

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085654	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2015
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	INITIAL COMMENTS An unannounced annual and complaint survey were conducted at this facility from March 3, 2015 through March 17, 2015. 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 122. The Stage 2 survey sample size was 28. Abbreviations used in this 2567 are as follows: DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; LPN - Licensed Practical Nurse; SSD - Social Service Director; CNA - Certified Nurse's Aide; MDS - Minimum Data Set-standardized assessment form used in nursing homes; Hospice-Type of care that focuses on the terminally ill patients' pain and symptoms; Incontinence- loss of control of bladder function; CHF - Congestive Heart Failure-heart's function as a pump is inadequate to deliver oxygen rich blood to the body.	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (B) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter	F 155	1. With the help of Hospice, R29 or family will be re-approached to attempt to encourage resident or family members to help participate in securing an Advance Directive. 2. All other hospice or palliative/comfort care residents will have their record reviewed to insure an Advance Directive is in place. If an Advance Directive is not in place, the Hospice provider and/or the resident or family member will be contacted in an attempt to encourage the resident or family members to help participate in securing an Advance Directive.	May 20, 2015

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

TITLE

(X6) DATE

[Signature] Administrator 4/1/15

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

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F 155	<p>Continued From page 1</p> <p>related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to ensure that one (R29) Hospice (end of life care), out of 28 Stage 2 sampled residents, had an Advance Directive (legal documents that allow you to spell out your decisions about end-of-life care ahead of time) in place. Findings include:</p> <p>The facility's Guideline on "Palliative/Comfort Care" stated, "... Advance Directives and prior expressed wishes must be reviewed ... All palliative care conferences will be documented carefully and thoroughly ... palliative care review form should be used at the first meeting, and the form placed into the medical record under the Advance Directive Section".</p> <p>Review of R29's record on 3/16/15 at approximately 2:00 PM revealed that this resident had no Advance Directive in place. R29 was certified to receive hospice and/or comfort care for a terminal disease condition of CHF.</p>	F 155	<p>3. Root cause analysis determined that the facility staff and Hospice lacked collaboration in securing an Advance Directive. Facility will review its guidelines on securing Advance Directives and update the guidelines if necessary. Staff development or designee will reinservice Licensed nurses and Social Services staff on the guidelines on securing an Advance Directive for residents on Hospice or a palliative/comfort care program. Point of focus to include discussion with the Hospice provider and/or MD; the Advance Directive Forms for the State of Delaware; and guidelines related to the completion of the Directive</p> <p>4. A Social Services or designee will conduct quarterly audits to insure all residents on hospice or a palliative / comfort care program have an Advance Directive in place or, documentation that the resident and/or family has received education and offers of assistance in securing an Advance Directive with the help of hospice, if applicable. Audit results will be reviewed monthly by the QA committee, until 100% compliance is achieved and then quarterly x 1 year</p>	

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FORM APPROVED
OMB NO. 0938-0391

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F 155	Continued From page 2 In an interview with E10 (SSD) on 3/16/15 at approximately 2:35 PM, she confirmed this finding. E10 stated that R29 was incapable of making decisions and the family did not want to get involved. However, the facility had no documented evidence of an attempt to coordinate team effort with Hospice to encourage family members to help participate in securing an Advance Directive or securing, for example, a designated POA (Power of Attorney) and/or a Public Guardian for end of life care.	F 155			
F 258 SS=C	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews with 3 (I#1, I#2 and I#3) out of 40 Stage 1 sampled residents, who wished to remain anonymous, it was determined that the facility failed to ensure comfortable sound levels. Findings include: 1. In an interview on 3/4/15 at 8:00 AM, Resident I#1 stated "noise from other patients; CNAs noisy and talking incessantly loud in the hall; and the PA (overhead paging) system".	F 258	1. All residents have the potential to be affected by this deficient practice. 2. Root cause analysis revealed that there was no other option for nurses to communicate between floors but to page overhead during 11-7 shift. 3. Facility will develop guidelines that will restrict paging overhead during the overnight hours. These guidelines will include an alternative form of communication other than paging overhead. Staff development or designee will inservice all nursing staff regarding the developed guidelines for the restricted use of the intercom system/overhead paging during the overnight hours. All staff will also be reinserviced on facility guidelines and options to take for maintaining comfortable sound levels throughout the entire day. continued next page	May 20, 2015	

