

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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
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NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION SILVERSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 3322 SILVERSIDE ROAD WILMINGTON, DE 19810
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from January 21, 2015 through January 29, 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 106. The Stage 2 survey sample size was 31.</p> <p>Abbreviations used in this report are as follows:</p> <p>NHA - Nursing Home Administrator; DON- Director of Nursing; ADON- Assistant Director of Nursing; RN - Registered Nurse; LPN- Licensed Practical Nurse; CNA - Certified Nurse's Aide; MDS - Minimum Data Set-standardized assessment form used in nursing homes; CAA- Care Area Assessment; RNAC - Registered Nurse Assessment Coordinator; FSD - Food Service Director; RD - Registered Dietician; MRR - Medication Regimen Review; FCS - Delaware Monthly Functional Care Summary - form required by Medicaid; NN- Nurse's Notes; ADL's -Activities of Daily Living - activity needed for daily living such as dressing, hygiene, eating, toileting and bathing; BP-Blood Pressure - the measure of force of the blood against the walls of a blood vessel; ml(s) - A measure of volume in the metric system. One thousand mls equal one liter. Also called milliliter;</p>	F 000		

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

TITLE

(X6) DATE

[Handwritten Signature]

NHA

2/19/15

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 000	Continued From page 1 SSD-Social Service Director; cognitive-thinking, perception; UM-Unit Manager; Incontinence - loss of control of bladder &/or bowel function; Urinary continence - Is the ability to prevent accidental leakage of urine from your bladder; Voiding Diary - a record of voiding (urinating) and leakage (incontinence) time of urine for 72 hours and/or 3 days; Urinary Continence coding - 1 (occasionally incontinent or less than 7 episodes of incontinence); Urinary Continence coding 2 (frequently incontinent/7 or more episodes of incontinence, but at least 1 episode of continent voiding); Urinary Continence coding 3 (always incontinent no episodes of continent voiding); UTI - Urinary Tract Infection-an infection anywhere in the urinary tract; UA - Urine Analysis - diagnostic test used to determine presence of infection; C&S -Culture and Sensitivity - a microscopic study of the urine culture performed to determine the presence of bacteria.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to maintain or	F 241	1. No resident was adversely affected. 2. All residents have the potential to be affected by the deficient practice. 3. Social worker/designee will re-educate staff on residents' rights to privacy including knocking, announcing oneself, and waiting for permission to enter before entering residents' room or bathroom. Continued on next page	3/23/15

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F 241	Continued From page 2 enhance one resident (R221) out of 31 Stage 2 sampled residents' dignity and respect in full recognition of his or her individuality. Findings include: During the medication pass observation on 1/21/16 at 8:45 AM, E10 (LPN) had finished administering medications and then opened the resident's shared bathroom and stated, "Oh" and immediately shut the door. When asked what happened, E10 stated that there was a resident (R221) and an aide in the bathroom. Immediately following this observation, findings were confirmed. E10 stated that she was supposed to knock first and then ask permission before entering the bathroom.	F 241	Cont'd 4. Social services to do 3 random observations and 3 resident interviews (attachment A) daily to assess compliance with residents' rights to privacy until 100% compliance. Social Services to then do 3 random observations and 3 resident interviews 3 times per week until 100% compliance is reached. Social Services to then do weekly observations and interviews, 3 each, for one month or until 100% compliance is reached. Social Services to observe and interview, 3 each, one month later to ensure problem has been resolved.	
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 \$1,000 for each assessment; or an individual who	F 278	1. R91 was not adversely affected. 2. All residents have the potential to be affected by the deficient practice. 3. RNAC to bring copy of section H of MDSs completed that day to afternoon Wrap-Up Meeting along with supporting documentation to include but not limited to voiding diary, toileting plan, CNA flow sheets and quarterly bowel and bladder assessment that was used to code Section H. Interdisciplinary Team (IDT) will review to ensure MDS is coded accurately prior to submission of MDS. 4. RNAC #2 to audit (attachment B) Section H and supportive documentation daily until 100% compliance is reached over 3 consecutive evaluation. Then, RNAC #2 will monitor sample 3 times per week until 100% compliance is reached at 3 consecutive evaluations. Then, RNAC #2 will monitor once per week until 100% compliance is reached over 3 consecutive evaluations. Finally, will monitor once in one month to ensure 100% compliance.	3/23/15

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F 278	<p>Continued From page 3</p> <p>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 interview, it was determined that for two (R9 and R91) residents reviewed out of 31 Stage 2 sampled residents the assessment completed by facility staff failed to accurately reflect R9 and R91's bladder function status. Findings include:</p> <p>Cross refer to F315, example 1. 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."</p> <p>1. The quarterly MDS assessment, dated 11/11/14, stated R91 cognition was moderately impaired, required two staff members and physical assist and was totally dependent on staff members for transfer and toilet use. The same MDS stated R91 was (2) frequently incontinent and was not on a toileting program, during the seven (7) day review time period (11/5/14 through 11/11/14).</p> <p>Review of the "CNA flowsheet" for the month of November revealed that R91 had 6 episodes of urinary incontinence and at least one episode of</p>	F 278	<ol style="list-style-type: none"> R9 was not adversely affected. All residents have the potential to be affected by the deficient practice. RNAC to bring copy of section H of MDSs completed that day to afternoon Wrap-Up Meeting along with supporting documentation to include but not limited to voiding diary, toileting plan, CNA flow sheets and quarterly bowel and bladder assessment that was used to code Section H. Interdisciplinary Team (IDT) will review to ensure MDS is coded accurately prior to submission of MDS. RNAC #2 to audit (attachment B) Section H and supportive documentation daily until 100% compliance is reached over 3 consecutive evaluations. Then, RNAC #2 will monitor sample 3 times per week until 100% compliance is reached at 3 consecutive evaluations. Then, RNAC #2 will monitor once per week until 100% compliance is reached over 3 consecutive evaluations. Finally, will monitor once in one month to ensure 100% compliance. 	3/23/15

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F 278	<p>Continued From page 4</p> <p>continent voiding during the seven (7) day review time period (11/5/14 through 11/1/14).</p> <p>On 1/28/15 at 3:51 PM, E3 (Corporate RN) confirmed R91 should have actually been coded as a (1)occasionally incontinent and not a (2). E3 confirmed that the quarterly MDS, dated 11/11/14, was miscoded.</p> <p>Cross refer to F315, example 2.</p> <p>2. The admisson MDS assessment, dated 8/13/14, stated R9 was occasionally Incontinent during the 7-day review period (8/7/13 through 8/13/14).</p> <p>Review of R9's clinical record during the 7-day review period for the 8/13/14 admission MDS assessment revealed the following:</p> <ul style="list-style-type: none"> - The three-day voiding diary listed R9 as incontinent four (4) times, specifically at 10:00 AM on 8/7/14, 8:00 AM on 8/8/14, 2:00 PM on 8/8/14 and 9:00 AM on 8/9/14; - The CNA Flow Sheet listed R9 as incontinent three (3) times, specifically twice on day shift on 8/7/14 and once on evening shift on 8/12/14; - The Scheduled Toileting Flowsheet listed R9 as incontinent three (3) times, specifically before bed on 8/11/14, upon awaking on 8/12/14 and upon awaking on 8/13/14. <p>Since R9 was incontinent ten times, the 8/13/14 admission MDS was incorrectly coded as occasionally incontinent when it actually should have been coded as frequently incontinent.</p>	F 278		

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<p>F 278</p> <p>F 279 SS=D</p>	<p>Continued From page 5</p> <p>Findings were reviewed with E1 (NHA) and E3 on 1/28/15 at approximately 1:00 PM.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that an individualized care plan was developed for an identified need for one (R91) out of 31 Stage 2 sampled residents. For R91, the facility failed to develop a UTI care plan. Findings include:</p> <p>Cross refer to F315, example 1. R91's admission MDS assessment, dated</p>	<p>F 278</p> <p>F 279</p>	<p>1. R91's care plan was initiated.</p> <p>2. All residents with UTI have the potential to be affected by deficient practice.</p> <p>3. RNAC, unit managers, and supervisors were educated on the need to care plan all residents with the diagnoses of UTI.</p> <p>4. Unit Managers will audit (attachment C) care plans for UTI diagnoses daily until 100% compliance is reached over three consecutive evaluations. Then three times a week for three evaluations until 100% compliance reached. Then audit once a week for three weeks until 100% compliance. Finally will audit one month later to ensure 100% compliance maintained and then deficient practice is resolved.</p>	<p>3/23/15</p>

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F 279	Continued From page 6 8/11/14, stated that the resident was able to make daily decisions, required extensive assist of one staff member for transfer and toilet use, and was always continent. The care area assessment (CAA), signed by E4 (RNAC) indicated urinary incontinence triggered for review. Review of the clinical record revealed that a report from the Emergency Room dated 9/8/14, noted R91 was diagnosed with hemorrhagic (heavy bleeding) UTI and returned to the facility on 9/8/14 with a prescription for an antibiotic, Macrobid twice a day for (7) seven days. On 9/11/14, R91's antibiotic was changed to Bactrim, for (7) days for the diagnosis of UTI. However, record review revealed there was no care plan developed for R91's UTI until 11/12/14, several months later.	F 279		
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	F 280	1. R9's care plan was initiated. 2. All residents with changes in continence have the potential to be affected by deficient practice. 3. RNAC, unit managers, and supervisors were educated on the need to revise care plans for all residents with changes in continence status. 4. Unit Managers will audit (attachment D) care plans for all residents with changes in continence status daily until 100% compliance is reached over three consecutive evaluations. Then three times a week for three evaluations until 100% compliance reached. Then audit once a week for three weeks until 100% compliance. Finally will audit one month later to ensure 100% compliance maintained and then deficient practice is resolved.	3/23/15

