

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808
--	--

(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	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from May 6, 2016 through May 17, 2016. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 115. The Stage 2 survey sample size was 36.</p> <p>Abbreviations/definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; RD-Registered Dietitian; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; FMD - Facility Maintenance Director; FSD - Food Service Director; SW - Social Worker; Activities of Daily Living-tasks needed for daily living such as dressing, hygiene, eating, toileting and bathing; amt-amount; Aseptic-free from contamination caused by harmful bacteria; constipation-difficulty in passing stool; cc-cubic centimeter, unit of volume; cognitive-mental process, thinking; dehydration-condition in which the body does not have enough fluid; med-medication; MDS - Minimum Data Set/assessment tool used in long term care facilities;</p>	F 000		
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 06/06/2016
---	-------	--------------------------------

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

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808	
(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 Biofilm - a thin usually resistant layer of microorganisms such as bacteria that form on and coat various surfaces; Foley catheter - narrow tube inserted into the bladder, held inside the bladder by a small inflated balloon and attached to a collection bag used to drain urine; Hospice-care provided to the terminally ill; Leg strap - strap used to secure a Foley catheter to the upper thigh to prevent pulling and/or dislodgement; ml-milliliter-unit of volume; PU-Pressure ulcer-sore area of skin that develops when the blood supply to it is cut off due to pressure; Respiratory - act of breathing air in and out of the lungs; Respiratory therapy- breathing treatments; s/s-signs and symptoms; Santyl-ointment used to help in the healing of PU; Stage IV PU-ulcer has become so deep that there is damage to the muscle and bone and sometimes to tendons and joints; Suctioning - the action of removing or clearing the airway of blood, saliva, vomit or other secretions to facilitate breathing by a medical device; Tracheostomy / trach - an opening made in the throat to assist breathing; Ventilator - machine designed to move breathable air into and out of the lungs for a patient who is physically unable to breathe; BM-bowel movement; MOM-Milk of Magnesia; Trochanter-bone area connecting to the hip bone.	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		7/15/16

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808		
(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 2 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for 4 rooms (208, 212, 214, and 259) out of 32 rooms surveyed. Findings include: On 5/6/16 and 5/9/16 during the Stage 1 review and during the environmental tour on 5/10/16 between 10:00 AM and 10:30 AM, the following were observed: 1. Room 208 - The air conditioning panel was loose. 2. Room 212 - The sink counter corner was chipped. 3. Room 214 - The wall by the air conditioning unit had dried brown marks on it. 4. Room 259 - The bathroom call bell had no pull cord, making it inaccessible to a resident who was lying on the floor. Findings were reviewed with E1 (NHA), E2 (DON), and E12 (FMD) on 5/17/16 at approximately 5:45 PM.	F 253	1. Room 208 panel will be replaced, Room 212 sink counter corner will be repaired, Room 214 wall has been cleaned and Room 259 new pull cord was installed on bathroom call box. 2. All rooms have the potential to be affected by this deficient practice. All rooms will be protected from this deficient practice by taking corrective action(s) outlined below in #3. 3. Director of Maintenance and/or designee and Director of Housekeeping and/or designee will conduct random audits of 10 resident rooms on a weekly basis to find items that need to be cleaned and/or repaired. If needed, corrective action will be taken immediately. Audit reports will be presented to the NHA for review. 4. The audits will continue weekly until 100% compliance has been achieved for three consecutive weeks. If 100% compliance has been achieved the deficiency will be considered resolved. Thereafter this will be part of Resident room Inspection. Audits reports will be presented and reviewed by the QA committee.		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		7/15/16	

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808		
(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 272	Continued From page 3 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; 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.	F 272			