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F 258	Continued From page 3 2. In an interview on 3/9/15 at 10:11 AM, Resident I#2 stated "staff from 4 to 6 AM seem to talk loudly and are noisy preparing things for the day's activities". 3. In an interview on 3/9/15 at 11:05 AM, Resident I#3 stated "noise at night in the hallway and announcements over the loud speaker". 4. An observation on 3/13/15 at 6:00 AM revealed an announcement made on the PA system that stated "Nurse Supervisor please call 310. Nurse Supervisor please call 310". In an interview on 3/13/15 at 7:07 AM, E6 (RN) confirmed the finding and stated the overhead page was a request by E7 (LPN) to unlock the supply closet so E7 could retrieve supplies for wound care. The facility failed to maintain comfortable sound levels.	F 258	4. NHA or designee will conduct audits daily x's 7 days until 100% compliant, then weekly x's 3 weeks until 100% compliant, then monthly x's 3 months until 100% compliant. Audits results will be reviewed by the QA committee on a quarterly basis x 1 year or compliance is achieved and maintained x 2 quarters		
F 272 SS-D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns;	F 272	1. R29 and R128 will have their MDS's corrected, per MDS guidelines, to reflect a prognosis as terminally ill with a life expectancy of six months or less. 2. All other residents on hospice or palliative/comfort care program will have their MDS reviewed and corrected as necessary, per MDS guidelines, to reflect a prognosis as terminally ill with life expectancy of six months or less. ...continued next page	May 20, 2015	

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F 272	<p>Continued From page 4</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to ensure that one (R29) out of 28 Stage 2 sampled residents' comprehensive assessments was accurate. Findings include: R29 was admitted to the facility with diagnosis of CHF. A Physician's Certification of Terminal Illness for Medicare Hospice Benefit, dated 6/4/14, indicated that from 5/15/14 through 7/14/14 R29 had the</p>	F 272	<p>3. A root cause analysis revealed that the Hospice physician certification was not placed on the medical record prompting the RNAC to check the "Prognosis" section. Staff development or designee will reinservice the RNAC's on the RAI manual specific to MDS assessment section for terminally ill patients. Facility will meet with Hospice organizations to review and revise the process for having the proper documentation in the medical record to support the terminal illness to so the RNACs can appropriately code the section "Prognosis".</p> <p>4. D.O.N. or designee will audit the MDS's for hospice residents quarterly to confirm the MDS accurately reflects a prognosis as terminally ill with a life expectancy of six months or less. Audits will be reviewed by the QA committee X 1 year or until compliance is achieved and maintained x 2 quarters</p>	

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F 272	Continued From page 5 diagnosis of CHF to support the resident's life expectancy of six months or less. According to R29's Significant Change MDS assessment dated 5/23/14, R29 was on Hospice care. However, the MDS assessment section entitled "Prognosis" was not checked and/or identified to indicate that R29 was "terminally ill with a life expectancy of six months or less". The facility failed to ensure that R29's assessment accurately reflected the resident's status. This finding was discussed with E1 (NHA), E2 (DON) and E11 (MDS Coordinator) on 3/17/2015 at approximately 3:30 PM.	F 272			
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 each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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	F 278	1. R29 and R128 will have their MDS's corrected to reflect a prognosis as terminally ill with a life expectancy of six months or less. R54 was discharged from the facility on January 26, 2015 2. All other residents on hospice or palliative/comfort care program will have their MDS reviewed and corrected as necessary, per MDS guidelines, to reflect a prognosis as terminally ill with life expectancy of six months or less. All residents coded as always continent have the potential to be affected by the deficient practice.	May 20, 2015	