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F 280	Continued From page 7 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: Based on record review and interview, it was determined that for one (R9) out of 31 Stage 2 sampled residents the facility failed to review and revise the urinary incontinence care plan for R9. Findings include: Cross refer to F315, example 2. The admission MDS assessment, dated 8/13/14, stated that R9 was occasionally incontinent. R9's care plan, dated 8/20/14, stated, "Resident on a scheduled toileting plan R/T (related to) hx (history) of urinary incontinence, present occ (occasional) urinary incontinence ...". The quarterly MDS assessment, dated 11/13/14, stated that R9 was frequently incontinent. R9's urinary incontinence care plan remained the same despite the change in incontinence. Findings were confirmed with E5 (RN, UM) on 1/28/15 at 10:45 AM. The facility failed to review and revise R9's urinary incontinence care plan.	F 280		
F 315	483.25(d) NO CATHETER, PREVENT UTI, SS=C RESTORE BLADDER	F 315		

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F 315	<p>Continued From page 8</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, interviews and review of facility documentation, it was determined that the facility failed to ensure that 2 (R9, R91) residents out of 31 stage 2 sampled residents, who were incontinent of bladder, received the appropriate treatment and services to restore as much bladder function as possible. The facility failed to assess R91's urinary status twice upon readmission, failed to develop a care plan and failed to identify potential causes for a UTI after R91's hospitalization, failed to implement a 3 day voiding diary when there was a decline in R91's urinary status, failed to comprehensively assess R91's bladder incontinence after the FCS dated 10/3/14 to 11/3/14 and the 11/11/14 quarterly MDS revealed a decline in bladder function, and failed to identify that R91's bladder function was not recorded by the CNA's from 12/13/14 to 12/17/14. For R9, the facility failed to comprehensively assess upon admission on 8/6/14 and after the 11/13/14 quarterly MDS, which indicated an increase in R9's urinary incontinence. In addition, the facility failed to identify, reassess and respond to R9's</p>	F 315	<p>1. Voiding diary initiated for R91 and completed and individualized toileting plan initiated.</p> <p>2. All residents have the potential to be affected by the deficient practice. All admissions and readmissions will have a three day voiding diary initiated. The three day voiding diary is then evaluated for the need for individualized toileting plan for the resident. All residents' continence status is assessed quarterly and with a significant change in condition. Residents who are noted with a decline in their urinary continence status will have a three day toileting diary initiated. The three day diary is then assessed for the need of an individualized toileting plan.</p> <p>3. Staff failed to implement an individualized toileting plan for this resident who was experiencing episodes of urinary incontinence as evidenced by the CNA flow record. All new admissions and readmissions will have a three day voiding diary initiated. The voiding diary will then be assessed by the Unit manager or designee and then will have an individualized toileting plan initiated if warranted. All residents will be assessed quarterly and with a significant change in condition for a change in urinary incontinence. RNAC will provide the IDT with residents who have triggered for a continence decline daily in afternoon wrap up meeting. A new voiding diary will be initiated for any residents that triggered for a decline in continence. A new voiding diary will be initiated if the original voiding diary was not completed in its entirety. After completion of voiding diary an individualized toileting plan will be initiated if warranted.</p> <p>Continued next page</p>	3/23/15

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F 315	<p>Continued From page 9</p> <p>Increase in urinary incontinence for approximately five (5) months (September 2014 through January 26, 2015). Findings Include:</p> <p>The facility's policy entitled "Incontinence (Treatment)", dated 7/12/13, stated, "Purpose: A resident who is incontinent of bladder will receive appropriate treatment and services to prevent urinary tract infection and to restore/improve normal bladder function as possible. Appropriate treatment begins with assessment ... Following the assessment, individualized goals will be developed and implemented ... The first step is to identify residents already experiencing some level of incontinence ... Every resident will be assessed for incontinence on admission, or re-admission, quarterly and with significant change ... 1... Identify those residents who are incontinent, or have experienced a decline in continence ... 2. On admission, all residents who code as 1, 2, or 3 should have a voiding diary completed. The diary need only be completed with new incontinence or changes in incontinence patterns (decline) ... 3. Complete the diary for three days (72 hours), evaluation (sic.) the resident every 2 hours ... 4. After 72 hours, review the Voiding Diary to determine if there is a voiding pattern. When evaluating the Voiding Diary, assess cognitive status and toilet use to determine appropriate plan of care (i.e. toileting plan). Complete the Incontinence Assessment. 5. If a toileting plan is developed, monitor the planned toileting times and its results. Modify the schedule as needed ... 9. On a quarterly basis utilize the Quarterly Continence Assessment to determine the appropriate plan of care. Update the care plan and the Toileting Program flow sheets as needed. Review with CNAs and follow through as needed."</p>	F 315	<p>3. Cont'd</p> <p>DON/designee will educate on the following:</p> <ul style="list-style-type: none"> -(nursing staff) The relevance and the importance of accuracy and completeness of this documentation. -(nursing staff) Second checks of voiding diaries to ensure completeness. -(Licensed nursing staff) the implementation of three day voiding diaries on admission, readmission and with any significant changes in urinary incontinence. -(Licensed nursing staff) Assessment of the voiding diaries, and the development and initiation of the residents toileting plan as needed based on the voiding diary assessment. <p>4. The goal of system change is to ensure all residents receive the appropriate services to restore/maintain as much normal bladder function as possible (attachment E). All admissions and re-admissions will be reviewed for the implementation of voiding diary and for the implementation of an appropriate individualized toileting plan. All residents will assess quarterly and with a significant change for incontinence changes. This will be assessed for accuracy by DON or designee, utilizing attachment for the identified deficient practice. This will be completed daily until the facility consistently maintains a 100% success rate over three consecutive evaluations. Then three times a week for three weeks until the facility maintains a 100% success rate over three consecutive evaluations. Then once a week until 100% success is reached over three consecutive evaluations. Then in a month to ensure 100% compliance is maintained.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION SILVERSIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 3322 SILVERSIDE ROAD WILMINGTON, DE 19810	
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F 315	Continued From page 10 The facility's policy entitled "Bowel and Bladder Assessment", last revised 6/26/13, stated, "On admission, after the three (3) day voiding diary, quarterly and with changes in bladder ..., the Bowel and Bladder Assessment will be completed. A review of the assessment will be conducted and if indicated a three day voiding ... diary will be completed or a toileting program will be put into place. Procedure: 1. The CNA/designee is to complete the voiding ... diary. 2. At the end of this three day period the DON/designee will complete the nursing evaluation. 3. The care plan/toileting plan will be updated accordingly." Cross refer to F327. 1. R91 was admitted to the facility on 8/4/14 with diagnoses that included schizoaffective disorder (a condition in which a person experiences a combination of schizophrenia symptoms - such as hallucinations or delusions - and mood disorder symptoms, such as mania or depression). Document review revealed the following: - Interagency Nursing Communication Record completed by the hospital and dated 8/4/14 - continent of bladder. - Bowel and Bladder Assessment dated 8/4/14 - always continent of urine. - FCS dated 8/4/14 to 9/4/14 - actively participates in toileting and did not identify incontinence as an issue. - Admission MDS assessment dated 8/11/14 - always continent. Review of the clinical record for August and September 2014 revealed the following nurse's notes, laboratory findings and other documents: - 8/16/14 at 11:09 AM "Resident c/o (complaint of	F 315	1. Voiding diary initiated for R9 and completed and individualized toileting plan initiated. 2. All residents have the potential to be affected by the deficient practice. All admissions and readmissions will have a three day voiding diary initiated. The three day voiding diary is then evaluated for the need for individualized toileting plan for the resident. All residents' continence status is assessed quarterly and with a significant change in condition. Residents who are noted with a decline in their urinary continence status will have a three day toileting diary initiated. The three day diary is then assessed for the need of an individualized toileting plan. 3. Staff failed to implement an individualized toileting plan for this resident who was experiencing episodes of urinary incontinence as evidenced by the CNA flow record. All new admissions and readmissions will have a three day voiding diary initiated. The voiding diary will then be assessed by the Unit manager or designee and then will have an individualized toileting plan initiated if warranted. All residents will be assessed quarterly and with a significant change in condition for a change in urinary incontinence. RNAC will provide the IDT with residents who have triggered for a continence decline daily in afternoon wrap up meeting. A new voiding diary will be initiated for any residents that triggered for a decline in continence. Continued next page	3/23/15

