STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	500 SOUTH BROAD STREET MIDDLETOWN, DE 19709

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual survey was conducted at this facility from May 28, 2019 through June 5, 2019. The facility census the first day of the survey was 108. 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 May 28, 2019 through June 5, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The facility census the first day of the survey was 108. The survey totaled 37 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN- Licensed Practical Nurse; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator. Antidepressant - drug to treat depression; Antipsychotic - drug to treat psychosis and other	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/28/2019

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	F 000		

mental/emotional conditions (such as Risperdal and Seroquel);
Arterial wound - wound or ulcer that develop as the result of damage to the arteries due to lack of blood flow to tissue;
Bipolar Disorder - mood disorder with periods of sadness and excitement;
Cul de sac - pulling the lower eyelid down to place eye drops;
Depression - mood disorder with feelings of sadness;
Dorsal - back;
Embolism - obstruction in a blood vessel due to a blood clot or other foreign matter;
Etiology - the study of a disease process;
Ischemic changes - decreased blood supply;
Lamictal - medication used to treat mood episodes in people that are bipolar;
Liters of oxygen - rate of oxygen flowing into a person over a period of 1 minute;
Major Depression Disorder - (MDD) - depression mental disorder;
Manic depression - condition with extreme high and low periods of sadness and excitement (bipolar disorder);
MDS - Minimum Data Set/standardized assessment tool used in long term care facilities;
ml - milliliter/unit of liquid measure, 30 ml equals one ounce;
Nasal cannula - a device used to supply oxygen;
Paroxetine - antidepressant use to treat depression, anxiety and other disorders;
PASRR and PASARR - Preadmission Screening and Resident Review - evaluation performed for determination of mental illness and recommendations;
Peripheral Artery Disease (PAD) - plaque build-up in arteries reducing circulation, often in legs;
Peripheral Vascular Disease (PVD) - disease of

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F 000	Continued From page 2 arteries and veins OR common circulatory problem with reduced blood flow to your arms/legs; Podiatry - the study, diagnosis, medical and surgical management of the foot; Psychotic disorder - mental disorders that cause abnormal thinking and perceptions; Risperdal - medication used to treat schizoaffective disorder; Respiratory failure - a decline in a person's breathing; RP - responsible person (decision maker for a resident deemed unable to make his/her own decisions); Schizoaffective disorder - mental disorder with hallucinations or delusions along with a mood disorder such as mania or depression; Stage 2 Pressure Injury/Ulcer - Blister or shallow open sore with red/pink color. Deeper tissues, fat, granulation tissue, slough and eschar are not present; Thrombosis - formation of a clot (thrombus) inside a blood vessel; Vascular disease - decrease in blood flow; Zyprexa - medication used to treat bipolar disorder.	F 000		
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	F 584		7/20/19

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F 584	Continued From page 3 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can 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 provide a homelike environment in one (Everett) out of four dining rooms by serving meals on trays. Findings include: 5/28/19 12:03 PM - An observation was made of	F 584	F584 A. No residents were adversely affected by the deficient practice. B. All residents have the potential to be affected by this deficient practice. Staff on	

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F 584	Continued From page 4 two residents sitting at tables in the common area and three residents eating in the Bistro. All were served their meal on trays. 5/30/19 12:18 PM - 12:21 PM - An observation was made of six residents sitting at tables in the common area and three residents in the Bistro eating their meals off of trays. 6/4/19 12:29 PM - An observation was made of five residents in the Bistro eating their meals off of trays. 6/4/19 12:31 PM - During an interview, R98 confirmed that he/she been living on this unit for three months and has always had lunch served on a tray, even when sitting at the dining room tables. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Educator), and E5 (Corporate) at the exit conference on June 4, 2019 at 3:15 PM.	F 584	the Everett Unit have been informed to remove trays at point of service in dining areas to ensure immediate compliance. Further education will follow. C. A root-cause analysis suggests that nursing staff on the Everett unit did not follow facilities protocol of transferring meals from the tray to residents table in dining areas on the Everett unit. To comply with a home-like environment, education will be provided to nursing staff by the Dietitian and or designee on all units that they must not place trays in front of resident□s while sitting in dining areas. This education will also be a part of the dietitian□s presentation during new hire orientation. A new policy will be implemented for dining area procedures. The dietitian and/or designee will monitor/ audit dining areas to ensure that compliance has taken place. D. The Dietitian and/or designee will conduct Audits to assure meals are removed from trays before serving daily x 5 days until 100% compliance is achieved, then weekly x 4 weeks until 100% compliance is achieved, then Monthly x 1 Month until 100% compliance is achieved. If at that time compliance is achieved, the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		7/20/19

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F 623	Continued From page 5 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30	F 623		

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F 623	Continued From page 6 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to	F 623		

