STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085052	A. BUILDING _____ B. WING _____	C 07/15/2019

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CADIA REHABILITATION RENAISSANCE	26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from July 8, 2019 through July 15, 2019. The facility census the first day of the survey was 48. 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, complaint and emergency preparedness surveys were conducted at this facility from July 8, 2019 through July 15, 2019. The deficiencies contained in this report were based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 117. The survey sample totaled forty-eight (48) plus one (1) additional FRI (facility reported incident) resident. Abbreviations/Definitions used in this report are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; FSD - Food Service Director; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RD - Registered Dietician; RN - Registered Nurse; SW - Social Worker;	F 000		

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

Electronically Signed | 08/06/2019

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F 000	Continued From page 1 UM - Unit Manager; eMAR - electronic medication administration record; Delusion -false belief that is thought to be true; Dementia - condition with loss of mental functions such as memory and reasoning that interferes with a person's daily functioning; Gastrostomy - surgical construction of a permanent opening from the outside surface of the abdominal wall into the stomach, usually for inserting a feeding tube; Jejunostomy - surgical creation of an opening through the skin; milliliter (ml) - unit of measurement; Minimum Data Set (MDS) - comprehensive clinical assessment of residents; pH - Measure of the acidity or basicity of liquid solutions; Psychosis/psychotic - loss of contact/touch with reality; pt - patient.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		9/10/19

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F 609	Continued From page 2 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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 record review and interview it was determined, that for one (R20) out of two residents sampled for abuse or neglect, the facility failed to identify and immediately report allegations of sexual abuse. Findings include: The facility policy on abuse and neglect, last updated 3/14/19, indicated "sexual abuse is non-consensual sexual contact of any type with a resident.... All alleged incidents involving abuse shall be reported to the NHA or designee. Witnessed or suspected incidents will be reportedly immediately... Allegations of resident abuse shall be reported to the state agency within 2 hours... the DON is responsible to conduct the abuse allegation." Review of R20's clinical record revealed the following: 4/17/19 4:09 PM - A progress note documented the following "Called into pt (patient) room this	F 609	A. There was no evidence that R20 was negatively impacted by this deficient practice. B. All residents have the potential to be impacted by this deficient practice. C. Staff Educator/designee will re-educate staff on the facility policy for investigating and reporting allegations of abuse by completion date. D. The DON/designee will audit all resident progress notes daily for indication of abuse allegations until 100% compliance is reached for 3 consecutive days, then 3 times weekly until 100% compliance is reached 3 consecutive times, then 1 time weekly until 100% compliance is reached for 3 consecutive weeks. When 3 audits are 100% compliant in 1 month the deficiency will be considered resolved. Audit results will be reviewing during monthly QA meetings for 3 months.	

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F 609	Continued From page 3 afternoon by roommate. Pt reports that another pt [R113] attempted to touch [R20's] chest inappropriately & kissed [R20] on the lips & patted [R20's] hand...DON & ADON notified." Review of R113's clinical record revealed the following: 4/17/19 4:18 PM - A progress note documented "reported this afternoon that this pt was attempting to touch another pt inappropriately & kiss them as well. Met with pt at the bedside along with ADON to talk about these behaviors. Pt denying these actions & states 'I have more respect for women than that'. CNA staff also reported that [R113] was making sexual comments regarding wife who is deceased today as well." 4/17/19 - A care plan was initiated for R113's behavioral symptoms related to socially inappropriate behavior, sexually inappropriate, grabbing at, groping staff or other residents and sexual comments. Review of the State Incident Reporting System revealed this allegation of sexual abuse was not reported to the State Agency. During an interview on 7/11/19 at 11:56 AM with E2 (DON) it was confirmed that the facility did not recognize this incident as an allegation of sexual abuse and subsequently did not report the allegation. This finding was reviewed with E1 (NHA) and E2 (DON) on 7/12/19 at 2:00 PM.	F 609		
F 641	Accuracy of Assessments	F 641		9/10/19

