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

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 _____	C 03/12/2019

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 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from March 7, 2019 through March 12, 2019. The deficiencies cited in this report are based on observations, record reviews, staff interviews, and review of other facility documentation. The survey sample size was eight (8). The facility census the first day of the survey was one hundred and fifteen (115). Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CCC - Corporate Clinical Consultant; cm / centimeter - length of measurement; CNA - Certified Nurse's Aide; DON - Director of Nursing; Eschar - hard dead tissue that can be tan, brown or black; Granulation - new tissue with blood vessels formed during wound healing; L - Length; LPN - Licensed Practical Nurse; Necrotic - black dead tissue; NHA - Nursing Home Administrator; Pressure Ulcer/Injury - sore area of skin over a boney prominence that develops when the blood supply to it is cut off due to pressure; RN - Registered Nurse; Slough - yellow, tan, gray, green or brown dead tissue; W - Width.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		4/26/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/01/2019

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 610	Continued From page 1 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, including review of policy and procedure, as indicated, it was determined that the facility failed to prevent further potential mistreatment, while the investigation was in progress for one (R7) out two sampled residents reviewed for allegations of mistreatment. Findings include: Review of the facility's policy and procedure titled, Abuse, Neglect, Mistreatment, Misappropriation, and Exploitation, with the most recent revision date of 12/28/18, indicated: "Protection: The facility will respond immediately to protect the alleged victim... Increased supervision, room changes, and staffing changes may be provided to the alleged victim and other resident." 1/18/19 - The Resident Concern/Compliment Form was completed by E15 (RN) after R7's family made an allegation of mistreatment by E16 (CNA) towards R7. The allegations included that	F 610	F610 A: Resident R 7 no longer resides at the facility. The staff member was removed from providing care to this resident but was not removed from the building at the time of the allegation. Upon notification of the allegation of verbal abuse, the administrative staff: suspended the employee, submitted a report to the appropriate State agency, initiated an investigation, and determined that the allegation was substantiated. The employee was terminated. No other residents were adversely affected by this deficient practice. B: All residents have the potential to be adversely affected by this deficient practice. The facility takes proactive measure to reduce the likelihood of such occurrences through: employee screening, employee training, prevention,	

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F 610	Continued From page 2 E16 told R7 that E16 did not want R7 to go to the bathroom frequently. Additionally, E16 told R7, that nobody (other facility staff members) want to be assigned to the hall, where R7's room was located because of R7. E15 immediately, upon receiving the allegation removed E16 from caring for R7 and assigned E16 to other residents for the remainder of the shift. The complaint was documented as resolved by E3 (ADON) on 1/23/19. 1/22/19 - Review of the facility's time card for E16 (CNA), revealed that E16 worked at the facility while the investigation of the allegation of mistreatment was being conducted. 3/8/19 at approximately 3:00 PM - An interview with E3 (ADON) confirmed that E3 was made aware of the allegation on 1/22/19 and the investigation was initiated and completed on 1/23/19. E3 confirmed that the day of the incident, E16 was removed from caring for R7 and E16 was assigned to other residents for the remaining shift on 1/18/19. E3 confirmed that E16 worked on 1/22/19, although the investigation was not completed until the following day, 1/23/19. The facility failed to protect R7 and other residents while the investigation of the alleged mistreatment was being conducted. 3/12/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (DON), and E4 (CCC) during the Exit Conference.	F 610	identification, investigation, protection, and reporting of abuse, neglect, and mistreatment, misappropriation of resident property, exploitation, and reasonable suspicion of crimes. Future residents will be protected from this deficient practice by the corrective action outlined below in section C. C: Upon completion of the root-cause analysis it was determined the policy was not adhered to by the house supervisor on duty. The accused employee should have been sent home immediately pending an investigation. The facility provided education to the supervisor as soon as the deficient practice was identified with emphasis placed on how to report the allegation, the timeliness of reporting, and the actions to be taken when an allegation of abuse is made. The facility's staff educator/designee will provide policy education to all facility Department Heads, Nurse Managers, and Nurse Supervisors related to abuse, neglect, mistreatment, misappropriation, exploitation, reasonable suspicion of a crime, and reporting protocols. D: The facility DON/designee will audit any reported allegations of abuse, neglect, mistreatment, misappropriation, exploitation, reasonable suspicions of crime, and reporting protocols for compliance daily x 5 days until 100% is achieved, then once a week X 4 weeks until 100% compliance is achieved for 4 consecutive weeks. The facility will then be deemed compliant. The audits will be provided to the QAPI committee for	

