

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

PRINTED: 06/19/2014
FORM APPROVED
OMB NO. 0938-0391

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 06/10/2014
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 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from June 03, 2014 through June 10, 2014. 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 118. The stage two survey sample was thirty-seven(37). Abbreviations used in this 2567 are as follows: NHA- Nursing Home Administrator DON - Director of Nursing ADON - Assistant Director of Nursing RN - Registered Nurse RNAC - Registered Nurse Assessment Coordinator LPN - Licensed Practical Nurse CNA - Certified Nurse's Aide	F 000	-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.	
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 and interview it was determined that the facility failed to treat three (R60, R318 and R317) out of 37 sampled residents with dignity. Findings include: 1. On 6/3/14 at 12:07 PM R318 was observed in the dining room with his lunch tray. E6, LPN told	F 241	A. R60 and R317 no longer eat on disposable tableware products. All residents on isolation precautions are served using regular tableware products. This was corrected on 6/9/14. R 318 Finger sticks are completed prior to meal trays delivery. This was corrected on 6/10/14. B. Disposable tableware products have been removed and all isolation residents now utilize regular tableware products. All Diabetic residents receiving insulin and or finger sticks are at risk for this deficient practice. Nurses are required to conduct finger sticks and/or administer insulin prior to the resident's meal delivery.	July 28, 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Susan F. [Signature]

TITLE

NHA

(X6) DATE

6/24/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	<p>Continued From page 1</p> <p>him not to eat his food that he needed his blood sugar checked before lunch. E6 left the area with another resident. All residents in the dining room including those at R318's table had lunch meals and were eating.</p> <p>An interview with the resident revealed that at the assisted living were he usually resides he gets his blood sugar checked 15 minutes before the start of the meal but can have it checked up to an hour before the meal.</p> <p>At 12:18 PM R318 verbalized to all staff in the area that he was still waiting for his blood sugar to be tested so he could eat his lunch. R318 was then escorted out of the dining room to get his blood sugar checked and returned to the dining room at 12:23 PM to eat his lunch.</p> <p>2. On 6/3/14 around 12:10 PM R317 was observed at lunch in the dining room with all disposable tableware products including food in a foam "to go" type container. The food was served off a white foam tray and all utensils were plastic. The resident's meal ticket documented "isolation". The facility determined it was appropriate for the resident to eat in the dining room.</p> <p>On 6/6/14 R317 was observed again during the lunch meal with disposable products including utensils and a foam "to go" container..</p> <p>3. On 6/3/14 around 12:10 PM R60 was observed at lunch in the dining room with all disposable tableware products including food in a foam "to go" type container. The food was served off a white foam tray and all utensils were plastic. The resident's meal ticket documented "isolation".</p>	F 241	<p>C. The facility policy stated that disposable or non disposable tableware could be utilized with residents on isolation precautions. The facility immediately changed this practice and eliminated all use of disposable tableware with isolation residents. Meal tickets no longer identify residents as "isolation" indicating a need for any disposable items. The Staff Developer will educate all licensed staff and dietary staff on the use of regular tableware with isolation residents. E6- Facility failed to assess resident's finger stick prior to delivery of his meal tray. Times have been assessed to ensure finger sticks are conducted and insulin is administered prior to the meal delivery times. The Staff Developer will educate all licensed personnel on Dignity of the residents in regards to ensuring finger sticks and insulin administration is completed prior to residents receiving their meal trays. The Staff Developer will educate all licensed staff and dietary staff on the meal delivery times.</p> <p>D. The goal of the system change is to ensure all staff provides resident care that maintains their Dignity and Respect. All isolation residents will be monitored by the DON or designee, Utilizing Attachment 1, for the identified deficient practice. This will be completed daily until the facility consistently maintains a 100% success rate over 3 consecutive evaluations, then 3 times a week, until the facility reaches 100% success at 3 consecutive evaluations. All isolation residents will then be monitored once a week, until the facility reaches 100% success at 3 consecutive evaluations. Finally, this will be measured one time a month for 3 consecutive months to ensure a 100% success rate has been reached.</p>		

Susan A. [Signature] NHA 6/24/14

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F 241	Continued From page 2 On 6/9/14 at 3 PM an interview with E5, RN, staff education/infection control revealed that up until today they were using disposable products on all residents on isolation. The facility determined it was appropriate for the resident to eat in the dining room. Findings reviewed with E1, NHA and E2, DON on 6/10/14 at 12:30 PM.	F 241	A random sample of 10 Diabetic residents will be monitored by the DON or designee, utilizing Attachment 2, for the Identified deficient practice. This will be completed daily until the facility consistently maintains a 100% success rate over 3 consecutive evaluations, then 3 times a week, until the facility reaches 100% success at 3 consecutive evaluations. All isolation residents will then be monitored once a week, until the facility reaches 100% success at 3 consecutive evaluations. Finally, this will be measured one time a month for 3 consecutive months to ensure a 100% success rate has been reached.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272		