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808		
(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 272	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R107 and R190) out of 35 sampled residents the facility failed to ensure the comprehensive assessment was accurate and/or complete in the areas of prognosis, cognitive patterns and mood. Findings include: 1. R107 was admitted to the facility on 3/21/16. Review of R107's admission MDS assessment, dated 3/28/16, revealed that Section C (Cognitive Patterns) and Section D (Mood) were not assessed or completed. On 5/16/16 at 12:20 PM interview with E5 (RNAC#2) revealed that as of November 2015, these two (2) sections (Cognitive Patterns and Mood) were completed by the facility Social Workers. During an interview on 5/17/16 at 10:10 AM, E6 (SW) stated that she "missed" the last day for completion of these two sections on R107's 3/28/16 admission MDS assessment. E6 stated she had some time off and it was too late to complete the sections upon her return. The facility failed to complete a comprehensive assessment for R190. On 5/17/16 at 10:40 AM, the findings were reviewed with E2 (DON). 2. R190 was admitted to the facility on 11/18/15 and was admitted to Hospice services on 12/26/15.	F 272	1 (a) 1. Resident R107 is no longer in the facility. No corrective action can be taken. 2. All residents have the potential to be affected by this deficient practice. Current and future residents will be protected from this deficient practice by taking corrective action(s) outlined below in # 3. 3. The Lead RNAC and/or designee will conduct random weekly audits on 10% of the MDSs to make sure they are accurately coded for the resident's prognosis. Any MDS found not to be properly coded will be corrected. Audit reports will be given to the NHA weekly for review. 4. These audits will continue weekly until 100% compliance has been achieved for three consecutive weeks. If 100% compliance has been achieved, the deficiency will be considered resolved. Audits reports will be presented and reviewed by the QA committee 2(b) 1. The MDS Assessment for Resident R190 will be updated to reflect resident's cognitive moods and patterns. The Root Cause Analysis revealed that the social worker(s) failed to meet the deadline for entering the data. 2. All residents have the potential to be affected by this deficient practice. Current and future residents will be protected from this deficient practice by taking corrective action(s) outlined below in # 3. 3. The Lead RNAC and/or designee will		

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808	
(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 272	Continued From page 5 A significant change MDS assessment, dated 1/7/16, stated R190 was receiving Hospice care. However, the 1/7/16 MDS assessment, Section J1400 Prognosis, was not checked to identify that R190 had "a condition or chronic disease that may result in a life expectancy of less than 6 months." On 5/16/16 at 12:20 PM, E5 (RNAC#2) was interviewed. The MDS RAI Version 3.0 Manual, dated October 2014, was reviewed with E5. It stated, "Coding Instructions:... Code 1, yes: if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services...". E5 confirmed that she completed R190's 1/7/16 MDS assessment. However, E5 stated she did not code terminal prognosis as yes because the RAI Manual stated not to code yes if there was no physician documentation. She also stated that reading it (RAI Manual) further does make it sound like it should be coded yes for terminal prognosis. The facility failed to accurately reflect R190's prognosis on the 1/7/16 significant change MDS assessment. On 5/17/16 at 10:40 AM, findings were reviewed with E2.	F 272	conduct random weekly audits on 10% of the MDSs to make sure they are accurately coded for the resident's prognosis. Any MDS found not to be properly coded will be corrected. Audit reports will be given to the NHA weekly for review. 4. These audits will continue weekly until 100% compliance has been achieved for three consecutive weeks. If 100% compliance has been achieved, the deficiency will be considered resolved. Audits reports will be presented and reviewed by the QA committee.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278		7/15/16

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808	
(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 278	<p>Continued From page 6</p> <p>each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R2) out of 36 Stage 2 sampled residents, the facility failed to accurately reflect his medical status in two quarterly MDS assessments. Findings include:</p> <p>1a. R2's clinical record revealed that he was dependent on a ventilator for breathing.</p> <p>The 12/19/15 quarterly MDS assessment stated that R2 did not receive daily respiratory therapy in the last 7 days under Special Treatments,</p>	F 278	<p>1 Resident R2's MDS will be coded accurately reflect his ventilator treatments on all future MDSs.</p> <p>2 All residents receiving ventilator and respiratory treatments have the potential to be affected by this deficient practice. Current and future residents will be protected from this deficient practice by taking corrective action(s) outlined below in # 3.</p> <p>3 The Lead RNAC and/or designee will conduct random weekly audits on 10% of</p>	

