STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	06/18/2019

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CADIA REHABILITATION CAPITOL	1225 WALKER ROAD DOVER, DE 19904

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E 000	Initial Comments An unannounced annual survey was conducted at this facility from June 11, 2019 through June 18, 2019. The facility census the first day of the survey was 117. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey no deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from June 11, 2019 through June 18, 2019. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred seventeen (117). The survey sample totaled forty seven (47). Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MD - medical doctor; UM - Unit Manager; CRN - Corporate Regional Nurse; CRNP - Certified Registered Nurse Practitioner; NP - Nurse Practitioner; CNA - Certified Nurse's Aide; OT - Occupational Therapy; PT - Physical Therapy / Physical Therapist; RD - Registered Dietitian;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/04/2019

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 RNAC - Registered Nurse Assessment Coordinator; # - pound; ? - question, unsure; ADL - Activities of Daily Living, such as bathing and dressing; ADL Self-Performance: - Extensive Assistance: resident involved in activity, staff provide weight-bearing support; - Limited Assistance: resident highly involved in activity, staff provide guided movement of limbs or other non-weight bearing assistance; - Supervision: oversight, encouragement or cueing; - Total Dependence: full staff performance every time activity performed; AEB - as evidenced by; Albuterol nebulizer treatment - respiratory medication; Abilify - anti-pychotic medication; Abnormal Involuntary Movement Scale (AIMS) - test to measure body movements the resident cannot control, side effect of antipsychotic medications; Albuterol Sulfate - respiratory medication; Anti-fungal - drug to treat fungal infections; Anti-psychotic- drug to treat psychosis and other mental/emotional conditions (e.g. Risperdal, Seroquel); Atorvastatin - medication for high cholesterol; Braden Scale - tool to determine risk of pressure sore development; Bacitracin - topical antibiotic ointment; BID - twice a day; BMP - basic metabolic panel - a lab test; Chronic kidney disease stage IV - severe kidney damage and loss of kidney function; cm - (centimeter) unit of measurement; c/o - complaint of;	F 000		

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F 000	Continued From page 2 Coccyx - tailbone; Cognition - thinking, memory; Cognitively Impaired - mental decline including losing the ability to understand, talk or write; Deep Tissue Injury (DTI) - Purple or maroon intact skin or blood-filled blister. May start as tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than surrounding tissue; Delusion - false beliefs; Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation; Dialysis - cleansing of the blood by artificial means when kidneys have failed; Dialysis communication book - binder with paper for facility and dialysis center to record resident assessment including pre and post treatment weights; Dry Weight - the weight without the excess fluid that builds up between dialysis treatments. It is the lowest weight one can safely reach after dialysis without developing symptoms of low blood pressure such as cramping, which can occur when too much fluid is removed; etc.- and so forth; e.g. - abbreviation that means "for example;" eMAR - Electronic Medication Administration Record; Epithelial - new skin cells; Foley catheter - tube held in the bladder by a small balloon to drain urine; Gluteus - buttocks area; Grams - a metric unit of mass equal to one thousandth of a kilogram; Grandfathered into - a rule that does not apply to something that happened before the rule was made; Hx - history of;	F 000		

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F 000	Continued From page 3 Incontinence - loss of control of bladder and/or bowel function; Ipratropium-albuterol solution (Duonebs) - a medication that is inhaled via nebulization to increase air flow to the lungs; K+ - potassium - referring to the amount of potassium in the blood; kg - kilogram; Klebsiella Pneumoniae - bacteria that can cause a life threatening infection; LAL - low air loss mattress - a mattress designed to prevent and treat pressure wounds. The mattress is composed of multiple inflatable air tubes that alternately inflate and deflate, mimicking the movement of a patient shifting in bed or being rotated by a caregiver, never leaving the patient in one position for any extended length of time. This action relieves pressure under the body; Lasix (furosemide) a medication to help remove the body of excess fluid; lb(s) - pound; Lipid panel - lab test for high cholesterol and lipids (fat); MASD - Moisture Associated Skin Dermatitis - broken and irritated skin as a result of exposure to moisture; MDS - Minimum Data Set/standardized assessment tool used in long term care facilities; Med Pass - a nutritional supplement; Miralax - medication for constipation; Mirtazapine - medication for depression and poor appetite; mg - milligrams-unit of weight; mL - milliliter a unit of measurement of fluid; MRSA - bacteria that can cause a life threatening infection; NAS - No added salt; Necrosis - dead tissue;	F 000		

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F 000	Continued From page 4 Offloading/Offload - removal of pressure from an area; OOB - out of bed; Partial thickness wounds - wounds that extend only into the first two layers of skin, the epidermis or dermis; Post - after; Pre - before; Pressure Ulcers (PUs) - sore area of skin that develops when blood supply to it is cut off due to pressure; PRN - as needed; prosthetic - an artificial part of the body; Psychosis - loss of contact/touch with reality; Psychoactive medication - drug used to change brain function to change mood, perception or consciousness; Psychotropic (medication) - medication capable of affecting the mind, emotions and behavior; R/T - related to; ROM-range of motion; Sacrum - large triangular bone at base of spine; Senna - medication for constipation; Stage III (3) Pressure Ulcer - open sore that goes into the tissue under below the skin; Trazodone - medication for depression; Unstageable Pressure Ulcer - actual depth of the ulcer cannot be determined due to the presence of slough (yellow, tan, gray, green or brown soft dead tissue) and/or eschar (hard dead tissue that is tan, brown or black. Eschar is worse than slough; Wet Weight - the weight with the excess fluid that builds up between dialysis treatments; x - times; %-percent.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		8/2/19

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F 550	Continued From page 5 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		

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F 550	Continued From page 6 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to promote care in a manner and environment that maintained or enhanced dignity for one (R57) resident out of 47 sampled residents and on one (Holly Unit) out of four nursing units. R57 was referred to as a "feeder". On the Holly Unit common area staff placed a towel on a chair seat before sitting on it during meals. Findings include: 1. During a random dining observation of the Scott unit middle hallway on 6/11/19 at 12:35 PM, E11 (CNA) referred to R57 as a "feeder" when explaining to E12 (CNA) what resident trays were left on the dining cart. E11 stated "all that's left is his/hers, he/she's a feeder". E12 then stated "oh yeah, that's R57, he/she is a feeder". 2. Cross refer to F584 6/12/19 9:33 AM - During an interview, A2 (family of a Holly Unit resident) reported that staff put towels on chair seats before sitting in a chair. 6/13/19 12:03 PM - An observation was made on the Holly Unit common area of E25 (CNA) placing a white bath towel on a chair seat before sitting on it and assisting residents to eat lunch. 6/13/19 4:45 PM - An observation was made on the Holly Unit common area of E26 (CNA) placing a white bath towel on a chair seat before sitting on it and assisting residents to eat dinner. However, residents were not observed sitting on towels.	F 550	1. 1.) R57 was not negatively impacted by this deficient practice. 2.) All residents who require assistance with feeding have the potential to be affected by this deficient practice. Residents will be protected from this deficient practice by taking the corrective actions outlined below in #3. 3.) The facility will conduct focused education for licensed nursing staff and certified nursing assistants on proper terminology regarding residents who require assistance with feeding and in regards to dignity and respect of individuality of residents. 4.) The Director of Nursing (DON)/designee will audit all units who are noted to have residents who require assistance with feeding to assess for proper staff terminology. The audit will be conducted daily until 100% compliance is achieved for 5 consecutive days. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.	

