

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

PRINTED: 09/13/2011
FORM APPROVED
OMB NO. 0938-0391

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| 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 08/31/2011 |
| NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3640 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 | INITIAL COMMENTS | F.000 | | |
| F.248 SS=D | <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide an ongoing program of activities designed to meet the needs of one (R150) out of 31 sampled residents in accordance with the residents' comprehensive assessments, interests, physical, mental and psychological well-being. Findings include:</p> <p>R150 was admitted to the facility on 7/8/09. Review of his annual Minimum Data Set (MDS) assessment, dated 6/8/11 revealed that he was in a persistent vegetative state due to TBI (traumatic brain injury). R150 had chronic respiratory failure and was total dependent on staff for all his activities of daily living.</p> | F.248 | <p>It is the practice of the facility to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>1.) Resident #150's activity needs are being met. A care plan meeting was held 9/22/11 with Resident #150'S Mother. Resident #150's Mother stated she wants her son to go to the lobby one to two times per week and stated she will take the Resident outside on occasion when the weather is nice.</p> <p>2.) All Resident's receiving 1:1 activity</p> | 11-8-11 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Frank Ramirez* TITLE *NHA Administrator* (X6) DATE *9-23-11*

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 248 | <p>Continued From page 1</p> <p>Review of R150's activities/preferences assessment, dated 8/1/09, revealed that his current interests included music, being outdoors, watching TV, having the bible read to him, watching a game called Uno. R150's activity care plan, dated 3/11/11, stated that "due to his current medical status, I am not able to initiate activities that are meaningful to me. I need help to achieve the highest level of quality of life possible for me, which must include 1:1 visits; Also, I like been outside if the weather is good ... ". The care plan goal included R150 to receive room visits 1:1 at least 1x/week. Approaches included providing 1:1 interaction and friendly visits.</p> <p>Throughout the survey (morning or afternoon), R150 was observed in his room with the TV on lying on his bed or sitting in a geri chair. R150 was not observed in any other activity during these times.</p> <p>In an interview with E6 (Activity Director) on 8/26/11 at 1:40 PM, she stated that her staff provided 1:1 interactions once per week in the afternoon or evenings. She stated the resident also had friendly visits with the staff and that the family visited often.</p> <p>Review of Activity logs from May 2011 to August 2011 revealed that R150 had not been taken outside in the last four months although he was getting the 1:1 visits.</p> <p>During a family interview with R150's responsible party (POA) on 8/29/11 at 4:00 PM, the family member stated that R150 enjoyed massages of his hands, going outside, spiritual/gospel music, and specific movies. She stated she has made</p> | F 248 | <p>interactions are at risk for this deficient practice.</p> <p>3.) A list of Resident's on 1:1 activity visits was obtained and their assessment evaluations were reviewed to determine that their activity needs have been identified. The Activity Director or designee will do random weekly audits to evaluate whether the activity staff are providing 1:1 visits according to their identified assessments.</p> <p>4.) The audit will be forwarded to the Quality Assurance and Assessment Committee for their review. The Quality Assurance and Assessment Committee will determine the need for further audits and or action plans.</p> | |

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| F 248 | Continued From page 2 requests to the activity staff for R150 to be taken outside during the day. She stated she visited the facility daily and on her days off, and that she had not observed R150 receiving 1:1 visits or being taken outside. The family member stated that R150 would benefit from going outside as he liked the outdoors. In an interview with E6 (Activity Director) on 8/30/11 at 11:55 AM, she stated that her staff had not taken R150 outside per the care plan because a family member took him outside. At 12:40 PM, E6 provided a copy of a revised activity care plan to the surveyor that indicated that R150 did not require going outside. In an interview with E4 (Corporate Nurse) on 8/30/11 at 1:10 PM, she stated that she checked with respiratory therapy and R150 did not require use of a ventilator during the day and would be able to go outside. E4 acknowledged this finding. The facility failed to provide an ongoing activity program that met R11's needs in regards to being taken outside as the assessment indicated and family requested. | | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an | F 280 | | |