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808	
(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 278	Continued From page 7 Procedures and Programs. Review of R2's progress notes from 12/13/15 through 12/19/15 revealed that daily respiratory assessments and care were provided. 1b. The 3/20/16 quarterly MDS assessment stated that R2 was not receiving ventilator respiratory treatment under Special Treatments, Procedures and Programs. Review of R2's progress notes from 3/14/16 through 3/20/16 revealed that R2 was receiving ventilator respiratory treatment 24 hours a day 7 days a week. In an interview on 5/17/16 at 10:40 AM, E4 (RNAC#1) confirmed the findings. The facility failed to accurately code that R2 was receiving daily respiratory therapy on the 12/19/15 quarterly MDS assessment and he was receiving ventilator respiratory treatment on the 3/20/16 quarterly MDS assessment. Findings were reviewed with E3 (ADON) on 5/17/16 at 11 AM.	F 278	the MDSs to make sure they are accurately coded for the resident's prognosis. Any MDS found not to be properly coded will be corrected. Audit reports will be given to the NHA weekly for review. 4 These audits will continue weekly until 100% compliance has been achieved for three consecutive weeks. If 100% compliance has been achieved, the deficiency will be considered resolved. Audits reports will be presented and reviewed by the QA committee	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		7/15/16

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808		
(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	<p>Continued From page 8 assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R2) out of 36 Stage 2 sampled residents, the facility failed to develop a comprehensive care plan for R2 to meet his respiratory/ventilator/trach needs that were identified in the comprehensive assessment. Findings include: R2's annual MDS assessment, dated 9/18/15, stated that he was ventilator dependent for breathing and required oxygen, suctioning and tracheostomy care. R2's record review revealed the absence of a care plan developed for his respiratory/ventilator/trach needs. In an interview on 5/16/16 at 4:19 PM, E3 (ADON) confirmed the finding. The facility failed to develop a comprehensive care plan for R2 to meet his respiratory/ventilator/trach needs that were identified in the 9/18/15 comprehensive assessment.</p>	F 279	<p>1 Resident R2's comprehensive care plan will be updated to reflect his respiratory/ventilator/trach needs that are identified on his MDS Assessment.</p> <p>2 All residents receiving ventilator and respiratory treatments have the potential to be affected by this deficient practice. Current and future residents will be protected from this deficient practice by taking corrective action(s) outlined below in # 3.</p> <p>3 The Unit Manager will conduct weekly audits on 10% of ventilator patients care plans to assure that their respiratory/ventilator trach needs are being properly care planned. Any deficient care plan will be updated immediately. Audit reports will be given to the DON on a weekly basis for review.</p> <p>4 These audits will continue weekly until 100% compliance has been achieved for three consecutive weeks. If 100% compliance has been achieved, the deficiency will be considered resolved.</p>		

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808	
(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 9	F 279		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</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 ensure that one (R239) out of 36 Stage 2 sampled residents, care plan was revised to include individualized approaches and to include input from the resident's representative to meet this resident's needs. Findings include: R239's clinical record was reviewed and revealed</p>	F 280	<p>Audits reports will be presented and reviewed by the QA committee</p>	7/15/16
			<p>1. Resident R 239's care plan will be updated to include individualized approaches to meet the resident's estimated daily fluid needs. The care plan will include the resident's POA input as to her daily fluid input.</p> <p>2. All residents have the potential to be affected by this deficient practice. Current and future residents will be protected from</p>	

