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

PRINTED: 05/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085056		C 05/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILLITATION SILVERSIDE	3322 SILVERSIDE ROAD WILMINGTON, DE 19810

(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 complaint survey was conducted at this facility from May 2, 2014 through May 8, 2014. The deficiencies contained in this report are based on observation, interviews, review of resident's clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 103. The survey sample totaled four (4) residents, two active and two closed.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R3) out of four sampled residents the facility failed to provide the necessary care and services to maintain the highest practicable physical, mental and psychosocial well-being. The facility failed to follow the plan of care when R3's antidepressant medication (Lexapro) dosage was ordered to be decreased for five days and then discontinued. The facility erroneously administered the original dose of the Lexapro on one occasion when it should no longer have been given. Additionally, the facility failed to administer one dose of Lasix (water pill) to R3 according to physician's orders.	F 309	F309 a. 1. R3 was discharged to home with no negative outcome. 2. All residents have the potential to be affected by deficient practice. 3. Paper recap process is being eliminated June 17, 2014. Facility will be converting to electronic MARs, therefore eliminating paper transcription errors during the recap process. Nurses in-serviced by DON on the 24 hour chart check procedure. Audits will be conducted on the 24 hour chart check process to assure that errors are caught immediately. 4. 10 random resident charts will be audited daily by 11-7 nursing supervisor to ensure accuracy of all order transcription and/or entry into EMAR for 3 consecutive days or until 100% compliance is achieved. Then 10 random charts will be reviewed 3 times per week for 3 consecutive weeks or until	7/28/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 6/11/14

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

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F 309	Continued From page 1 Findings include: 1a. R3 was admitted to the facility on 3/18/14. Review of admission orders, dated 3/18/14, revealed R3 was receiving Lexapro 10 mg (milligrams) daily for depression [felling of sadness]. On 3/25/14, a physician's order was written to decrease the Lexapro to 5 mg daily for five (5) days and then discontinue. Review of the Medication Administration Record (MAR) revealed the Lexapro 5 mg was given from 3/26/14 through 3/30/14 and then noted as discontinued on the March, 2014 MAR. Review revealed that prior to implementing the April 2014 MAR, the facility failed to ensure the accuracy of the medications listed. The Lexapro 10 mg was not noted to have been discontinued and still appeared on the April, 2014 MAR as a current medication. On 4/1/14, Lexapro was signed off as having been administered despite it's being discontinued after the 3/30/14 dose. Findings were acknowledged by E2 (Director of Nursing) during an interview on 5/8/14 at approximately 11:30 AM. b. R3's admission orders, dated 3/18/14, included an order for Lasix (water pill) 20 mg (milligrams) one tablet daily as needed for leg swelling (edema). The facility's "Skin Rounds" sheet, dated 3/22/14, revealed the notation "BLE (bilateral [both sides] lower extremity [legs] edema). Review of the MAR lacked evidence that R3 was given any Lasix on 3/22/14 for the leg swelling as per	F 309	100% compliance. Then, 10 random charts will be audited once per week for 3 weeks or until 100% compliance. 10 random charts will be audited in one month. If 100%, then problem has been successfully addressed. b. 1. R3 was discharged to home with no negative outcome. 2. All residents have the potential to be affected by deficient practice. 3. Staff Developer in-serviced nurses on acute condition changes, documentation of acute condition changes, treatment of acute condition changes including the use of prn medications, and notification of MD. All skin round sheets will now be reviewed weekly in Clinical Review Meeting by DON/designee to ensure changes in resident conditions are addressed properly. 4. Unit Managers/designee will audit 10 random EMARs for appropriate use and documentation of prn medication daily for 3 days or until 100%	

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F 309	Continued From page 2 physician's orders. Findings were acknowledged by E2 during an interview on 5/8/14 at approximately 11:30 AM.	F 309	compliance. Then UM/designee will audit 10 random EMARS three times per week for 3 weeks or until 100% compliance. Then UM/designee will audit 10 random EMARs once per week for 3 weeks or until 100% compliance. Then UM/designee will audit 10 random charts in one month. If 100%, the problem has been successfully addressed.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that each resident's drug regimen was	F 329	F329 a. 1. R4 remains in facility with no negative outcome. 2. All residents have the potential to be affected by the deficient practice. 3. Paper recap process is being eliminated June 17, 2014. Facility will be converting to electronic MARs, therefore eliminating paper transcription errors during the recap process. Nurses in-serviced by DON on the 24 hour chart check procedure. Audits will be	7/28/14