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F 610	Continued From page 3	F 610	review.	
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 interview, review of the clinical record, facility documentation and professional clinical resources as indicated, it was determined that for one (R5) out four sampled residents with pressure ulcers (PU), the facility failed to ensure that a resident received the necessary treatment and services, consistent with professional standards of practice. R5 had a new stage 2 PU of the right heel and the facility failed to accurately assess the PU. Findings include: According to the National Pressure Ulcer Advisory Panel (April 2016), the following are the stage 1 and stage 2 pressure injuries/ulcers categorization: Stage I (1) - a reddened area of intact skin usually over a boney prominence, that when pressed does not turn white. This is a sign that a PU is starting to develop. Stage II (2) - skin blisters or skin forms an open	F 686	POC F 686 A: R5 no longer resides at the facility. R5 was not affected by this deficient practice. However there was a potential for adverse effects because misclassification of a wound can affect obtaining the appropriate treatment that will promote wound healing in a timely manner. E14 will be re-educated by the Staff Educator/designee regarding classification of wounds. B: All residents have the potential to adversely be effected by this deficient practice. Future residents will be protected from this practice by the corrective actions outlined below in section C.	4/26/19

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F 686	Continued From page 4 sore. The area around the sore may be red and irritated. Review of R5's clinical record revealed the following: 1/17/19 - R5 was admitted to the facility without a PU. 1/27/19 - A Skin Integrity Events - New Wound Assessment, initiated by E14 (LPN) documented a wound on the right heel measuring 7.6 cm L x 10 cm W with thin, watery, clear drainage and the color of the wound bed was described as granulation (tissue). In the section titled, "Wound Team Only - Answered by member of wound team only", E2 (DON) later documented this was a stage 2 PU, although granulation would not be a characteristic of a stage 2 PU. According to the http://www.npuap.org/national-pressure-ulcer-advisory-panel, for a stage 2 pressure ulcer/injury "Granulation tissue, slough and eschar are not present..." 3/8/19 at approximately 10:00 AM - An interview with E2 (DON) confirmed the inaccuracy in E14's wound bed description that indicated that R5's PU was a stage beyond stage 2. E2 stated it was an oversight since the area was a fluid filled blister, a stage 2 PU. 3/12/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (DON), and E4 (CCC) during the Exit Conference.	F 686	C: Root cause analysis revealed that the wound was incorrectly staged on the Wound Event form. The facilities Staff Educator/designee will educate all nurses on the necessary treatment and services consistent with professional standards related to assessing skin integrity and documentation on New Wound Events. The facility uses RELIAS as a training resource and will utilize the following titled educational modules: (ABOUT WOUND CARE: IDENTIFICATION AND ASSESSMENT) & (WOUND CARE: ASSESSMENT). D: Staff Educator/designee to audit wound event assessments daily x 5 days for correct assessment until 100% compliance is achieved. Then weekly x 4 weeks till 100% compliance is achieved. At this time the deficient practice will be considered resolved. All audits will be discussed and reviewed at the QAPI 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: March 12, 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 complaint survey was conducted at this facility from March 7, 2019 through March 12, 2019. The deficiencies cited in this report are based on observations, record reviews, staff interviews, and review of other facility documentation. The survey sample size was eight (8). The facility census the first day of the survey was one hundred and fifteen (115).		
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:** Cross refer to CMS 2567-L survey completed March 12, 2019: F610 and F686.	Cross Refer F610 and F686	04/26/2019

Provider's Signature Frank J Reinhold Title Administrator Date 4-1-19