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F 550	Continued From page 7 6/17/19 1:40 PM - During an interview, when asked why he/she put a towel on the chairs before sitting on it, E25 (CNA) stated all of the staff put towels on the chairs because residents are incontinent on the chairs and we have to protect our uniforms from getting wet and stained. Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the exit conference beginning on 6/18/19 at 12:40 PM.	F 550	2. 1.) No resident was negatively impacted by this deficient practice. 2.) All residents who reside in the Holly Wing have the potential to be affected by this deficient practice. Residents will be protected from this deficient practice by taking the corrective actions outlined below in #3. 3.) All seating surfaces in Holly will be thoroughly cleaned. Staff will be in-serviced on the expectation that they do not line the seats with towels for themselves to sit on. 4.) The Holly Unit Manager/designee will audit seating surfaces in unit to ensure staff are not covering seating surface with towels. The audit will be conducted daily at different times until 100% compliance is achieved for 5 consecutive audits. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.	F 554		8/2/19

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F 554	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation as indicated, the facility failed to determine whether the right to self administer medications was clinically appropriate for two (R86 and R70) out of nine residents observed receiving medications. Findings include: The facility policy entitled "Self Administration of Medication", last updated December 2012 indicated "Each resident has the right to self administer medications unless the interdisciplinary team which includes the doctor, nurse, social worker, RNAC, and activities director determines for each resident this practice is unsafe". 1. During a random medication administration observation on 6/11/19 at 3:54 PM E13 (LPN) was observed preparing and administering medications to R86. E13 prepared a powdered laxative that was mixed in water and then left it on R86's bedside table. E13 then stated that R85 "likes to take it in bed, so I just leave it until she is put to bed", when asked what time R86 usually goes to bed, E13 responded "around 4:00 PM or 5:00 PM, soon", when asked whether R86 had been assessed for self medication, E13 stated "I'm not sure". Review of R86's clinical record revealed there was no evidence that the interdisciplinary team was involved in determining whether the self-administration of medications was clinically appropriate for R86. 2. Review of R70's clinical record revealed the following:	F 554	1. 1. R86 was not negatively impacted by the cited deficient practice. Staff is no longer leaving the laxative at bedside. 2. All residents that we administer medications to have the potential to be affected by this deficient practice. Residents will be protected by taken the action outlined below. 3. All nurses who administer medication will be re-educated to not leave medicine at bedside, they are to watch the resident take the medicine and then document that it was given. 4. DON/Designee will conduct medication pass audits to ensure that nurses are following medicine administration procedure. The audit will be conducted daily until 100% compliance is achieved for five consecutive audits. Then the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA meeting. 2. 1. R70 was not negatively impacted by the cited deficient practice. 2. All residents that self administer medication have the potential to be affected by this deficient practice. Residents will be protected by taking the	

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F 554	Continued From page 9 3/14/19 - R70 was admitted to the facility. 3/14/19 - A physician order for ipratropium-albuterol solution (Duonebs - a medication that is inhaled with the use of a nebulizer machine to increase air flow to the lungs) for nebulization four times a day. Review of the March, April, May and June 2019 MARs (medication administration record) documented that the facility nurses administered Duonebs four times a day. During a resident interview on 6/14/19 at 11:35 AM, E9 (LPN) was observed entering R70's room and placing a plastic vial that contained Duonebs in R70's hand for R70 to self administer while E9 left the room. Review of R70's clinical record revealed there was no evidence that the interdisciplinary team was involved in determining whether the self-administration of medications was clinically appropriate for R70. During an interview on 6/14/19 at 2:45 PM, E9 (LPN), E31 (LPN) and E32 (LPN) confirmed that R70 has been self-administrating the Duonebs treatment since she was admitted on 3/14/19 because R70 insisted that he/she would administer it him/herself. They were not aware of documentation that interdisciplinary team had determined that R70 was safe to self-administration medication. During an interview on 6/17/19 at 9:15 AM, E2 (DON) confirmed that there was no physician's order for R70 to self-administer the Duonebs	F 554	corrective action below. 3. Unit Managers for each unit have confirmed that there are no other residents in the building currently that self administer medication. Going forward any resident that is being assessed by Nurse Practitioner or Doctor for the appropriateness to self administer will be approved by DON prior to being given that privilege. 4. The DON/designee will audit new orders to ascertain if there are any new orders for residents to self administer and confirm that facility procedure is being followed. The audit will be conducted three times a week until 100% compliance is achieved for five consecutive audits. Then the audit will be conducted once weekly until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA meeting.	

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F 554	Continued From page 10 treatment and the interdisciplinary team did not determine R70 was safe to self-administration. Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the exit conference beginning on 6/18/19 at 12:40 PM.	F 554		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		8/2/19

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F 582	Continued From page 11 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide the appropriate notices when a resident was moved from short term care to long term care for one (R71) out of two residents reviewed for a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN). Findings include: 1/31/19 - R71 was admitted for Medicare Part A skilled services. 2/19/19 - A progress note revealed that R71's family was notified of an available long term bed, but the family had not made a decision on whether R71 would remain in the facility or not. Notice of Medicare Non-Coverage (NOMNC) was	F 582	1. No residents were negatively impacted by this deficient practice. 2. Any resident that moves from our short term care to long term care unit could potentially be affected by this deficient practice. Future residents will be protected by our taking the corrective actions outlined below. 3. The facility will conduct a focus review of all residents transitioned from short term to long term stay in the past 30 days and verify that appropriate notice of a Skilled nursing Facility Advance Beneficiary Notice (SNFABN) was provided. Social Services department will be in-serviced and provided with tools to	