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F 278	<p>Continued From page 6</p> <p>\$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 record reviews and interviews, it was determined that the facility failed to ensure that the MDS assessment accurately reflected the resident's status for three (R29, R54 and R128) out of 28 Stage 2 sampled residents. Findings include: The facility's policy entitled "Minimum Data Set 3.0 Completion", dated 7/15/13, stated, "Guideline: To ensure an interdisciplinary approach to the timely and accurate completion of the MDS 3.0." 1. The quarterly MDS assessment, dated 12/27/14, stated R54 was occasionally incontinent (less than 7 episodes of incontinence) of urine, during the seven (7) day review time period (12/21/14 through 12/27/14). Review of the "CNA Flowsheet" for the month of December revealed that R54 had no episodes of incontinence during the seven (7) day review time period (12/21/14 through 12/27/14). An interview with E5 (RNAC) on 3/16/15 at 1:55 PM confirmed the findings and verbalized that the</p>	F 278	<p>3. A root cause analysis revealed that the Hospice physician certification was not placed on the medical record supporting the need for the RNAC to check the "Prognosis" section and the RNAC that coded R54 as Incontinent stated the error was due to human error. Staff Development or designee will reinservice the RNAC's on the RAI manual specific to MDS assessment accuracy for bowel and bladder and for terminally ill patients. Facility will meet with Hospice organizations to review and revise the process for having the proper documentation in the medical record to support the terminal illness so the RNACs can appropriately code the section "Prognosis"</p> <p>4. RNAC or designee will audit Section H and supportive documentation monthly until 100% compliance is reached over 3 consecutive evaluations. Audit results will be reviewed by the QA committee. On a quarterly basis x 1 year or until compliance is achieved and maintained x 2 quarters</p>	

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F 278	<p>Continued From page 7</p> <p>MDS should have been coded as always continent (control of bladder and bowel function) of urine.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 3/17/15 at 3:10 PM.</p> <p>2. R29's quarterly MDS assessments dated 8/23/14, 11/25/14 and 2/25/15 indicated that this resident was on Hospice care. However, the section entitled "Prognosis" was not checked off that stated "terminally ill with a life expectancy of six months or less". The physician had certified and recertified R29 for terminal illness from 8/23/14 through 2/25/15.</p> <p>3. R128's quarterly MDS assessment, dated 12/15/14, indicated that this resident was in a persistent vegetative state (absence of responsiveness and awareness) and was totally dependent upon staff for all activities of daily living (ADLs). R128 was also receiving respiratory treatments such as oxygen and suctioning of tracheostomy (an opening made in the throat to assist breathing) tube and he was also identified as receiving Hospice care. R128 was certified and recertified by the physician for terminal illness from 12/10/14 through 2/7/15. However, this same MDS assessment failed to identify or check off the section entitled "Prognosis" as "terminally ill with a life expectancy of six months or less".</p> <p>These findings were discussed with E1, E2 and E12 (RN Clinical Consultant) on 3/17/15 at approximately 3:30 PM.</p> <p>The facility failed to ensure that these quarterly</p>	F 278			

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F 278	Continued From page 8 MDS assessments accurately reflected the residents' status.	F 278			
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 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. This REQUIREMENT is not met as evidenced by: Cross refer to F155. Based on record review and interviews, it was determined that for one (R29) out of 28 Stage 2 sampled residents, the facility failed to ensure that the care plan was reviewed and revised to address R29's Hospice/Palliative care status in coordination with the Hospice staff and with input from this resident's representative that included goals and interventions to promote quality of life	F 280	1. All hospice residents have the potential to be affected by this deficient practice. 2. Facility will meet with Hospice organizations to review and revise the process for care plans to insure coordination with the Hospice staff that addresses each residents Hospice status/Palliative Care that included goals and approaches to promote quality of life and comfort. 3. Staff development or designee will reinservice Social Service staff and Unit mahagers concerning care plan coordination for Hospice residents. 4. D.O.N. or designee will audit all Hospice resident care plans monthly x's three months with a goal of 100% compliance with care plan coordination. The audits will be reviewed by the QA committee and Hospice Services, if applicable.	May 20 2015	