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| F 280 | <p>Continued From page 3</p> <p>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 of record review and interview, it was determined that the facility failed to ensure that three (3) residents' (R129, R150 and R43) out of 31 sampled residents care plans were revised by a team of qualified persons after each assessments. Findings include:</p> <p>1. R129 had diagnoses that included Chronic Renal Failure (CRF) and shortness of breath (SOB) when sitting and/or lying flat in bed. According to R129's Minimum Data Set (MDS) assessment dated 8/3/11, his cognitive skills for daily decision-making were independent. R129 was non-ambulatory, needed extensive assistance of staff for all of his activities of daily living (ADLs) and used the wheelchair as his mobility device. This resident's special treatment included Dialysis three times a week on Tuesdays, Thursdays and Saturdays.</p> <p>The facility initiated a care plan dated 7/28/2011 entitled "Resident has potential for alteration of nutrition r/t need for dialysis and variable PO</p> | F 280 | <p>It is the practice of the facility to develop a comprehensive care plan within seven 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>1.) (a). Resident #129 no longer resides at facility. (b). Resident #150's care plan was reviewed and revised to include interventions per family request and activity assessment. (c). Resident #43's care plan was reviewed and revised to include that the resident is staying long term at the facility.</p> <p>2.) All resident's are at risk for this deficient practice.</p> | 11-8-11 | |

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| F 280 | <p>Continued From page 4 intake". The care plan interventions that were identified were care specific to R129's nutrition and maintenance of stable weight. The care plan was not revised to address specific dialysis related care needs such as fluid volume requirement, risk for adverse medication effects of the diuretic lasix, care of dialysis access site, Infection control measures, monitoring of vital signs and other monitoring requirements before and after dialysis treatments.</p> <p>This finding was discussed and confirmed by E5 (RN,unit manager) on 8/30/11.</p> <p>2. Cross refer to F248 Although the facility had an activity care plan for R150 revised on the computer on 8/30/11 (for 6/7/11 late entry), the care plan failed to carry over the intervention of taking the resident outside per family request and activity assessment.</p> <p>Review of R150's activity care plan, dated 3/2/11, indicated a problem focus as follows: "due to his current medical status, I am not able to initiate activities that are meaningful to me. I need help to achieve the highest level of quality of life possible for me, which must include 1:1 visits; Also, I like being outside if the weather is good ...".</p> <p>In an interview with E6 (Activity Director) on 8/30/11 at 11:55 AM, she provided an updated care plan for 6/7/11, which did not include taking resident outside.</p> <p>In an interview with E4 (Corporate Nurse), she stated that the facility updated the care plan dated</p> | F 280 | <p>3.) (a). The Staff Developer or designee will in-service Nursing Staff on the development of a comprehensive care plan on dialysis residents. (b). The Staff Developer will in-service the Activity Director on revision of activity care plans to include interventions per family request and activity assessments. (c) The Staff Developer or designee will in-service the Social Worker on the revision of care plans related to and Social Services when a resident is changing from a short term stay to a long term stay. (d). The Director of Nursing or designee will do random weekly audits to evaluate whether those residents receiving dialysis have a comprehensive care plan for dialysis. (e) The Director of Nursing or designee will do random weekly audits to evaluate whether activity care plans include interventions per family request and activity assessments. (f) The Director of Nursing or designee will do random weekly audits to evaluate whether care plan revisions have occurred when a resident's status has changed from short term care to long term care.</p> | |

