM use.  On 8/11/15 around 1:00 PM the surveyor asked E2 (DON) for a printed copy of R84's care plan. A printed care plan was provided a few hours later which included the problem entitled Potential for constipation related to decreased mobility (dated 8/11/15).  The facility did not develop a care plan problem to address an identified need until informed by the surveyor.  These findings were reviewed with E1 (NHA) and E2 on 8/12/15 at 1:30 PM.	F 279		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEMIGERS  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		

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NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE		STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966	
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F 323	<p>Continued From page 7</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview it was determined that the facility failed to be free of an accident hazard for one (337) out of 32 rooms reviewed. Findings include:</p> <p>Observation on 8/3/15 around 1:00 PM revealed that the bathroom sink in room 307 was loose from the wall. Maintenance was informed immediately.</p> <p>An interview on 8/7/15 at 9:30 AM with E3, Maintenance Director confirmed that the sink had been loose. E3 further revealed that drywall will need to be removed and a stronger support added within the wall. The sink was temporarily tightened the day before until a complete repair could be made.</p> <p>These findings were reviewed with E1, NHA and E2, DON on 8/12/15 at 1:30 PM.</p> <p>F 371 489.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p>	F 323	<p>A. The sink in Room 207 has been completely repaired. No residents were affected by the practice</p> <p>B. All sinks have the potential to be loose from the wall with potential harm to the residents. Maintenance staff completed visual inspection of all resident rooms sinks and found no other sinks in need of repair. Nursing/Housekeeping or other staff will immediately notify Maintenance department when a repair need is identified to a resident room sink in order to prevent injury to a resident.</p> <p>C. Maintenance staff completed a focused review and found no other issues. Maintenance staff/designee will complete weekly audits (attachment 5) on the resident area sinks to assure all are tightened to the wall. Staff will be educated by the Staff Developer/Designee to report maintenance repair needs by completing a Repair Requisition form (attachment 5A).</p> <p>D. Maintenance/designee will audit sink placement monthly until 100% compliance is achieved for 3 consecutive months, then quarterly until 100% compliance is achieved for 3 consecutive quarters.</p>

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NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 36002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19963	
(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 371	Continued From page 8  This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to distribute and serve food under sanitary conditions for 1 (R215) out of 34 sampled residents. Findings include:  During the dining observation on 8/6/15 at 8:09 AM in the Bethany unit dining room, E1 (CNA) placed R215's plates, cups and utensils on the table from the tray then cut up the pancakes. The resident had already picked up the sausage patty with her fingers and began eating. E1 unppeled a banana and used her unclean bare hand to set it on the resident's plate instead of putting on a clean glove or using a utensil to serve the banana.  These findings were reviewed with E1 (NHA) and E2 (DON) on 8/12/15 at 1:30 PM.	F 371	A. Resident R215 was monitored for illness following the unsanitary food distribution.  B. All residents have the potential to be impacted by unsanitary food distribution. Staff will wear gloves or use utensils when serving food to all residents.  C. Staff Developer/designee will educate staff on the proper way to distribute and serve food under sanitary conditions. Focused review conducted and no other issues were identified.  D. Unit Manager/designee will audit (attachment 6) meals daily until 100% compliance is achieved for 3 consecutive weeks, then audit weekly until 100% compliance is achieved for 3 consecutive weeks, then audit quarterly until 100% compliance is achieved.	10/5/15
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS  The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.	F 412		

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NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE		STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966		
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F 412	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to offer to arrange dental services for one (R90) out of 34 sampled residents. Findings include:</p> <p>R90 was admitted 7/27/14. Annual HDS's dated 7/20/14 and 8/3/14 stated "None Present" referring to problems with her teeth.</p> <p>Upon interview and observation of R90, on 8/10/15 at 1:40 PM, the resident stated she had not seen a dentist since she was admitted and did not know that the service is offered through the facility, despite the fact that the facility has a contract with a dental provider. Upon observation, R90 pointed out she only has two teeth on the bottom and was missing a few teeth on top. It was noted her teeth are discolored and chipped. R90 states, "They break off when you get old."</p> <p>During an interview on 8/10/15, at 2:00 PM with E4 (Social Services), it was revealed that there was no documentation that a dental consult was performed. E4 stated the resident's daughter is very active in the resident's care and attends care plan meetings often along with the resident. Her dental status had never come up during care plan meetings.</p> <p>On 8/11/15 at 10:10 AM, an interview was conducted with E4 who reviewed the chart and acknowledged that no dental services were arranged for R90 and she had spoken to the resident's daughter and the resident regarding the options.</p>	F 412	<p>A. R90 and Responsible party are aware of the availability of dental services. Arrangements have been made by the facility for a dental evaluation for this resident. Resident was not impacted by this deficient practice.</p> <p>B. All residents with dental issues have the potential to be affected by this deficient practice. Nursing will communicate immediately with resident/responsible party to offer dental services when deemed appropriate.</p> <p>C. Staff Developer/Designee will educate nursing to identify dental needs of the residents and to offer appropriate dental services as needed. A focused review was conducted and no other issues were identified.</p> <p>D. Unit Manager/Designee will audit (attachment 7) the need for dental services monthly until 100% compliance is achieved for 3 consecutive months and then quarterly until 100% compliance is achieved for 3 consecutive quarters.</p>	10/5/15