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CADIA REHABILITATION CAPITOL	1225 WALKER ROAD DOVER, DE 19904

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F 582	Continued From page 12 discussed. 2/20/19 - A progress note revealed that R71 was moved to a long term care bed. R71 was not discharged from the facility. 2/25/19 - R71's last covered day of Medicare Part A services. 6/14/19 12:00 PM - During an interview with E14 (SW) it was explained that the family never received the required Skilled Nursing Facility Advance Beneficiary Notice for Non-coverage (SNFABN) because, at first, the family hadn't decided if R71 would remain in the facility or be discharged. E14 confirmed that once the decision was made that R71 would remain at the facility, the SNFABN should have been given to the family. Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the exit conference beginning on 6/18/19 at 12:40 PM.	F 582	guide them in ensuring the appropriate notification procedure is followed when a resident is moved from short term to long term care going forward. 4. The Director of Social Services or designee, will audit residents who have transitioned from short-term to long-term care since the survey completion date for appropriately being provided the SNFABN. The audit will be conducted weekly until 100% compliance is achieved over five consecutive audits. Then the audit will be conducted every other week until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA meeting.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		8/2/19

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F 584	Continued From page 13 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to maintain a clean, comfortable and homelike environment in one (Holly Unit) out of four nursing units. Findings include: Cross refer to F550 6/13/19 1:30 PM - During an interview, A1 (family of a Holly Unit resident) reported that the Holly	F 584	1. No residents were negatively impacted by this deficient practice. 2. Any resident that resides in our Holly Unit could potentially be affected by this deficient practice. 3. All of the flooring and seating surfaces have been thoroughly cleaned. A housekeeping employee is designated specifically to the Holly Wing daily to ensure cleanliness throughout the entire	

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F 584	Continued From page 14 Unit is very dirty. Housekeeping staff should be keeping floor clean in the common area. There is always food on the floor. Staff should expect residents' with dementia are going to drop food on the floor while eating and plan to keep the floor clean. 6/12/19 9:33 AM - During an interview, A2 (family of a Holly Unit resident) reported that all of the Holly Unit is dirty. His/her family member wanders around the unit and his/her slipper-socks are filthy. Tables in the common area are always sticky. Even staff put towels on chair seats before sitting in a chair. 6/13/19 12:03 PM - An observation was made on the Holly Unit common area of E25 (CNA) placing a white bath towel on a chair seat before sitting on it and assisting residents to eat lunch. 6/13/19 4:00 PM - An observation was made on the Holly Unit's TV area of the sofa that residents frequently sit on. The sofa had multiple red and brown stains on the 3 seat cushions. The sofa lining under the seat cushions was almost totally covered with stains. 6/13/19 4:25 PM - During an interview with E2 (DON) and E8 (RN, Unit Manager), this sofa was examined and the above stains were confirmed. 6/13/19 4:45 PM - An observation was made on Holly Unit common area of E26 (CNA) placing a white bath towel on a chair seat before sitting on it and assisting residents to eat dinner. 6/17/19 1:40 PM - During an interview, when asked why he/she put a towel on the chairs before sitting on it, E25 (CNA) stated all of the	F 584	unit including floors and furniture. The floors are mopped daily and swept clean and spot cleaned after every meal. Furniture is wiped clean daily and steam cleaned monthly. Spot deep cleaning of furniture is done as needed. 4. The Director of Environmental Services or designee, will audit Holly daily to ensure that our high standards of cleanliness are met and the entire unit is sanitary, orderly and comfortable for residents, staff and visitors. The audit will include all furniture and flooring in addition to other areas of the Holly Unit .The audit will be conducted daily until 100% compliance is achieved for 2 full weeks (14 days) to include weekend, audits will be conducted at different times of day to include all 3 shifts. Then the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA meeting.	

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F 584	Continued From page 15 staff put towels on the chairs because residents are incontinent on the chairs and we have to protect our uniforms from getting wet and stained. Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the exit conference beginning on 6/18/19 at 12:40 PM.	F 584		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:	F 585		8/2/19

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F 585	Continued From page 16 (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and	F 585		

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F 585	Continued From page 17 as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. 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 establish and implement a grievance policy that included posting of the Grievance Official's name and contact information in prominent locations throughout the facility. Additionally, the facility failed to identify the steps and procedures in filing grievances anonymously. Findings include: During a resident meeting with surveyors on 6/12/19 at approximately 1:45 PM, only two (2) out of the ten (10) residents, who wished to remain anonymous, were aware of how to file a	F 585	1. No residents were negatively impacted by this deficient practice. 2. Any resident that has a grievance and needs to understand the process to voice their concern could potentially be affected by this deficient practice. The corrective actions outlined below will rectify this deficiency. 3. Postings are now displayed in prominent locations throughout the facility containing information about our grievance process, the fact that Grievances can be filed anonymously, identifying the Grievance Officer, how to	

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F 585	Continued From page 18 grievance verbally. Not one among the ten (10) residents was aware of how to file a written grievance nor how to file a grievance anonymously. When asked if they know the facility's Grievance Official, the residents answered, "No". The Policy entitled "Grievances" effective February 2009 (revised 10/12/18) documented: 1. The facility will make information on how to file a grievance or complaint available to residents by posting in prominent locations throughout the facility of the right to file grievances or by providing such notice directly to residents in writing. Such posting and/or notice shall include: a. The right to file a grievance orally (spoken) or in writing; b. The right to file grievance anonymously; c. The contact information of the grievance official with whom a grievance can be filed (name, business mailing address and email, business phone number); d. A reasonable expected time frame for completing the review of the grievance; e. The right to obtain a written decision regarding the grievance; f. The contact information of independent entities with whom grievance may filed, including all regulatory agencies ..." An observation of Scott 1 and Scott 2 halls on 6/12/19 at approximately 2:30 PM, lacked evidence of any postings in prominent locations throughout the facility containing information regarding the facility's grievance process identifying who the Grievance Officer was and how to contact them. In addition, the facility lacked evidence of postings containing the State Survey Agency's hotline contact information in	F 585	contact Grievance Officer and the State Survey Agency s Hotline contact information. The grievance process and Grievance Officer contact information has also been added to the monthly Resident Council Agenda. 4. The Director of Social Services or designee, will survey 5 residents as to their understanding of how to file a grievance and who they can file it with. The audit will be conducted weekly until 100% compliance is achieved with resident understanding of the grievance process for 3 consecutive audits. Then the audit will be conducted every other week until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA meeting.	