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| F 280 | <p>Continued From page 5</p> <p>6/7/11 on 8/30/11 that enumerated the same information as the care plan of 3/2/11 yet did not include taking the resident outside.</p> <p>The care plan was revised but failed to include the preferences of the family for the resident to be taken outside during good weather and per the activity assessment.</p> <p>3. R43 was admitted to the facility on 4/4/11 with diagnoses that included hypertension, diabetes, respiratory failure and anxiety disorder.</p> <p>A care plan for problem of "Resident admitted to ECH for short term stay for rehab to home and will need assistance with discharge planning when goals are met...", with last revision date of 7/28/11, indicated the goal for R43 was that "resident will adjust to and be comfortable in long term care setting X 90 days". The approach or intervention included "allowing resident/family time to express feelings, assist resident/family with securing all necessary support services for discharge if d/c is the goal", educate resident/family on medical condition, and honor residents/family rights regarding death and dying, treatment and hospitalization".</p> <p>Although the facility implemented a care plan to address R43's short term stay, the care plan failed to be revised to include that resident was staying long term at the facility.</p> <p>In an interview, E14 (Social Services Director) on 8/25/11 confirmed this finding. Additionally, on 8/26/11, in an interview, E15 (Admissions Director) stated that the resident was on a ventilator unit and was long term care.</p> | F 280 | <p>4.) The results of these audits will be forwarded to the Quality Assurance and Assessment meeting for their review. The Quality Assurance and Assessment Committee will determine the need for further audits and or action plans.</p> | | |

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| F 333 SS=D | <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that one (R246) out of 31 sampled residents was free from any significant medication errors. Findings include:</p> <p>Review of R246's clinical record revealed that she had diagnoses of chronic pain, spinal stenosis, osteoarthritis and degenerative joint disease. On 6/15/11 R246 had surgery to remove metal from her left knee due to infection from previous Open Reduction Internal Fixation (ORIF) of that knee. On 7/22/11 R246 returned to the facility from the hospital after having left knee tendon reconstruction surgery.</p> <p>Physician's orders, dated 7/22/11 stated R246 was to receive Oxycodone HCL 30 mg every four hours as needed (PRN) for severe pain, Oxycodone HCL 15 mg every four hours PRN for moderate pain and Oxycodone 40 mg every 12 hours. The MAR (Medication Administration Record) stated that the Oxycodone 40 mg was to be given at 9AM and 21:00.</p> <p>Physician progress notes, dated 6/25/11 and 7/14/11 stated that R246 has degenerative joint disease and chronic pain and to continue the Oxycodone.</p> | F 333 | <p>It is the practice of the facility to ensure that residents are free of any significant medication errors.</p> <ol style="list-style-type: none"> Resident # 246 no longer resides at facility. All residents receiving Oxycodone are at risk for this deficient practice. (a). Staff Developer completed one on one in-servicing with E 10 related to narcotic administration. (b). The Staff Developer or designee will conduct random weekly medication administration observation passes to evaluate whether Oxycodone is administered according to the physician's order written on the Medication Administration Record. Results of the Medication Administration Pass will be forwarded to the Quality Assurance and Assessment Committee. The Quality Assurance and Assessment Committee will determine the need for further audits and or action plans | 11-8-11 | |

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| F 333 | Continued From page 7 Review of Medication Administration Records (MARs) for June through August 2011 revealed that, R246 was receiving PRN Oxycodone 30mg and PRN 15 mg doses on a daily basis. During the medication administration observation on 8/25/11 with E10(RN) for R246, it was revealed that after the surveyor counted the medications in the cup, that E10 did not dispense the Oxycodone 40mg with the other medications to be administered at that time. When confirming this with E10, she stated that all the medications were in the cup. E10 proceeded to count the medications in the cup and verified that there was one pill missing. Upon further investigation, E10 confirmed that she had returned the card of Oxycodone 40mg to the narcotic drawer in the medication cart without dispensing the Oxycodone 40mg into the cup with the other medications. Without surveyor intervention R246 would not have received the Oxycodone 40mg as ordered by the physician. | | | | |
| F 334 SS=D | 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal | F 334 | | 11-8-11 | |

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| F 334 | <p>Continued From page 8</p> <p>representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical</p> | F 334 | <p>It is the practice of the facility to develop policies and procedures that ensure that (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization ; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> | |