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NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966	
(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 412	Continued From page 10 The facility failed to offer or provide the resident with assistance obtaining routine dental services.	F 412		
F 428 SS=F	This was reviewed with the NHA (E1) and the DON (E2) on 8/12/2015 at 1:30 PM. 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACTION The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for 4 (R17, R49, R195, and R84) out of 5 sampled residents the facility failed to ensure drug regimen reviews were conducted monthly by the pharmacist. Additionally no drug regimen reviews were performed on any resident during the two month period when the pharmacist was out on medical leave. Findings include:  1. Review of R17's clinical record revealed that the Consultant Pharmacist Review was missing documentation for October, 2014.  2. Review of R49's clinical record revealed that the Consultant Pharmacist Review was missing documentation for October, 2014.	F 428	A. R17, R49, R195 and R84 had no adverse effects from the deficient practice. All 4 Resident drug regimens were reviewed in December 2014 and monthly after that.  B. All residents have the potential to be affected by this practice. Drug Regimens for all residents were reviewed in December 2014 and monthly after that.  C. The drug regimen of each resident must be reviewed at least once per month by a licensed pharmacist. Upon entrance to the facility to conduct monthly review, Consultant Pharmacist will be provided with a facility census which will be used to cross reference census with actual reviews to ensure all residents were reviewed. Pharmacy recommendation forms will be given to the DON/designee as second check to ensure all residents were reviewed. In the event the consultant pharmacist is unavailable for the monthly review, the Pharmacy Director will coordinate with the DON/NHA to ensure the review will be completed by another licensed pharmacist in order to meet the monthly review regulation.	10/5/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/12/2015
NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966	
(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 428	Continued From page 11  3. Review of R195's clinical record revealed that the Consultant Pharmacist Review was missing documentation for October, 2014.  4. Review of R84's clinical record revealed that the Consultant Pharmacist Review was missing documentation for October, 2014 and November, 2014.  Interview on 8/11/15 at 10:50 AM with E5 (L/M) confirmed that the consultant pharmacist was on sick leave in the Fall of 2014, and consequently no resident reviews were done during this period.  These findings were confirmed and reviewed with E1 (NHA) and E2 (DON) on 8/12/15 at 1:30 PM.	F 428	D. DON/designee will audit (attachment 8) compliance ensuring each resident in facility has had a monthly review completed on a monthly basis for three consecutive months until 100% compliance is achieved and then quarterly for three quarters or until 100% compliance has been achieved and then deficient practice will be considered resolved.	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that the call bell system was functioning for 2 (307 and 308) out of 32 rooms reviewed. Findings include:  During an observation on 8/6/15 around 1:00 PM it was observed in rooms 307 and 308 that the call bell cords were wrapped around the handrail in the bathroom. This prevented the call bell from	F 463	A. Residents in rooms 307 and 308 were not impacted by the practice. Call bell cords in the bathrooms in these two rooms were immediately unwrapped from the handrail. No residents were impacted by this deficient practice.  B. All residents have the potential to be affected by this practice. Staff will immediately unwrap call bell cords that are found to be wrapped around handrails in resident rooms.  C. Staff Developer/Designee will educate staff regarding proper call bell cord placement to facilitate communication from residents' rooms to the nursing station. A focused review was conducted no other issues were identified.	10/5/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/12/2015
NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966	
(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 463	Continued From page 12 activating when pulled from below the grab bar.  Follow-up observation on 8/11/15 around 2:00 PM revealed that the call bell in 308 was wrapped around the grab bar in the bathroom. An observation on 8/12/15 at 9:24 AM revealed that the call bell in 307 was wrapped around the grab bar in the bathroom.  These findings were reviewed with E3, Maintenance Director on 8/12/15 at 10:20 AM.  These findings were reviewed with E1, NHA and E2, DON on 8/12/15 at 1:30 PM.	F 463	D. Unit Manager/Designee will audit (attachment 9) call bell cord placement weekly until 100% compliance is achieved during 3 consecutive evaluations, then will be audited monthly until 100% compliance is achieved during 3 consecutive evaluations and then deficient practice will be considered resolved.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to maintain clinical records on each resident that are complete and accurately documented for 2 (R84	F 514		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  093052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/12/2015
NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE		STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966	
(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)
F 514	<p>Continued From page 13</p> <p>and R195) out of 34 sampled residents. For R84 there was a conflict between facility documentation and resident interview. For R195 the clinical record was incomplete for 7/19/15 regarding the presence or absence of a BM. Findings include:</p> <ul style="list-style-type: none"> <li>The facility's Bowel Protocol dated 4/13 states:             <ul style="list-style-type: none"> <li>* BMs are recorded in the ADL Flowsheet/BM Record on every shift.</li> <li>* The nurse is responsible for ensuring completeness and reporting by CNAs.</li> <li>* The nurse reviews the BM Records daily to identify residents with no BM x 9 shifts.</li> <li>* Any resident who is identified as having gone 9 shifts without a BM has the bowel protocol implemented.</li> <li>* The resident's name is placed on the laxative list for that day. The BM protocol is documented on the eMAR at this time.</li> <li>* Each portion of the protocol will be given and documented results are noted on the laxative list until effectiveness is achieved.</li> <li>* Effectiveness of the protocol is communicated from shift to shift and documented in the medical record.</li> </ul> </li> <li>Protocol consists of the following:             <ul style="list-style-type: none"> <li>* On 7-3 shift MCM to be administered on the day shift following discovery that 9 shifts have passed without a bowel movement.</li> <li>* On 3-11 shift suppository (laxative) to be given following administration of MCM, if MCM has not been effective.</li> <li>* On 11-7 shift if no results by the following 11-7 shift, an enema is to be given on the first med [medication] pass.</li> </ul> </li> </ul> <p>1. R84's BM Record from July, 2015 indicated</p>	F 514	<p>10/3/15</p> <p>A1. Resident R84 was not impacted by the deficient practice. Unable to correct documentation in the clinical record.</p> <p>A2. Resident R195 was not impacted by the deficient practice. Unable to correct documentation in the clinical record.</p> <p>B. All residents on laxative list have potential to be affected. All residents who receive laxatives will have this medication documented in the clinical record. All resident bowel movements will be documented in the clinical record.</p> <p>C. Staff developer/Designee will educate staff on the documentation of bowel movements in the ADL books and the documentation of Laxatives in EMAR.</p> <p>D. DON/Designee will audit (attachment 4) the documentation of BM's in the ADL books, and the documentation of laxatives in EMAR, daily until 100% compliance is achieved for 3 consecutive weeks, then audit weekly until 100% compliance is achieved for 3 consecutive weeks, then audit quarterly until 100% compliance is achieved.</p>