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F 623	Continued From page 7 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R22) out of three residents sampled for hospitalization the facility failed to provide timely written notification to the responsible person (RP) when the resident was transferred emergently to the hospital including the reason for the transfer. Findings include: Review of R22's clinical record revealed: 5/7/19 - 5/11/19 - R22 was hospitalized for fever and respiratory failure. 5/19/19 - 5/23/19 - R22 was hospitalized for respiratory failure. 5/22/19 3:32 PM - E10 (Admissions) documented in a progress note, "RP returned phone call in regards to bed-hold. Explained that resident bed-hold had been exhausted and that when he/she returns to the facility, it will reset after 30 days of uninterrupted status in the facility. RP	F 623	F623 A. R22 was not affected by the deficient practice. B. Residents who transfer or discharge from the facility have the potential to be affected by the same deficient practice. C. All residents who transfer or discharge from the facility will be issued a Notice of Transfer/ Discharge. The Admissions Director and/or designees will identify these residents during the facilities□ daily interdisciplinary team meetings. Transfer/ Discharge notices will be sent per our centers policy and procedures (i.e. Resident and Ombudsman Notification of Transfer). A notice of Transfer/ Discharge will be mailed to every resident and/or resident representative upon transfer to the hospital. Admissions Director and/or	

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F 623	Continued From page 8 verbalized understanding. Notice of transfer to be mailed and ombudsman to be notified." 5/31/19 12:30 PM - During an interview, E10 (Admissions) confirmed that no written notification was provided to R22's RP for the 5/7/19 hospitalization. On 5/22/19 a "Notice of Transfer" form was sent to the RP for the 5/19/19 hospitalization. E10 explained that his/her understanding was the transfer notice only needed to be sent after a resident was hospitalized 7 days in a 30 day period. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Educator), and E5 (Corporate) at the exit conference on June 4, 2019 at 3:15 PM.	F 623	designee will call the resident/ resident representative and explain that this notice will be mailed to them. Admissions Director and/or designee will document that conversation occurred and that the ombudsman will be notified, in the residents progress notes. A notice of transfer/ discharge will be mailed to every resident and/or resident representative upon discharge from the facility. All notices will be scanned into the residents electronic chart. All notices will be scanned and emailed to the Office of the State Long Term Care Ombudsman including: the reason for the transfer/discharge, the effective date of the transfer/discharge, the location to which the resident transferred/ discharged, and statement of the resident appeal rights with contact information to initiate an appeal. The Admission Director and Admissions Assistants will receive training from the facility Staff Educator/ designee related to the facilities Transfer/Discharge policies and procedures. D. The Admissions Director and or designee will conduct audits of all notices to ensure the deficient practice will not recur. The audit will begin with 100% of all residents who transfer and/or discharge from the facility Daily x 5 until 100% compliance is achieved, then Weekly x 4 weeks until 100% compliance is achieved, then Monthly x 1 Month until 100% is achieved. If at that time compliance is achieved the deficient practice will be noted as resolved. Audits	

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F 623	Continued From page 9	F 623	will be reviewed by our QA Committee.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide bed-hold notice in a timely fashion to the responsible person (RP) for one (R22) out of	F 625	F625 A. R22 was not affected by the deficient practice.	7/20/19

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F 625	Continued From page 10 three residents sampled for hospitalization. Findings include: Review of the facility's policy and procedure (last revised 11/2/18), entitled "Bed Holds" stated, "if the resident leaves the facility for emergency treatment at a hospital..., the Admission Director/Designee will call the resident's family member or legal representative, explain the Bed Hold Policy, and advise the family member or legal representative that the written notice will be mailed to them for review..." Review of R22's clinical record revealed: 5/7/19 - 5/11/19 - R22 was hospitalized for fever and respiratory failure. 5/19/19 - 5/23/19 - R22 was hospitalized for respiratory failure. 5/22/19 3:32 PM - E10 (Admissions) documented in a progress note, "RP returned phone call in regards to bed-hold. Explained that resident bed-hold had been exhausted and that when he/she returns to the facility, it will reset after 30 days of uninterrupted status in the facility. RP verbalized understanding. Notice of transfer to be mailed and ombudsman to be notified." 5/31/19 12:30 PM - During an interview, E10 (Admissions) confirmed that written notification of the bed-hold notice was not provided to R22's RP for the 5/7/19 hospitalization. On 5/22/19, a "Notice of Transfer" form which included the bed-hold notice was sent to the RP for the 5/19/19 hospitalization. E10 explained that his/her understanding was the bed-hold notice only needed to be sent after a resident is hospitalized	F 625	B. Residents who transfer to the hospital from the facility have the potential to be affected by the same deficient practice. C. All residents who transfer out of the facility for a hospitalization and/or absence from the facility, will be issued a written hard copy of the facility□s bed hold policy. The Admissions Director will identify these residents during the facility daily interdisciplinary team meeting. Our facility Bed Hold Policy will be sent per our centers policy and procedures (i.e. Bed Hold Policy Review). A bed hold policy will be mailed to every resident and/or resident representative upon transfer to the hospital and/or absence from the facility. Admissions Director/ designee will call each resident/resident representative and explain the bed hold policy to them based on the resident□s insurance coverage. Bed hold rates will be offered to resident/ resident representative to each individual. Admissions Director/ designee will document that the conversation occurred and it will be documented to assure resident/resident representative is aware of bed hold policy. Bed hold policy will be scanned and entered into the resident□s electronic chart. All bed hold policies will be scanned and emailed to the Office of the State Long Term Care Ombudsman including: the bed hold policy and the denotation that it was mailed to resident/ resident representative. The Admissions Director and Admission Assistant will receive training from our Staff Educator/designee	