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808	
(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 280	<p>Continued From page 10 the following:</p> <p>R239 was identified by the facility to have the potential for dehydration and the need to maintain good nutrition and hydration.</p> <p>11/15/2015 a care plan was initiated entitled, "Need to maintain good nutrition and hydration". The approaches were assist with setup/meals as needed; Diet, weights, supplement and labs as ordered; offer fluids at/with meals.</p> <p>11/20/15 a care plan was initiated entitled, "Potential for dehydration related to constipation". The approaches were, Administer medications as ordered; Diagnostic studies as ordered/indicated; monitor for constipation; monitor for mental status change; monitor for s/s/ of hydration alteration; and monitor urine for odor, color, clarity and decreased output;</p> <p>Review of the dietary assessments and progress notes indicated that R239's fluid needs were estimated at 1477 cc per day; had poor intake; refuse to drink and will only take sips on occasion.</p> <p>The facility failed to revise the care plan to include individualized proactive approaches to R239's problem/needs in order to meet her estimated fluid needs per day and to include the resident's and representative's input which the representative had posted on R239's bedside table.</p> <p>This finding was discussed with E13 (RD) and E14 (Unit Manager) on 5/12/16 at approximately 4:00 PM.</p>	F 280	<p>this deficient practice by taking corrective action(s) outlined below in # 3.</p> <p>3. The Unit Manager/RD will review intake sheets at the morning clinical meeting to identify residents at risk for dehydration. Consistent PO intake of less than 50% for 3 days will be addressed by adding fluid approaches on the care plan. Care Plan will be updated to reflect fluid goals and interventions to meet these individual goals. Audit will be done randomly by the RD and or UM each week on those identified at risk for dehydration. Audits will include checking if fluid goals are met and if individual approaches are carried through. Corrective action will be taken to resolve any issues. Audit reports will be given to the DON for review and follow up.</p> <p>4. Audits will be done 3 times per week for 4 weeks or until 100% compliance is achieved. If 100% compliance is achieved, the deficiency will be considered resolved. Audits reports will be reviewed and discussed by the QA committee</p>	

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808	
(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 F 309 SS=D	Continued From page 11 483.25 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 observation, record review and interview, it was determined that the facility failed to ensure that each resident received and the facility provided 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 for one (R190) out of 36 Stage 2 sampled residents. The facility failed to have a leg strap in place to prevent displacement of R190's Foley catheter. Findings include: R190 was admitted to the facility on 11/18/15 with a Foley catheter in place. A physician's order, dated 11/19/15, stated "leg strap at all times." On 5/11/16 at 8:25 AM, R190 was observed lying in bed with her breakfast tray in front of her. R190 was asked if she had a leg strap in place securing her Foley catheter? R190 stated no she did not, and proceeded to lift the bed sheets to show this surveyor. On 5/11/16 at 2:00 PM, R190 was seated in a wheelchair next to her bed watching TV. R190	F 309 F 309	1. Resident R190 had leg strap placed by employee E9 on 5/11/16 after confirming to surveyor that the resident did not have a leg strap on. Root cause Analysis determined that the employee was unaware of the physician order. 2. All residents with a Foley catheter have the potential to be affected by this deficient practice. An audit will be conducted of all resident currently using a Foley catheter to determine if the deficient practice was an isolated event of a facility wide practice. Current and future residents will be protected from this deficient practice by taking corrective action(s) outlined below in # 3. 3. To decrease the likelihood of a recurrent problem the use of a leg strap will be documented as part of our catheter care. Staff members will be reminded during shift huddles times for one week, to apply leg straps when a resident(s) has a Foley catheter. Education will be provided to current nursing staff and all new hires related to this practice during new hire	7/15/16

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808		
(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 12 was asked again if she had a leg strap in place? She stated she did not. Immediately afterwards E9 (CNA) was interviewed. E9 stated she was assigned to R190 and confirmed R190 did not have a leg strap in place securing the Foley catheter. E9 stated she would go and apply a leg strap. The facility failed to ensure a leg strap was in place according to R190's physician orders. On 5/17/16 at 10:40 AM, findings were reviewed with E2 (DON).	F 309	orientation. 4. The UM and/or designee will conduct an audit of all residents using a Foley catheter q. shift to determine effectiveness with measures listed in #3 above. Audits will continue until there is 100% compliance with the use of the leg strap for 5 continuous days per resident. Random weekly audits will be conducted until 100% compliance is noted per one audit for 4 consecutive weeks. A random audit will be done during the next month to determine a permanent change has been made and the deficient practice has been resolved.		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and interview, it was determined that the facility failed to ensure that one (R223) out of 36 Stage 2 sampled residents, received the necessary treatment and services related to wound dressing change and treatment to promote healing and prevent infection of the Stage 4 right hip pressure	F 314	1. Employee E15 was informed of the deficient practices observed by the Surveyor during wound care performed on R223. The basic principles of wound care dressing changes were discussed with employee E15 by E2 after the deficient practice was identified.	7/15/16	