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F 315	Continued From page 11) painful urination. New order (n/o) to collect urine for UA CS. No temp (temperature) noted...." - 8/17/14 UA and C&S which resulted in no growth and no new orders. - 9/3/14 at 7:45 AM " ...complained of having frequent and painful urination..." - 9/3/14 UA and C&S which resulted in no growth and no new orders. - 9/7/14 at 5:24 PM "This nurse was made aware that resident has change in MS (mental status) as known to her regular CNA. Resident's urine had a strong odor, c/o dysuria (difficult or painful urination) ...Urine noted to be dark brown in color and thick, noted with Hematuria (blood in the urine)..." -9/8/14 at 6:21 AM "resident awake all night, very lethargic and tearful, resident urinating frank red blood, change mental status..." The same day urine C&S revealed a positive UTI and R01 was sent to the hospital. - 9/8/14 the report from the Emergency Room (ER) noted that the chief complaint was urinating blood for 18 hours prior to admission and the patient stated that she felt as though she had less control over her bladder and felt as though she had to "pee" more often. The hospital diagnosed her with a hemorrhagic urinary tract infection and prescribed an antibiotic, Macrobid twice a day for (7) seven days. - 9/8/14 at 1:43 PM "Resident back from ER, @ (at) 1200 PM via a w/c (wheelchair) with 1 person assist ..." - 9/10/14 at 2:41 PM "Urine culture and sensitivity results called to Dr (doctor).... and orders received and processed to change abx." - 9/11/14, R01 was prescribed a different antibiotic, Bactrim, for (7) days for diagnosis of UTI.	F 315	#3 Cont'd 3. A new voiding diary will be initiated for any residents that triggered for a decline in continence. A new voiding diary will be initiated if the original voiding diary was not completed in its entirety. After completion of voiding diary an individualized toileting plan will be initiated if warranted. DON/designee will educate on the following: -(nursing staff) The relevance and the importance of accuracy and completeness of this documentation. - (nursing staff) Second checks of voiding diaries to ensure completeness. - (Licensed nursing staff) the implementation of three day voiding diaries on admission, readmission and with any significant changes in urinary incontinence. -(Licensed nursing staff) Assessment of the voiding diaries, and the development and initiation of the residents toileting plan as needed based on the voiding diary assessment. 4.The goal of system change is to ensure all residents receive the appropriate services to restore/maintain as much normal bladder function as possible. All admissions and re-admissions will be reviewed for the implementation of voiding diary and for the implementation of an appropriate individualized toileting plan. All residents will assess quarterly and with a significant change for incontinence changes. Continued on next page		

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F 315	Continued From page 12 There was lack of evidence in the clinical record that upon readmission a bowel/bladder assessment was done and care plan was implemented for R91's UTI. Review of the clinical record for October 2014 revealed the following nurse's notes, laboratory findings and other documents: - FCS dated 10/3/14 to 11/3/14 - now incontinent daily yet the record lacked evidence that interventions were put into place to restore R91's bladder function. - 10/4/14 at 3:47 PM "Resident with c/o urinary discomfort and frequency, but does not wish to be straight cath (a flexible tube inserted to allow the passage of drainage of urine from the bladder)...NP (Nurse Practitioner) ...made aware, new order to obtain u/a c&s, may straight cath if resident allow or clean catch ..." - 10/6/14 UA and C&S which resulted in no growth and no new orders. - 10/18/14 at 5:15 AM "Resident c/o needing to urinate but unable to..." - 10/20/14 at 9:41 AM "Resident has been c/o having to urinate, however she is unable. n/o UA C/S may straight cath." - 10/21/14 at 6:27 AM "Resident refused to be straight cath, ..." - 10/21/14 at 1:36 PM "Resident refused to be straight cath to collect urine specimen for UA C&S. Unable to collect a clean catch specimen because urine was contaminated with stool." - 10/22/14 at 2:11 PM "Resident has been refusing to be straight cathed for urine specimen and cognitively cannot do a clean catch. Resident is voiding without problems, physician aware. N/O to d/c (discontinue) UA C/S". - 10/22/14 UA and C&S which resulted in no growth and no new orders.	F 315	#4 Cont'd This will be assessed for accuracy by DON or designee, utilizing attachment----- ----- for the identified deficient practice. This will be completed daily until the facility consistently maintains a 100% success rate over three consecutive evaluations. Then three times a week for three weeks until the facility maintains a 100% success rate over three consecutive evaluations. Then once a week until 100% success is reached over three consecutive evaluations. Then in a month to ensure 100% compliance is maintained.	

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F 315	Continued From page 13 - 10/24/14 UA and C&S which resulted in no growth and no new orders. Review of the clinical record for November 2014 revealed the following nurse's notes, laboratory findings and other documents: - R91 had increased behaviors where she refused care and had lodged false allegations toward staff. - 11/11/14 UA and C&S resulted in a new order for an antibiotic, Macrobid, twice a day for (7) days for diagnosis of UTI. - 11/11/14 quarterly MDS assessment stated R91's cognition was moderately impaired. The same MDS stated R91 was now coded as a (2) frequently incontinent and was not on a toileting program, during the seven (7) day review time period (11/5/14 through 11/11/14). - 11/11/14 Bowel and Bladder Assessment noted that the resident was confused, able to make self understood, occasionally incontinent and listed dribbles as a voiding symptom/problem. -11/13/14 at 1:53 PM, "Quarterly MDS ... done, indicates possible Significant [SIG] Change/decline. However, resident has had increased accusatory behaviors over the past week which has resulted in the need for two staff members to be present for all conversation and care. Resident also with a positive UTI. Present decline in ADL's is considered to be self limiting as part of behavioral management and also related to UTI. No Sig Change will be done at this time. Behavioral care plans adjusted as needed." - 11/13/14 care plan for "Urinary Incontinence r/t (related to) Impaired mood/behaviors and Impaired mobility" was developed. The goal target date of this care plan was 2/13/2015 and it stated, "resident will be clean, dry ...r/t	F 315			

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F 315	<p>Continued From page 14</p> <p>Incontinence X 90days. Approaches Included: "bowel and bladder on admission, quarterly, and PRN (as needed); toileting schedule as per diary results. Adjust as needed and monitor effectiveness. Voiding diary on admission to assess bladder/bowel patterns."</p> <p>The clinical record lacked evidence that a 3 day voiding diary was completed and analyzed in order to establish a toileting schedule. There was no evidence that the facility developed an individualized toileting schedule since R91 lacked a voiding diary or assessed toileting needs for managing incontinence.</p> <p>-11/26/14 at 6:37 PM "Notified by nurse that resident appeared weak ... T (temperature) 101.8. Gave PRN (as needed) Tylenol (medication for fevers) ..."</p> <p>-11/26/14 at 10:07 PM "Resident still appears weak. Cannot maintain upright position in wheelchair ... Upon start of shift patient had 101.1 fever and was given ... Tylenol ... fever resolved ..."</p> <p>- 11/28/14 at 6:31 AM "Hydration encouraged ..."</p> <p>- 11/29/14 UA and C&S which resulted in a new order for an antibiotic, Bactrim, twice a day for (7) days for diagnosis of UTI.</p> <p>Review of the clinical record for December 2014 and January 2015 revealed the following nurse's notes, laboratory findings and other documents: - 12/10/14 R91 was transferred to the hospital with a hospital documented diagnoses of dehydration (a condition in which the body has less than normal fluid) and hypernatremia (excessive amounts of sodium in the blood). On 12/13/14, R91 was readmitted back into the facility.</p> <p>There was lack of evidence in the clinical record that upon readmission a bowel/bladder</p>	F 315			

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F 315	<p>Continued From page 15 assessment was done as per facility protocol for R91.</p> <ul style="list-style-type: none"> - 12/10/14 physician's progress note stated, hyponatremia was resolved on 12/12 and that the facility did not agree with the diagnoses of dehydration, since the lab values did not support it. - 12/18/14 UA and C&S which resulted in no growth and no new orders. - 12/31/14 at 2:55 PM "Resident has requested to urinate multiple times this shift without any urine..." - 1/5/15 UA and C&S which resulted in a new order for an antibiotic, Doxycycline Monohydrate, twice a day for (7) days for diagnosis of UTI. <p>Review of the "CNA Flowsheet", completed by CNAs that capture if the resident is continent or incontinent of bladder, for August 2014 through January 2015 revealed the following:</p> <ul style="list-style-type: none"> - 8/4/14 through 8/31/14 consisted of a total of 84 shifts (3 shifts per day) during which R91 had no episodes of incontinence (0%). - 9/1/14 through 9/30/14 consisted of a total of 90 shifts during which R91 was incontinent on 5 out of the 90 shifts (6%). - 10/1/14 through 10/31/14 consisted of a total of 93 shifts during which R91 was incontinent on 25 out of the 93 shifts (27%). - 11/1/14 through 11/30/14 consisted of a total of 90 shifts during which R91 was incontinent on 29 out of the 90 shifts (32%). - 12/1/14 through 12/31/14 consisted of a total of 84 shifts during which R91 was incontinent on 23 out of the 84 shifts (27%). In the month of December, R91 was hospitalized from 12/10/14 to 12/13/14. In addition, there was no record of R91's bladder function from 12/13/14 through 12/17/14. 	F 315			

