

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

PRINTED: 05/24/2016
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 04/18/2016
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 April 7, 2016 through April 18, 2016. The deficiencies contained in this report are based on observations, interviews, review of clinical record and other facility documentation as indicated. The facility census the first day of the survey was 102. The Stage 2 survey sample was 33.</p> <p>Abbreviations/definitions 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; FMD- Facility Maintenance Director; FSD - Food Service Director; UM- Unit Manager; NP - Nurse Practitioner; MDS - Minimum Data Set/assessment tool used in long term care facilities; PU - Pressure Ulcer/sore - area of skin that develops when the blood supply to it is cut off due to pressure; NSS - Normal Saline Solution; CDD - clean dry dressing; TAR - Treatment Administration Record; N/O - New Order; IDT - Interdisciplinary Team; HOB - head of bed; NN - Nurse's note; PPE - Personal Protective Equipment (mask, gown, gloves, etc.); Pt. - patient;</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/06/2016
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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 Q - every; # - number; #24 - left central incisor, lower front tooth on the left center; #26 - right lateral incisor, lower front tooth on the right side; c - with; cm - centimeter, unit of length; r/t - related to; Rt/R - right; Aspiration - inhaling fluid or food into the lungs; Care Area Summary (CAA) - part of the MDS assessment which assists in identifying and planning for potential problem care areas; Cariou roots - decay of the root of the tooth; C-diff - Clostridium difficile/bacterial overgrow that releases toxins that attack the lining of the intestines; Cognitively Impaired - abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; Contact Precautions - procedures used to prevent transmission of infectious agents; Dentition - teeth; Dysphagia - difficulty swallowing; e.g.-for example; etc.-and so forth; Epithelialization - formation of granulation tissue in an open wound; Erythema - a diffuse redness of the skin; Extraction - a tooth is removed from its socket, a surgical extraction and may require the expertise of an oral surgeon; Exudate - accumulation of fluids in a wound; Gingiva - the gums of the mouth; Gingivitis - a disease in which the gums become red, swollen, and sore;	F 000		

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F 000	Continued From page 2 Gluteal - pertaining to the buttock muscles or the buttocks; Granular/granulation - kind of tissue formed during wound healing, with a rough or irregular surface; Hand hygiene - referring to any method of hand cleansing; Hydrogel - wound treatment; HOB-head of bed; Induration - an area of hardened tissue; Ischial - bony areas on each buttock; Nectar thick- pourable liquids that are comparable to apricot nectar; Pathogens- a bacterium, virus or other microorganism that can cause disease; Peri-wound - skin/tissue surrounding a wound; Plaque - a soft, sticky film that builds up on your teeth and contains millions of bacteria. The bacteria in plaque cause tooth decay and gum disease if they are not removed regularly through brushing and flossing; Puree-cooked foods that have been ground to a consistency of a creamy paste; Serous - a thin, clear, light yellow watery fluid found in many body cavities; Serum filled blister - filled with clear fluid; Sinus tracts - course or pathway extending in any direction from the wound base; Slough - yellow, tan, gray, green or brown dead tissue covering a wound bed; Standard Precautions - a set of infection control practices used to prevent transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin (including rashes), and mucous membranes; Tunneling - channels that extend from a wound into and through tissue or muscle; Undermining - skin edges have lost supporting tissue under intact skin.	F 000			

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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that each resident received and the facility provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one (R173) out of 33 Stage 2 sampled residents. The facility failed to ensure that R173 was properly positioned in bed during meal time to prevent the potential for aspiration. Findings include: R173 was admitted to the facility on 2/18/16 with a diagnosis of dysphagia. A care plan for the potential for aspiration, dated 3/30/16, included the approach, "HOB at 90 degrees during and for 30 minutes after meals". R173's physician's order, dated 4/6/16, stated the resident was to receive a puree consistency diet and nectar thick liquids.</p>	F 309	<ol style="list-style-type: none"> 1. R173 was placed in 90 degree angle position immediately and not negatively impacted by deficient practice. 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking corrective action(s) outlined below in #3. 3. Facility to create and implement a new visual identifier system on proper positioning during meals to be placed in all resident rooms. Speech therapist to inservice nursing staff on proper positioning of residents during meals as well as the new visual identifier system. 4. Dietitian to audit 10 random residents who prefer to eat meals in bed to ensure proper position daily until 100% compliance is met over 3 consecutive days. Dietitian will audit three times weekly until 100% success for 3 consecutive audits. Dietitian will then audit weekly until 100% success over three consecutive weeks. Dietitian will then audit in one month, if 100% compliance the deficiency will be 	7/1/16	