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F 641 SS=D	Continued From page 4 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 and interview it was determined that the facility failed to ensure the MDS assessment was correct for one (R60) out of four residents sampled for dementia or behavioral / emotional investigations. Findings include: 1. Review of R60's clinical record revealed: 2/11/19 - State of Delaware Department of Health and Social Services PASRR (Preadmission Screening and Resident Review) Determination Decision documented a Level II Summary. 3/5/19 - R60 was admitted to the facility and the PASRR Determination Decision form was scanned and attached to R60's electronic medical record. 3/12/19 - R60's Admission MDS assessment documented that R60 did not have a PASRR Determination Decision. 7/10/19 (11:35 AM) - During an interview with E8 (RNAC), the error was confirmed and E8 stated that he/she would "make a correction." Findings were reviewed with E1 (NHA) and E2 (DON) on 7/15/19 during the exit conference beginning at 11:10 AM.	F 641	A. R60 was not negatively impacted by this deficient practice. B. All residents have the potential to be impacted by this deficient practice. C. Corporate Assessment Coordinator/designee will re-educate RNACS on PASRR coding accuracy on the MDS. System change will be to have the Admissions Director/designee notify the RNAC of new admissions and re-admissions to the facility who have a PASRR Level II Determination decision. D. The Admissions Director/designee will audit 2 Annual Assessments and 1 New Admission or Re-admission 5 day Asessment daily until 100% compliance is achieved during 3 consecutive audits, then 1 time weekly until 100% compliance is achieved during 3 consecutive weeks, then 1 time monthly until 100% compliance is achieved during 3 consecutive months. At that time the deficiency will be considered resolved. Audit results will be reviewed at monthly QA meeting for 3 months.	
F 644	Coordination of PASARR and Assessments	F 644		9/10/19

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F 644 SS=D	Continued From page 5 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 (R91) out of one sampled residents reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to make a referral to the State authority when a new mental illness was identified. Findings include: Review of R91's clinical records revealed: 8/30/17 - A PASRR was completed with a determination that "Individual does not require additional evaluation due to the following determination and needs can be met at a Nursing Facility: individual does not have a documented serious mental illness (.....major depression....)	F 644	A. R91 was not negatively impacted by this deficient practice. Referral was made on 8/6/2019 to the State PASRR Team for re-assessment following a new diagnosis of mental illness requiring medication. B. Residents with new diagnosis of mental illness requiring medication have the potential to be impacted by this deficient practice. C. The system change will be for Social Services to use the Matrix Order Report by Drug Class weekly to identify those residents with new diagnosis of mental illness requiring medication who have not	

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F 644	Continued From page 6 and individual needs can be met in a Nursing Facility." 9/15/17 - R91 was admitted to the facility with diagnoses that include unspecified dementia without behavioral disturbance, unspecified psychosis not due to a substance or known physiological condition, and delusional disorders. 9/27/17 - The Admission MDS revealed R91 had a diagnosis of psychotic disorder. 11/26/18 - An antidepressant medication was initiated for R91. 11/27/18 - Major depressive disorder was added to R91's list of medical diagnoses. 12/20/18 - The quarterly MDS revealed that "depression" was added as an active diagnosis. 7/11/19 approximately 11:00 AM - An updated PASSR was requested from E2 (DON) and the PASRR dated 8/30/17 was provided in response to this request. 7/15/19 8:17 AM - During an interview with E4 (Social Worker), it was confirmed that 8/30/17 was the date of the most recent PASRR and that there were no additional evaluations. There was no evidence that the State PASRR authority was contacted to re-assess R91 when a new mental illness requiring medication was identified. Findings were reviewed with E1 (NHA) and E2 (DON) on 7/15/19 at the exit conference beginning at 11:10 AM.	F 644	previously been referred to the State PASRR Team for re-assessment. D. Social Service Director/designee will begin with audit of all current residents at the facility. Thereafter, audits of the Matrix report will be done daily until 100% compliance is achieved for 3 consecutive days, then 3 times weekly until 100% compliance is achieved on 3 consecutive days, then 1 time weekly until 100% compliance is achieved for 3 consecutive weeks. At that time the deficiency will be considered resolved. Audit results will be reviewed at monthly QA meeting for 3 months.	