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808	
(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 314	<p>Continued From page 13 sore. Findings include:</p> <p>R223's care plan entitled "Actual Pressure Ulcer-Right Trochanter-Stage 4" was initiated on 11/12/2015 last edited on 11/16/2015. The Long Term Goal dated 02/12/2016 stated, "Area will show no s/s of infection x 90 days. The interventions included: "Skin treatments as ordered".</p> <p>The facility's Nursing Guidelines dated 02/2014 entitled "Dressing Change/Aseptic and Clean Technique" stated "...Establish a clean field. Place all items to be used during procedure on clean field"; Complete hand hygiene; Put on clean gloves, remove old dressing, and discard dirty dressing. Remove gloves; Complete hand hygiene; Put on clean gloves, ...; Clean wound...; Complete hand hygiene; Don clean gloves then proceed with treatment..."</p> <p>On 5/11/16 at approximately 9:00 AM, a wound dressing change and treatment of R223's right hip Stage 4 pressure ulcer was performed by E15 (Wound Care Nurse). The observation of the wound treatment revealed the following series of events:</p> <p>There was no clean field prepared for the supplies needed. E15 washed hands, donned a pair of clean gloves, opened a packet of sterile dry 4x4 gauze dressing and placed the sterile 4x4 gauze on top of R223's contaminated drawsheet that R223 was laying on instead of an established clean field area or on a clean barrier. E15 removed the old dressings on R223's wound, and discarded them into a lined trash can. E15 removed her soiled pair of gloves and donned</p>	F 314	<p>2. All resident with wounds have the potential to be affected by the deficient practice. Current and future residents will be protected from the deficient practice by taking corrective action(s) as outlined in #3 below.</p> <p>3. The Root Cause Analysis the causative factors included nervousness about being observed and the treatment cart did not have clean barriers stocked. Clean barriers were immediately obtained and placed on all treatment carts. Employee E15 received training on proper infection control techniques to be followed when treating resident wounds. Training was given to E15 by the DON on 5/11/16. Nurses involved in wound care treatment will receive training on proper infection control techniques. Training will be provided by the Staff Educator. Nursing Administration will conduct random audits during wound care rounds to assure proper infection control techniques are being used. Corrective action including re-training will be taken if proper techniques are not being demonstrated. Audit reports will be given to the NHA for review.</p> <p>4. Wound Care audits will be conducted by Nursing Administration on 5 residents per week for 2 weeks or until 100% compliance has been achieved for 2 consecutive weeks. Once 100% compliance has been achieved Nursing Administration will audit 2 treatments per week for 2 weeks. If 100% compliance is achieved the deficient practice will be considered resolved. Audit results will be reviewed and discussed by the QA</p>	

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808		
(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 314	Continued From page 14 another pair of clean gloves without handwashing. E15 proceeded with the wound treatment by wiping the periwound [around] area with a skin protectant, applied Santyl and covered it with a 3x3 foam dressing with a silicon adhesive border. This finding was discussed with E15 on 5/11/16 at approximately 9:30 AM. and with E2 (DON) on 5/17/16 at approximately 5:00 PM during the exit conference.	F 314	committee.		
F 329 SS=D	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 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.	F 329		7/15/16	