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F 585	Continued From page 19 prominent locations throughout the facility. 6/14/19 8:39 AM - In an interview, E4 (Corporate Director) stated that all units have postings of the facility's Corporate Compliance Hotline information where residents can place their anonymous complaints. The surveyor informed E4 of Resident Council's general statement at the meeting that the residents do not know how to file a grievance anonymously and that the residents do not know who is the facility designated Grievance Officer. 6/14/19 9:47 AM - During an interview, E1 (NHA) presented to the surveyor a posting indicating E1 as the designated Grievance Official with the contact information. E1 further led this surveyor into the lobby to show the framed poster placed on top of the foyer table by the main entrance. When asked if the same information is posted across all the nursing units and throughout the facility, E1 answered, "No, we have this posting only here in the lobby because everybody walks in through here." The facility failed to establish and implement a grievance policy that included posting of the Grievance Official's name and contact information in prominent locations throughout the facility. The facility failed to identify the steps and procedures in filing grievances anonymously. Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the exit conference beginning on 6/18/19 at 12:40 PM.	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		8/2/19

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F 641	Continued From page 20 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the MDS (Minimum Data Set) assessment accurately reflected the residents' status for two (R8 and R35) out of 47 sampled residents. Findings include: 1. Review of R35's clinical record revealed the following: 10/30/15 - R35 was admitted to the facility. 4/4/19 - The Quarterly MDS assessment incorrectly documented that R35 was receiving renal dialysis. 6/17/19 11:45 AM - During an interview, E24 (MDS Coordinator) confirmed the above error and that R35 did not receive renal dialysis. 2. Review of R8's clinical record revealed the following: 2/3/16 - R8 was admitted to the facility. R8's Annual and Significant Change comprehensive MDS assessments on 12/10/18 and 12/19/19 respectively documented that R8 did not have any tobacco usage. 6/11/19 2:28 PM - During an interview, R8 stated that he/she was a tobacco user and is aware of the facility's policy on Smoke - Free Campus.	F 641	1. 1. No residents were negatively impacted by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. Residents will be protected by taken the action outlined below. 3. Resident R35 s MDS was corrected to reflect that he is not receiving renal dialysis. The facility will conduct a focus review of 20 MDS assessments completed since survey exit to ensure accurate completion of Section O, which includes dialysis. A training session for facility RNAC will be conducted by corporate RNAC to ensure understanding of the importance of ensuring the MDS assessment accurately reflects residents status. 4. DON/Designee will conduct random selection audits of 8 MDS assessments to ensure assessment accurately reflects the residents status pertaining to dialysis. The audit will be conducted daily until 100% compliance is achieved for five consecutive audits. Then the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA meeting.	

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F 641	Continued From page 21 6/11/19 2:35 PM - R8 was observed accompanied by E18 (Activity Assistant) smoking outside of the facility building at the walkway across from the Disabled Parking Area. When asked if the resident is a tobacco user, R8 answered "Yes, I smoke." 6/11/19 2:45 PM - During an interview, E18 (Activity Assistant) stated that he is very familiar with R8 and confirmed that R8 smoked and was "grandfathered into" (a rule does not apply to something that happened before the rule was made.) 6/14/19 8:39 AM - During an interview, E4 (Corporate Director) confirmed that R8 was grandfathered into and thus continues to smoke outside of the facility building. 6/17/19 11:35 AM - During an interview, E19 (MDS Coordinator) confirmed that all of R8's MDS comprehensive assessments on tobacco usage were inaccurately recorded as non tobacco user. E19 further added that, "I will do modifications on my MDS assessments." Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the exit conference beginning on 6/18/19 at 12:40 PM.	F 641	2. 1. No residents were negatively impacted by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. Residents will be protected by taken the action outlined below. 3. Resident R8 s MDS was corrected to reflect that he is a smoker. The facility will conduct a focus review of 20 MDS assessments completed since survey exit to ensure accurate completion of Section J, which includes smoking. A training session for facility RNAC will be conducted by corporate RNAC to ensure understanding of the importance of ensuring the MDS assessment accurately reflects residents status. 4. DON/Designee will conduct random selection audits of 8 MDS assessments to ensure assessment accurately reflects the residents status pertaining to smoking. The audit will be conducted daily until 100% compliance is achieved for five consecutive audits. Then the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA meeting.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655		8/2/19

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F 655	Continued From page 22 Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting	F 655		

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F 655	Continued From page 23 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility failed to ensure that the baseline care plan for one (R162) out of one sampled residents reviewed for urinary catheter properly reflected that R162 had an indwelling Foley catheter upon admission. Findings include: Review of R162's records revealed the following: 5/28/19 - R162 was admitted to the facility with an indwelling Foley catheter. 5/29/19 - The Baseline careplan did not include reference to R162's Foley catheter. Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the exit conference beginning on 6/18/19 at 12:40 PM.	F 655	1. R162 was not negatively impacted by the cited deficient practice. The comprehensive care plan for R162 correctly indicated a Foley Catheter. 2. All new residents have the potential to be affected by the cited deficient practice. Future residents will be protected from this cited deficient practice by taking the corrective actions outlined in #3 3. The facility will conduct a focus review of all residents admitted in the past 15 days to verify findings cited in the resident baseline care plan are accurate and inclusive of all information necessary to properly care for resident. Staff educator will conduct training for all nurses involved in the care planning process to ensure a thorough understanding of the importance of baseline care plan to properly reflect an indwelling Foley catheter. 4. The DON/designee will audit residents admitted from the survey completion date going forward for accuracy of the initial assessment. The audit will be conducted three times a week until 100% compliance is achieved over five consecutive audits. Then the audit will be conducted once weekly until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the	

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F 655	Continued From page 24	F 655	facility QA meeting.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure quality of care was maintained for one (R74) out of one residents reviewed for general concerns, who did not receive medication as ordered from 3/9/19 through 3/28/19. Findings include: Review of R74's clinical record revealed: R74's care plan for fluid maintenance created 11/15/18, last updated 6/4/19, included the intervention to administer medications as ordered. Review of R74's electronic physician's orders revealed an order for Lasix (furosemide) a medication to help rid the body of excess fluid were as follows: 2/8 -2/21/19 - Lasix 40 mg twice a day. 2/22/19 - Lasix 40 mg twice a day through 3/9/19.	F 684	1. R74 was not negatively impacted by the cited deficient practice. R74 currently has orders for Lasix. 2. All residents with orders for Lasix have the potential to be affected by the cited deficient practice. Residents will be protected from this cited deficient practice by taking the corrective actions outlined in #3 3. All residents currently with orders for Lasix have been reviewed for any indication of a planned stop date or a dose change to ensure that order is being followed and progress notes and follow-up notes indicate same. Staff educator will provide training to nurses on the importance of administering medication as ordered and ensuring accuracy with order transcribing. 4. The DON/designee will audit all residents in house with Lasix orders to ensure they are receiving Lasix as ordered. The audit will be conducted	8/2/19