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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 record review, interview and review of other facility documentation it was determined that, for one (R60) out of five residents sampled for medication review, the facility failed to administer an antibiotic according to physicians' orders. Findings include: January 2009 - Review of facility policy entitled Medication / Treatment Incidents (last revised 5/1/19) included the process for reporting incidents. Upon identification of a medication and / or treatment incident, assess the resident and provide emergency care and / or monitoring as indicated. The provider is notified of the incident. The Nurse documents the notification in the record and notes any new orders. The family or responsible party is notified that the incident has occurred. The incident is investigated and the Medication / Treatment Incident Report is completed. The Medication / Treatment Incident Report is given to the Director of Nursing (DON) or designee. The DON / designee determines the level of error and the appropriate action is taken. Review of R60's clinical record revealed:	F 684	A. R60 was not negatively impacted by this deficient practice. The medication error was discovered on 6/28/19. Resident assessment, physician and responsible party notification all made on same date. On 7/10/19, the DON signed the incident report and immediately educated the identified nurse regarding accurate transcription of orders. B. All residents have the potential to be impacted by this deficient practice. C. Staff Educator/designee will re-educate nursing staff on correct medication transcription process. D. Director of Nursing/designee will audit medication transcriptions for all residents daily until 100% compliance is achieved for 3 consecutive times, then weekly until 100% compliance is achieved, then monthly times 3 months until 100% compliance is achieved. At that time the deficiency will be considered resolved. Audit results will be reviewed at monthly	9/10/19

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F 684	Continued From page 8 5/18/19 - Urine culture results scanned into the electronic record contained a handwritten medication order received by E9 (RN) dated 5/20/19 at 6:20 PM. The order included "[name and strength of antibiotic] BID (twice a day) for 7 days." 5/20/19 (6:24 PM) - E9's (RN) nursing progress note documented that the nurse "reviewed urine sensitivity report with [E12, NP]. Orders for [name and strength of antibiotic] BID x 7 days (twice a day for 7 days)." 5/20/19 (6:27 PM) - E9 (RN) entered the order in the computer as being received from R13 (MD) instead of E12 (NP). The antibiotic frequency was entered as once a day for 7 days instead of twice a day as ordered. May, 2019 - Review of R60's eMAR revealed that R60 received the antibiotic once a day for 7 days instead of twice a day as ordered. 5/24/19 and 5/30/19 - E11's (NP) progress notes identified that R60 received [name of antibiotic] for urinary tract infection / urine retention (inability to empty bladder completely). E11 did not identify the dosing frequency (number of times per day) of the antibiotic. 6/19/19 - The consultant pharmacist's Medication Regimen Review (MRR) identified the error in antibiotic frequency. The MRR paper contained a handwritten "OK, 6/28, [E11, NP initials]." 6/28/19 - Review of the Medication Incident Report revealed the error was discovered 6/19/19 by the consultant pharmacist during the MRR.	F 684	QA meeting for 3 months.	

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F 684	Continued From page 9 Resident assessment, physician and responsible party notification occurred 6/28/19. E2 (DON) signed the incident report and documented E9's (RN) education (on 7/10/19) regarding accurate transcription of orders. 7/12/19 (3:05 PM) - During an interview with E10 (RN, UM) to review order entry into the computer, E10 stated if the NP is "not available [as an option to select] in the computer, staff were told to enter the doctor." E10 confirmed the antibiotic order written on the urine culture results was for twice a day and the order entered in the computer was only for once a day. E10 added that he/she was not sure if there was a reason for a lesser dosing. 7/15/19 (8:15 AM) - During an interview E9 (RN) confirmed he/she made a "data entry" error when transcribing the order into the computer. Findings were reviewed with E1 (NHA) and E2 (DON) on 7/15/19 during the exit conference beginning at 11:10 AM.	F 684		
F 693 SS=C	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		9/10/19