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F 315	<p>Continued From page 16</p> <p>- 1/1/15 through 1/27/15 consisted of a total of 78 shifts during which R91 was Incontinent on 26 out of the 78 shifts (33%). Inclusive on January 1st, during the day shift (7 AM - 3 PM), R91 had 10 episodes of incontinence.</p> <p>The following information was gathered during Interviews with employees of the facility:</p> <p>- 1/28/15 at 9:18 AM E20 (CNA) stated that it was facility practice for the CNA to write the number of times that the person was continent or incontinent during the shift. E20 stated that if any resident was on a voiding diary, the medication RN would tell you in the morning because her paper would have it. E20 also stated that they would not document this in their monthly CNA flowsheet, voiding diaries are kept on a separate clipboard at the nurse's station. There was no clipboard at the nurses station because no residents are on a voiding diary.</p> <p>- 1/28/15 at 10:05 AM E21 (CNA) stated that, as R91's usual aide since September of 2014, R91 likes to be very independent. E21 stated that she could not recall R91 ever being on a voiding diary. When asked if R91 was more continent or incontinent since her admission, E21 stated that she was more incontinent.</p> <p>- 1/28/15 at approximately 10:45 AM, E5 (UM) stated the RNAC is the person responsible for implementing and revising the care plan if they see a decline in the MDS. E5, stated that the UM is responsible to implement a care plan if the UM gets the "MDS Decline Notification Form", which is usually sent via e-mail. E5 would then sign the form and send it back to the RNAC. With regards to the Urinary Incontinence care plan, dated 11/13/14 by the RNAC, E5 stated she could not</p>	F 315		

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F 315	<p>Continued From page 17</p> <p>recall getting an e-mail about this new care plan. When asked if she recalled R91 having a voiding diary, E5 stated she thought R91 had them because they are supposed to be done upon admission and re-admission. E5 was unable to provide the surveyor documentation of any voiding diaries for R91 since admission.</p> <p>- 1/28/15 at 10:54 AM E4 (RNAC) stated in order to determine the coding for the Bladder and Bowel section of the MDS, she would use tools such as the voiding diaries and the toileting schedules. When asked what she would use if these tools were not present, E4 stated she would use the CNA documentation flowsheets. E4 stated that she would not implement a care plan for urinary continence, she would use the MDS Decline Notification sheet to communicate to the UM to do a care plan. E4 stated she did not keep copies of those sheets, the DON would have a copy of them. E4 was shown the Urinary Incontinence care plan, dated 11/13/14 that had her signature as implementing it. E4 then stated she could not say either way whether she did or did not communicate to the UM this particular care plan. With regards to the FCS, E4 stated, "It is just a paper we fill out for Medicaid. It is a form that we have to fill out for Medicaid." R91 went from just being toileted for the period 9/4/14 to 10/3/14 to toileting and incontinence in the 10/3/14 to 11/3/14 time frame. When asked if the information between two months are compared to see a resident's status, E4 stated, "No." When asked if the information gathered on this paper is shared, E4 stated, "No."</p> <p>- 1/28/15 at 3:51 PM E3 (Corporate RN) stated that during the seven (7) day review time period (11/5/14 through 11/11/14) for the 11/11/14</p>	F 315		

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F 316	<p>Continued From page 18</p> <p>quarterly MDS, they identified a miscoding and R91 should have actually been coded as a (1) occasionally Incontinent and not a (2) frequently Incontinent.</p> <p>- 1/29/15 at 9:38 AM E23 (SSD) stated that NP1, the psych NP that assessed R91 on 11/11/14 would not do anything because the results of the UA were pending. Once the results indicated that the UA was positive, the NP would not treat the patient since the behaviors were attributed to her infection and therefore did not admit her to the Psych Unit. E23 stated this was verbally communicated to her via E24, the clinical liaison.</p> <p>- 1/29/15 at 11:20 AM E8 (LPN) who has worked at the facility since their opening, stated that the Bowel/Bladder assessments are done on new admissions and readmissions. E8 stated that in order to do an assessment she would listen to the resident's bowel sounds; look at the fluid intake captured in the MAR and meal Intake book; look at the resident's meds to see if they are ordered any diuretics and pain meds; talk to the CNAs that have the resident; talk to the resident; encourage fluids and monitor fluids for 24 hours; and check the voiding diary that is initiated by the UM. With regards to R91 who was positive for a UTI and was on antibiotic therapy, E8, stated she would have started a voiding diary.</p> <p>Findings were reviewed with E1 (NHA) and E3 (Corporate RN) on 1/28/15 at approximately 1:00 PM.</p> <p>Review of supplemental information provided by the facility on 2/4/15, indicated that R91 was admitted on Zyprexa (medication used to treat a mental disorder) and Simvastatin (medication</p>	F 315			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
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NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION SILVERSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 3322 SILVERSIDE ROAD WILMINGTON, DE 19810
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F 315	<p>Continued From page 19</p> <p>used to treat high cholesterol) which can cause urinary incontinence. Although there was a care plan for her schzoaffective disorder to report any adverse side effects to the primary doctor and psychiatry, there was lack of evidence in the clinical record that the incontinence was communicated since her Zyprexa was increased in the month of November. There was also a lack of evidence in the clinical record that R91's high cholesterol care plan listed urinary incontinence as a potential side effect or to report any side effects with regards to the medication. Also, despite a decrease in both Zyprexa and Simvastatin in the month of December, her episodes of urinary incontinence increased in January.</p> <p>The facility twice failed to assess R91's urinary status upon readmission; failed to develop a care plan and failed to identify potential causes for a UTI after R91 was hospitalized; failed to implement a 3 day voiding diary when there was a decline in R91's urinary status; failed to comprehensively assess R91's bladder incontinence after several documents revealed a decline in bladder function and failed to identify that R91's bladder function was not recorded by CNAs for four days in the month of December.</p> <p>2. R9 was admitted to the facility on 8/6/14 with diagnoses that included Parkinson's disease (progressive disorder of the nervous system that affects body movement).</p> <p>An admission Bowel and Bladder Assessment, dated 8/6/14, stated that R9 was alert and oriented; required assistance for mobility; and was always incontinent of urine. The facility identified the type of R9's incontinence as a</p>	F 315		

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F 315	<p>Continued From page 20</p> <p>functional type, that is, the inability to toilet in time. Additionally, another identified contributing factor to her incontinence was the use of narcotic analgesics (pain medication).</p> <p>On 8/7/14, the facility initiated a three-day (72 hours) voiding diary to determine R9's voiding pattern. However, review of the 3-day voiding diary revealed that the facility failed to complete it as there were 19 missing hours from 8/7/14 through 8/9/14.</p> <p>On 8/11/14, E5 (RN) initiated a toileting program for R9 based on an incomplete and/or inaccurate voiding pattern assessment.</p> <p>R9's toileting program was scheduled as follows: toilet upon rising, after breakfast, after lunch, before dinner, after dinner and before bed.</p> <p>The admission MDS assessment, dated 8/13/14, stated R9 was cognitively intact (able to make daily decisions), however, she required extensive assist of one staff for transfers and toilet use. The same MDS identified R9 as occasionally incontinent of bladder, which did not reflect the admission bladder assessment, dated 8/8/14, as "always incontinent".</p> <p>Review of R9's 3-day voiding diary, the CNA Flow Sheet and the Scheduled Toileting Flowsheet during the 7-day assessment review period revealed that R9 was incontinent of urine ten (10) times, thereby, the 8/13/14 admission MDS was incorrectly coded as occasionally incontinent when it actually should have been coded as frequently incontinent.</p> <p>On 8/20/14, the facility initiated R9's care plan as</p>	F 315		

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F 315	<p>Continued From page 21</p> <p>"Resident on a scheduled toileting plan R/T (related to) hx (history) of urinary incontinence, present occ (occasional) urinary incontinence ...". The care plan approaches included: ... Complete a bladder record for 3 days upon admission and prn (as needed) any changes in bladder continence, evaluate and develop or revise toileting program as needed ... Toilet as scheduled per toileting program".</p> <p>There was no record of a repeat voiding diary done to re-assess R9's voiding pattern in accordance with this care plan.</p> <p>Review of R9's Scheduled Toileting Flowsheets and the CNA Flowsheets revealed the following:</p> <p>8/11/14 - 8/31/14 (7 AM - 11 PM) - Incontinent of urine 30 times out of 123 opportunities or 24%; (11 PM - 7 AM) - continent 100%.</p> <p>9/14 (7 AM - 11 PM) - Incontinent of urine 58 times out of 180 opportunities or 32%; (11 PM - 7 AM) - Incontinent 23 times out of 30 opportunities or 77%.</p> <p>10/14 (7 AM - 11 PM) - Incontinent of urine 42 times out of 186 opportunities or 23%; (11 PM - 7 AM) - Incontinent 29 times out of 31 opportunities or 94%.</p> <p>11/14 (7 AM - 11 PM) - Incontinent of urine 57 times out of 180 opportunities (32%); (11 PM - 7 AM) - incontinent 100%.</p> <p>Additionally, on 11/1/14 R9 was diagnosed with mild Congestive Heart Failure (CHF/heart unable to pump enough blood to meet the body's needs).</p>	F 315		

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F 315	<p>Continued From page 22</p> <p>On 11/3/14 and 11/4/14, R9 was prescribed 2 doses of Lasix (water pill) which may contribute to frequent urination, for the treatment of CHF.</p> <p>A quarterly Bowel and Bladder Assessment, dated 11/13/14, stated that R9 was aware of bladder urges and requested toileting; required assistance for mobility; and was occasionally Incontinent of urine. The assessment was Incomplete as It failed to identify predisposing diagnoses, voiding symptoms/problems and contributing factors and medications.</p> <p>The quarterly MDS assessment, dated 11/13/14, stated R9 was cognitively intact and required extensive assist of one staff for transfers and toilet use. The same MDS stated that R9 was frequently Incontinent. The two assessments, both dated 11/13/14, contradicted each other as the Bowel and Bladder Assessment stated R9 was occasionally Incontinent while the MDS assessment stated she was frequently Incontinent.</p> <p>12/14 (7 AM - 11 PM) - Incontinent of urine 59 out of 186 opportunities or 32%; (11 PM - 7 AM) - Incontinent 29 out of 31 opportunities or 94%.</p> <p>1/1/15 - 1/26/15 (7 AM - 11 PM) - Incontinent of urine 51 out of 156 opportunities or 33%; (11 PM - 7 AM) - Incontinent 100%.</p> <p>In an interview on 1/28/15 at 9:19 AM, E9 (CNA) stated that R9 was on a toileting program and she was usually Incontinent of urine upon rising in the morning. E9 stated that R9 does not recognize "the urgency" to urinate.</p>	F 315		