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F 625	Continued From page 11 7 days in a 30 day period. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Educator), and E5 (Corporate) at the exit conference on June 4, 2019 at 3:15 PM.	F 625	related to the facilities bed hold policy and procedures. D. The Admissions Director and/or designees will conduct audits of all notices to ensure the deficient practice will not recur. The audit will begin with 100% of all residents who transfer and/or discharge from the facility Daily x 5 until 100% compliance is achieved, then Weekly x 4 weeks until 100% compliance is achieved, then Monthly x 1 Month until 100% is achieved. If at that time compliance is achieved the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision.	F 636		7/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	06/05/2019

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CADIA REHABILITATION BROADMEADOW	500 SOUTH BROAD STREET MIDDLETOWN, DE 19709

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F 636	Continued From page 12 (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months.	F 636		

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F 636	Continued From page 13 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 MDS (Minimum Data Set) comprehensive assessment was accurate for one (R78) out of 37 sampled residents. Findings include: Review of R78's clinical record revealed: 8/10/17 - R78 was admitted to the facility with diagnoses including schizoaffective disorder, bipolar disorder and major depressive disorder. 8/22/17 - A State of Delaware Level 1 Preadmission Screening and Resident Review (PASRR) documented that R78 had a serious mental illness. 8/16/18 - The annual MDS in PASRR sections A1500 and A1510 coded R78 as not having a serious mental illness. 6/4/19 10:45 AM - E9 (RNAC) confirmed during an interview, that R78's MDS was incorrectly coded and that E9 would submit a correction. 6/4/19 1:45 PM - The above finding was discussed with E5 (Corporate). Findings were reviewed with E1 (NHA), E2 (DON), E4 (Educator), and E5 (Corporate) at the exit conference on June 4, 2019 at 3:15 PM.	F 636	F636 A. R78 was not negatively impacted by this deficient practice. On 6/4/19, the Annual MDS questions A1500 and A1510 were corrected to reflect the diagnosis of serious mental illness. B. Residents with a diagnosis of mental illness have the potential to be affected by the same deficient practice. All residents with a diagnosis of mental illness will be protected from this deficient practice by taking the corrective action outlined below in section C. C. The RNAC was educated on accurate coding of the PASSAR section on the MDS by the facility Lead RNAC. The facility Lead RNAC will review all current residents with a diagnosis of serious mental illness, and review comprehensive MDS for accurate coding of questions A1500 and A1510. D. The facility Lead RNAC will conduct audits on completed MDS to ensure PASSAR sections are completed accurately. The audits will occur Daily x 5 days until 100% compliance and achieved, then Weekly x 4 until 100% compliance is achieved, then Monthly x 1 Month until 100% compliance is achieved. If at that time compliance is achieved the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee.	

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §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, it was determined that for one (R56) of 37 sampled residents the facility failed to ensure the accuracy of the MDS (Minimum Data Set) assessment for R56 in the area of oxygen therapy. Findings include: Review of R56's records revealed the following: 10/1/18 - An order for "oxygen via nasal cannula at 3 liters continuous" (documented under R56's computerized orders at the time of survey). 4/18/19 - A quarterly MDS documented under Section O (Special Treatments and Programs) that Oxygen therapy was not checked as being a service that R56 was receiving. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Educator), and E5 (Corporate) at the exit conference on June 4, 2019 at 3:15 PM.	F 641	F641 A. R37 was not negatively impacted by this deficient practice. On 6/26/19, the quarterly MDS was corrected to include oxygen use. B. Residents with oxygen use have the potential to be affected by the same deficient practice. All residents with oxygen use will be protected from this deficient practice by the taking the corrective action outlined below in section C. C. The facility Lead RNAC will review all current residents with oxygen use, and review the MDS for accuracy. The facility Lead RNAC will routinely conduct a weekly review of future residents Admission MDS for accuracy with oxygen use. D. The facility Lead RNAC will conduct audits on completed MDS to ensure Oxygen use is coded accurately on the MDS. The audits will occur Daily x 5 days until 100% compliance is achieved, then Weekly x 4 until 100% compliance is achieved, then Monthly x 1 month until 100% compliance is achieved. If at that	7/20/19

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F 641	Continued From page 15	F 641	time compliance is achieved the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R10) out of three sampled residents reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to make a referral to the state authority. Findings include: Review of R10's clinical records revealed: 6/14/16 - Admission to the facility.	F 644	F644 A. R10 was not affected by the deficient practice. On 6/5/19 a referral was made to the state PASARR team to re- assess due to diagnosis of new mental illness requiring medication. Level 1.5 PASARR was issued on 6/12/19 B. Residents with new dx of mental illness requiring medication have the potential to	7/20/19