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F 309	Continued From page 4 On 4/13/16 at 9:45 AM, R173 was observed lying in bed at a 45 degree angle. R173's breakfast tray was on the tray table in front of her with all items opened and ready for eating. R173 was observed reaching for a bowl of cream of wheat to begin eating. R173 was not positioned at a 90 degree angle to decrease the risk of aspiration. E5 (RN) was called into the room to check R173's positioning. Upon observing R173, E5 confirmed the resident needed to be pulled up in bed and the HOB raised higher before R173 began eating.	F 309	considered resolved. Results of audits to be presented and discussed at QA committee meeting.		
F 314 SS=D	Findings were reviewed with E2 (DON) on 4/18/16 at approximately 9:30 AM. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure a resident with a pressure ulcer/sore (PU) received the treatment and services to promote healing for one (R275) out of 33 Stage 2 sampled residents. The facility failed to comprehensively assess R275's right buttock PU according to current clinical practice guidelines	F 314	1. R275 seen by wound nurse practitioner immediately to assure accurate assessments and proper treatments in place. R275's wound healed completely. Resident was discharged home from facility. 2. All residents with wounds have the potential to be affected by the deficient	7/1/16	

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F 314	Continued From page 5 upon admission to the facility and failed to complete PU treatment on two (2) occasions. Findings include: The International NPUAP/EPUAP (National Pressure Ulcer Advisory Panel/European Pressure Ulcer Advisory Panel) Pressure Ulcer Classification System identifies six (6) categories/stages. Two (2) of those categories/stages are: - Stage II: presents as a shallow open ulcer with a red pink wound bed, without slough; may also present as an intact or open/ruptured serum-filled blister; presents as a shiny or dry shallow ulcer without slough or bruising. - Stage III: full thickness tissue loss; subcutaneous fat may be visible but bone, tendon or muscle are not exposed; slough may be present but does not obscure the depth of tissue loss. The International NPUAP//EPUAP (National Pressure Ulcer Advisory Panel/European Pressure Ulcer Advisory Panel) Clinical Practice Guideline, second edition published 2014, states "...Pressure Ulcer Classification Systems...". verify that there is clinical agreement in pressure ulcer classification amongst the health professionals responsible for classifying pressure ulcers...Pressure Ulcer Assessment 1. Assess the pressure ulcer initially and re-assess it at least weekly...3. Assess and document physical characteristics including: location, category/Stage, size, tissue type (s), color, periwound condition, wound edges, sinus tracts, undermining, tunneling, exudate, and odor..." R275 was admitted to the facility on 3/30/16 with an open area on the right buttock.	F 314	practice. Future residents will be protected from this deficient practice by taking corrective action(s) outlined below in #3. 3. Nursing administration team met to implement new work flow and audit process related to wound assessment and documentation. Facility policy and procedure inservice on completing treatments as ordered and proper documentation to be given to licensed nurses by ADON (head of wound team)/designee. Upon discovery of all new wounds, nurse will complete head to toe inspection of skin. If there are areas of skin impairments noted during assessment, nurse is to measure, describe and obtain treatment order from physician. Wound nurse/designee will do a follow up assessment on all new wounds or/and new admissions with wounds and document wound stage within 24 hours to assure proper treatment in in place. Wound Nurse Practioner to assess all wounds weekly as appropriate on weekly wound rounds. 4. Staff Developer or designee will audit all new wound alerts to ensure compliance with policy and procedure daily until 100% success achieved. Then Staff D/designee will audit three times a week until 100% success achieved for three consecutive audits. Staff D/designee will then audit weekly until 100% success over 3 consecutive weeks then once in one month. If 100% compliance is achieved then deficiency is resolved. Results of all audits to be presented and discussed at QA		