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F 315	Continued From page 23 In an interview on 1/28/15 at 10:45 AM, E5 (RN) stated she was not aware of R9's increase in urinary incontinence. E5 could not provide additional information as to the facility's response to the increase in R9's urinary incontinence. The facility failed to recognize, accurately assess, re-assess, monitor, review R9's incontinence episodes and revise approaches to managing R9's urinary incontinence and to restore as much normal bladder function as possible. Findings were reviewed with E1 and E3 on 1/28/15 at approximately 1:00 PM.	F 315		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility failed to ensure that one (R91) out of 31 Stage 2 sampled residents was provided with sufficient fluid intake to maintain proper hydration and health. The facility failed to monitor R91's daily fluid intake. Findings include: Cross refer to F315, example 1. R91 was admitted to the facility on 8/4/14. The admission MDS, dated 8/11/14, indicated the resident was independent with daily decision making and eating with only setup help.	F 327	1. R91 had no adverse effects 2. All residents have the potential to be affected by this deficient practice 3. Nursing staff and dietary staff in-serviced on new intake form (see attached) to document all food and fluid intakes. Unit managers and nursing supervisors will review form daily to check for completeness. Fluid intake concerns to be discussed in daily clinical meetings. Hydration assessment to be completed on residents as appropriate. Dietitian to make recommendations based on assessment. 4. Unit manager/designee will audit (attachment F) intake documentation for completeness and accuracy daily until 100% success is completed over three consecutive evaluations or until 100% compliance is achieved. Then, will monitor three times a week until 100% success is achieved consistently. Then, once a week for three weeks until consistent consecutive evaluations of 100% compliance are achieved. One more time a month later until 100% compliance is reached then deficient practice will be	3/23/15

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F 327	<p>Continued From page 24</p> <p>Review of R91's meal intake records from 9/1/14 through 9/7/14 revealed that her average daily fluid intake prior to the diagnosis of a UTI on 9/8/14 was 440 ml's despite her estimated fluid needs of 1700 to 2045 mls as noted per the 8/5/14 Nutritional Assessment. Further review of R91's clinical record revealed a NN, dated 9/5/14, to encourage hydration.</p> <p>Review of R91's meal intake records from 11/4/14 through 11/10/14 revealed that her average daily fluid intake prior to the diagnosis of a UTI on 11/11/14 was 246 mls despite her 11/11/14 quarterly Nutritional Assessment that stated "Intake meets needs ... urine collected for UA ... appears hydrated at present, accepting fluids ... continue to monitor for changes ... continue with POC (plan of care) ...".</p> <p>The quarterly MDS assessment, dated 11/11/14, stated R91's cognition was moderately impaired and the resident remained independent with eating with only setup help.</p> <p>Review of the clinical record revealed that on 11/12/14 a care plan was initiated for "Potential for complications R/T (related to) UTI ...". Approaches included: "... encourage fluid intakes ... hydration monitor per facility protocol." As early as 8/5/14, R91 had two care plans (pressure ulcer and nutritional status) that had approaches to monitor po intake. In addition, an approach was added on 11/13/14 to R91's self care deficit care plan to "... monitor for adequate dietary intake".</p> <p>Review of R91's meal intake records from 11/22/14 through 11/28/14 revealed that her average daily fluid intake prior to the diagnosis of</p>	F 327		

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F 327	<p>Continued From page 25</p> <p>a UTI on 11/29/14 was 310 ml's despite her 11/11/14 quarterly Nutritional Assessment that stated "Intake meets needs ... continue to monitor for changes ... continue with POC ...".</p> <p>Review of the December 2014 MAR revealed that R91 was ordered to receive extra fluids of 240 mls every shift and Med Pass (supplement) 120 mls twice a day starting on 12/8/14.</p> <p>On 12/10/14, R91 was transferred to the hospital with a hospital documented diagnoses for dehydration and hypernatremia and returned to the facility on 12/13/14.</p> <p>On 12/16/14, a physician's progress note stated, hypernatremia was resolved on 12/12 and that the facility did not agree with the diagnoses of dehydration, since the lab values did not support it.</p> <p>Review of R91's meal intake records from 12/29/14 through 1/4/15 revealed that her average daily fluid intake prior to the diagnosis of a UTI on 1/5/15 was 1286 mls despite her estimated fluid needs of 1400 to 1700 mls as noted per the 12/15/14 Nutritional Assessment.</p> <p>On 1/29/15 at 10:47 AM, E7 (RD) was asked to explain what was the facility's hydration protocol. E7 stated there was a "Hydration Monitor Form" that is on paper and not on the computer. This form is an alert sheet for any resident on antibiotics, diagnosed with a UTI, URI (upper respiratory infection), C-Diff (bacteria overgrowth that release toxins that attack the lining of the intestines) and pneumonia (lung inflammation caused by bacteria or viral infection). This was one of the tools that she would use to establish if</p>	F 327		

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F 327	Continued From page 26 they would need extra fluids every shift, for example, the length of antibiotic therapy. E7 stated that an order would be placed on the MAR for the nurses to administer extra fluids if they saw that a resident had a decline in PO (by mouth) intake. Review of R91's record and facility documentation failed to reveal the presence of this form. When asked what other tools she would review, E7 stated the CNA meal intake book, which records the percentage of the meals and the amount of fluids (mls) consumed. It was unclear how the nurses would determine which residents should receive extra fluids due to a lack of a monitoring system. On 1/29/15 at 10:55 AM, E6 (Corporate RD) stated that the residents at a minimum received 1500 mls of fluid intake on all meal trays unless someone was on a fluid restriction. E6 also stated that meals consumed are recorded by percentage and the amount of fluids consumed would be recorded in mls. The facility failed to monitor R91's daily fluid intake as per her plan of care and per the facility's hydration protocol. Findings were reviewed with E1 (NHA) and E3 (Corporate RN) on 1/28/15 at approximately 1:00 PM.	F 327		
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371	1. Area cited during the survey was corrected immediately by District Manager and plated food was removed from service. 2. No residents were affected by the deficient practice, audits and monitors will be implemented 3. The root cause of the deficient practice was that the Dietary employee handled the plate by the edge with a gloved hand. All staff will be in-serviced on the deficient area. Continued next page	3/23/15

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F 371	<p>Continued From page 27 under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of facility documentation, it was determined that the facility failed to prepare and serve food under sanitary conditions when they failed to follow the facility policies in regards to touching food-contact surfaces, lack of handwashing between glove changes, use of wet plates and use of chipped ceramic plates. Additionally, the facility failed to have completed dietary health forms for new kitchen staff. Findings Include:</p> <p>The facility's undated policy, entitled, "5-E Employee Guidelines - Infection Control Practices" stated, "... To prevent the contamination of food with infectious microorganisms (germs), Dining Service employees are expected to observe the following Infection Control Practices ... Handle plates by the bottom or the edge; keep hands off the eating surface. Keep thumb and fingers away from food on the plate ...".</p> <p>The facility's policy, dated 3/1/07 and last reviewed 5/20/13, and entitled, "Infection Control Hand Hygiene" stated, "... All personnel will use the hand hygiene techniques ... always after removing gloves ...".</p> <p>The facility's undated policy, entitled, "5-P Storage of Pots, Dishes, Flatware, Utensils" stated, "... Air dry pots, dishes ... before storage</p>	F 371	<p>Cont'd</p> <p>4. To ensure we are 100 percent compliant with the plate handling, the dietary supervisor will monitor daily using a monitoring form. The audit (attachment G) will be completed each day x 30 days or until 100 % compliance is achieved for 2 consecutive weeks. The audit will then be done once a week x 4 weeks until 100% compliance is achieved. To maintain compliance, 2 random audits will be done per month until 100% compliance is achieved for 2 months.</p> <p>1. Employee was made to remove gloves and wash hands before proceeding with task 2. No residents were affected by the deficient practice, audits and monitors will be implemented 3. The root cause of the deficient practice was that the employee failed to wash hands when changing gloves. To ensure that we are 100 percent compliant, the dietary supervisor will in-service all staff and audit practice of glove/hand washing hygiene. 4. The audit (attachment H) will be completed each day x 30 days or until 100 % compliance is achieved for 2 consecutive weeks. The audit will then be done once a week x 4 weeks until 100% compliance is achieved. To maintain compliance, 2 random audits will be done per month until 100% compliance is achieved for 2 months.</p>	3/23/15