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808	
(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 329	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that two (R32 and R239) out of 36 Stage 2 sampled residents, were free from unnecessary drugs used. Findings include: 1. R239 had diagnoses that included constipation. The facility initiated a care plan dated 11/20/15 (last revised on 3/23/16) entitled, "Potential for dehydration related to constipation". The interventions included, "monitor for constipation and initiate facility bowel protocol per policy". An undated facility policy entitled "Bowel Protocol" stated, "BM's are recorded in the ADL Flow Sheet/BM record on every shift; The nurse is responsible for assuring completeness and reporting by CNA's; The nurse reviews the BM records daily to identify residents with no BM x 9 shifts; Any resident who is identified as having gone 9 shifts without a BM has the Bowel protocol implemented; ...Protocol consists of the Following:7-3 shift; MOM 30 ml to be administered on the day shift following discovery that 9 shifts have passed without a BM..." Additionally, a Physician's order dated 11/11/15 stated, "MOM suspension: 8%; amt. 30 ml oral as needed for constipation". A nurse's note dated 5/12/16 stated, Last documented BM, 5/7/16, resident started on bowel protocol, MOM given..results pending.	F 329	1. (a) 1. Resident R239 received Milk of Magnesium when not indicated as being needed per review of the record for bowel movements. The resident did have a bowel movement after the administration of the medication. A retrospective review was conducted of the resident's record to attempt to reveal the reasoning for this medication when not indicated. The Root Cause Analysis revealed that the nurses did not review the flow sheets. 2. All residents have the potential to be affected by the deficient practice. Current and future residents will be protected from the deficient practice by taking corrective action(s) as outlined in #3 below. 3. Nursing staff will receive in-service training on how to prevent the use of un-necessary medications and how to monitor for the proper use of medications. Training will be conducted by the Staff Educator. Nursing Administration will conduct audits of MARs and behavior sheets to assure residents are receiving medications with proper indications for use of medications. Nursing administration will audit bowel records to assure that medications are needed per facility protocol. Audit reports will be given to the DON for review. 4. Audits will be conducted weekly on 10% of residents until 100% compliance has been achieved for four consecutive	

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808	
(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 329	<p>Continued From page 16</p> <p>5/12/2016 12:41 PM stated..."Milk of Mag was administered to resident last shift 11-7, had positive effect this shift. Resident has been sleeping all day, attempted to wake her to administer med pass several times, resident would awaken for only a couple minutes to take a few sips and would fall back asleep".</p> <p>Review of the 5/16 CNA's BM monitoring flow sheet revealed that on 5/7/16 on the 3-11 PM shift, R239 had 2 BMs as documented, 0 on 3 shifts on 5/8/15 and had 1 BM documented each day on the 3-11 PM shifts from 5/9 through 5/11/15. R239 was administered the MOM without adequate indications for its use.</p> <p>This finding was discussed with E14 (Unit Manager) on 5/16/15 at approximately 1:30 PM and with E2 (DON) on 5/17/16 in the exit conference at approximately 5:30 PM.</p> <p>2. Review of R32's current physician orders included the medications Abilify (ordered for psychosis), Paxil (ordered for depression) and Clonazepam (ordered for involuntary movements).</p> <p>The facility failed to provide adequate monitoring of R32's medication regimen regarding Abilify, Paxil and Clonazepam. Review of March- May 2016 behavior monitoring sheets listed medications no longer in use (Valium and Lorazepam), medications listed on behavior sheets with no target behaviors and/or inappropriate behaviors. Additionally, it was unclear at times what behaviors were intended for</p>	F 329	<p>weeks. Thereafter audits will be conducted on 5% of residents for 2 weeks or until 100% compliance has been achieved. Thereafter audits will be conducted on 5% of residents for 1 week or until 100% compliance has been achieved. If compliance has been achieved the deficiency will be considered resolved. Audit reports will be reviewed and discussed by the QA committee 2(b)</p> <ol style="list-style-type: none"> 1. Resident R32□s will be monitored for the use of Abilify, Paxil and Clonazepam. The Root Cause Analysis revealed that the nurses failed to use the behavior monitoring sheets to justify the use of these medications. 2. All residents have the potential to be affected by the deficient practice. Current and future residents will be protected from the deficient practice by taking corrective action(s) as outlined in #3 below. 3. Nursing staff will receive in-service training on how to use behavior monitoring sheets and how to monitor for the proper use of medications. Training will be conducted by the Staff Educator. Nursing Administration will conduct audits of medications and behavior sheets to assure residents are receiving medications with proper indications for use of medications. Nursing administration will audit resident records to assure that medications are needed per facility protocol. Audit reports will be given to the DON for review. 4. Audits will be conducted weekly on 10% of residents until 100% compliance has been achieved for four consecutive 	