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F 329	Continued From page 3 free from unnecessary drugs for two (R3 and R4) out of four sampled residents. The facility failed to ensure that there was an appropriate indication for use of an antianxiety medication (Xanax) for R3. The facility failed to ensure that R4's Vitamin D3 (supplement) was not an excessive dosage. Findings include: 1. R4 was admitted on 4/7/14 from another nursing facility. Review of interagency transfer forms, including active orders from the transferring facility, revealed R4 was to receive Vitamin D3 50,000 Units one (1) capsule once a month. Review of the facility's admission orders revealed that the Vitamin D3 order was erroneously transcribed by the nurse as Vitamin D3 50,000 units one capsule daily. A second nurse signed off that she had also reviewed the orders. The 24-hour chart check log (night shift nurse signs off that all orders written in the preceding 24 hours were reviewed for accuracy) for 4/8/14 was blank, indicating that a check of the orders was not completed. On 4/8/14, the physician signed off on the orders and failed to identify the excessive dosage of the Vitamin D. Laboratory results revealed that R4 had a Vitamin D blood level drawn on 4/9/14. The reported results stated R4's level was within normal limits. Review of the medication administration record (MAR) revealed that from 4/8/14 through 5/6/14, R4 was offered and/or received a dose of the Vitamin D3 daily. R4 did refuse to take the Vitamin D3 on nine(9) days during this time frame. Despite multiple staff administering the Vitamin D3, no one identified the excessive	F 329	conducted on the 24 hour chart check process to assure that errors are caught immediately. Staff Developer to in-service nurses on Vitamin D3 dosing and administration. 4. 10 random resident charts will be audited daily by 11-7 nursing supervisor to ensure accuracy of all order transcription and/or entry into EMAR for 3 consecutive days or until 100% compliance is achieved. Then 10 random charts will be reviewed 3 times per week for 3 consecutive weeks or until 100% compliance. Then, 10 random charts will be audited once per week for 3 weeks or until 100% compliance. 10 random charts will be audited in one month. If 100%, then problem has been successfully addressed. b. 1. R3 was discharged from facility with no negative outcome. 2. All residents have the potential to be affected by the deficient practice.	

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F 329	Continued From page 4 dosage being given. Additionally, the pharmacy provider did not question or clarify the excessive dosage of the Vitamin D3 before supplying the facility with daily doses. On 4/16/14, the consultant pharmacist, who completes a monthly review of resident's medications, sent a recommendation, "Note To Attending Physician/Prescriber," which stated that R4 was receiving Vitamin D 50,000 Units daily and to consider frequent Vitamin D levels to monitor. On 4/22/14 this recommendation was signed off by the physician and a Vitamin D blood level was ordered to be drawn. Again the physician failed to identify that R4 was receiving an excessive dose of Vitamin D. On 4/23/14, R4 had a Vitamin D blood level drawn. The results reported revealed that R4's level was at the higher end of the "sufficient range," but was approaching the "potential intoxication" range. On 5/6/14 an observation of R4's Vitamin D3 supply on the medication cart was made. Two (2) blister packs were found. One pack was from the prior facility that R4 had transferred from and was labeled "Vitamin D 50,000 Units capsule give 1 capsule orally once a month." This packet was intact and contained one (1) capsule of Vitamin D 50,000 Units. The second packet had been sent by the current facility's pharmacy and was labeled "Vitamin D 50,000 Units 1 capsule by mouth every day." Despite multiple nurses administering the medication, no one questioned the presence of the two blister packs with different instructions. Findings were acknowledged by E3 (Assistant Director of Nursing) on 5/6/14 at approximately	F 329	3. Staff Developer to in-service nurses on proper indications for use of medications per diagnosis. EMAR system will be amended to automatically highlight diagnosis for medications in bold print. 4. Unit Managers/designee will audit 10 random EMARs for appropriate use and documentation of prn medication daily for 3 days or until 100% compliance. Then UM/designee will audit 10 random EMARS three times per week for 3 weeks or until 100% compliance. Then UM/designee will audit 10 random EMARs once per week for 3 weeks or until 100% compliance. Then UM/designee will audit 10 random charts in one month. If 100%, the problem has been successfully addressed.	