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F 371	Continued From page 29 (FSD) confirmed the findings.	F 371		
F 428 SS=E	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for four (R24, R44, R76, and R90) 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:</p> <p>1. Review of R76's "Consultant Pharmacist Record of MRR" lacked evidence of a monthly medication regimen review being completed in October, 2014.</p> <p>Findings were reviewed with E1 (NHA) and E3 (Corporate RN) during an interview on 1/28/15 at approximately 4:00 PM. There was no additional information provided to the surveyors regarding this deficient practice.</p>	F 428	<p>1. R90 had no adverse effects from deficient practice.</p> <p>2. All residents have the potential to be affected by this deficient practice.</p> <p>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.</p> <p>4. Pharmacy Director/designee will audit (attachment J) 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.</p>	3/23/15

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F 428	<p>Continued From page 30</p> <p>2. Review of R90's "Consultant Pharmacist Record of MRR" lacked evidence of a monthly medication regimen review being completed in October, 2014.</p> <p>Findings were reviewed with E1 and E3 during an interview on 1/28/15 at approximately 4:00 PM. There was no additional information provided to the surveyors regarding this deficient practice.</p> <p>3. According to the facility's "Pharmacy Policies and Procedures" dated 2006, the specific activities that the consultant pharmacist performs included "Reviewing the medication regimen of each resident at least monthly or more frequently...documenting the review and findings in the resident's medical record".</p> <p>On 1/27/15 at 3:30 PM, Review of R44's "Consultant Pharmacist Record of MRR (Medication Regimen Review)" revealed that R 44's record lacked evidence of a monthly medication regimen review being completed by the Pharmacist in October, 2014.</p> <p>Finding was reviewed with E2, (DON) on 1/27/15 at approximately 3:30 PM and confirmed that the pharmacist failed to conduct a review of R44's drug regimen in October, 2014.</p> <p>4. Review of R24's "Consultant Pharmacist Record of MRR" revealed a lack of evidence of a</p>	F 428	<p>1. R44 had no adverse effects from deficient practice.</p> <p>2. All residents have the potential to be affected by this deficient practice.</p> <p>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.</p> <p>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.</p> <p>1. R24 had no adverse effects from deficient practice.</p> <p>2. All residents have the potential to be affected by this deficient practice.</p> <p>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.</p> <p>Continued next page</p>	<p>3/23/15</p> <p>3/23/15</p>

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
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NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION SILVERSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 3322 SILVERSIDE ROAD WILMINGTON, DE 19810
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F 428	Continued From page 31 completed monthly medication regimen review in October 2014. Findings were confirmed with E5 (RN) on 1/29/15 at 12:01 PM. The facility failed to have R24's drug regimen reviewed by the pharmacist for the month of October 2014.	F 428	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.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. 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. 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. 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	F 431	1. No residents were affected by this deficient practice. 2. All residents receiving narcotics have the potential to be affected. 3. Focus review was completed by DON of facility narcotic sheets. Narcotic count sheet has been revised to meet requirements of F431. All staff has been in serviced on policy and procedure for narcotic count. The Unit manager/designee will audit daily for compliance with narcotic count and documentation. 4. Unit manager/designee will monitor (attachment K) the narcotic count sheet daily until 100% success is completed over three consecutive evaluations or until 100% compliance is achieved. Then, will monitor three times a week until 100% success is achieved consistently. Then, once a week for three weeks until consistent consecutive evaluations of 100% compliance are achieved. One more time a month later until 100% compliance is reached then deficient practice will be resolved.	3/23/15

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F 431	<p>Continued From page 32 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 review of facility records and interviews, it was determined that the facility failed to ensure that a system for the reconciliation of controlled medications (medications whose use and distribution is tightly controlled by regulations) was performed by two licensed nurses, on multiple occasions at each shift change, in 1 out of 4 hallways (1 out of 5 medication carts). Findings include:</p> <p>The facility policy entitled, "Medication Storage in the Facility", dated 8/1/08, stated, "... At each shift change, a physical inventory of all controlled medications, ... is conducted by two licensed nurses and is documented on the controlled medication accountability record ... When completed, the accountability records are submitted to the director of nursing and kept on file for (5) years at the facility ...".</p> <p>On 1/29/15 at 12:15 PM, review of the facility's narcotic count forms for the first floor, Brandywine South revealed the following:</p> <p>A. For December 2014, there were 4 out of 93 shifts where either the nurse going off duty or the nurse coming on duty failed to sign the form. Additionally, there were some entries of signatures that were undated.</p> <p>B. For January 2015 (1/1/15 through 1/29/15 7-3</p>	F 431			

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F 431	<p>Continued From page 33</p> <p>shift) there were 49 out of 93 shifts where either the nurse going off duty or the nurse coming on duty or both did not sign the narcotic count form. This included 1/1/15 through 1/12/15 3-11 shift where there was no documentation available (35 shifts). In an interview on 12/29/14 at 12:20 PM, E11 (LPN) confirmed that although she counted this morning, she did not sign to indicate that the count was correct at the beginning of her shift. Additionally, there were some entries of signatures that were undated.</p> <p>During an interview on 1/29/15 at 1:12 PM, E2 (DON) and E3 (Corporate RN) confirmed the finding.</p> <p>During an interview on 1/29/15 at 1:34 PM, E2 stated that there were no records for 1/1/15 through 1/11/15. When asked who was responsible to ensure these forms were complete, E2 stated that it was the unit managers. The facility failed to ensure that the narcotic inventory counts were reconciled by two licensed nurses during shift changes multiple times from 12/1/14 through 1/29/15 (7-3 shift).</p>	F 431		
F 514 SS=E	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and</p>	F 514	<ol style="list-style-type: none"> R9 had no adverse effects from deficient practice. All residents have the potential to be affected by deficient practice. Unit manager will come to Wrap-Up Meeting with continence documentation to include but not limited to voiding diary, toileting plan, CNA flow sheets. Interdisciplinary Team (IDT) will review to ensure documentation is complete and accurate. Unit manager to audit (attachment L) continence documentation daily until 100% compliance is reached over 3 consecutive evaluations. Then, Unit Manager will monitor sample 3 times per week until 100% compliance is reached at 3 consecutive evaluations. Then, Unit manager will monitor once per week until 100% compliance is reached over 3 consecutive evaluations. Finally, will monitor once in one month to ensure 100% compliance. 	3/23/15

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F 514	<p>Continued From page 34</p> <p>services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for two (R9 and R91) out of 31 Stage 2 sampled residents the facility failed to maintain clinical records, on multiple occasions, for each resident in accordance with accepted professional standards and practices that are complete and accurately documented. Findings include:</p> <p>Cross refer to F315, example 2.</p> <p>1a. On 8/7/14, the facility initiated a three-day voiding diary to determine R9's voiding pattern. Review of R9's three-day voiding diary, dated 8/7/14, revealed that the facility failed to complete it as there were 4 hours missing on 8/7/14 and 15 hours missing on 8/9/14.</p> <p>Findings were confirmed with E5 (RN) on 1/28/15 at 10:45 AM.</p> <p>1b. Review of R9's monthly Scheduled Toileting Flowsheet revealed that the facility lacked evidence of toileting provided as follows:</p> <ul style="list-style-type: none"> - 8/14 lacked evidence of toileting 5 times; - 9/14 lacked evidence of toileting 7 times; - 10/14 lacked evidence of toileting 8 times; - 11/14 lacked evidence of toileting 16 times; - 12/14 lacked evidence of toileting 27 times; and - 1/1/15 through 1/26/15 lacked evidence of toileting 10 times. 	F 514	<ol style="list-style-type: none"> 1. R91 had no adverse effects from deficient practice. 2. All residents have the potential to be affected by deficient practice. 3. Unit manager will come to Wrap-Up Meeting with continence documentation to include but not limited to voiding diary, toileting plan, CNA flow sheets.. Interdisciplinary Team (IDT) will review to ensure documentation is complete and accurate. 4. Unit manager to audit continence documentation daily until 100% compliance is reached over 3 consecutive evaluations. Then, Unit Manager will monitor sample 3 times per week until 100% compliance is reached at 3 consecutive evaluations. Then, Unit manager will monitor once per week until 100% compliance is reached over 3 consecutive evaluations. Finally, will monitor once in one month to ensure 100% compliance. 	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
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NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION SILVERSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 3322 SILVERSIDE ROAD WILMINGTON, DE 19810
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F 514	<p>Continued From page 35</p> <p>Findings were confirmed with E5 (RN) on 1/28/15 at 10:45 AM.</p> <p>1c. Review of R9's quarterly Bowel and Bladder Assessment, dated 11/13/14, revealed that it was incomplete as it failed to identify predisposing diagnoses, voiding symptoms/problems and contributing factors and medications.</p> <p>Findings were confirmed with E8 (LPN) on 1/29/15 at 11:20 AM.</p> <p>Cross refer F315, example 1, 2. Review of the December "CNA flowsheet" from 12/13/14 through 12/17/14 revealed there were blanks with regards to R91's bladder function.</p> <p>The facility failed to have complete and accurate documentation regarding incontinence for R91 for the month of December.</p> <p>Findings were reviewed with E1 (NHA) and E3 (Corporate RN) on 1/28/15 at approximately 1:00 PM.</p>	F 514	<p>1. R9 and R91 had no adverse effects from the deficient practice.</p> <p>2. All residents have the potential to be affected by the deficient practice.</p> <p>3. All continence audit results will be reviewed during QAA to ensure compliance with policy and procedure related to continence.</p> <p>4. DON/designee will assure that all continence audit results are reported monthly in QAA monthly for three months until 100% compliance is achieved. Then quarterly for three quarters until 100% compliance achieved. If 100% compliance is achieved then deficient practice will be considered resolved.</p>	3/23/15
F 520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance</p>	F 520		