Susan J. Alford NHA 6/24/14

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F 272	Continued From page 3 Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to conduct an accurate comprehensive assessment for one (R48) out of 37 sampled residents in the area of urinary continence (ability to control urine). Findings include: R48 was admitted to the facility on 2/1/14. The following documentation was contained in the clinical record; 2/2/14 through 2/8/14 - CNA flow sheet that is utilized to document incidents of urinary continence / incontinence (Inability to control urine) documented 7 episodes of incontinence during this assessment period. The documentation indicated that R48 was frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continence) of urine. 2/8/14 - Admission Minimum Data Set (MDS) assessment tool utilized in long term care)	F 272	A. R48 - Resident is deceased. MDS modification was completed on 6/20/14 with the correct entry made of frequently incontinent. B. All residents are at risk for this deficient practice. Copies of the CNA flow sheets are now made and submitted to the DON, with each MDS assessment in the area of urinary continence. The DON will second check entries in the area of urinary continence for correct coding. C. During the data entry process, the resident's comprehensive assessment was incorrectly keyed. This resident was marked as continent when the CNA flow records indicated the resident was indeed frequently incontinent. RNAC will now make copies of the CNA flow sheets with each MDS entry in the area of urinary continence. The copies will be submitted to the DON for a second check of the entry. The Staff Developer will educate the RNAC staff on efficient keying of data when completing resident's comprehensive assessments (RAI), to ensure proper coding is made for appropriate treatment and services are given to the residents as indicated by this data. D. The goal of the system change is to ensure that all resident comprehensive assessment, in the area of urinary continence is accurately coded. This will ensure that all residents who are incontinent of bladder receive appropriate treatment and services to prevent Urinary Tract infections and to restore / maintain as much normal bladder function as possible.	July 28, 2014	

Susan P. [Signature] 6/24/14

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F 272	Continued From page 4 assessment incorrectly documented R48 was continent (full control of bladder) of urine. On 6/10/14 at approximately 10:30 AM an interview with E2, DON confirmed the resident was frequently incontinent of urine and that the MDS had been coded incorrectly according to the CNA flow sheet that documented 7 episodes of incontinence during the assessment period. The above information was reviewed with E1, NHA and E2, DON on 6/10/14 at approximately 1:00 PM.	F 272	All resident comprehensive assessments in the area of urinary continence will be checked for accurate coding by the DON or designee, utilizing Attachment 3, for the identified deficient practice. This will be completed daily until the facility consistently maintains a 100% success rate over 3 consecutive evaluations, then 3 times a week, until the facility reaches 100% success at 3 consecutive evaluations. All isolation residents will then be monitored once a week, until the facility reaches 100% success at 3 consecutive evaluations. Finally, this will be measured one time a month for 3 consecutive months to ensure a 100% success rate has been reached.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure the appropriate treatment and services to restore and/or maintain bladder function were implemented for one (R48) resident out of 37 sampled residents. Findings include: The facility's Incontinence (Inability to control	F 315	A. R 48 - Resident is deceased, unable to correct this action for this resident. B. All residents are at risk for this deficient practice. All admission and readmissions are placed on a 3 day voiding diary. The 3 day voiding diary is then assessed for the need of an individualized toileting program for the resident. All residents' continence status is assessed quarterly and with a significant change in condition. Residents, who are noted with a change in their urinary continence, will have a 3 day voiding diary initiated. The 3 day voiding diary is then assessed for the need of an individualized toileting program for the resident. C. Staff failed to complete all entries on the resident's voiding diary and then failed to restart a new 3 day voiding diary, due to the missed documentation. Staff failed to implement an individualized toileting program for this resident who was experiencing episodes of urinary incontinence as evidence on the CNA flow record.	July 28, 2014

Susan P. [Signature]