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F 684	Continued From page 25 3/28/29 - 4/12/19 - 40 mg of Lasix daily. 2/22/19 2:00 PM - A nurses note [Recorded as Late Entry on 2/25/19 2:01 PM] documented "R74 called this nurse to room and stated that she wanted to keep taking her Lasix since her doctor had ordered it. MD made aware and Lasix resumed for remainder of 30 days per resident request. On 3/9/19 resident will resume taking 40 mg Lasix daily in evening." 2/25/19 2:24 PM - A nurses note documented "per request from E22 (NP) R74's pulmonary doctor was called to enquire if he wanted to continue Lasix or not based on resident's recent labs that he had requested. Awaiting call back." 2/25/19 3:34 PM - A nurses note documented "return call received from R74's pulmonologist. New verbal order in reference to lab results to continue with Lasix 40 mg by mouth twice a day until 3/9/19 then resume Lasix 40 mg by mouth daily... E22 (NP) made aware and is in agreement with new orders received. Resident made aware." Review of R74's March 2019 eMAR revealed documentation that Lasix was not given 3/9/19 - 3/28/19. During an interview on 6/11/19 at 9:51 AM R74 reported "they misread my prescription and I didn't get my Lasix for two weeks and now my legs are swollen". During an interview on 6/17/19 at 1:50 PM with E7 (LPN) it was confirmed that the facility did not follow the physician's order as directed to resume R74's Lasix 40 mg by mouth daily after 3/9/19.	F 684	weekly until 100% compliance is achieved over five consecutive audits. Then the audit will be conducted once every other week until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA meeting.	

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F 684	Continued From page 26 Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the exit conference beginning on 6/18/19 at 12:40 PM.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the necessary care and services to promote healing of a pressure ulcer were received for one (R57) out of four residents reviewed for pressure ulcers. R57 did not receive a recommended low air loss (LAL) mattress until 29 days after the initial recommendation. Findings Include: Review of R57's clinical record revealed: 2/15/19 2:57 PM - A nurses note documented "resident with MASD to coccyx this afternoon. New orders implemented. MD and responsible party notified."	F 686	1. R57 was not negatively impacted by the cited deficient practice. R57 currently has a Low Air Loss Mattress. 2. All residents with orders and/or recommendations for Low Air Loss Mattress have the potential to be affected by the cited deficient practice. Residents will be protected from this cited deficient practice by taking the corrective actions outlined in #3 3. All residents with wounds have been assessed for appropriateness for a Low Air Loss Mattress. All residents who have recommendations for a Low Air Loss Mattress have orders and a Low Air Loss	8/2/19

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F 686	Continued From page 27 2/18/19 - A care plan for actual skin integrity was initiated for R57 with interventions to monitor for signs of infection and treatments as ordered. 3/13/19 - A wound care note documented R57 as having a "partial thickness ulceration of sacrum measuring 1.3 x 0.7 x 0.1 cm MASD moisture erosions along the sacrum. Plan: continue repositioning in accordance with facility policy, offloading, monitor nutritional intake, float heels off mattress, recommended a LAL mattress. Interventions in place: pressure redistribution support surface, gel cushion to wheelchair." 3/14/19 - A quarterly MDS assessment documented R57 as having no unhealed pressure ulcers, but at risk for developing a pressure ulcer and receiving pressure reducing devices, turn and repositioning program, nutrition, and application of non-surgical dressings and ointments. R57 required extensive assistance for bed mobility and was always incontinent of bowel and bladder. 3/20/19 - A wound care note documented R57 as having "- partial thickness ulceration of the sacrum measures 0.5 x 0.3 x 0.1 wound base clean pink epithelial no evidence of necrosis, patient does not demonstrate evidence of pain. Plan - MASD of the sacral region hx of mixed incontinence and decreased mobility, continue repositioning in accordance with facility policy off load pressure on area." 3/20/19 11:35 AM - A nurses note documented "coccyx assessed on wound rounds with wound nurse E6 (wound care NP), site stable at this time. Orders obtained to continue with treatment."	F 686	Mattress in place. Staff educator will provide education for Unit Managers to review and follow up with any recommendations from wound nurse. 4. The ADON/designee will audit all weekly wound round recommendations. An audit will be conducted weekly to ensure that any recommendations for Low Air Loss Mattresses have an order entered, the mattress is in place and the care plan is reflective of implementation of the Low Air Loss Mattress until 100% compliance is achieved for five consecutive audits. Then the audit will be conducted once every other week until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA meeting.	

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F 686	Continued From page 28 4/10/19 - A wound care note documented R57's wound as "full thickness ulceration of the sacrum 1.0 x 0.7 x 0.1 80% slough 20% marbled granular tissue reclassified unstageable ulceration injury to sacrum previously MASD not improving discontinue current treatment... recommend LAL mattress, interventions in place pressure redistribution surface, gel cushion to wheelchair. " 4/10/19 2:20 PM - A nurses note documented "sacrum assessed on wound rounds, site noted with decline. Now reclassified from MASD to unstageable pressure injury. Orders obtained to change treatment." 4/11/19 8:20 AM- A nutrition progress note documented "update. Resident with change in altered skin. Nursing continues to encourage 240 ml fluids BID. 90 ml Med Pass (supplement) BID providing additional calories; 14 grams of protein. Estimated needs with altered skin...Average meal intake 65% meals...Oral intake appears to be meeting greater than estimated needs. Palliative care continues with no weights. Will increase med pass to 120 ml BID. Monitor wound healing." 4/11/19 - An order was written for R57 to have an "air mattress to bed at all times". 4/11/19 - An order was written to limit time out of bed time up to 2 hours intervals at a time, indication: unstageable pressure injury. 4/17/19 - A wound care note written by E6 (wound care NP) documented R57's wound as "full thickness 0.7 x 0.4 x 0.1 wound base 80% slough analysis improving...LAL in place ."	F 686		

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F 686	Continued From page 29 4/19/19 9:00 AM - A nurses note documented "sacrum assessed on wound rounds. Site is improving, continue current treatment." 4/22/19 - R57's care plan for actual impaired skin integrity, unstageable pressure injury to sacrum, was MASD. Interventions updated to include: limit out of bed time to 2 hour intervals. Report abnormal findings to MD, treatments as ordered. air mattress as ordered. 4/22/19 A wound care note written by E6 (wound care NP) documented R57's wound as "reclassified stage 3 previously unstageable." 4/23/19 - An order was written for R57 to receive liquid protein daily wound healing. 4/23/19 1:34 PM - A nutrition progress note documented "resident with improvement in altered skin... Stage III. Taking 120 ml Med Pass (supplement) twice a day... nursing to provide... [intake] 76-100% of meals. Will add 30 ml liquid protein daily to provide additional protein." 5/13/19 2:53 PM - A nurses note documented "Resident wound cultured results came back positive for MRSA and Klebsiella Pneumoniae (other bacteria). New order for antibiotics." 5/15/19 - A wound care note documented R57's wound as "stage 3 ...analysis improving wound culture MRSA started on antibiotics." 5/16/19 11:30 AM - A nurses note documented R57's "stage 3 wound to coccyx improving, wound culture positive for MRSA, currently being treated with antibiotics."	F 686		