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F.280	<p>Continued From page 9 and comfort rather than prolongation of life to meet the needs of this hospice resident. Findings include:</p> <p>The facility's Guideline (Policy) entitled, "Palliative/Comfort Care" stated, "... 6. A palliative care/comfort measure care plan will be placed on the resident's chart. This care plan will include approaches to be used by the staff to meet the resident's goals/wishes ... 8. The Palliative Plan of Care will be reviewed during interdisciplinary plan of care meetings and reevaluated whenever the facts or conditions that led to the initial discussion change, or whenever the resident, or POA or other involved person requests it ...".</p> <p>On 3/13/15, R29's care plans were reviewed. The care plans were initiated by facility staff. Except for the category of "Nutritional Status on R29's potential poor intakes r/t (related to) ... Hospice status", the care plan failed to show that a revision was made to address this resident's Hospice and/or Palliative Care Status for all care provided in coordination with the Hospice staff.</p> <p>Interview on 3/13/15 at approximately 4:30 PM, E8 (ADON) stated that the facility made their own care plan for R29 and Hospice made their own. However, Hospice care plans were not found in R29's clinical record.</p> <p>On 03/16/15 at 2:32 PM, E10 (SSD) stated that there was no palliative care review/conferences held with the family because the family did not wish to be involved.</p> <p>The facility failed to demonstrate in R29's care plan that it was reviewed and revised in coordination with the Hospice staff that</p>	F 280		

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F 280	Continued From page 10	F 280			
F 309	addressed this resident's Hospice status/Palliative Care that included goals and approaches to promote quality of life and comfort.	F 309			
SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING		1. R200 was discharged home March 14, 2015.	May 20 2015	
	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.		2. All residents have the potential to be affected by the facility failure to initiate the bowel protocol as per policy.		
	This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and staff interviews, the facility failed to ensure that two (R200 and R317) residents out of 28 Stage 2 Sampled residents received the necessary care and services to attain or maintain the highest practicable physical well-being in accordance with their plan of care. For R200, the facility failed to initiate the bowel protocol when he went 18 shifts with no bowel movement (BM). For R317, the facility failed to monitor R317's left AVF (arteriovenous fistula - connection of a vein and an artery, usually in the forearm, to allow access to the vascular system for dialysis, a procedure that performs the functions of the kidneys in people whose kidneys have failed) every shift since 2/23/15 [over 54 shifts] as per her plan of care. Findings include:		3. Root cause analysis revealed that the cause of the failure to implement the bowel protocol was due to the inaccurate documentation of the nursing assistants and the licensed nurse's failure to monitor documentation accurately. Facility will review facility bowel protocol. Staff Development will reinservice all nursing assistants and licensed staff on the bowel protocol.		
	1. The facility's policy entitled "Bowel Protocol", dated 4/2013, stated "Residents will be monitored for bowel elimination so that timely interventions		4. D.O.N. or designee will monitor all residents daily x's 4 weeks to insure 100% compliance with the bowel protocol. When 100% compliance is achieved then the D.O.N. or designee will monitor weekly X's 4 weeks or until 100% compliant then monthly x's 3 months. QA committee will review results of audits		

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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		
(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	<p>Continued From page 11</p> <p>can be implemented to prevent potentially serious complications ... 4. Any resident who is identified as having gone 0 shifts without a BM has the Bowel protocol implemented ...".</p> <p>R200 was care planned for potential for constipation on 2/2/14 with an intervention to institute BM protocol as per facility policy.</p> <p>Review of the February 2015 CNA Flow Sheet revealed that R200 did not have a bowel movement from 2/21/15 through 2/26/15, a total of 18 shifts.</p> <p>Review of the February 2015 MAR lacked evidence that the bowel protocol was initiated.</p> <p>In an interview on 3/13/15 at approximately 3:45 PM, E9 (RN) confirmed the finding. The facility failed to initiate the bowel protocol as per R200's plan of care.</p> <p>2. The facility's policy entitled "Dialysis Residents", dated 6/2013, stated "... 5. Routine monitoring of the dialysis access site will be performed by the licensed staff ...".</p> <p>R317 was admitted to the facility on 2/22/15 with diagnoses including End Stage Renal Disease (disease where the kidneys stop working) requiring dialysis. R317 had two dialysis access sites, a right chest wall catheter (tube) and a left AVF.</p> <p>R317's dialysis care plan, dated 2/23/15, stated "... 2. Check dialysis ... catheter ... q (every) shift and PRN (as needed)" and "check for bruit/thrill (assessment of sound and sensation indicating that the blood is flowing through the blood vessel</p>	F 309	<p>1. R317 was discharged from the facility March 27, 2015</p> <p>2. All residents with a dialysis access site will have the dialysis access site checked for bruit/thrill.</p> <p>3. Root cause analysis revealed staff perception that an unused dialysis access site did not require Q shift monitoring as is the case for a dialysis access site in use for dialysis. Facility will review and revise the guidelines for monitoring a dialysis access site. Staff development or designee will reinservice all licensed nurses on the guidelines for monitoring all dialysis access sites.</p> <p>4. D.O.N. or designee will monitor all dialysis residents daily x's 4 weeks to insure 100% compliance with the dialysis access site per facility policy. When 100% compliance is achieved then the D.O.N. or designee will monitor weekly X's 4 weeks or until 100% compliant then monthly x's 3 months until 100% compliant. QA committee will review results of audits</p>	May 20 2015	