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F 329	Continued From page 5 11:30 AM. On 5/6/14 an order was written to discontinue R4's Vitamin D. In an interview with E2 (Director of Nursing) on 5/8/14 at 12:00 PM, she stated that this should have been caught back when the second nurse reviewed the admission orders on 4/7/14. 2. R3 was admitted to the facility on 3/18/14. Admission orders, dated 3/18/14, included an order for R3 to receive the anti-anxiety medication Xanax every 8 hours as needed for anxiety. Review of the medication administration record (MAR) revealed that R3 was given Xanax on 3/20/14 at 12:35 AM. According to a corresponding nurse's note, this dose of Xanax was administered due to R4's complaints of inability to sleep. There was no indication for use of the Xanax, as it was ordered for anxiety, not as a sleep aide. The MAR revealed R3 received a dose of Xanax on 3/21/14 at 9:00 AM. Review of the clinical record lacked any indication for use of the Xanax on this occasion. Findings were acknowledged by E2 during an interview on 5/8/14 at 12:00 PM.	F 329		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 425		

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F 425	Continued From page 6 supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide pharmaceutical services including the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for one (R4) out of four sampled residents. Findings include: The facility pharmacy manual under section IA1: Provider Pharmacy Requirements, effective August 1, 2008 stated, "...D. The provider pharmacy agrees to perform the following pharmaceutical services, including but not limited to:..10) Screening each new medication order for...appropriate drug dose, dosing interval, and..." Cross refer to F329, example #1 R4 was admitted on 4/7/14 from another nursing facility. Review of interagency transfer forms, including active orders from the transferring	F 425	F425 1. R4 remains in the facility with no adverse effect. 2. All residents have the potential to be affected by the deficient practice. 3. New system to be implemented in pharmacy where upon receipt of a narrow therapeutic index (NTI) medication order, including but not limited to fat soluble vitamins, all drug alerts will be reviewed by pharmacist. Pharmacist will notify facility of any NTI alerts to obtain clarification order from MD. Pharmacy will not dispense medication until clarification order is received. Staff Developer to in-service nursing staff on new procedure. 4. See attached audit tool. NTI audit/log to be maintained in the pharmacy and log entries will be completed immediately upon receipt of NTI order as appropriate.	7/28/14

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F 425	Continued From page 7 facility, revealed R4 was to receive Vitamin D3 50,000 Units one (1) capsule once a month. Review of the facility's admission orders revealed that the Vitamin D3 order was erroneously transcribed by the nurse as Vitamin D3 50,000 units one capsule daily. A second nurse signed off that she had also reviewed the orders and the orders were then sent to the pharmacy. There was no evidence that the pharmacy provider questioned or attempted to clarify the excessive dosage of the Vitamin D3 before supplying the facility with a daily dose. During an interview with E4 (Consultant Pharmacist) on 5/6/14 at 12:55 PM, she stated that she would have expected that the pharmacy would have questioned this dose before delivering the medication. Findings were acknowledged by E3 (Assistant Director of Nursing) on 5/6/14 at approximately 11:30 AM.	F 425		

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 Silverside

DATE SURVEY COMPLETED: May 8, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from May 2, 2014 through May 8, 2014. The facility census the first day of the survey was 103. The survey sample totaled four (4) residents (two active and two closed). The survey process involved observations, record reviews, interviews, and review of other documentation as indicated.	
3201	**Regulations for Skilled and Intermediate Care Facilities**	
3201.1.0	**Scope**	
3201.1.2	**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**	Cross refer to Plan of Correction CMS-2567 survey ending 5/8/14, F309, F329, F425. 7/28/14

Provider's Signature [signature] Title NHA Date 6/11/14

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	reference. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L report exit date 5/8/14, F309, F329 and F425.	

Provider's Signature [signature] Title NHA Date 6/11/14