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F 644	Continued From page 16 6/14/16 - A PASRR was completed with a determination of "No indication of mental illness, mental retardation/related conditions appropriate for admission/continuous stay." 7/4/18 - An order for Risperidone tablet with an indication of MDD with psychotic features. 7/5/18 - A physician's order was written to monitor side effects associated with the use of the anti-psychotic medication Risperdal (Risperidone). 9/4/18 - The quarterly MDS revealed a psychotic disorder as an active diagnosis. 9/6/18 - A care plan documented that R10 used anti-psychotic medications for major depressive disorder with psychotic features and having behaviors such as hitting the staff, refusing care, paranoid thoughts and aggressive behavior. 12/4/18 - A Significant Change MDS revealed a psychotic disorder as an active diagnosis. 3/4/19 - A Quarterly MDS revealed a psychotic disorder as an active diagnosis. There was no evidence that the State PASRR authority was contacted to re-assess R10 when a new mental illness requiring medication was identified. 6/3/19 - During an interview at 3:42 PM, E14 (Social Worker) confirmed that the request for an updated PASRR was sent to the state on 5/31/19. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Educator), and E5 (Corporate) at the	F 644	be affected by the same deficient practice (see section C for corrective action) C. Social Services to review all current residents to identify residents with diagnosis of new mental illness requiring medication. Social Services will run weekly report to (Matrix report by drug class) to identify residents with diagnosis of new mental illness requiring medication. For residents with new diagnosis of mental illness requiring medication, Social Services will refer to the state PASARR unit to be re- assessed for updated PASARR. D. The Social Service Director or designee will conduct audits for all residents identified with new diagnosis of mental illness requiring medication to ensure the deficient practice will not recur. The audit will begin with 100% of all current residents at facility. Social Services Director or designee will audit residents with new diagnosis of mental illness requiring medication Daily x 5 days until 100% compliance is achieved, then Weekly x 4 weeks until 100% compliance is achieved, then Monthly x 1 Month until 100% compliance is achieved. If at that time compliance is achieved the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee.	

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F 644	Continued From page 17 exit conference on June 4, 2019 at 3:15 PM.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under	F 645		7/20/19

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F 645	Continued From page 18 paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R24) out of three sampled residents for Preadmission Screening and Review (PASRR) review the facility failed to complete a PASRR on R24 to reflect a new mental illness requiring medication. Findings include:	F 645	F645 A. R24 was not affected by the deficient practice. On 5/30/19 a referral was made to the state PASARR team to re- assess due to diagnosis of new mental illness requiring	

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F 645	Continued From page 19 The following was reviewed in R24's clinical record: 7/18/14 - A (PASRR) was completed indicating that R24 was taking an antipsychotic and met the physician's requirement exemption criteria. 7/9/16 - The most recent readmission to the facility lacked evidence of a PASRR assessment. 6/19/18 - The annual MDS included diagnoses of depression, manic depression, psychotic disorder and that R24 received both antipsychotic and antidepressant medications. 6/19/18 - The annual MDS was incorrectly coded "no" to the question "Is the resident currently considered by the State level II PASRR process to have serious mental illness and/or intellectual disability, mental retardation in federal regulation or a related condition?" According to physician orders in July of 2018, R24 was taking Lamictal 150 mg every day for bipolar disorder with agitation and false accusations, Paroxetine 20 mg every day for a major depressive disorder due to being withdrawn and crying, and Zyprexa 20 mg at bedtime for bipolar disorder with paranoid thoughts and refusing care. 6/3/19 - An email contact with the State PASARR unit revealed that no screening had been done for R24. During an interview on 6/3/19 at 10:45 AM, E7 (Social Worker) stated that the facility does not have an appropriate PASRR for R24. E7 (SW)	F 645	medication. Level 1.5 PASARR was issued on 6/12/19. B. Residents with new dx of mental illness requiring medication have the potential to be affected by the same deficient practice (see section C for corrective action) C. Social Services to review all current residents to identify residents with diagnosis of new mental illness requiring medication. Social Services will run weekly report to (Matrix report by drug class) to identify residents with diagnosis of new mental illness requiring medication. For residents with new diagnosis of mental illness requiring medication, Social Services will refer to the state PASARR unit to be re- assessed for updated PASARR. D. The Social Service Director or designee will conduct audits for all residents identified with new diagnosis of mental illness requiring medication to ensure the deficient practice will not recur. The audit will begin with 100% of all current residents at facility. Social Services Director or designee will audit residents with new diagnosis of mental illness requiring medication Daily x 5 days until 100% compliance is achieved, then Weekly x 4 weeks until 100% compliance is achieved, then Monthly x 1 Month until 100% compliance is achieved.If at that time compliance is achieved the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee.	