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FORM APPROVED
OMB NO. 0938-0301

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 C 03/17/2015
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F 309	Continued From page 12 and functioning properly) q shift and PRN". R317's clinical record from 2/23/15 through 3/13/15 lacked evidence of monitoring the left AVF for bruit/thrill every shift. In an interview on 3/13/15 at 3:49 PM, E9 (RN) confirmed the finding. The facility failed to monitor R317's left AVF since 2/23/15 [over 54 shifts].	F 309			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, it was determined that the facility failed to ensure that one resident (R31), who was unable to carry out activities of daily living (ADLs), out of 28 Stage 2 sampled residents, received the necessary services to maintain good grooming and personal hygiene. The facility failed to provide consistent hair washing and/or hair brushing for R31. Findings include: The annual MDS assessment, dated 1/13/15, stated R31 was independent in daily decision making skills and was totally dependent on one staff person for bathing and personal hygiene (included combing hair). This MDS also stated R31 had impairment in range of motion of the upper and lower extremities on both sides of the	F 312	1. R31 had her hair washed on March 17, 2015 2. All other residents have the potential to be affected by this deficient practice 3. Root cause analysis revealed that all options were not explored for a resident that was refusing care. Facility will review options to be tried to promote appropriate washing of resident's hair. Staff development or designee will reinservice all nursing staff on options available for maintaining hair cleanliness. 4. D.O.N. or designee will routinely monitor all residents who refuse to have their hair washed to insure appropriate interventions have been implemented or attempted as determined necessary.	May 20 2015	

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F 312	<p>Continued From page 13 body.</p> <p>R31's care plan for self care deficit, dated 1/27/15, included the approach to "assist with daily hygiene, toileting, dressing, grooming and oral care as needed."</p> <p>On 3/11/15 at 10:40 AM, E4 (CNA) called this surveyor to R31's room at the resident's request. This surveyor observed a large clump of hair that had come from the hairbrush that E4 was using to brush R31's hair. Observation of R31's hair revealed that it was extremely matted and greasy in the back. Additionally, large white flakes were observed in the hair and on the scalp. R31 stated that her hair is not brushed regularly and it gets all matted. R31 was asked when her hair was last washed? R31 stated that it hasn't been washed in a long time, that they used to use the dry shampoo, but that hasn't been done in awhile either.</p> <p>On 3/13/15 at 11:25 AM, a second observation of R31 revealed her hair pulled up on top of her head. The sides were visibly dirty with large white flakes and crust on the scalp.</p> <p>Review of CNA Behavior Flowsheets from 2/15 through 3/13/15 revealed that although staff were documenting R31's refusal of specific care, there was no evidence that R31 was offered and refused having her hair washed and/or brushed.</p> <p>The facility failed to ensure R31, who is unable to carry out activities of daily living, received the necessary services to maintain good grooming and personal hygiene.</p> <p>Findings were reviewed with E2 (DON) during an</p>	F 312			