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F 686	Continued From page 30 During an interview on 6/17/19 at 12:42 PM with E6 (wound care NP) it was explained that R57's initial mattress, a "pressure redistribution mattress is static and appropriate for people more able to turn on their own, but for the immobile, LAL mattress... the significance of a LAL mattress is to offload pressure to a specific area and helps keep pressure moving in that area. I've seen it help them heal a little faster than if its not implemented." E6 then reported that R57's pressure ulcer was "improving, almost closed, probably within a week." When asked "was the lack of timeliness of the facility to provide the LAL a major contribution to R57's worsening pressure ulcer?", E6 stated "no, for him/her a lot of different factors, time in the chair, overall decline. Once it got worse we changed several things. Also the main thing was the MRSA infection. There was a history of MRSA so it probably is colonized on her skin. Once we treated the infection we saw a progression in healing." The facility failed to initiate a LAL mattress to assist with the healing of R57's pressure ulcer until 29 days after the initial recommendation by E6 (wound care NP). Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the exit conference beginning on 6/18/19 at 12:40 PM.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical	F 688		8/2/19

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F 688	Continued From page 31 condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that a resident with limited range of motion was accurately assessed and failed to address a finding of new contractures for one (R3) out of three residents investigated for a limited range of motion (ROM), positioning and mobility. Findings include: Review of R3's record revealed the following: 3/20/17 - R3 was admitted to the facility. 10/5/18 - A therapy ROM assessment form was completed by E29 (Physical Therapist) documenting no contractures of any joint. 4/10/19 - A therapy ROM assessment form was completed by E27 (Occupational Therapist) and documented: Left shoulder - minimal contracture. Right shoulder - minimal contracture. Right elbow - minimal contracture. Left hand - contractures of 3 joints in 2 of 5	F 688	1. R3 was not negatively impacted by the cited deficient practice. R3 was assessed by a seasoned therapist and found to have no contractures. 2. All residents with or being assessed for contractures have the potential to be affected by the cited deficient practice. Residents will be protected from this cited deficient practice by taking the corrective actions outlined in #3 3. The current form being used to document contractures has been updated to allow for therapists to elaborate on their findings when assessing for contractures. Additionally, an in-service is being completed with all treating physical and occupational therapists related to how to accurately assess a resident with limited range of motion for contractures and document findings. When new or worsening contractures are identified treating therapists are required to alert Director of Rehab immediately to ensure proper procedure is to address findings of	

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F 688	Continued From page 32 fingers which is a change from previous assessment. 6/17/19 - A therapy ROM assessment form completed by E30 (Occupational Therapist) documented: no contractures of any joint, but unable to obtain accurate measurement secondary to patient's physical/behavior resistance. 6/17/19 12:30 PM - During an interview questioning how the facility responded to the 4/10/19 ROM assessment in which multiple contractures were identified, E1 (NHA) stated that at the time of this assessment E27 (Occupational Therapist) was both a new Occupational Therapist and a new employee and miss (sic) documented his/her assessment in the electronic medical record (EMR). E1 explained that E27 documented that contractures were present when R3 resisted allowing E27 to move the joint any further. E1 added that the facility had an experienced therapist assessed R3 today and no contractures were found. 6/17/19 12:30 PM - E1 (NHA) provided the surveyor a document written by E27 (Occupational Therapist) on 6/17/19 which explained: I (E27) completed on 4/10/19 our bi-annual range of motion screen for R3 utilizing the EMR observation report. My findings documented contractures of left shoulder, right shoulder, right elbow, and left hand. Due to limited experience, being a new graduate (of Occupational Therapy training) and working in the facility for one month, I based my range of motion measurements on where the resident began resisting based on his/her behavioral limitations. On the electronic medical record observation	F 688	new or worsening contractures. 4. The Director of Therapy/designee will audit all Range Of Motion Assessments daily to ensure proper assessment, documentation and follow up occurs until 100% compliance is achieved over five consecutive audits. Then the audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA meeting.	

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F 688	Continued From page 33 report, these measurements appear to be contractures because there was no option to justify that the measurements were unobtainable due to resident's physical and behavioral resistance. As per further education, I have now learned that the EMR has a comments box next to each measurement to write a description, progress note and for follow-up with appropriate plan of care. 6/17/19 1:00 PM - During an interview, E28 (Physical Therapist, Rehab Director) acknowledged that the facility should of identified new contractures were found on the 4/10/19 ROM assessment and then re-evaluated R3 to confirm the assessment of a new therapist. E28 confirmed that if the 4/10/19 assessment was accurate, the facility should of implemented interventions to prevent further decline. Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the exit conference beginning on 6/18/19 at 12:40 PM.	F 688		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was	F 693		8/2/19

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F 693	Continued From page 34 clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. 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 residents with gastric (stomach) (feeding) tubes, received appropriate care and services to prevent complications for two (R13 and R15) out of two residents observed for gastric tube feeding care and management. Direct care staff was observed checking placement of the gastric tube using methods no longer considered standard of practice and facility policy did not reflect the current standards of practice. Findings include: Auscultation (listening) is no longer recommended for checking placement of the feeding tube. Movement of air would likely be heard whether the tube was in the correct or incorrect location. Additional information regarding monitoring of feeding tubes may be found at, https://www.ismp.org/tools/articles/ASPEN.pdf "Auscultation verification of gastric tube (feeding tube) placement solely by auscultation (listening), which involves instillation of air into the tube while simultaneously listening with a stethoscope over the epigastric (abdominal) region for the sound of	F 693	1. 1. No resident was negatively impacted by the cited deficient practice. 2. Any residents with gastric tubes have the potential to be affected by this deficient practice. 3. A new policy that is aligned with current standards of practice has been developed and is attached, to reflect the standard of practice for maintenance and care of a feeding tube, including a procedure for correctly checking placement of the tube. Additionally, staff training will be done for all nurses ensuring that the new policy and procedure is being adhered to. 4. The Director of Nursing/Designee will observe staff check for placement of a feeding tube to ensure proper method is being followed per new policy. Audits will be completed across all shifts. This will be done daily until 100% compliance is achieved for 5 consecutive audits. Then the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved,	

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	085048	A. BUILDING _____ B. WING _____	06/18/2019