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F 645	Continued From page 20 will initiate the process for a PASRR today. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Educator), and E5 (Corporate) at the exit conference on June 4, 2019 at 3:15 PM.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		7/20/19

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F 656	Continued From page 21 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R54) out of 37 sampled residents, the facility failed to include documentation of an arterial wound on R54's right heel and related care being provided in R54's care plan. Findings include: The following was reviewed in R54's clinical record: 5/15/16 - The skin care plan documented, "R54 has potential for skin breakdown at pressure points related to decreased functional mobility", which was subsequently edited on 4/19/19. 4/19/19 - A podiatry consultation documented a finding of "peripheral vascular disease". 5/17/19 - A progress note revealed the following: "Skin: Patient seen for dried blister on right heel." 5/18/19 - The skin care plan documented, "Actual pressure ulcer: Right heel". 5/21/19 - The Weekly Wound Assessment described the identification of a stage 2 pressure ulcer on the right heel.	F 656	F656 A. R54 was not adversely affected by this deficient practice. However there was a potential for adverse effects for incorrect treatment because the care plan did not match the diagnosis of PVD. B. All residents have the potential to be adversely affected by this deficient practice. Future residents will be protected by the actions outlined below in section C. C. Root cause analysis revealed that R54 was initially care planned for a pressure ulcer due to heel blister. Diagnosis was changed to PAD after she was seen by vascular. The care-plan was not changed/updated to reflect the new diagnosis. The treatment remained the same. Staff Educator/designee will educate nursing staff to change/update care plans when diagnosis is changed. D. RNAC/designee will audit care plans for accurate diagnosis Daily x 5 days until	

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F 656	Continued From page 22 5/23/19 - A vascular surgery note revealed that R54 was evaluated for "peripheral artery disease (PAD)... with early ischemic changes"... (He/She) does have extensive vascular disease... Consideration for primary amputation should patient develop nonhealing wounds... or other foot complications were reviewed." 5/23/19 - A nurses note documented "Resident status post vascular appointment. (He/She) was seen for peripheral arterial disease (PAD) and right ankle dorsal foot wound.... Resident has extensive vascular disease... As such, consideration for primary amputation should patient develop nonhealing wounds... or other foot complications..." 5/25/19 - A provider note documented that R54 had "a new dime size heel wound" with a history of PAD and, further, that the resulting foot pain (for which pain medication was prescribed) is "multifactorial in nature". 5/28/19 - A wound rounds note documented that R54 was seen by the wound care team for an area on the right heel, the etiology of which was not defined. 6/4/19 9:50 AM - During an interview and observation with E6 (Unit Manager) and E17 (LPN), E6 (UM) confirmed the heel wound was an arterial wound and not a pressure ulcer. Assessment of area revealed a healing, dime sized, dry blister with reddened areas noted on both heels. 6/4/19 - Review of care plans lacked evidence of any reference to PAD or the existence of an	F 656	100% compliance is achieved, then Weekly x 4 weeks until 100% compliance is achieved, then Monthly x 1 month until 100% compliance is achieved. If at that time compliance is achieved the deficient practice will be considered resolved. All audits will be discussed and reviewed at the QA meeting.	

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F 656	Continued From page 23 arterial wound, despite references made by the podiatrist and vascular surgeon, along with the drastic treatment of amputation suggested by the foregoing provider if nonhealing wounds develop. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Educator) and E5 (Corporate) at the exit conference on June 4, 2019 at 3:15 PM.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview and review of other facility documents, it was determined that for one (R357) out of 37 sampled residents, the facility failed to meet professional standards in the areas of medication administration. The nursing staff failed to administer eye drop medications to one (R357) resident in accordance with the acceptable nursing clinical standards of practice. Findings include: The American Society of Ophthalmic Registered Nurses recommended practice for administration of eye drops (dated August 2013) stated to: Gently retract the lower lid. Instill a drop into the cul-de-sac. Avoid application of a drop directly on the cornea. Retracting the lower eyelid creates a pocket into which medications can be instilled. 6/3/19 at approximately 1:20 PM - During	F 658	F658 A. R357 was not adversely affected by the nurse instilling the eye drops without pulling the lower eye lid down. However there was a potential for adverse effects for the medication to come in contact with her cornea because the lower eye was not pulled down to create a pocket for the medication to be instilled. B. All residents receiving eye drops have the potential to be adversely affected by this deficient practice. Future residents receiving eye drops will be protected from this deficient practice by the actions outlined below in section C. C. Root cause analysis showed that the nurse did not know that the lower eye lid	7/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 24 observation of medication administration, E8 (LPN) was observed instilling an eye drop medication directly into each of R357's eyes without pulling the lower lid down and not instilling the drop into the lower lid per the practice standard. 6/3/19 3:30 PM - During an interview, E2 (DON) stated that the facility did not have a policy or procedure specifically for eye drop administration. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Educator), and E5 (Corporate) at the exit conference on June 4, 2019 at 3:15 PM.	F 658	had to be gently pulled down to create a pocket in which the medication will be instilled. The facility□s Staff Educator / designee will educate all nurses on the professional standards of eye drops administration. D. Director of Nursing / designee to audit eye drops administration Daily x 5 days for correct administration until 100% compliance is achieved, then Weekly x 4 weeks until 100% compliance is achieved, then Monthly x 1 month until 100% compliance is achieved. At this time the deficient practice will be considered resolved. All audits will be discussed and reviewed at the QA meeting.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	F 661		7/20/19

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	085050	A. BUILDING _____ B. WING _____	06/05/2019