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F 520	<p>Continued From page 36</p> <p>committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to identify issues for 2 (R9 and R91) out of 31 Stage 2 sampled residents, to which quality assessment and assurance activities were necessary and developed and implemented appropriate plans of action to correct the identified quality deficiencies related to their incontinences in bladder functions. Findings include:</p> <p>Cross-refer to F315 examples 1 and 2. During an interview with E1 (NHA) on 1/29/15 at approximately 1:15 PM, and review of documented QAA (Quality Assessment and Assurance) sign up sheets of their quarterly meetings, the facility had an ongoing Quality Assessment and Assurance committee that meets at least quarterly to identify quality deficiencies to ensure that care practices were consistently applied.</p>	F 520		

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F 520	<p>Continued From page 37</p> <p>The facility failed to ensure the appropriate treatment and services to restore and/or maintain bladder function for R9 and R91 were implemented and additionally, prevent frequent UTIs (Urinary Tract Infections) for R91.</p> <p>According to R9's admission MDS assessment dated 8/13/14, R9 was occasionally incontinent of bladder. However, further review of R9's record prior to this assessment date, revealed that R9's bladder function was miscoded and should have been identified as frequently incontinent of urine. The facility failed to correctly identify, reassess and implement a plan of treatment for R9's decline in bladder function to frequently incontinent, in a timely manner.</p> <p>R91 was admitted to the facility with continent bladder function on admission and declined to frequently incontinent of bladder and additionally, experienced frequent UTIs (Urinary Infections). The facility failed to recognize, assess and implement a plan of care and treatment when R91 started to become incontinent and to maintain and prevent further decline in continence.</p> <p>The facility's QAA failed to identify, develop and to implement appropriate plans of action to correct these identified quality deficiencies to ensure that care practices were consistently applied for R9 in a timely manner and R91 to maintain as much normal bladder function as possible and prevent UTIs.</p> <p>This finding was discussed on 01/29/15 at approximately 3:00 PM with E1, E2 (DON), E3 (Corporate RN), E6 (RD) and E12 (Corporate</p>	F 520			

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F 520	Continued From page 38 Management/Owner) and P1 (Medical Director).	F 520		



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
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(302) 677-6661

STATE SURVEY REPORT

Page 1 of 14

NAME OF FACILITY: Cadla Rehabilitation Silverside

DATE SURVEY COMPLETED: January 29, 2015

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>3201.7.0</p>	<p>An unannounced annual survey was conducted at this facility from January 21, 2015 through January 29, 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 106. The Stage 2 survey sample size was 31.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 1/29/15, F241, F278, F279, F280, F315, F428, F431, F371, F514 and F520.</p> <p>Plant, Equipment and Physical</p>	<p>Cross refer to CMS 2567-L survey Report date completed 1/29/2015, F241, F278, F279, F280, F315, F327, F371, F428, F431, F514, and F 520</p>
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Provider's Signature *Shirley D. Dittman* Title NHA Date 2/19/15



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STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Silverside

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3201.7.5	<p>Environment</p> <p>Kitchen and Food Storage Areas.</p> <p>Facilities shall comply with the Delaware Food Code.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on the dietary observations during the survey, it was determined that the facility failed to comply with sections 2-103.11, 2-201.11, 2-201.12, 2-301.14 (F), 4-101.11 (D), 4-901.11 (A), and 4-904.11 (A).</p> <p>2-103.11 Person in Charge.</p> <p>The person in charge shall ensure that:</p> <p>(M) FOOD EMPLOYEES and CONDITIONAL EMPLOYEES are informed of their responsibility to report in accordance with LAW, to the PERSON IN CHARGE, information about their health and activities as they relate to diseases that are transmissible through FOOD, as specified under ¶ 2-201.11(A).</p> <p>2-201.11 Responsibility of Permit Holder, Person in Charge, and Conditional Employees.</p> <p>(A) The PERMIT HOLDER shall require FOOD EMPLOYEES and CONDITIONAL EMPLOYEES to report to the PERSON IN CHARGE information about their health and activities as they relate to diseases that are transmissible through FOOD. A FOOD EMPLOYEE or CONDITIONAL EMPLOYEE shall report</p>	



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NAME OF FACILITY: Cadia Rehabilitation Silverside

DATE SURVEY COMPLETED: January 29, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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	<p>the information in a manner that allows the PERSON IN CHARGE to reduce the RISK of foodborne disease transmission, including providing necessary additional information, such as the date of onset of symptoms and an illness, or of a diagnosis without symptoms, if the FOOD EMPLOYEE or CONDITIONAL EMPLOYEE: reportable symptoms (1) Has any of the following symptoms:</p> <ul style="list-style-type: none"> (a) Vomiting, (b) Diarrhea, (c) Jaundice, (d) Sore throat with fever, or (e) A lesion containing pus such as a boil or infected wound that is open or draining and is: <ul style="list-style-type: none"> (i) On the hands or wrists, unless an impermeable cover such as a finger cot or stall protects the lesion and a SINGLE-USE glove is worn over the impermeable cover, (ii) On exposed portions of the arms, unless the lesion is protected by an impermeable cover, or 32 (iii) On other parts of the body, unless the lesion is covered by a dry, durable, tight-fitting bandage; <p>(2) Has an illness diagnosed by a HEALTH PRACTITIONER due to:</p> <ul style="list-style-type: none"> (a) Norovirus, (b) Hepatitis A virus, (c) Shigella spp., (d) ENTEROHEMORRHAGIC or SHIGA TOXIN-PRODUCING ESCHERICHIA COLI, or (e) Salmonella Typhi; <p>Reportable past illness</p> <p>(3) Had a previous illness, diagnosed by a HEALTH PRACTITIONER, within the past 3 months due to Salmonella Typhi, without having received antibiotic therapy, as determined by a HEALTH</p>	
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	<p>PRACTITIONER; Reportable history of exposure 4) Has been exposed to, or is the suspected source of, a CONFIRMED DISEASE OUTBREAK, because the FOOD EMPLOYEE or CONDITIONAL EMPLOYEE consumed or prepared FOOD implicated in the outbreak, or consumed FOOD at an event prepared by a PERSON who is infected or ill with:</p> <ul style="list-style-type: none"> (a) Norovirus within the past 48 hours of the last exposure, (b) ENTEROHEMORRHAGIC or SHIGA TOXIN-PRODUCING ESCHERICHIA COLI, or Shigella spp. within the past 3 days of the last exposure, (c) Salmonella Typhi within the past 14 days of the last exposure, or (d) Hepatitis A virus within the past 30 days of the last exposure; or <p>Reportable history of exposure (5) Has been exposed by attending or working in a setting where there is a CONFIRMED DISEASE OUTBREAK, or living in the same household as, and has knowledge about, an individual who works or attends a setting where there is a CONFIRMED DISEASE OUTBREAK, or living in the same household as, and has knowledge about, an individual diagnosed with an illness caused by:</p> <ul style="list-style-type: none"> (a) Norovirus within the past 48 hours of the last exposure, (b) ENTEROHEMORRHAGIC or SHIGA TOXIN-PRODUCING ESCHERICHIA COLI, or Shigella spp. within the past 3 days of the last exposure, (c) Salmonella Typhi within the past 14 days of the last exposure, or (d) Hepatitis A virus within the past 30 days of the last exposure. <p>Responsibility of person in charge to notify the regulatory authority</p>	



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	<p>B) The PERSON IN CHARGE shall notify the REGULATORY AUTHORITY when a FOOD EMPLOYEE is:</p> <ul style="list-style-type: none"> (1) Jaundiced, or (2) Diagnosed with an illness due to a pathogen as specified under Subparagraphs (A)(2)(a) - (e) of this section. <p>Responsibility of the person in charge to prohibit a conditional employee from becoming a food employee</p> <p>(C) The PERSON IN CHARGE shall ensure that a CONDITIONAL EMPLOYEE:</p> <ul style="list-style-type: none"> (1) Who exhibits or reports a symptom, or who reports a diagnosed illness as specified under Subparagraphs (A)(1) - (3) of this section, is prohibited from becoming a FOOD EMPLOYEE until the CONDITIONAL EMPLOYEE meets the criteria for the specific symptoms or diagnosed illness as specified under § 2-201.13;P and (2) Who will work as a FOOD EMPLOYEE in a FOOD ESTABLISHMENT that serves as a HIGHLY SUSCEPTIBLE POPULATION and reports a history of exposure as specified under Subparagraphs (A)(4) - (5), is prohibited from becoming a FOOD EMPLOYEE until the CONDITIONAL EMPLOYEE meets the criteria as specified under ¶ 2-201.13(l). <p>Responsibility of the person in charge to exclude or restrict</p> <p>(D) The PERSON IN CHARGE shall ensure that a FOOD EMPLOYEE who exhibits or reports a symptom, or who reports a diagnosed illness or a history of exposure as specified under Subparagraphs (A)(1) - (5) of this section is:</p> <ul style="list-style-type: none"> (1) EXCLUDED as specified under ¶¶ 2-201.12 (A) - (C), and Subparagraphs 	