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F 312	Continued From page 14	F 312		
F 323	483.25(h) FREE OF ACCIDENT	F 323		
SS=D	HAZARDS/SUPERVISION/DEVICES			
	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, it was determined that the facility failed to ensure that the resident environment remained as free of accident hazards as is possible for one (R200) out of 28 Stage 2 sampled residents. The facility failed to ensure that R200 wore non-skid footwear and bilateral fall mats were placed on the floor when the resident is in bed. Findings include:</p> <p>R200 was admitted to the facility on 1/30/15 with a history of falls.</p> <p>R200 was care planned for potential of falls with interventions that included non-skid footwear and safety devices (bilateral fall mats).</p> <p>Review of R200's clinical record revealed that he fell four (4) times (2/13/15, 2/14/15, 2/18/15 and 2/26/15) with no injury since admission on 1/30/15.</p> <p>An observation on 3/13/15 at 11:23 AM revealed</p>		<p>1. R200 was discharged March 14, 2015</p> <p>2. All other residents with the potential for falls have the potential to be affected by this deficient practice</p> <p>3. Root cause analysis revealed that the nursing assistant assigned to R200 failed to follow the resident care planned interventions. Nursing assistant is no longer employed with the facility. Staff development or designee will reinservice all nursing staff regarding following the care plan interventions related to their plan of care.</p> <p>4. Assistant D.O.N or designee will complete audits daily x's 4 weeks to insure 100% compliance with the resident care planned falls interventions. When 100% compliance is achieved then the Assistant D.O.N. or designee will monitor weekly X's 4 weeks or until 100% compliant then monthly x's 3 months. Audit results will be reviewed by the QA committee</p>	May 20 2015

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F 323	Continued From page 15 R200 lying in bed awake with only one fall mat placed on the floor next to the bed and bare feet. R200 was observed lifting his bare feet up and moving them off the right side of the bed to the floor where there was no fall mat present. In an interview on 3/13/15 at 11:28 AM, E9 (RN) located the other fall mat which was placed up against R200's wardrobe closet. E9 confirmed the findings that R200 was care planned for bilateral fall mats and non-skid socks.	F 323		
F 387 SS=D	The facility failed to ensure that R200 wore non-skid footwear and bilateral fall mats were placed on the floor when the resident is in bed. 483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility failed to ensure that one (R152) out of 28 Stage 2 sampled residents was seen by a physician at least once every 30 days for the first 90 days after admission. Findings include: R152 was admitted to the facility on 9/30/14.	F 387	1. R152 was discharged from the facility on January 19, 2015 2. All other residents have the potential to be affected by this deficient practice 3. Root cause analysis revealed that this was an oversight by the physician. Facility will review the policy for monitoring physician visits to insure they are in compliance with the state and federal regulations. Staff development or designee will reinservice Medical records staff on the policy for timely physician visits and monitoring of those visits. 4. Medical records staff or designee will audit resident medical records monthly x's 3 months to insure 100% compliance with the regulations concerning physician visits. Audits will be reviewed by the QA committee.	May 20 2015

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F 387	Continued From page 16 Review of the clinical record revealed that R152 was seen nine (9) times in October 2014 and one (1) time in November 2014. The clinical record lacked evidence that R152 was seen by a physician in December 2014. In an interview on 3/16/15 at 4:12 PM, EB (ADON) confirmed the finding. The facility failed to ensure that R152 was seen at least once every 30 days for the first 90 days after admission.	F 387		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R124) out of five (5) residents sampled for an unnecessary drug review, the facility failed to ensure that a monthly medication regimen review (MRR) was completed at least monthly. Findings include: Review of R124's "Consultant Pharmacist Record of MRR" lacked evidence of a monthly MRR being completed in October 2014.	F 428	1. R124 had no adverse effects from deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. Pharmacy consultant will be provided a facility census upon entrance into facility to conduct monthly review and pharmacy consultant will cross reference census with actual reviews to ensure all residents were reviewed. Pharmacy recommendation forms will then be given to DON/designee as second check to ensure all residents were reviewed. 4. Pharmacy Director/designee will audit compliance ensuring each resident in facility has had a monthly review completed on a monthly basis for three consecutive months until 100% compliance is achieved and then quarterly for three quarters or until 100% compliance has been achieved and then deficient practice will be considered resolved. QA committee will review results of audits	May 20 2015