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F 661	Continued From page 25 (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that for one (R74) out of one sampled residents reviewed for a closed record review, the facility failed to complete a discharge summary. For R74, the facility failed to provide a summary of R74's stay upon discharge to the community. Findings include: Review of R74's record revealed the following: 5/23/19 - A progress note revealed that R74 was discharged to his/her daughter-in-law at 4:45 PM. He/She received all of his/her medications and took his/her belongings with him/her at the time of discharge. 5/23/19 - Review of a document entitled "Discharge Summary" disclosed the date of discharge: 5/23/19 and the reason for discharge: therapy completed. Under "Summary (Brief Summation of Resident's Stay"), there was no documentation written to summarize R74's stay at the facility. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Educator), and E5 (Corporate) at the exit conference on June 4, 2019 at 3:15 PM.	F 661	F661 A. R74 was not affected by a deficient practice. On 5/22/19 a Discharge Summary was initiated and completed prior to residents d/c on 5/23/19. B. Residents without a Discharge Summary have the potential to be affected when a Discharge Summary is not completed. On 5/22/19 a Discharge Summary was initiated and completed prior to residents discharge on 5/23/19 C. Social Services Director or designee will continue to monitor Discharge Summaries to assure summaries are initiated prior to discharge. D. Social Services Director will audit all Discharge Summaries to assure summaries are initiated prior to discharge Daily x 5 until 100% compliance is achieved, then Weekly x 4 until 100% compliance is achieved, then Monthly X 1 month until 100% compliance is achieved.	

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	085050	A. BUILDING _____ B. WING _____	06/05/2019

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F 661	Continued From page 26	F 661	If at that time compliance is achieved the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676		7/20/19

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F 676	Continued From page 27 §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for one (R99) out of one resident sampled for the restorative program, the facility failed to provide the restorative walking program on 38 occasions for the months of April and May 2019. Findings include: 5/8/19 - The care plan documented that R99 was on a "daily walking program with a goal of 300 feet with rolling walker. Provide stand by assistance and allow for a seated break." One of the approaches was to "document distance and tolerance daily." During an interview on 5/29/19 at 10:44 AM, R99 stated that staff do not help him/her to walk with a walker. 6/3/19 - Record review revealed that during the months of April and May 2019 R99 missed 38 out of 61 opportunities (62%) to participate in the daily walking program. An interview on 6/3/19 at 11:30 AM with E6 (Nurse Manager), confirmed that there was no documentation or proof that the walking program was implemented for the 38 occasions in April and May 2019. An interview with E12 (Restorative Aide) on 6/4/19 at 11:54 AM, revealed that if R99 refused after multiple attempts, he/she would document	F 676	F676 A. R99 was not affected by this deficient practice. However there was a potential for adverse effects because the refusal of ambulation was not documented on the resident□s ambulation sheet. B. All residents have the potential to be adversely affected by this deficient practice. Future residents will be protected from this deficient practice by the actions outlined below in section C. C. Root cause analysis revealed that even though resident had multiple episodes of refusal to ambulate the restorative aide did not inform the Unit Manager or record the refusals in the ambulation sheet. The facility□s Staff Educator / designee will educate all nursing staff to document refusal of ambulation on the ambulation sheet; inform Nurse /Unit Managers at the time of refusal. The Unit Manager / Nurse will speak to the resident to determine the reason for the refusals, and follow up with necessary interventions e.g. referral to therapy. D. Director of Nursing / designee will audit ambulation sheets to ensure all	

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F 676	Continued From page 28 that R99 refused and not leave it blank. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Educator), and E5 (Corporate) at the exit conference on June 4, 2019 at 3:15 PM.	F 676	refusals are documented, communicated to the Nurse / Unit Manager and a follow-up to determine refusal reason have been done by Unit Manager / Nurse. Audits will be completed Daily X 5 days till 100% compliance is achieved, then Weekly x 4 weeks till 100% compliance is achieved, then Monthly x 1 month till 100% compliance is achieved. At this time the deficient practice will be considered resolved. All audits will be discussed and reviewed at the QA meeting.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policies, it was determined that the facility failed to ensure that respiratory care was provided in a manner consistent with professional standards for two (R56 and R80) out of four sampled residents reviewed for respiratory care. The facility failed to ensure that R56 received continuous oxygen therapy in accordance with physician orders. The facility failed to provide oxygen services with safe handling and cleaning of respiratory equipment for R80. Findings include:	F 695	F695 1. A. R80 no longer resides at the facility. R80 was not adversely affected by this deficient practice. However there was potential for adverse effects because the tubing and the humidifier bottle were not labeled with the dates when they were set up to ensure safe handling and cleaning of respiratory equipment.	7/20/19