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NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE		STREET ADDRESS, CITY, STATE, ZIP CODE 28002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966	
(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)
F 614	<p>Continued From page 14</p> <p>that the resident did not have a bowel movement from July 14 (evening shift) through July 19 (evening shift). The bowel protocol was implemented and the resident was placed on the July 18 laxative list. The laxative list from 7/18/15 showed a handwritten comment that the resident stated he had a medium bowel movement, however this bowel movement was not recorded on the BM Record.</p> <p>R84 was on the laxative list again on 7/19/15 but should not have been since the resident had a bowel movement the day prior. The July, 2015 eMAR showed the resident received MCM at 3:15 PM on 7/19/15. Nurses note dated 7/19/15 at 3:00 PM stated the MCM was not effective. It was not clear as to why the day shift nurse documented the lack of effectiveness before the medication was documented as being given.</p> <p>Nurses note dated 7/19/15 at 7:53 PM stated the resident refused a suppository but requested another dose of MCM. A second dose of MCM was documented in the progress note but was not recorded on the eMAR. Nurses note dated 7/20/15 at 12:35 AM stated the resident reported having a bowel movement at 10:30 PM.</p> <p>During an interview on 8/11/15 at 10:50 AM E5 (UM) stated that if a medicine was given on the laxative list, then it should be on the eMAR.</p> <p>The facility failed to accurately document bowel movements on the BM record for R84 which caused the resident to have the bowel protocol implemented when it was not necessary. Bowel protocol medication was not consistently documented on the eMAR which could lead to duplicate administration of laxative.</p>	F 614	