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F 314	<p>Continued From page 6</p> <p>Review of the facility's "Skin Integrity Events - New Wound Assessment" revealed the document consisted of two (2) parts. The first part was completed by the nurse initially identifying a wound, the second part was to be completed by the Wound Team.</p> <p>3/30/16 - The Skin Integrity Events - New Wound Assessment, Section 1 listed the following:</p> <ul style="list-style-type: none"> - open area on the right buttock; - measured 2 cm (length) by 2 cm (width); - no drainage, no slough, no odor; - peri-wound appearance was "inflamed[sic]-reddened, erythema"; - wound bed had epithelialization-deep pink, pearly pink/light purple; - resident exhibited or complained of pain at the site at a level 2 severity (with 0 being no pain and 10 being the most severe pain ever experienced). <p>Section 1 failed to identify the Stage and depth of the wound, and failed to describe the wound edges or whether there were any sinus tracts, undermining or tunneling.</p> <p>3/31/16 - R75's physician ordered "cleanse open area to Rt buttock with NSS, apply CDD daily". Review of the TAR revealed the treatment was scheduled to be completed on the 7:00 AM to 3:00 PM shift.</p> <p>3/31/16 through 4/4/16 the TAR revealed:</p> <ul style="list-style-type: none"> - the treatment was not signed off as completed on 3/31/16; - 4/1/16 treatment was signed as not completed due to "resident unavailable". There was no evidence the treatment was completed on the next shift; - 4/2/16 through 4/4/16 treatments were signed as completed. 	F 314	committee meeting.		

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F 314	<p>Continued From page 7</p> <p>4/4/16 at 8:10 AM - the progress note stated "Resident wound assessed. Stage II noted on R buttock, 2 cm x 2 cm x 0.1 cm; periwound area slightly bruised and discolored. N/O to cleanse area with NSS, apply Hydrogel, and cover with CDD...no pain at this time...".</p> <p>4/5/16 through 4/11/16 TAR revealed treatments completed as ordered.</p> <p>4/6/16 - the admission MDS assessment stated R275 has a Stage 3 PU which was present on admission, measuring 2.0 x 0.8 x 0.1 with granulation tissue.</p> <p>4/6/16 The Skin Integrity Events - New Wound Assessment, Wound Team Only (Section 2) stated the following: - type of wound - pressure; - Stage of wound - Stage 3; - "Do you agree with description of wound as described in section 1? - response "No"; - description of wound: "stage 3 measures 2.0 x 2.0 x 0.2 cm. wound bed is 100% granular, with scan (sic) serous drainage". The facility did not complete the Wound Team portion of the R buttock wound assessment until 4/6/16, seven (7) days after it was first identified (on/3/30/16).</p> <p>4/6/16 - the wound consultant report stated, "...seen for evaluation and management of a right gluteal wound...(+) full-thickness wound of the right gluteus - 2.0 x 0.8 x 0.1 cm. Wound base 100% granular with scant, non-odorous serous drainage; wound edges with (+) evidence of contraction. Periwound without erythema or induration. Patient does not demonstrate</p>	F 314		
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F 314	<p>Continued From page 8</p> <p>evidence of pain...Pressure Ulcer of Right Buttock - Stage 3...Present Upon Admission...Cleanse site with normal saline...hydrogel to wound base and cover with a foam dressing Q day...".</p> <p>4/13/16 at 8:40 AM - Observed wound team rounds for R275 with C1 (NP/Wound Care Consultant) and E4 (RN).</p> <p>4/13/16 at 8:50 AM - During an interview, C1 stated she was very pleased with the progress of the PU and that there were characteristics present indicating this wound was of longer duration and more than a Stage 2 on admission to the facility.</p> <p>4/13/16 at approximately 11:00 AM - Findings were reviewed with E2 (DON) regarding the lack of a complete, initial wound assessment, including the lack of staging until seven (7) days after admission. When asked about a policy/procedure for completion of the assessment, E2 stated that they do not have one that state a timeframe for completion. When asked what the expectation would be for completion of the wound team portion, she stated that it should be done within 24-48 hours after admission. E2 stated that the admission nurse completes Section 1 of the Skin Integrity Events - New Wound Assessment form, but does not do staging of the wound, and it then goes to IDT and is reviewed by E3 (ADON), who looks at staging and makes sure all components of care have been addressed (e.g., appropriate treatment, care plan, nutrition, etc.). E2 confirmed that a seven (7) day lapse between completion of the two sections of the Skin Integrity Event Report was a problem.</p>	F 314		