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| F 334 | <p>Continued From page 9 contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policies, and staff interview, it was determined that the facility failed to offer the influenza vaccination to one (R143) out of five sampled residents, Findings include:</p> <p>The facility's policy entitled "Influenza Immunization Program" stated "inoculations will be administered during October and November in accordance with CDC recommendations. They will be completed by the end of November. Immunizations will be offered to new admissions through January or as directed by Public Health".</p> <p>R143 was admitted to the facility on 9/14/10. Review of the facility's influenza immunization informed consent, dated 10/1/10 revealed that R143 gave the facility consent to administer the vaccine.</p> <p>Record review lacked evidence that the influenza vaccination was administered. Interview with E4 (Corporate Nurse) on 8/30/11 confirmed that R143 had not received the vaccination as he was</p> | F 334 | <ol style="list-style-type: none"> 1.) Resident 143 will be offered the influenza vaccination. 2.) All Resident's are at risk for this deficient practice. 3.) (a). A list of Resident's who have consented to receive an influenza vaccination will be obtained. The Director of Nursing or designee will conduct a random weekly audit to evaluate whether those Resident's consenting to have their influenza vaccination have received their vaccination. 4.) Results of this audit will be forwarded to the Quality Assurance and Assessment Committee for their review. The Quality Assurance and Assessment Committee will determine the need for further audits and or action plans. | |

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| NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808 | | |
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| F 334 | Continued From page 10 very sick when he first came in to the facility and remained that way for a while. E4 acknowledged this finding in the exit conference meeting on 8/31/11 and acknowledged that the flu season was through March 31 but that the facility failed to administer the vaccine at a later date. | | | | |
| F 364 SS=D | 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on resident interviews and test tray results, it was determined that the facility failed to provide food that was palatable, and served at the proper temperature. Findings include: During an interview with R5 on 8/24/11 at 9:56AM, R89 on 08/23/2011 at 11:27 AM, and R119 on 08/23/2011 at 2:24 PM, all three residents stated that the food was not always hot. R119 stated that the food temperatures were fine when you ate in the dining room. On 8/26/11 at 12:15 PM, a test tray was sampled on the second floor for temperature and palatability. The milk temperature was 52 degrees Fahrenheit (F) and was found to be unpalatable. On 8/26/11 at 12:55 PM, a test tray was sampled on the first floor for temperature and palatability. The test tray was hand delivered by staff directly | F 364 | It is the practice of the facility that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. | 11-8-11 | |

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| F 364 | Continued From page 11 from the kitchen. The food temperatures were as follows: spinach=114 degrees Fahrenheit (F), fish=113 F; soup=127 F; rice=109. The food was found to be unpalatable. | F 364 | 1. (a) The Food Service Director or designee has reviewed food temperature variance concerns with R 89, R 119 and R 5. (b).The milk was discarded. | |
| F 371 SS=E | <p>In an interview with E7 (Food Services Director) on 8/29/11, he acknowledged the finding. During an interview with E8 (Dietician) on 8/31/11, she also acknowledged the findings.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observation of the kitchen and interviews, it was determined that the facility failed to prepare, distribute and serve food to the residents under sanitary conditions. Findings include:</p> <p>1a. Observation of the kitchen reach-in refrigerator next to the steam table on 8/22/11 at approximately 10:50 AM with E7 (Food Services Director) revealed a covered, but undated deep pan of cooked beef stored inside the refrigerator. In an interview with E7 on 8/22/11, he stated that the beef was made over the weekend, and</p> | | <p>2. The Food Service Director or designee will routinely round facility and meet with residents to identify the same deficient practice.</p> <p>3. (a). The Food Service Director or designee will in-service the dietary staff on proper tray line holding temperatures of foods / and Milk. (b).The Food Service Director or designee will conduct random weekly audits of food and milk to evaluate proper temperatures.</p> <p>4. The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for their review The Quality Assurance and Assessment Committee will determine the need for further audits and or action plans.</p> | |