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F 695	Continued From page 29 1. Review of R80's clinical record revealed: 5/17/19 - A Physician's Order for oxygen at 2 liters via nasal cannula (which was discontinued on 5/21/19). 5/29/19 9:00 AM - An oxygen condenser was observed in R80's room next to his/her bed. No date was observed on the tubing or the humidifier bottle. Although the oxygen was discontinued on 5/21/19, the equipment remained in the room in a ready to use state. The humidifier bottle should have been labeled with the date when set up. 5/29/19 11:20 AM - During an interview, E11 (LPN) confirmed there was no date on the oxygen condenser's humidifier bottle. E11 removed the oxygen condenser from R80's room. 2. Review of R56's records revealed a diagnosis of "Personal history of other venous thrombosis and embolism, Dependence on supplemental oxygen". 5/31/18 - A care plan conveyed the following: "Problem Start Date: 5/31/18.... R56 has potential for ineffective breathing related to history of pulmonary embolus/deep vein thrombosis." 10/1/18 - R56 had a physician's order for oxygen via nasal cannula at 3 liters continuously. 5/29/19 10:14 AM - R56 was observed with his/her nasal cannula tubing (through which resident receives supplement oxygen) dislodged and not properly positioned in the nostrils. 5/30/19 9:17 AM - R56 was observed with his/her	F 695	B. All residents have the potential to be adversely affected by this deficient practice. Future residents will be protected by this deficient practice by the corrective actions outlined below in section C. C. Root cause analysis revealed that the order was for PRN oxygen and staff failed to label and date oxygen tubing and humidifier bottle when they were applied to the concentrator. Staff Educator / designee to educate nursing staff on the dating of all respiratory equipment when they are placed on equipment, change oxygen tubing and humidifier bottle weekly, and remove equipment from room when not in use to be consistent with standard practice to ensure that proper respiratory care is delivered to the residents. D. Director of Nursing / designee will audit all residents receiving respiratory care to ensure that the equipment is labeled with the correct date. Audits will be completed Daily x 5 days till 100% compliance is achieved, then weekly x 4 weeks till 100% compliance is achieved, then Monthly x 1 month till 100% compliance is achieved. At this time the deficient practice will be considered resolved. All audits will be discussed and reviewed at the QA meeting. 2. A. R56 was not adversely affected by this	

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F 695	Continued From page 30 nasal cannula tubing dislodged and not properly positioned in the nostrils. 5/31/19 10:58 AM - R56 was observed holding the nasal cannula in his/her hand. E18 (CNA) replaced the nasal cannula to ensure proper oxygen administration and stated that R56 pulls on the nasal cannula. 6/3/19 11:25 AM - R56 was observed in the activity room wearing clothing protector (in anticipation of lunch). It was observed that the nasal cannula was not visible. E18 (CNA) came over and discovered that it had fallen off and subsequently replaced it. 6/3/19 1:55 PM - R56 was observed in bed sleeping with the nasal cannula properly positioned. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Educator), and E5 (Corporate) at the exit conference on June 4, 2019 at 3:15 PM.	F 695	deficient practice. However R56 had the potential to be affected by this deficient practice because she is dependent on supplement oxygen with a history of pulmonary embolus/deep vein thrombosis. B. All residents with dependence on supplemental oxygen have the potential to be adversely affected from this deficient practice. Future residents will be protected by this deficient practice by the corrective actions outlined below in section C. C. Root cause analysis revealed that patient has a history of removing oxygen tubing from her nose due to her diagnosis of dementia. Staff Educator / designee will educate nursing staff on checking residents receiving supplemental oxygen that the tubing is properly positioned in nostrils, and adjusted immediately if it is noted that the tubing is not properly positioned. D. Director of Nursing / designee will audit residents using supplemental oxygen for proper positioning of tubing every shift daily x 5 days till 100% compliance is achieved, then Weekly x 4 weeks till 100% compliance is achieved, then Monthly x 1 month until 100% compliance is achieved. At this time this deficient practice will be considered resolved. All audits will be discussed and reviewed at the QA meeting.	
F 711	Physician Visits - Review Care/Notes/Order	F 711		8/20/19

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F 711 SS=D	Continued From page 31 CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that for four (R52, R54, R56 and R103) out of four sampled residents reviewed for documentation of weights, it was determined that the facility failed to ensure that provider notes were accurately completed with regard to residents' weight status. Findings include: Review of clinical records for R52, R54, R56 and R103 revealed the following: 1. R52: 3/4/19 - An order for "weights discontinued". 5/10/19 - Documentation under Assessment/Plan, Practitioner/Provider Note revealed, "weight stable". 2. R54:	F 711	F711 1. A. R52 was not affected by this deficient practice. Resident is a Long Term patient with "no weights" order. B. All residents with weights monitoring have the potential to be adversely affected by this deficient practice. Future residents will be protected from this deficient practice by the corrective actions outlined below in section C. C. Unit Manager / Dietitian will put updated list of patients whose weights are no longer being obtained in MD's book. Book will be updated monthly and as	

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	085050	A. BUILDING _____ B. WING _____	06/05/2019