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F 315	Continued From page 5 urine) policy documented that a resident who is incontinent of bladder (involuntary loss of control of urine) will receive appropriate treatment and services to restore/improve normal bladder function as possible. Every resident will be assessed for Incontinence on admission, or re-admission, quarterly and with significant change. Incontinency is assessed on admission and all residents who are incontinent should have a voiding diary completed for 3 days and the voiding diary is reviewed to determine the need for a toileting program. R48 was admited to the facility 2/1/14. The following documentation was contained in the clinical record: 2/2/14 through 2/8/14 - CNA flow sheet that is utilized to document incidents of urinary continence [control of urine] / Incontinence documented 7 episodes of Incontinence. This documentation indicated that R48 was frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continence) of urine. 2/2/14 - 3 day Voiding Diary (form used to document continence status of R48 every 2 hours for 3 days) was Initiated. There was no documentation completed on 2/2/14, there were no episodes of incontinence documented on 2/3/14, and one episode of bladder incontinence was documented on 2/4/14. 2/8/14 - Admission Minimum Data Set ([MDS] assessment tool used in long term care) assessment incorrectly documented R48 was continant (full control of bladder) of urine.	F 315	All new admissions and readmissions, with incontinence, will have a 3 day voiding diary placed in their admission chart, to be initiated and completed in its entirety. The voiding diary will then be assessed by the Unit Manager, and an individualized toileting program will be developed, as necessary, from the voiding diary assessment. All residents will also be assessed quarterly and with a significant change in condition for a change in urinary continence. RNAC will provide the Unit Manager with a MDS Decline form for all noted declines. A 3 day voiding diary will then be started and completed in its entirety. The voiding diary will then be assessed by the Unit Manager, and an individualized toileting program will be developed as necessary, from the voiding diary assessment. A new voiding diary will be started if the initial voiding diary is not completed in its entirety. The Staff Developer will educate on the following: - (nursing staff) The relevance of the voiding diary and the importance of accuracy and completeness of this documentation. -(nursing staff) Second checks to ensure the voiding diaries are completed in their entirety. - (licensed nursing staff) The implementation of a 3 day voiding diary on admission, readmission, and with any significant changes in urinary continence. - (licensed nursing staff) Assessment of the voiding diary, and the development and initiation of resident's toileting programs, as needed, based on the voiding diary assessment. - (nursing staff) The Utilization of the Early Warning Tool to notify nursing of changes in residents continence status. - (RNAC and Unit Managers) The utilization of the MDS Decline Form for notification of	

Juan P. Hernandez

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F 315	Continued From page 6 On 6/6/14 at approximately 12:30 PM E7, Unit Manager reviewed R48's 3 day Voiding Diary for 2/2/14 - 2/4/14 and confirmed that 2/2/14 was not completed and also that when the diary is not complete (data missing) it must be restarted to ensure an accurate assessment over 3 consecutive days. The facility failed to complete the voiding diary in its entirety and failed to implement an individualized toileting program for R48 who was experiencing episodes of urinary incontinence. On 6/10/14 at approximately 10:30 AM an interview with E2, DON confirmed that a voiding diary was not completed in its entirety and that a toileting program had not been initiated. The above information was reviewed with E1, NHA and E2, DON on 6/10/14 at approximately 1:00 PM.	F 315	significant changes noted in the area of urinary continence during the residents comprehensive assessment. D. The goal of the system change is to ensure that all residents receive the appropriate treatment and services to restore / maintain as much normal bladder function as possible. All Admissions and readmissions will be reviewed for the implementation of a 3 day voiding diary and for the implementation of an appropriate individualized toileting program, as needed. All residents will be assessed quarterly and with a significant change for incontinence, and for the implementation of a 3 day voiding diary and for the implementation of an appropriate individualized toileting program, as needed. This will be checked for accuracy by the DON or designee, utilizing Attachment 4 and Attachment 5, for the identified deficient practice. This will be completed daily until the facility consistently maintains a 100% success rate over 3 consecutive evaluations, then 3 times a week, until the facility reaches 100% success at 3 consecutive evaluations. All isolation residents will then be monitored once a week, until the facility reaches 100% success at 3 consecutive evaluations. Finally, this will be measured one time a month for 3 consecutive months to ensure a 100% success rate has been reached.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329		