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	<p>(D)(1), (E)(1), (F)(1), or (G)(1) and in compliance with the provisions specified under §§ 2-201.13(A) - (G); or (2) RESTRICTED as specified under Subparagraphs 2-201.12 (D)(2), (E)(2), (F)(2), (G)(2), or §§ 2-201.12(H) or (I) and in compliance with the provisions specified under §§ 2-201.13(D) - (I). Conditions of exclusion and restriction 2-201.12 Exclusions and Restrictions. The PERSON IN CHARGE shall EXCLUDE or RESTRICT a FOOD EMPLOYEE from a FOOD ESTABLISHMENT in accordance with the following: symptomatic with vomiting or diarrhea (A) Except when the symptom is from a noninfectious condition, EXCLUDE a FOOD EMPLOYEE if the FOOD EMPLOYEE is: (1) Symptomatic with vomiting or diarrhea; or (2) Symptomatic with vomiting or diarrhea and diagnosed with an infection from Norovirus, Shigella spp., or ENTEROHEMORRHAGIC or SHIGA TOXIN-PRODUCING E. COLI.P jaundiced or diagnosed with hepatitis A infection (B) EXCLUDE a FOOD EMPLOYEE who is: (1) Jaundiced and the onset of jaundice occurred within the last 7 calendar days, unless the FOOD EMPLOYEE provides to the PERSON IN CHARGE written medical documentation from a HEALTH PRACTITIONER specifying that the jaundice is not caused by hepatitis A virus or other fecal-orally transmitted infection; (2) Diagnosed with an infection from hepatitis A virus within 14 calendar</p>	



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	<p>days from the onset of any illness symptoms, or within 7 calendar days of the onset of jaundice; or (3) Diagnosed with an infection from hepatitis A virus without developing symptoms, diagnosed or reported previous infection due to S. Typhi (C) EXCLUDE a FOOD EMPLOYEE who is diagnosed with an infection from Salmonella Typhi, or reports a previous infection with Salmonella Typhi within the past 3 months as specified under Subparagraph 2-201.11(A)(3). Diagnosed with an asymptomatic infection from Norovirus (D) If a FOOD EMPLOYEE is diagnosed with an infection from Norovirus and is ASYMPTOMATIC: (1) EXCLUDE the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT serving a HIGHLY SUSCEPTIBLE POPULATION; or (2) RESTRICT the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION. Diagnosed with Shigella spp. Infection and asymptomatic (E) If a FOOD EMPLOYEE is diagnosed with an infection from Shigella spp. and is ASYMPTOMATIC: (1) EXCLUDE the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT serving a HIGHLY SUSCEPTIBLE POPULATION; or (2) RESTRICT the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION. Diagnosed with EHEC or STEC and asymptomatic (F) If a FOOD EMPLOYEE is diagnosed with an infection from</p>	



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	<p>ENTEROHEMORRHAGIC or SHIGA TOXIN-PRODUCING E. COLI, and is ASYMPTOMATIC: (1) EXCLUDE the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT serving a HIGHLY SUSCEPTIBLE POPULATION; or (2) RESTRICT the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION. symptomatic with sore throat with fever (G) If a FOOD EMPLOYEE is ill with symptoms of acute onset of sore throat with fever: (1) EXCLUDE the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT serving a HIGHLY SUSCEPTIBLE POPULATION; or (2) RESTRICT the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION. symptomatic with uncovered infected wound or pustular boil (H) If a FOOD EMPLOYEE is infected with a skin lesion containing pus such as a boil or infected wound that is open or draining and not properly covered as specified under Subparagraph 2-201.11(A)(1)(e), RESTRICT the FOOD EMPLOYEE. exposed to foodborne pathogen and works in food establishment serving HSP (I) If a FOOD EMPLOYEE is exposed to a foodborne pathogen as specified under Subparagraphs 2-201.11(A)(4) or (5), RESTRICT the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT serving a HIGHLY SUSCEPTIBLE POPULATION. Asymptomatic and works in food establishment serving HSP</p>	
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	<p>(b) Retain the EXCLUSION for the FOOD EMPLOYEE, who is ASYMPTOMATIC for at least 24 hours and works in a FOOD ESTABLISHMENT that serves a HIGHLY SUSCEPTIBLE POPULATION, until the conditions for reinstatement as specified under Subparagraphs (D)(1) or (2) of this section are met. Shigella spp. Diagnosis adjusting exclusion for food employee who was symptomatic and is now asymptomatic</p> <p>(3) If a FOOD EMPLOYEE was diagnosed with an infection from Shigella spp. and EXCLUDED as specified under Subparagraph 2-201.12(A)(2):</p> <p>(a) RESTRICT the FOOD EMPLOYEE, who is ASYMPTOMATIC for at least 24 hours and works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION, until the conditions for reinstatement as specified under Subparagraphs (E)(1) or (2) of this section are met; or retaining exclusion for food employee who was asymptomatic and is now asymptomatic</p> <p>(b) Retain the EXCLUSION for the FOOD EMPLOYEE, who is ASYMPTOMATIC for at least 24 hours and works in a FOOD ESTABLISHMENT that serves a HIGHLY SUSCEPTIBLE POPULATION, until the conditions for reinstatement as specified under Subparagraphs (E)(1) or (2) , or (E)(1) and (3)(a) of this section are met.</p> <p>EHEC or STEC diagnosis</p> <p>(4) If a FOOD EMPLOYEE was diagnosed with an infection from ENTEROHEMORRHAGIC or SHIGA TOXIN-PRODUCING ESCHERICHIA COLI and EXCLUDED as specified under Subparagraph 2-201.12(A)(2):</p>	
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	<p>adjusting exclusion for food employee who was symptomatic and is now asymptomatic</p> <p>(a) RESTRICT the FOOD EMPLOYEE, who is ASYMPTOMATIC for at least 24 hours and works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION, until the conditions for reinstatement as specified under Subparagraphs (F)(1) or (2) of this section are met; or retaining exclusion for food employee who was symptomatic and is now asymptomatic and works in food establishment serving HSP</p> <p>(b) Retain the EXCLUSION for the FOOD EMPLOYEE, who is ASYMPTOMATIC for at least 24 hours and works in a FOOD ESTABLISHMENT that serves a HIGHLY SUSCEPTIBLE POPULATION, until the conditions for reinstatement as specified under Subparagraphs (F)(1) or (2) are met.</p> <p>hepatitis A virus or jaundice diagnosis -see regs for additional requirements</p> <p>2-201.12 Exclusions and Restrictions. The PERSON IN CHARGE shall EXCLUDE or RESTRICT a FOOD EMPLOYEE from a FOOD ESTABLISHMENT in accordance with the following: symptomatic with vomiting or diarrhea</p> <p>(A) Except when the symptom is from a noninfectious condition, EXCLUDE a FOOD EMPLOYEE if the FOOD EMPLOYEE is:</p> <p>(1) Symptomatic with vomiting or diarrhea; or</p> <p>(2) Symptomatic with vomiting or diarrhea and diagnosed with an infection from Norovirus, Shigella spp., or ENTEROHEMORRHAGIC or SHIGA</p>	
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	<p>TOXIN-PRODUCING E. COLI.P 35 jaundiced or diagnosed with hepatitis A infection (B) Exclude a FOOD EMPLOYEE who is: (1) Jaundiced and the onset of jaundice occurred within the last 7 calendar days, unless the FOOD EMPLOYEE provides to the PERSON IN CHARGE written medical documentation from a HEALTH PRACTITIONER specifying that the jaundice is not caused by hepatitis A virus or other fecal-orally transmitted infection; (2) Diagnosed with an infection from hepatitis A virus within 14 calendar days from the onset of any illness symptoms, or within 7 calendar days of the onset of jaundice; or (3) Diagnosed with an infection from hepatitis A virus without developing symptoms diagnosed or reported previous infection due to S. Typhi (C) EXCLUDE a FOOD EMPLOYEE who is diagnosed with an infection from Salmonella Typhi, or reports a previous infection with Salmonella Typhi within the past 3 months as specified under Subparagraph 2-201.11(A)(3). diagnosed with an asymptomatic infection from Norovirus (D) If a FOOD EMPLOYEE is diagnosed with an infection from Norovirus and is ASYMPTOMATIC: (1) EXCLUDE the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT serving a HIGHLY SUSCEPTIBLE POPULATION; or (2) RESTRICT the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION. diagnosed with Shigella</p>	



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	<p>spp. infection and asymptomatic (E) If a FOOD EMPLOYEE is diagnosed with an Infection from Shigella spp. and is ASYMPTOMATIC: (1) EXCLUDE the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT serving a HIGHLY SUSCEPTIBLE POPULATION; or (2) RESTRICT the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION.</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey completed 1/29/15, F371, example 4.</p> <p>2-301.14 When to Wash.</p> <p>Food employees shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles P and:</p> <p>(F) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. P</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey completed 1/29/15, F371, example 2.</p> <p>4-101.11 Characteristics.</p>	



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	<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> <p>(D) Finished to have a smooth, easily cleanable surface.</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey completed 1/29/15, F371, example 3.</p> <p>4-901.11 Equipment and Utensils, Air-Drying Required.</p> <p>After cleaning and sanitizing, equipment and utensils:</p> <p>(A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food.</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey completed 1/29/15, F371, example 3.</p> <p>4-904.11 Kitchenware and Tableware.</p> <p>(A) Single-service and single-use articles and cleaned and sanitized utensils shall be handled, displayed, and dispensed so that contamination of</p>	
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	<p>food and lip-contact surfaces is prevented.</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey completed 1/29/15, F371, example 1.</p>	