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NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE		STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19968		
(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 514	<p>Continued From page 16</p> <p>2. R195's July, 2015 BM Record showed the resident had no bowel movement from July 18 (evening shift) to July 23 (night shift) with nothing written for July 19 day shift. Review of the record found no nurses note from 7/19/15 to indicate whether or not the resident had a bowel movement. If the blank entry was meant to state the resident did not have a bowel movement, then the bowel protocol should have been implemented on July 22. But if the blank entry was meant to indicate the resident had a bowel movement, then the bowel protocol should have been carried out on July 23.</p> <p>R195 was on the laxative list for 7/21/15. The July, 2015 eMAR showed the resident received MOM on July 22 at 2:15 PM. The 7/22/15 laxative list recorded R195 received a suppository at 10:00 PM without effect. The suppository was not documented on the eMAR. The eMAR showed that the resident received an enema on 7/23/15 at 6:15 AM with the reason documented as no effect from MOM or suppository. The eMAR stated the resident had a large bowel movement after the enema, but the 7/23/15 bowel movement was not written on the BM record.</p> <p>During an interview on 8/12/15 at 8:00 AM, E2 (DON) confirmed that medications given using the bowel protocol should also be recorded on the eMAR. E2 verified the process for counting shifts with no bowel movement and when the bowel protocol should be initiated. The DON confirmed R195's missing entry on the BM Record and stated that the blank entry would be counted as if the resident did not have a bowel movement if there was no other documentation.</p>	F 514		

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NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE		STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966		
(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 514	<p>Continued From page 16</p> <p>anywhere else in the chart. Like the progress notes. This clarification meant the resident's bowel protocol was appropriately implemented.</p> <p>The facility failed to document a bowel movement on the BM Record which could lead to activation of the bowel protocol when it was not necessary. Bowel protocol medication was not consistently documented on the MAR, which increased the chance of duplicate administration of laxatives.</p> <p>These findings were reviewed with E1 (NHA) and E2 on 8/12/15 at 1:30 PM.</p> <p>F 520 : 483.75(o)(1) QAA SS=D COMMITTEE MEMBERS MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committees except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify</p>	F 514	<p>A. New Medical Director has been obtained by the facility and has been educated on Quarterly QA meeting attendance.</p> <p>B. All Quarterly QA meetings could be affected by this practice. NHA/DON will assure Medical Director attendance at all meetings.</p> <p>C. New Medical Director has been educated on the requirement for participation in the Quarterly QA meeting, and has been given the QA Meeting Schedule for the remainder of 2015/2016 (attachment 11).</p> <p>D. DON/ NHA will confirm availability of the Medical Director for the scheduled meeting date and will re-schedule meeting if necessary to allow the Medical Director to participate.</p>	10/5/15

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NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION RENAISSANCE		STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 520	<p>Continued From page 17</p> <p>and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of facility documents and interview it was determined that the facility failed to ensure the Medical Director attended all the quarterly QA meetings. Findings include:</p> <p>Review of QA attendance sheets from July 2014 through July 2015 revealed that the Medical Director only attended three meetings: 8/28/14 and 1/29/15 and 7/22/15. The Medical Director did not attend all the quarterly QA meetings.</p> <p>An interview on 8/11/15 at 2:40 PM with E2, DOM confirmed the lack of Medical Director attendance.</p> <p>These findings were reviewed with E1, NHA and E2 on 8/12/15 at 1:30 PM.</p>	F 520		



**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 Renaissance

DATE SURVEY COMPLETED: August 12, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p><b>3201</b> <b>3201.1.0</b> <b>3201.1.2</b></p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from August 6, 2015 through August 12, 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 105. The stage two survey sample was thirty-four (34).</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></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 August 12, 2015 F241, F253, F272, F279, F323, F371, F412, F423, F463, F514, and F520.</p>	<p>Please refer to the Plan of Correction on CMS 2567 Report dated 8/12/15 for:</p> <p>F241 F253 F272 F279 F323 F371 F412 F423 F463 F514 F520</p>	<p>10/5/15</p>

Provider's Signature

*[Handwritten Signature]*  
*[Handwritten Signature]*

Title

NHA  
NHA

Date

8/21/15  
9/10/15 (re-submitted)