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F 314	Continued From page 9 The facility failed to complete a comprehensive, initial assessment of R275's R buttock PU upon admission to the facility. There was no evidence that the facility staged the PU upon admission or shortly thereafter. The second portion of the initial wound assessment was not completed in its entirety until seven (7) days later. Additionally, the facility failed to provide treatments as ordered on two occasions (3/31/16 and 4/1/16). Findings were reviewed with E1 (NHA) and E2 during the exit conference on 4/18/16 at approximately 3:45 PM.	F 314		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on dining observations and interviews, it was determined that the facility failed to serve food under sanitary conditions. Findings include: 1. On 4/7/16 at 12:15 PM during a lunch observation in the second floor dining room, E11 (cook), was observed plating food. E11 touched plates, utensils and other non-food contact	F 371	(1) 1. E11 immediately discarded sandwich. Resident was not impacted by deficient practice. 2. All residents have the potential to be affected by the deficient practice. Future residents will be protected from this deficient practice by taking corrective	7/1/16

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F 371	<p>Continued From page 10</p> <p>surfaces with his disposable gloves. E11, then, opened the plastic covering on a chicken salad sandwich, removed the two halves of the sandwich with his contaminated gloves and placed the sandwich halves directly onto a plate to be served.</p> <p>Findings were reviewed with E12 (Director of Food Service) on 4/18/16 at 11:38 AM.</p> <p>2. On 4/18/16 at 12:30 PM, in the 2nd floor dining room, E7 (CNA) was observed incorrectly using his bare hands to insert a straw into the cover of R98's personal cup. E7 held the top of the straw, where R98 would sip, and pushed it into the hole in the cover of the cup.</p> <p>On 4/18/16 at 12:35 PM, in an interview, E7 acknowledged the finding and stated he was not aware that he should not touch the tip of the straw with his bare hands.</p> <p>The facility failed to ensure that food was served under sanitary conditions for R98. On 4/18/16, at 3:30 PM, this finding was discussed with E2 (DON).</p>	F 371	<p>action(s) outlined below in #3.</p> <p>3. Staff Educator/Designee to inservice dietary and nursing staff on proper food handling using sanitary conditions.</p> <p>4. Meal service audits will be completed by RD/Food Service Director daily until 100% compliance is achieved for three consecutive audits. Then three times a week times three weeks until 100% compliance. Then once a week times three weeks until 100% compliance. Then once a month until 100% compliance at which time deficiency is resolved. Results of audits to be presented and discussed at QA committee meeting.</p> <p>(2)</p> <p>1. R98 was immediately given new cup and straw and was not negatively impacted by this deficient practice.</p> <p>2. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking corrective action(s) outlined below in #3.</p> <p>3. Staff Educator/Designee to inservice dietary and nursing staff on proper food handling using sanitary conditions.</p> <p>4. Meal service audits will be completed by RD/Food Service Director daily until 100% compliance is achieved for three consecutive audits. Then three times a week times three weeks until 100% compliance. Then once a week times three weeks until 100% compliance. Then once a month until 100% compliance at which time deficiency is resolved. Results of audits to be</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 371	Continued From page 11	F 371		
F 412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that dental services were obtained to meet the needs of one resident (R67) out of 33 Stage 2 sampled residents. Findings include:</p> <p>R67's dental status care plan, "poor natural dentition", initiated 10/15/14 included approaches to coordinate arrangements for dental care including transportation as needed and dental consults as ordered/indicated.</p> <p>On 7/29/15, R67 was seen at the facility by a mobile dental service including a hygienist and a dentist. The hygienist consultation findings stated, "...Has a few root tips. Heavy plaque on upper/lower teeth, gums sore, red, used soft toothbrush to remove soft food debris, he grunted a little due to sore gums ... Please have CNA help</p>	F 412	<p>presented and discussed at QA committee meeting.</p> <ol style="list-style-type: none"> 1. R67 was not negatively impacted by deficient practice. Dentist in to see resident during survey to ensure no acute dental issues. 2. All residents have the potential to be affected by the deficient practice. Future residents will be protected from this deficient practice by taking corrective action(s) outlined below in #3. 3. New process developed that all dental recommendations are to be delivered to front office during regular business hours where they will be placed in Social Service Director's mailbox to ensure proper and timely follow through. Social Service Director to follow through with nursing on all residents' dental needs within 24-72 hours. DON/designee to educate Dental Service that recommendations are not to 	7/1/16