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F 428	Continued From page 17	F 428		
F 431 SS=E	<p>Although the facility provided the "Executive Summary of Consultant Pharmacist's Medication Regimen Review," which listed residents who received nine (9) or more medications during the review dates between 10/1/14 and 10/4/14, R124's name was not listed. Review of R124's October monthly physician order sheet revealed this resident received approximately 22 different medications daily.</p> <p>Findings were confirmed with E2 (DON) during an interview on 3/16/15 at approximately 4:35 PM.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p>	F 431	<ol style="list-style-type: none"> 1. No residents were affected by this deficient practice. 2. All residents receiving narcotics have the potential to be affected. 3. Focus review will be completed by DON of facility narcotic sheets. Narcotic count sheet will be revised to meet requirements of F431. All staff will be reinserviced on policy and procedure for narcotic count. The Unit manager/designee will audit daily for 30 days or until compliance is achieved for greater than 1 month for compliance with narcotic count and documentation. 4. Unit manager/designee will monitor the narcotic count sheet daily x 30 days or until 100% success is noted over a 30 day period. Then, monitoring will be done three times a week for 3 consecutive weeks of until 100% success is achieved. Then once a month until 100% compliance is achieved for 3 consecutive months. Once compliance is achieved, the audit will be discontinued. QA committee will review results of audits 	May 20 2015

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F 431	<p>Continued From page 18</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure that a system of records (Narcotic Shift Count Sheet) kept for the receipt and disposition of all controlled medications was conducted by two (2) licensed nurses at each shift. This deficient practice was found on two (2) out of two (2) floors/units which had three (3) medication carts each (six medication carts total). Findings include:</p> <p>The facility policy entitled "Controlled Medication Storage," dated February 2015, stated "... 4. At each shift change, a physical inventory of all controlled medications, including emergency supply, is conducted by two licensed nurses and is documented on the controlled medication accountability record ...".</p> <p>Review of the narcotic shift count sheets from 12/8/14 through 3/9/15 for rooms 101 through 117 revealed missing nurse on and/or nurse off signatures on the following dates: 1/16/15, 1/23/15, 1/29/15 and 2/24/15.</p>	F 431		
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F 431	<p>Continued From page 19</p> <p>Review of the narcotic shift count sheets from 12/28/14 through 3/8/15 for rooms 150 through 159 revealed missing nurse on and/or nurse off signatures on the following dates: 12/30/14, 1/2/15, 1/4/15, 1/14/15, 1/30/15, 2/1/15, 2/2/15 and 2/24/15.</p> <p>Review of the narcotic shift count sheets from 10/21/14 through 3/9/15 for rooms 160 through 168 revealed missing nurse on and/or nurse off signatures on the following dates: 10/22/14, 10/23/14, 10/24/14, 11/2/14, 11/8/14, 11/10/14, 11/13/14, 11/24/14, 11/27/14, 11/28/14, 11/29/14, 11/30/14, 12/4/14, 12/9/14, 12/11/14, 12/13/14, 12/17/14, 12/18/14, 1/5/15, 1/6/15, 1/7/15, 1/13/15, 1/22/15, 2/11/15, 2/12/15, 2/16/15, 2/17/15, 3/5/15, 3/6/15 and 3/7/15.</p> <p>Review of the narcotic shift count sheets from 10/13/14 through 3/8/15 for rooms 201 through 205 and 250 through 255 revealed missing nurse on and/or nurse off signatures on the following dates: 10/14/14, 10/16/14, 10/24/14, 10/27/14, 11/10/14, 11/13/14, 11/28/14, 11/29/14, 11/30/14, 12/1/14, 12/9/14, 12/18/14, 12/30/14, 1/2/15, 1/9/15, 1/11/15, 1/26/15, 2/15/15, 2/16/15, 2/17/15, 2/18/15, 2/19/15, 2/28/15 and 3/5/15.</p> <p>Review of the narcotic shift count sheets from 10/13/14 through 3/8/15 for rooms 206 through 215 revealed missing nurse on and/or nurse off signatures on the following dates: 10/13/14, 10/21/14, 11/10/14, 11/24/14, 11/25/14, 12/24/14, 1/30/15, 3/6/15, 3/7/15 and 3/8/15.</p> <p>Review of the narcotic shift count sheets from 10/19/14 through 3/8/15 for rooms 256 through 265 revealed missing nurse on and/or nurse off</p>	F 431			