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F 693	Continued From page 35 air, is no longer recommended." (Emergency Nurses Association, Clinical Practice Guidelines: Gastric Tube Placement Verification, 2017). Nurses should not use the auscultatory (air bolus) or water bubbling method (holding tube under water) to determine tube location - American Association of Critical-Care Nurses updates Practice Alert on feeding tube placement 4/1/16. The facility policy on Enteral Tube Management and Enteral Feeding Guidelines : Gastric and Jejunostomy last revised 1/4/19 indicated the following: Purpose: minimize complications associated with enteral tube feeding medication administration and management. Gastric Residual Volume Check: Draw up 30 milliliters of air into a 60 ml, catheter-tipped syringe and attach to the open end of the gastrostomy tube flush the tube with air. Medication administration: verify tube placement prior to medication administration. Draw 10-30 ml of air into 60 ml catheter tipped syringe. Flush tube with air. Flush tube with water after placement is verified. Review of R15's clinical record revealed: 1. 3/11/19 - A physician order for R15's feeding tube directed staff to check for placement prior to: each feeding, flush and medication administration. 3/28/19 - A care plan was initiated for R15's tube feeding for potential for aspiration and other complications such as vomiting, diarrhea, and/or abdominal distention due to tube feeding with the goal that R15 will not have any significant	F 693	the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA meeting. 2. 1. No resident was negatively impacted by the cited deficient practice. 2. Any residents with gastric tubes have the potential to be affected by this deficient practice. 3. A new policy that is aligned with current standards of practice is being developed to reflect the standard of practice for maintenance and care of a feeding tube, including a procedure for correctly checking placement of the tube. Additionally, staff training will be done for all nurses ensuring that the new policy and procedure is being adhered to. 4. The Director of Nursing/Designee will observe medication administration through a feeding tube to ensure when verifying placement staff are adhering to new procedure that is aligned with current standard of practice. Audits will be completed across all shifts. This will be done daily until 100% compliance is achieved for five consecutive audits. Then the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA meeting.	

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F 693	Continued From page 36 complications related to tube feeding for 90 days. There were multiple interventions including check tube for placement and patency prior to administering medications, flushes or feedings. On 6/13/19 at 9:32 AM E17 (LPN) was observed disconnecting and removing R15's tube feeding, then verifying placement of R15's feeding tube by instilling 30 mL of air drawn into the syringe then pushing the air through R15's tube while simultaneously listening with a stethoscope over R15's abdomen. During a second observation on 6/13/19 at 12:00 PM E17 drew 30 mL of air into a syringe to verify placement of R15's feeding tube, prior to starting R15's scheduled tube feeding. Review of R15's progress notes indicated that injection of air into the feeding tube for verification of placement was documented almost daily. During an interview on 6/14/19 at 9:45 AM E16 (RN and facility staff educator) confirmed that staff was expected to verify tube feeding placement using air injected into the tube feeding. During an interview on 6/14/19 at 10:43 AM with E4 (Regional Clinical Director) it was explained that policy review, revision and verification "is handled at the corporate level, we review then send out a weekly notification to the facilities". 2. During an observation of medication administration through a feeding tube on 6/14/19 at 9:53 AM E15 (RN) verified placement of R13's feeding tube by instilling 30 mL of air drawn into a syringe then pushing the air through R13's tube while listening with a stethoscope over R13's	F 693		

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F 693	Continued From page 37 abdomen. The facility failed to ensure feeding tube placement was checked in accordance to current standards of practice. In addition, the facility failed to ensure their policy was updated to reflect the standard of practice for maintenance and care of a feeding tube, including a procedure for correctly checking placement of the tube. Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the exit conference beginning on 6/18/19 at 12:40 PM.	F 693		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to communicate and clarify with the dialysis center a recommendation for a fluid restriction for one (R81) out of one resident investigated for dialysis. Findings include: The facility policy entitled Dialysis Protocol (last revised 5/3/18) included the following procedure: "A communication record is used to ensure open, transparent communication regarding the resident's pre and post dialysis condition between the facility and the dialysis center; The communication record accompanies the resident	F 698	1. Resident R81 was not negatively impacted by the cited deficient practice. Resident R81 is currently on a fluid restriction. 2. Any residents on dialysis have the potential to be affected by this deficient practice. 3. All residents in the building since the survey exit that are on dialysis have been reviewed and are currently on a fluid restriction. Going forward, facility will follow up with physicians and dialysis center on all new dialysis patients to determine if a fluid restriction is	8/2/19

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F 698	Continued From page 38 to dialysis;...Hydration Monitoring will be implemented upon Registered Dietitian recommendation." Review of R81's clinical record revealed: 1/24/18 - R81 was admitted to the facility. 1/25/18 - A nutrition care plan was developed identifying the need for a therapeutic diet related to chronic kidney disease stage IV; weight loss with hospitalization; dialysis; weight gain ... with interventions that included "offer fluids at/between meals within restrictions. Assist with meal set up and feeding as needed". 6/20/18 - A care plan was developed identifying the potential for complications related to dialysis ... with interventions that included "monitor food and fluid intakes". 3/14/19 - R81 was readmitted to the facility with a readmission weight of 129.4 lbs (pounds). 4/2/19 11:20 AM - A progress note update by E21 (RD) documented that, " ...Weekly/monthly weight noted to be 150.8 # which reflects 7.7% weight gain over 1 month; 14% x 3 months; 16% x 6 months ...MD and nursing aware of weight change. 76-100% NAS diet. ? need for fluid restriction r/t (related to) dialysis and increase weight." 4/4/19 1:16 PM - A progress note by E2 (DON) documented that, "High risk review for weight gain - was hospitalized from 3/7-3/14. Gain noted after hospitalization. Resident continues on dialysis and eats 76-100% of meals and candy and food that family brings to the facility. RD	F 698	warranted. Staff training will be completed to ensure that there is a through understanding of the importance to communicate and clarify when needed any recommendations from dialysis center related to fluid restrictions. 4. The Director of Nursing/Designee will audit all residents on dialysis to identify if they are on a fluid restriction, if not, they will ensure that our staff partnered with physician, dietician and dialysis center to review if a fluid restriction is warranted. This will be done daily until 100% compliance is achieved with all dialysis patients in house. Then the audit will be conducted every other week until 100% compliance with all dialysis patients in house is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved with all dialysis patients in house, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA meeting.	