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| F 371 | <p>Continued From page 12</p> <p>proceeded to remove the beef pan from the refrigerator.</p> <p>b. Observation of the kitchen reach-in refrigerator on 8/26/11 at approximately 11:45 AM revealed a dated, but uncovered large deep pan of fried chicken. In an interview with E7, he confirmed this finding.</p> <p>In an interview with E8 (Dietician) on 8/31/11, she acknowledged that food inside the refrigerators needed to be covered and dated.</p> <p>2. On 8/22/11 at approximately 10:30 AM, food debris or grease deposits were observed in the kitchen as follows:</p> <p>a. Two (2) out of three (3) food pans stored on the ready to use rack had food debris on the food contact areas of the pans. Additionally, two (2) of five (5) deep pots, or sauce pans, had food debris on the food and nonfood contact surface of the pans.</p> <p>b. The Vulcan oven top burner area was encrusted with food debris and grease deposits. Additionally, encrusted food debris/grease was observed on the top area of the new self cleaning (Rational Convection Oven).</p> <p>c. The stainless steel prep counters in the kitchen had food debris. In an interview with E7, he revealed they were still cleaning from breakfast. They were observed preparing food for lunch.</p> <p>d. Eleven (11) of eleven (11) pans stored in the ready-to-use dry storage rack were wet.</p> <p>e. One 20-inch frying pan stored in the ready to use rack, above the 3-compartment sink, was in disrepair and had encrusted food debris on the food contact surface of the pan.</p> | F 371 | <p>It is the practice of the facility to (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.</p> <p>1.) (a) The cooked beef stored inside the refrigerator was discarded. (b) The dated, uncovered fried chicken was covered. (c) The two out of three food pans stored on the ready to use rack were cleaned. The two of the five deep pots, were cleaned. (d) The Vulcan oven top burner areas and the Convection oven were cleaned. (e) The stainless steel prep counters were cleaned. The eleven of eleven pans were removed from the dry storage rack and were placed on the drying rack. (f) The frying pan was discarded. (g) The deli/meat slicer was cleaned.</p> <p>2.) The Food Service Director will conduct weekly random audits to identify this deficient practice.</p> | 11-8-11 | |

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| F 371 | Continued From page 13 f. The deli/meat slicer located in the kitchen prep area had food deposits of ham. | F 371 | 3.) (a). The Food Service Director or designee will in-service the dietary staff on the proper handling, storage, and labeling of foods. (b) The Food Service Director or designee will in-service the dietary staff on the proper cleaning/ sanitizing of areas / equipment within the Dietary Department. These items/areas include (but are not limited to): Pots and pans, the Vulcan oven top burner, the outside surfaces of the convection oven, the stainless steel prep counters, pot and pan clean/dry storage area and the meat slicer. (c).The Food Service Director or designee will conduct random weekly audits of equipment and surface areas to evaluate compliance with cleaning and sanitizing. (c). The Food Service Director or designee will conduct random weekly audits on proper food handling, storage, and labeling of foods. | | |
| F 441-SS=E | E7 confirmed these findings. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens | | | | |