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808	
(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 329	Continued From page 17 what medications. Review of the March- May 2016 behavior monitoring sheets revealed the following: March- - incorrectly identified target behaviors of agitation/anxiety and psychosis for Clonazepam, which was given for involuntary movements. - no target behaviors identified for Abilify on the behavior sheet although Abilify was listed on it. - psychosis was incorrectly identified as a target behavior for Clonazepam, however, although it is what Abilify was given for, it was not a target behavior. April- - Clonazepam and Lorazepam incorrectly identified target behaviors of sadness and agitation. - no target behaviors identified for Abilify on the behavior sheet although Abilify was listed on it. May- - incorrectly identified behaviors of crying, depressed, and sad listed Abilify as the medication to be given for these behaviors (should have been Paxil). - target behavior of very agitated incorrectly listed Valium (used for anxiety) as the medication to be given for this behavior.	F 329	weeks. Thereafter audits will be conducted on 5% or residents for 2 weeks or until 100% compliance has been achieved. Thereafter audits will be conducted on 5% of residents for 1 week or until 100% compliance has been achieved. If compliance has been achieved the deficiency will be considered resolved. Audit reports will be reviewed and discussed by the QA committee.	

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808	
(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 329	Continued From page 18 - no target behaviors identified for Abilify on the behavior sheet although Abilify was listed on it. Lorazepam and Valium (both used for anxiety) were not currently being given to R32; they were discontinued in 2015. Findings were reviewed and confirmed with E8 (UM) during an interview on 5/11/16 at 3:13 PM. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 5/17/16 at approximately 5:40 PM.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to prepare and serve food under sanitary conditions to prevent the outbreak of food-borne illness. The following were observed during the initial kitchen tour on 5/6/16 between 8:15 AM and 9:15 AM: 1. A dirty wet paper towel was resting on a clean	F 371	(1) and (2) 1. The wet paper towel was immediately removed by the Regional Director of Food Service and the ice machine was immediately cleaned by the Regional Director of Food Service. No residents were affected by the deficient practice. The Ice Machine was immediately cleaned by the Regional food Service	7/15/16

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808		
(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	<p>Continued From page 19</p> <p>dish drying shelf. When the issue was presented to E10 (Regional FSD), he immediately removed the paper towel.</p> <p>2. The ice machine filter was dirty with biofilm growing on it. E10 immediately cleaned it with a sanitizer wiping cloth.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E10, and E11 (Facility FSD) on 5/17/16 at approximately 5:40 PM.</p> <p>3. During a lunch dining observation on 5/6/16 at 12:05 PM in the first floor dining room, E16 (LPN) was setting up R16's lunch. During the process, E16 took the bread out from inside a plastic wrap with her bare hands and cut the bread in half to put some butter also with her bare hands.</p> <p>The facility failed to ensure that food was served under sanitary condition for R16.</p> <p>This finding was discussed with E16 (LPN) and E10 (Regional Food Director) on 5/6/16 at 1:00 PM and with E2 on 5/17/16 during the exit conference at approximately 5:45 PM.</p> <p>4. A lunch observation was conducted in the 2nd floor dining room on 5/6/16 from approximately 12 PM to 12:45 PM. E7 (cook) was observed plating food and touching non-food contact items/surfaces such as plates. At 12:35 PM and 12:39 PM, E7 removed her gloves and donned new gloves without washing her hands between glove changes.</p> <p>5. A second lunch observation was conducted in the 2nd floor dining room on 5/17/16 from</p>	F 371	<p>Director. No residents were adversely affected by the deficient practice. Root Cause analysis determined the Ice Machine was not properly assessed for cleanliness and maintenance needs. Root Cause Analysis determined the wet paper towel was left through carelessness.</p> <p>2. All residents have the potential to be affected by the deficient practices. Residents will be protected from the deficient practices by taking corrective action(s) as outlined in #3 below.</p> <p>3. Dietary staff will be in-serviced by the dietary supervisor on the proper cleaning and maintenance on the ice machine.</p> <p>4. To ensure 100% compliance the dietary supervisor will monitor the ice machine daily using a monitoring form. Audits will be conducted once a week for 4 weeks or until 100% compliance is achieved for 4 consecutive weeks. The audit then be done twice a month times 3 months until 100% compliance is achieved. If 100% compliance is achieved the deficient practice will considered resolved. Audits will be reviewed by the QA committee.</p> <p>(3)</p> <p>1. Employee E16 was in-serviced on proper food handling techniques on 5/6/16. No residents were adversely affected by the deficient practice. Root Cause Analysis determined the employee was unaware of proper food handling techniques.</p> <p>2. All residents have the potential to be affected by the deficient practices. Residents will be protected from the deficient practices by taking corrective</p>		