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F 698	Continued From page 39 questioning possible need for fluid restriction from dialysis and NP; waiting on response. Will continue on weekly weights at this time." 4/5/19 10:42 AM - A physician observation note completed by E22 (NP) showed R81's weight as 150.8 lbs but did not indicate a follow up note regarding fluid restriction. 4/5/19 3:53 PM - A progress note by E7 (RN) documented that, "Resident with weight gain; was 140 lbs and now 150 lbs, lungs are clear but diminish, no coughing or SOB (shortness of breath), resident will will (sic) while eating ice cubes. No edema noted to legs and feet, resident denied any discomfort at present. Daughter (name) is aware and in MD book for review ..." 5/29/19 9:45 AM - A physician observation note completed by E22 (NP) showed R81's weight as 155.1 lbs but did not indicate a follow up note regarding fluid restriction. 5/29/19 1:56 PM - A progress note by E7 (RN) documented that E7 called the dialysis center to inquire about R81's wet and dry weight. The weights before and after dialysis were 68.9 kg (151.58 lbs) and 65.8 kg (144.76 lbs) respectively. E7 further documented that, " ...they (dialysis) would like resident to be 62.5 kg (137.5 lbs). The nurse I spoke with was asking for the resident to be on fluid restriction because dialysis residents should be on fluid restriction. Dietitian notified and E22 (NP) too." There was no evidence of follow up on the dialysis center request for a fluid restriction. 6/14/19 1:00 PM - Review of R81's March, April,	F 698		

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F 698	Continued From page 40 May and June 2019 EMAR (Electronic Medication Administration Record) lacked evidence of a fluid restriction. 6/14/19 3:03 PM - In an interview, E2 (DON) stated that there was no order from the Dietitian nor from the Nurse Practitioner for a specific amount of fluid restriction for R81. 6/14/19 3:20 PM - During an interview, E2 (DON) explained to the surveyor that the facility did not receive any communication note from the dialysis center regarding fluid restriction with parameters. E2 said she called and clarified with D1 (Dialysis Center Dietitian) and a 1200 ml/day fluid restriction recommendation was confirmed by the dialysis center. E2 further stated that, "A physician's order was also obtained for R1 effective immediately." 6/17/19 7:55 AM - A progress note update by E21 (RD) documented that he/she spoke with D1 (Dialysis Center Dietitian) and a new order was noted for 1200 ml fluid restriction. E21 further noted that, "Dietary aware...Fluid gain noted above goal. Now on fluid restriction..." 6/18/19 8:45 AM - During an interview, E7 (RN) confirmed that he/she notiifed E21 (RD) and E22 (NP). 6/18/19 9:15 AM - During an interview, E21 (RN) explained to the surveyor that she spoke with D1 yesterday and further confirmed that R81 is now on fluid restriction. The facility failed to follow up with the physician and dialysis center to determine if a fluid restriction was needed.	F 698		

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F 698	Continued From page 41 Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the exit conference beginning on 6/18/19 at 12:40 PM.	F 698		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756		7/26/19

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F 756	Continued From page 42 maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R3 and R59) out of five residents reviewed for drug regimen review the facility failed to ensure pharmacist recommendations were acknowledged by the physician/prescriber. Prior to this survey, the facility conducted a root cause analysis, revised the process, provided education for the nursing unit mangers and evaluated the effectiveness of the new process; therefore, the failure to ensure pharmacist recommendations were acknowledged by the physician/prescriber is past non-compliance. Findings include: The facility's policy for Pharmacist Monthly Drug Review last revised 2/20/17 documented: For those issues that require physician/prescriber intervention, physician/prescriber will either accept or reject recommendations. If rejected, reason for rejecting recommendation will be provided. Facility will alert the Medical Director when recommendations are not addressed by the attending physician within 30 days. 1. The following was reviewed in R3's clinical record: 11/26/18 - The Consultant Pharmacist Report recommendations to the physician/prescriber:	F 756	Past noncompliance: no plan of correction required.	

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F 756	Continued From page 43 -Evaluate duplicate depression/appetite medications that are prescribed (Mirtazapine and Trazodone) - consider taper of Trazodone and titration of Mirtazapine if appropriate. -BMP 10/2018 K+ elevated - would recheck be of benefit? 12/19/18 - The Consultant Pharmacist Report stated, "Pharmacy recommendations for last month not in chart. Please check". There was no acknowledgement that the physician/prescriber reviewed these recommendations. 2. The following was reviewed in R59's clinical record: 11/27/18 - The Consultant Pharmacist Report recommendations to the physician/prescriber: -Receives Senna 2 tablets daily - consider stopping Miralax. -Evaluate continued need for Atorvastatin - lipid panel. There was no acknowledgement that the physician/prescriber reviewed these recommendations 2/12/19 The Consultant Pharmacist's Medication Regimen Review form for the three January 2019 Pharmacist's recommendations were signed and dated by the prescriber to acknowledge that the recommendations were reviewed, but wrote "no" next to one of the recommendations and did not provide a reason for rejection. 6/14/19 10:55 AM - During an interview with E2 (DON) to review the above findings and the	F 756		

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F 756	Continued From page 44 facility's process for pharmacist monthly drug review, E2 confirmed the above findings and explained that in January 2019 he/she identified this issue and revised the process to put additional accountability on the unit nurse managers to ensure pharmacist recommendations were acknowledged by the physicians/prescribers. 6/19/19 - E2 (DON) provided the facility's QAPI (Quality Assurance Process Improvement) Immediate Action Plan for the need to have a thorough and timely response to pharmacy recommendations (dated 2/1/19) and the monthly audit results for January - May 2019. The facility audited monthly and achieved 100% compliance in February, March, April and May of 2019. Prior to February of 2019, the facility failed to ensure pharmacist recommendations were acknowledged by the physician/prescriber. During this survey no issues were identified with pharmacy recommendations made in February - May for the five residents reviewed for drug regimen review. . During the survey the facility was in substantial compliance with this requirement. Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the exit conference beginning on 6/18/19 at 12:40 PM.	F 756		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:	F 868		8/2/19

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F 868	Continued From page 45 (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interview, it was determined that the facility failed to ensure that the Medical Director or a designee, attended the quarterly QAA (Quality Assurance Administration) meetings. Findings include: Review of attendance sign in sheets from the quarterly QAA committee meetings since July 2018 revealed that the Medical Director did not attend the January 16, 2019 meeting. During an interview on 6/18/19 at 8:31 AM with E1 (NHA), it was confirmed that the Medical Director or a designee, was not in attendance. Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the exit conference beginning on 6/18/19 at 12:40 PM.	F 868	1. No resident was negatively impacted by the cited deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. The facility will now verify the availability of the Medical Director/Designee prior to holding the QAA committee meeting. In the event that the Medical Director/Designee is not available, the meeting will be rescheduled within the required timeframe to ensure participation of Medical Director/Designee. 4. The NHA will ensure attendance of the Medical Director or Designee prior to holding meeting. In the event Medical Director or Designee is unavailable, meeting will be rescheduled.	

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 Capitol **DATE SURVEY COMPLED: June 18, 2019**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from June 11, 2019 through June 18, 2019. The facility census the first day of the survey was 117. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey no deficiencies were cited.	Plan outlined in Epoc system	8/2/19
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by the following:** Cross refer to CMS 2567-L survey completed June 18, 2019: F550, F554, F582, F584, F585, F641, F655, F684, F686,		

Provider's Signature [illegible], NHA Title Administrator Date 7-29-19

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 Capitol

DATE SURVEY COMPLED: June 18, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	F688, F693, F698, F756, and F868.	Plan outlined and submitted to Epoc system	8/2/19

Provider's Signature [illegible], NHA Title Administrator Date 7-29-19