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| F 441 | <p>Continued From page 14</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and interview, it was determined that the facility failed to ensure that staff maintained and implemented the infection prevention and control program designed to prevent the development/transmission of disease and infection for three (R230, R150 and R275) out of 31 sampled residents. The facility failed to ensure that handwashing was completed when indicated and failed to follow isolation precautions to minimize the spread of infection. In addition, the facility's infection control surveillance report lacked documentation identifying the organisms that infected the residents, lacked analysis and investigation of any increase in the rate of infections and failed to establish controls to prevent infections for the months of July and August 2011. Findings include:</p> <p>1. On 8/25/2011 at approximately 8:40 AM, during the medication administration pass observation, E11 (LPN) failed to wash hands before she donned her gloves, then prepared and administered R150's medications via PEG (Percutaneous Endoscopic Gastrostomy tube) tube.</p> <p>2. R230 had an alteration in respiratory status related to ventilator dependence, respiratory failure and tracheostomy. R230 was admitted</p> | F 441 | <p>4.) Results of these audits will be forwarded to the Quality Assurance and Assessment Committee for their review. The Quality Assurance and Assessment Committee will determine the need for further audits and or action plans.</p> <p>It is the practice of the facility to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>1.) (a) E11 was in-serviced on the proper technique for hand washing prior to applying gloves, (b). Resident 230 currently is hospitalized. (c) R275 no longer resides at the facility (d). The monthly infection control logs have been updated to include July and August data.</p> <p>2.) All Residents are at risk for this</p> | 11-8-11 |

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| F 441 | <p>Continued From page 15</p> <p>from the hospital with diagnosis of MRSA (Methicillin Resistant Staphylococcus Aureus) in the sputum. R230 was placed on "droplet" (contact precaution generated from the source person during coughing, sneezing, talking and performance of procedures such as suctioning) isolation precaution. The most current laboratory test result, dated 7/22/11, for a C&S (culture and sensitivity) of R230's sputum tested positive for the organism Staphylococcus aureus (MRSA) requiring treatment with Bactrim DS twice a day x 7 days.</p> <p>On 8/23/11, E12 (CNA) was observed performing passive range of motion (PROM) for R230 without wearing a gown and a mask when a mask and gown was required to be worn. This was witnessed by E13 (CNA) and this finding was discussed with and confirmed by E2 (DON) on 8/30/11.</p> <p>3. Observation on 8/25/11 of E10 (RN) during medication administration revealed E10 applied two Lidoderm patches (pain medication) to the back of R275 without wearing gloves or washing hands before or after administration of the Lidoderm patches per facility policy. After the application of the Lidoderm patches, E10 proceeded to hand the resident her oral medications in a cup.</p> <p>Review of the facility policy entitled, Preparation and General Guidelines IIA2: Medication Administration General Guidelines Policy And Procedure Section A Preparation #8 states "Hands are washed before and after administration of topical, ophthalmic, otic, parenteral, enteral, rectal and vaginal</p> | F 441 | <p>deficient practice.</p> <p>3.) (a) The Staff Developer in-serviced E11 on the proper technique for hand washing prior to applying gloves. (b) The Staff Developer in-serviced E12 on the wearing of a gown/mask when performing passive range of motion on a resident on droplet precautions. (c) The Staff Developer in-serviced E10 on the proper hand washing procedure related to administration of Lidoderm patch. (d) The Director of Nursing or designee will conduct random medication observation passes to evaluate whether hands are being washed prior to applying gloves. (e) The Director of Nursing or designee will conduct random weekly audits to</p> | | |

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| F 441 | <p>Continued From page 16 medications".</p> <p>Findings were confirmed and discussed with E10 on 8/25/11.</p> <p>4. The infection control program and reports were requested on 8/22/11 and were reviewed. This review included the infection manual and infection control reports.</p> <p>Review of Monthly Infection Control Logs, Infection Control Reports, and Action Plan Reports entitled "Compliance Program Data Collection Summary, from January 2011 to August 2011 with E9 (Infection Control Nurse, ICN) on 8/24/11 revealed that the facility monitored the occurrence of infections and took actions to control infections at the facility from January to June 2011, however, it failed to identify the type of organisms infecting the residents for July and August 2011. The data indicated that the facility also failed to analyze and investigate any increase in the rate of infections, and failed to establish controls to prevent infections in the facility for July 2011 and August 2011. The line listings or infection control logs were incomplete for both July and August 2011 and did not identify the organism.</p> <p>In an interview with E9 on 8/24/11, she confirmed she had not completed the infection control reports for July 2011 and August 2011. She stated that the August infection surveillance data were analyzed a month later, or in September. E4 (Corporate Nurse) with E9 and E1 (Administrator) on 8/24/11 confirmed the facility had a formalized monitoring and tracking system in place to control, investigate and prevent infections in the facility. They confirmed the July 2011 analyses</p> | F 441 | <p>evaluate whether Restorative Certified Nursing Assistants are wearing gowns/gloves while performing passive range of motion on Resident's on droplet precaution isolation. (f) The Director of Nursing or designee will conduct random weekly medication observation passes to evaluate whether Nursing staff is washing their hands before and after administration of Lidoderm topical patch. (g) The Staff Developer has been in-serviced on the completion of line listings/infection control log timely. The Director of Nursing or designee will randomly audit the line listings/infection control logs weekly to evaluate timely completion.</p> <p>4.) The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for their review. The Quality Assurance and Assessment Committee will determine the need for further audits and or action plans.</p> | | |