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808		
(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	<p>Continued From page 20</p> <p>approximately 12 PM- 12:20 PM. E7 was observed taking food temperatures at 12:10 PM and then changing gloves without any handwashing before donning new gloves. At 12:15 PM, E7 changed gloves after plating food and did not wash her hands between glove changes.</p> <p>Findings were reviewed with E1 and E2 during the exit conference on 5/17/16 at approximately 5:40 PM.</p>	F 371	<p>action(s) as outlined in #3 below.</p> <p>3. The Staff educator will in-service nursing staff on proper food handling techniques using sanitary conditions.</p> <p>4. Meal service audits will be completed by the RD and/or Food Service Daily until 3 100% compliance is achieved for 3 consecutive audits. Then once a week for three weeks until 100% compliance is achieved. Then once a month or until 100% compliance at which time deficiency is resolved. Audits will be presented and discussed at the QA committee meeting.</p> <p>(4)</p> <p>1. Employee E7 was in-serviced on 5/18/16 on hand washing procedures and washing hand when changing gloves. No residents were adversely affected by this deficient practice. The Root Cause of this deficient practice was that the employee failed to recognize the need to wash hands when changing gloves.</p> <p>2. All residents have the potential to be affected by the deficient practices. Residents will be protected from the deficient practices by taking corrective action(s) as outlined in #3 below.</p> <p>3. The dietary supervisor will in-service staff and conduct audits of glove and hand washing hygiene.</p> <p>4. Audits will be conducted 7 days/week for 4 weeks or until 100% compliance is achieved. The audit will then be done once a week for 2 weeks until 100% compliance is achieved. Thereafter 2 random audits will be done per month until 100% compliance is achieved for 2 months at which time the deficiency is</p>		

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

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808	
(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 21	F 371		
F 463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>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 in one room (room 100) out of 32 rooms. Finding include:</p> <p>During an observation on 5/6/16 at 1:25 PM, it was observed that the bed side call bell for room 100 B bed was not functioning. The resident residing in the bed (R16) was capable of using the call bell.</p> <p>Finding was reviewed with E1 (NHA), E2 (DON), and E12 (FMD) on 5/17/16 at approximately 5:45 PM.</p>	F 463	<p>resolved. Audits will be presented and discussed at the QA committee meeting.</p> <ol style="list-style-type: none"> 1. The call bell was replaced in Room 100 Bed B was replaced on 5/6/16. 2. All residents have the potential to be affected by this deficient practice. Current and future residents will be protected from this deficient practice by taking corrective action(s) outlined below in # 3. 3. The Director of Maintenance and/or designee will test the call bells in 10% of the resident rooms on a weekly basis to assure the call bells are functioning properly. Any call bell found to not be functioning will be immediately replaced. Test results will be reviewed by the NHA. 4. Test results will be done on a weekly basis until 100% compliance has been achieved for four consecutive weeks. If compliance has been achieved the deficiency will be considered resolved. Test results will be reviewed and discussed by the QA committee. 	7/15/16



**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: Cadla Rehabilitation Pike Creek

DATE SURVEY COMPLETED: May 17, 2016

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>An unannounced annual survey was conducted at this facility from May 6, 2016 through May 17, 2016. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 115. The Stage 2 survey sample size was 36.</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 CMS 2567-L survey date completed May 17, 2016: F253, F272, F278, F279, F280, F309, F314, F329, F371, and F463.</p>	<p><i>Cross reference EPOC submitted on 6/6/16 for F253, F272, F278, F279, F280, F309, F314, F329, F371 and F463. This is our POC for F tags noted above.</i></p>	<p><i>8/1/16</i></p>

Provider's Signature *Joseph J. [Signature]* Title *Administrator* Date *6/6/16*