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F 412	<p>Continued From page 12</p> <p>brush teeth, tongue and gums daily (Very Important)". The dentist consultation report stated, "See hard copy". The dentist's "service rendered" note behind the consultation report, dated 7/29/15 stated, "...Recommend oral surgery consult to extract retained carious roots #24 & 26. Upon touching gingiva assoc (associated) c #24, pt. expressed discomfort (gingivitis apparent) ...".</p> <p>Review of R67's progress notes revealed the following: On 7/31/16 at 12:03 PM, a NN stated R67 was seen at the facility by dental services on 7/29/15. The consult showed heavy plaque on upper and lower teeth. Gums were noted as red and sore with the recommendation to brush teeth, tongue and gums daily;</p> <p>From 8/14/15 through 11/7/16, the progress notes lacked evidence that any further dental services were provided or that R67 was scheduled for a consultation at the oral surgeon's office.</p> <p>The annual MDS, dated 11/11/15, stated R67 was severely cognitively impaired, was dependant with assistance of one person for personal hygiene and had obvious or likely cavities/broken natural teeth.</p> <p>The CAA summary associated with the 11/11/15 annual MDS stated the care plan decision was "yes" to develop/review a dental care plan for R67 due to carious dentition with potential for pain/negative outcomes.</p> <p>From 11/15/15 through 1/3/16, the progress notes lacked evidence that any further dental services were provided or that R67 was scheduled for a</p>	F 412	<p>be placed in progress notes and only on approved order form. DON/designee to also educate front office staff, Social Service Director, Unit Managers, and charge nurses on new process for dental recommendation follow through.</p> <p>4. 10 random charts will be audited weekly by Unit manager/designee weekly for three consecutive weeks or until 100% compliance is achieved. Then 5 random charts will be audited weekly until 100% compliance is achieved. Then in a month 10 charts will be audited and if 100% compliance deficiency will be resolved. Results of all audits to be presented and discussed at QA committee meeting.</p>		

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F 412	Continued From page 13 consultation at the oral surgeon's office. On 1/6/16, R67 was seen at the facility by the hygienist from the mobile dental service. The hygienist consultation findings stated, "... Some root tips... poor gums, red, irritated, sore to touch on the lower left side...". From 1/12/16 through 4/1/16, the progress notes lacked evidence that R67 was scheduled for a consultation at the oral surgeon's office. On 4/8/16 at 8:07 AM and on 4/12/16 at 12:37 PM, R67's mouth observations revealed 2 tooth stubs/decayed, broken teeth, in the lower front jaw and 2 tooth stubs in the upper front jaw. R67's mouth appeared clean, without food debris. On 4/12/16 at 3:19 PM, in an interview, E8 (LPN) stated he wrote the 7/31/15 progress note about the dental hygienist recommendations, but, stated he did not see the dentist's note to consult an oral surgeon. On 4/12/16 at 3:52 PM, in an interview, E9 (RN UM) reviewed R67's medical record and stated she was unable to find any follow up to the 7/29/15 dental consult recommendation for an oral surgery consult. The facility failed to ensure the dental service consult, dated 7/29/15, was acted upon for R67. On 4/14/16 at 11 AM, in an interview, E2 (DON) confirmed the findings.	F 412		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		7/1/16

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F 441	<p>Continued From page 14</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was</p>	F 441	(1)	