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| F 441 | Continued From page 17 and reporting of the infection data was not completed yet. Facility failed to trend the organisms to determine if there was a pattern of infection that the facility needed to address and implement corrective actions for July 2011. The facility also failed to track organism of the infections on an ongoing basis. | F 441 | | | |



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STATE SURVEY REPORT

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NAME OF FACILITY: Cadia Rehabilitation Pike Creek

DATE SURVEY COMPLETED: August 31, 2011

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED |
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| <p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p> <p>3201.7.5</p> | <p>An unannounced annual survey was conducted at this facility from August 22, 2011 through August 31, 2011. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other documentation as indicated. The facility census the first day of the survey was 114. The Stage II survey sample totaled 31 residents.</p> <p>Regulations for Skilled and Intermediate Nursing 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>Cross refer to the CMS 2567-L survey report date completed 8/31/11, F156, F248, F280, F333, F334, F364, F371 and F441.</p> <p>Kitchen and Food Storage Areas.</p> | <p>Cross Refer to CMS 2567 F-156, F-248, F-280, F-333, F-334, F-364, F-371, F-441</p> |

Provider's Signature *Carol R...*, NHA Title Administrator Date 9-23-11



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| | <p>Facilities shall comply with the Delaware Food Code.</p> <p>Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 3-302.11, 3-305.11, 3-501.17, 4-101.11, 4-601.11 and 4-901.11 of the State of Delaware Food Code. Findings include:</p> <p>3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) Food shall be protected from cross contamination by: (1) Except as specified in (1)(c) below, separating raw animal foods during storage, preparation, holding, and display from: (4) Except as specified under Subparagraph 3-501.15(B)(2) and in ¶ (B) of this section, storing the FOOD in packages, covered containers, or wrappings;</p> <p>3-305.11 Food Storage. (A) Except as specified in ¶¶ (B) and (C) of this section, food shall be protected from contamination by storing the food: (1.) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination;</p> <p>This requirement was not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 8/31/11, F371, Example #1b</p> <p>3-501.17 Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Date Marking. (A) Except when packaging food using</p> | <p><i>Cross Refer to cms 2567 F-371</i></p> |



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| | <p>a reduced oxygen packaging method as specified under § 3-502.12, and except as specified in ¶¶ (D) and (E) of this section, refrigerated, ready-to-eat, potentially hazardous food (time/temperature control for safety food) prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days.</p> <p>This requirement was not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 8/31/11, F371, Example #1a</p> <p>4-101.11 Characteristics.</p> <p>Materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be:</p> <p>(A) Safe; (B) Durable, corrosion-resistant, and nonabsorbent; (C) Sufficient in weight and thickness to withstand repeated warewashing; (D) Finished to have a smooth, easily cleanable surface; and (E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition.</p> <p>This requirement was not met as evidenced by:</p> | <p>Cross Refer to cms 2567 F-371</p> |
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| | <p>This requirement was not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 8/31/11, F371, Example #2d.</p> | <p><i>Cross refer to cms 2567 F-371</i></p> |