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(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 431	Continued From page 20 signatures on the following dates: 10/31/14, 11/1/14, 11/2/14, 11/4/14, 11/7/14, 11/23/14, 11/24/14, 12/6/14, 12/7/14, 12/8/14, 12/18/14, 1/5/15, 1/12/15, 1/21/15, 2/4/15, 2/5/15; 2/6/15, 2/7/15, 3/2/15 and 3/7/15. During an interview with E2 (DON) on 3/16/15 at approximately 4:30 PM, she stated that if a nurse works a double shift they try to assign them to the same medication cart. E2 stated that the expectation is that the narcotic count is completed on each shift unless the nurse is retaining control of the same medication cart for a second shift. The count would then be completed when the nurse hands off the medication cart keys to the oncoming shift nurse.	F 431		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility failed	F 514	1. R152 was discharged January 19, 2015 2. All other residents with psych behaviors have the potential to be affected by this deficient practice. 3. Root caused analysis revealed that psych services at that time were not sufficiently reviewing resident information or documentation. The facility's expectations for Psychoactive Medication review will be discussed with the Psychiatrist by the DON or designee. 4. D.O.N or designee will review all psychiatric service progress notes monthly x's 3 months or until 100% compliant. Audits results will be reviewed by the QA committee.	May 20 2015

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

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 C 03/17/2015
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NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 21</p> <p>to ensure that one (R152) out of 28 Stage 2 sampled residents' clinical records was maintained in accordance with accepted professional standards and practices that are accurately documented. For R152, the 12/18/14 psychiatric [psych] progress note did not reflect the resident's current status. Findings include:</p> <p>A physician order, dated 10/2/14, stated to discontinue Seroquel (medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality) and Aricept (dementia medication).</p> <p>Review of R152's MARs for October 2014, November 2014 and December 2014 revealed that R152 was not administered Aricept or Seroquel since they were discontinued.</p> <p>However, review of the December 2014 CNA Behavior Flowsheet revealed multiple episodes of physical aggression, i.e. resisting care by hitting, kicking, swinging at staff, during all three (3) shifts from 12/1/14 through 12/13/14.</p> <p>A psychiatry progress note, dated 12/18/14, stated "Patient seen for routine follow up visit. Current Meds (medications) - Aricept ... Seroquel ... No acute behavior problems or changes at this time ... Doing well on curent (sic) meds ...". This progress note failed to demonstrate knowledge of the current plan of care.</p> <p>In an interview on 3/16/15 at 4:12 PM, E8 (ADON) acknowledged the findings and stated that the psychiatry practice was no longer</p>	F 514		

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

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 C 03/17/2015
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 514	Continued From page 22 affiliated with the facility. The facility failed to ensure that R152's clinical record was accurately documented as the 12/18/14 psych progress note did not reflect the current status of R152 in respect to current psych medications and episodes of behavior.	F 514			



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Pike Creek

DATE SURVEY COMPLETED: March 17, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual and complaint survey were conducted at this facility from March 3, 2015 through March 17, 2015. 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 122. The Stage 2 survey sample size was 28.</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>Cross reference POC F155, F258, F272, F278, F280, F309, F312, F323, F387, F428, F431, F514</p>	

Provider's Signature

Title

Administrator

Date

4/1/15



DELAWARE HEALTH AND SOCIAL SERVICES

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STATE SURVEY REPORT

NAME OF FACILITY: Cadla Rehabilitation Pike Creek

DATE SURVEY COMPLETED: March 17, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 3/17/15, F155, F202, F258, F272, F278, F280, F309, F312, F323, F387, F428, F431 and F514.</p>		

Provider's Signature _____ Title _____ Date _____