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F 711	Continued From page 32 2/16/18 - An order for "no weights". 4/28/19 - A History and Physical documented, "weight stable". 3. R56: 1/12/17 - An order for "weights discontinued". 4/9/19 - A History and Physical documented, "weight stable". 4. R103: 2/16/18 - An order for "no weights". 4/4/19 - Documentation under Assessment/Plan, Practitioner Provider Note revealed, "weight stable". The facility failed to ensure that provider notes were accurately completed with regard to residents' weight status. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Educator), and E5 (Corporate) at the exit conference on June 4, 2019 at 3:15 PM.	F 711	needed. D. DON / designee will audit MD weight documentation for accuracy Daily x 5 days until 100% compliance is achieved, then Weekly x 4 weeks until 100% compliance is achieved, then Monthly x 1 month until 100% compliance is achieved. At this time the deficient practice will be considered resolved. All audits will discussed and reviewed at the QA Meeting. 2. A. R54 was not adversely affected by this deficient practice. Resident is a Long Term patient with "no weights" order. B. All residents with weight monitoring have the potential to adversely affected by this deficient practice. Future residents will be protected from this deficient practice by the corrective actions outlined below in section C. C. Unit Manager / Dietitian will put updated list of patients whose weights are no longer being obtained in MD's book. Book will be updated monthly and as needed. D. DON / designee will audit MD weight documentation for accuracy Daily x 5 days until 100% compliance is achieved, then Weekly x 4 weeks until 100% compliance is achieved, then Monthly x 1 month until 100% compliance is achieved. At this time the deficient practice will be considered resolved. All audits will discussed and	

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	085050	A. BUILDING _____ B. WING _____	06/05/2019

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F 711	Continued From page 33	F 711	reviewed at the QA Meeting. 3. A. R56 was not adversely affected by this deficient practice. Resident is a Long Term patient with "no weights" order. B. All residents have the potential to be adversely affected by this deficient practice. Future residents will be protected from this deficient practice by the corrective actions outlined below in section C. C. Unit Manger/ Dietitian will put updated list of patients whose weights are no longer being obtained in MD's book. Book will be updated monthly and as needed. D. Director of Nursing / designee will audit MD weight documentation for accuracy Daily x 5 days until 100% compliance is achieved, then Weekly x 4 weeks until 100% compliance is achieved, then Monthly x 1 month until 100% compliance is achieved. At this time the deficient practice will be considered resolved. All audits will discussed and reviewed at the QA Meeting. 4. A. R103 was not adversely affected by	

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F 711	Continued From page 34	F 711	this deficient practice. Resident is a Hospice care patient with "no weights" order. B. All residents with weights monitoring have the potential to be adversely affected by this deficient practice. Future residents will be protected from this deficient practice by the corrective actions outlined below in section C. C. Unit Manager / Dietitian will put updated list of patients whose weights are no longer being obtained in MD's book. Book will be updated monthly and as needed. D. Director of Nursing / designee will audit MD weight documentation for accuracy Daily x 5 days until 100% compliance is achieved, then Weekly x 4 weeks until 100% compliance is achieved, then Monthly x 1 month until 100% compliance is achieved. At this time the deficient practice will be considered resolved. All audits will discussed and reviewed at the QA Meeting.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an	F 791		7/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	500 SOUTH BROAD STREET MIDDLETOWN, DE 19709

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 35 outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review it was determined that for one (R99) out of two sampled residents reviewed for dental services, the facility failed to provide routine	F 791	F791 A. R99 was not adversely affected by this deficient practice. However there was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 791	Continued From page 36 dental services for R99, after recommendations were made to follow up with the dentist. Findings include: The following was reviewed in R99's record: 5/16/18 - The Nursing to Rehab Communication form documented that R99 received his/her upper and lower dentures and needed a speech evaluation. 5/24/18 - The speech evaluation documented that R99 was to "continue mechanical soft thin liquids. Reevaluate when dentures more comfortable (large clicking with adhesive) recommend follow up with dentist." 6/4/18 - A progress note documented that R99 was refusing to eat in the dining room secondary to the altered diet. R99 reported the new dentures were too large. An interview with E6 (Nurse Manager) on 6/3/19 at 2:54 PM, confirmed there was no follow up appointment made with the dentist in reference to R99's complaint about the dentures being too large. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Educator), and E5 (Corporate) at the exit conference on June 4, 2019 at 3:15 PM.	F 791	potential for adverse effect due to dentures being too large. Resident□s weights and intakes did not decline. B. All residents have the potential to be adversely affected by this deficient practice. Future residents will be protected by this deficient practice by the actions outlined below in section C. C. Root cause analysis revealed that R99 received new upper and lower dentures. She reported that the dentures were too large, and was seen by speech therapy with a recommendation to follow up with a dental consult. Follow up dental consult was not scheduled. Dental appointment was made upon identification of this deficient practice. Staff Educator / designee will educate nursing staff to review residents with any concerns about dentures for proper fit, and follow-up dental consult as indicated. D. Unit Managers / designee will audit residents for dental concerns Daily x 5 days until 100% compliance is achieved, then Weekly x 4 weeks until 100% compliance is achieved, then Monthly x 1 month until 100 % compliance is achieved. At this time the deficient practice will be considered resolved. All audits will be discussed and reviewed at the QA meeting.	

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 Broadmeadow **DATE SURVEY COMPLETED: June 5, 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 May 28, 2019 through June 5, 2019. The facility census the first day of the survey was 108. 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.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**	Cross Refer: F584, F623, F625, F636, F641, F644, F645, F656, F658, F661, F676, F695, F711, F791	7/20/19
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:** Cross refer to CMS 2567-L survey completed June 5, 2019: F584, F623, F 625, F636, F641, F644, F645, F656, F658, F661, F676, F695,F711 and F791.		

Provider's Signature [signature] NHA Title Administrator Date 6-28-19