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F 441	<p>Continued From page 15</p> <p>determined that the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility failed to ensure that appropriate signage for isolation precautions was posted outside R180's room and failed to ensure staff wore appropriate PPE when providing care for R180. Findings include:</p> <p>The facility policy and procedure titled "Isolation/Discontinuation in Multi-drug Resistant Organisms (MDRO)," revised 11/2/15, stated, "...Standard Precautions have an essential role in preventing Multi-drug resistant organism (MDRO) transmission...Hand hygiene is an important component of Standard Precautions. Contact Precautions are intended to prevent transmission of infectious agents, which are transmitted by direct or indirect contact with the patient or the patient's environment...Healthcare staff caring for patients on Contact Precautions should wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning gown and gloves upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (for example C.difficile)...".</p> <p>1. During the initial tour of the facility on 4/7/16 at 8:30 AM, R180's door was open and PPE was observed stored on the inside of the door, which opened out to the hall. There was no signage outside of the room indicating there were isolation precautions.</p>	F 441	<p>1. R180 resident was adversely affected by deficient practice.</p> <p>2. All residents have the potential to be affected by deficient practice. Future residents will be protected from this deficient practice by taking corrective action(s) outlined below in #3.</p> <p>3. Staff Developer/designee to reeducate staff on policy and procedure and proper isolation precautions. Also new visual identifier system created and implemented to alert staff on necessary PPE (personal protective equipment) prior to entering resident's room, specific to organism.</p> <p>4. Staff Developer/designee to do infection control rounds daily x 3 days or until 100% compliance. Then Staff D/designee to do infection control rounds 3x a week x 3 weeks or until 100% compliance. Then Staff D/designee to do infection control rounds weekly x 3 weeks or until 100% compliance. Staff D will then do infection control rounds in one month and if 100% compliance then deficiency is resolved. Results of audits and infection control rounds to be presented and discussed at QA committee meeting.</p> <p>(2)</p> <p>1. R180 resident was adversely affected by deficient practice.</p> <p>2. All residents have the potential to be affected by deficient practice. Future residents will be protected from this deficient practice by taking corrective action(s) outlined below in #3.</p> <p>3. Staff Developer/designee to re-educate staff on policy and procedure</p>		

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F 441	<p>Continued From page 16</p> <p>E13 (RN) was interviewed on 4/7/16 at 8:35 AM and stated that R180 was receiving an antibiotic for C. difficile. E13 confirmed that a stop sign should have been posted outside of the room.</p> <p>On 4/7/16 at approximately 8:50 AM, a stop sign was posted outside of R180's room that stated, "STOP- Please see nurse before entering room."</p> <p>2. R180 had a care plan for "Isolation Precautions r/t C-diff", dated 3/22/16, which included the approaches "...Maintain isolation precautions per guidelines" and "Make staff, resident and visitors aware of isolation precautions".</p> <p>On 4/13/16 at 8:45 AM, E6 (CNA) was observed by the surveyor and E4 (RN/Infection Control Nurse) exiting R180's bathroom, where he was providing care to the resident. E6 was wearing disposable gloves, but no gown. E6 got a clean brief for R180 from the closet and stated he needed to place the brief on the resident. E6 removed R180 from the bathroom in a wheelchair and was about to wheel him out of the room when E4 instructed him (E6) to first wash his hands before leaving the room.</p> <p>In an interview immediately after the observation, E6 stated that he was aware R180 was on isolation/contact precautions and he "thought that it was alright to only wear gloves."</p> <p>During an interview on 4/13/16 at 9:40 AM, E4 confirmed that E6 was required to wear a gown and gloves while providing care for R180.</p> <p>Findings were reviewed with E2 (DON) on 4/18/16 at approximately 9:30 AM.</p>	F 441	<p>and proper signage. Also new visual identifier system created and implemented to alert staff on necessary PPE (personal protective equipment) prior to entering resident's room, specific to organism.</p> <p>4. Staff Developer/designee to do infection control rounds daily x 3 days or until 100% compliance. Then Staff D/designee to do infection control rounds 3x a week x 3 weeks or until 100% compliance. Then Staff D/designee to do infection control rounds weekly x 3 weeks or until 100% compliance. Staff D will then do infection control rounds in one month and if 100% compliance then deficiency is resolved. Results of audits and infection control rounds to be presented and discussed at QA committee meeting.</p>	

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**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Silverside

DATE SURVEY COMPLETED: April 18, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>An unannounced annual survey was conducted at this facility from April 7, 2016 through April 18, 2016. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 102. The Stage 2 survey sample size was 33.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 4/18/2016, F309, F314, F371, F412, and F441.</p>	<p>Cross refer to CMS 2567-L survey ending 4/18/16, F309, F314, F371, F412, F441.</p>	<p>6/15/16</p>

Provider's Signature

[Handwritten Signature] Title NHA

Date

5/11/16