Susan P. [Signature] 6/24/14

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F 329	<p>Continued From page 7</p> <p>given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to adequately monitor the drug regimen for one (R199) out of 37 sampled residents. Findings include:</p> <p>The facility's nursing guideline Atypical Anti-Psychotics (used to treat mental and emotional conditions) Medication documented that when anti-psychotic medications are being considered to treat residents, that the side-effects of the medication will be monitored.</p> <p>The facility's guideline for AIMS (Abnormal Involuntary Movement test) Testing documented that when a resident is admitted to the facility on an anti-psychotic medication the nurse will administer an AIMS test.</p> <p>The following documentation was obtained in the clinical record;</p> <p>R199 was admitted to the facility on 5/6/14 and was already taking Zyprexa (anti-psychotic medication) before admission to the facility.</p>	F 329	<p>A. R199 - Behavior Monitoring Record for side effects implemented on 6/1/14. AIMS assessment completed on 6/9/14.</p> <p>B. All residents on atypical anti-psychotic medications and anti-psychotic medications are at risk for this deficient practice. AIMS assessment will be completed on all residents who are receiving anti-psychotic medications. This will be completed on admission, readmission, and twice annually for all residents on these class of medications. Behavior Monitoring Records will be completed for all residents receiving atypical anti-psychotic and anti-psychotic medications.</p> <p>C. The admitting nurse failed to initiate a Behavior Monitoring Record and failed to complete an AIMS assessment on admission, for a resident on an anti-psychotic medication. All admissions and readmissions will be checked during the clinical morning meeting, to identify residents on atypical anti-psychotic and anti-psychotic medications. Residents who are found to be on these medications will be reviewed to ensure an AIMS assessment is completed and the Behavior Monitoring Record is in place. The Pharmacy's Monthly Psychoactive Medication Report will be reviewed by the DON or designee ensuring that residents identified to be prescribed these classes of medications have a Behavior Monitoring Sheet in place as well as an AIMS assessment as indicated. All new orders will be reviewed during the clinical morning meeting for atypical anti-psychotics and anti-psychotic medications. Residents identified on these classes of medications will be reviewed to ensure the Behavior Monitor Record is completed and AIMS assessment, as indicated. The Staff Developer will educate all licensed personnel on: -Atypical anti-psychotic and psychotic medications, and side effects. -Initiation and Utilization of the Behavior Monitoring Records for atypical anti-psychotics and psychotic medications. -AIMS assessments with antipsychotic medications on admission, readmission, and twice annually.</p> <p>D. The goal of the system change is to ensure that all residents on atypical anti-psychotics and psychotic medications are monitored for side effects. All admissions and readmissions on an atypical anti-psychotics and psychotic medications will be checked for</p>	July 28, 2014	

Jessie P. [Signature] N/A 6/10/14

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F 329	Continued From page 8 5/6/14 - Physician order for Zyprexa. Review of the medical record revealed that the facility failed to monitor for side-effects for Zyprexa until 6/1/14 (25 days after admission). On 6/8/14 at approximately 11:00 AM an interview with E7, Unit Manager confirmed that there had been no side effect monitoring completed for R199 from admission, 5/6/14 through 5/31/14. The above information was reviewed with E1, NHA and E2, DON on 6/10/14 at approximately 1:00 PM.	F 329	Behavior Monitoring Records and AIMS assessments by the DON or designee, utilizing Attachment 6, for the Identified deficient practice. . This will be completed daily until the facility consistently maintains a 100% success rate over 3 consecutive evaluations, then 3 times a week, until the facility reaches 100% success at 3 consecutive evaluations. All isolation residents will then be monitored once a week, until the facility reaches 100% success at 3 consecutive evaluations. Finally, this will be measured one time a month for 3 consecutive months to ensure a 100% success rate has been reached. All residents with a new order for an atypical anti-psychotics and/or psychotic medications will be checked for Behavior Monitoring Records and AIMS assessments by the DON or designee, utilizing Attachment 7, for the Identified deficient practice. . This will be completed daily until the facility consistently maintains a 100% success rate over 3 consecutive evaluations, then 3 times a week, until the facility reaches 100% success at 3 consecutive evaluations. All isolation residents will then be monitored once a week, until the facility reaches 100% success at 3 consecutive evaluations. Finally, this will be measured one time a month for 3 consecutive months to ensure a 100% success rate has been reached. All residents identified on the Monthly Pharmacy Psychoactive report as being on an atypical anti-psychotics and/or psychotic medication, will be checked for Behavior Monitoring Records and AIMS assessments by the DON or designee, utilizing Attachment 8, for the Identified deficient practice. . This will be completed daily until the facility consistently maintains a 100% success rate over 3 consecutive evaluations, then 3 times a week, until the facility reaches 100% success at 3 consecutive evaluations. All isolation residents will then be monitored once a week, until the facility reaches 100% success at 3 consecutive evaluations. Finally, this will be measured one time a month for 3 consecutive months to ensure a 100% success rate has been reached.		

Handwritten signature and date: Susan K. [unclear] 6/24/14



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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Wilmington, Delaware 19806
(302) 577-6861

STATE SURVEY REPORT

Page 1 of 2

NAME OF FACILITY: Cadia Renaissance

DATE SURVEY COMPLETED: June 10, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from June 03, 2014 through June 10, 2014. 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 118. The stage two survey sample was thirty-seven (37).</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:</p>	<p>Please refer to Plan of Correction on CMS 2567 Report dated June 10, 2014 for:</p> <p>F241 F272 F315 F329</p>

Provider's Signature *Jessica P. Lewis* Title NHA Date 6/24/14



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	Cross refer to the CMS 2567-L survey report ending June 10, 2014, F241, F272, F315 and F329.	
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Provider's Signature Susan A. Flanagan Title WHA Date 6/24/14