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F 693	Continued From page 10 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 record review and interview it was determined that the facility failed to ensure that a resident with a gastric (stomach) feeding tube, received appropriate care and services to prevent complications for one (R46) out of one resident reviewed for gastric tube feeding care and management. Additionally, the facility policy did not reflect the current standards of practice for tube placement verification. 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 air, is no longer recommended." (Emergency Nurses Association, Clinical Practice Guidelines: Gastric Tube Placement Verification, 2017).	F 693	A. R46 was not negatively impacted by the deficient practice. B. All residents with a gastric tube has the potential to be impacted by this deficient practice. C. Staff Educator/designee will educate licensed nursing staff on updated facility policy (revised August 2, 2019)titled "Enteral Tube Management and Feeding Guidelines: Gastric and Jejunostomy" which aligns with current standards of practice for tube placement verification by the completion date. D. The Staff Educator/designee will conduct daily audits of staff conducting tube placement verification on all residents with gastric tubes until 100% compliance is achieved on 3 consecutive days, then 3 times weekly until 100% compliance is achieved, then weekly times 3 weeks until 100% compliance is achieved. At that time the deficiency will be considered resolved. Audit results will be reviewed at monthly QA meeting for 3	

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F 693	Continued From page 11 Nurses should not use the auscultatory (air bolus) ... - American Association of Critical-Care Nurses updates Practice Alert on feeding tube placement 4/1/16. The facility policy (effective date June 2013) 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 milliliter, 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 R46's clinical record revealed: Undated - A physician's order directed nursing staff to check tube for placement prior to: each feeding; flush; and medication administration, every shift. 5/24/17 - A care plan was initiated under the category of "Tube Feeding" for "Potential for aspiration and other complications such as vomiting, diarrhea, and/or abdominal distention due to tube feeding and swallow precautions" with a goal that [R46] would not have any significant complications related to tube feeding for 90 days. There were multiple interventions including "Check tube for placement and patency prior to	F 693	months.	

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(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 693	Continued From page 12 administering medications, flushes or feedings." During an interview on 6/14/19 at 10:43 AM with E4 (Regional Clinical Director) at a sister facility, it was explained that policy review, revision and verification was "handled at the corporate level, we review then send out a weekly notification to the facilities". During an interview on 7/11/19 at approximately 1:24 PM, E5 (RN) confirmed that placement was checked by adding air and listening. When asked if pH of stomach contents is tested, E5 (RN) responded that while this could be done, R46 did not have test strips to be used to determine pH of the stomach contents. The facility failed to ensure feeding tube placement was checked in accordance to current standards of practice including measuring the external length of the feeding tube and assessing or measuring pH of the contents aspirated from the tube. 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) and E2 (DON) during the exit conference beginning on July 15, 2019 at 11:10 AM.	F 693		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 725		9/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085052	A. BUILDING _____ B. WING _____	C 07/15/2019

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F 725	Continued From page 13 resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility documentation it was determined, that for seven residents who wished to remain anonymous (A1, A2, A3, A4, A5, A6, and A7) and four other residents (R22, R170, R76, and R79), the facility failed to provide sufficient nursing staff on a 24 hour basis to meet resident care needs. Findings include: Review of resident grievances from April - June 2019 revealed the following: 4/25/19 - A grievance form on behalf of R22 documented that R22 "rang the call bell 3-4 times	F 725	A. None of the 11 residents were negatively impacted by this deficient practice. B. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined in section C. C. The facility maintains a Per Patient Day (PPD) ratio that is above the recommended guidelines for staffing. Sufficient staffing is a subjective finding.	

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F 725	Continued From page 14 over the last 2-3 hours telling CNA that the urinal was full and can you do something about it ? The same CNA answered and walked out without helping." 6/10/19 - A grievance form on behalf of R170 documented that "pt stated having waited from 3:00 PM to 4:00 PM then to 5:00 PM for someone to come and put R170 to bed. When the CNA brought the dinner tray R170 was so upset at waiting so long that R170 refused to eat." 6/18/19 - A grievance form on behalf of R76 documented "pt reports having had to wait an extended period of time on the toilet. Report staff at nurses station but nurses in rooms reports the incident occurred around 7:00 PM - 8:00 PM." 6/25/19 - A grievance form on behalf of R79 documented "wife upset that because we are short staffed we do not always get the medicine on time." During an interview on 7/8/19 at 9:41 AM A4 stated "sometimes I have to wait up to 55 minutes before they answer the bell." During an interview on 7/8/19 at 10:50 AM A5 stated "staffing is the worse at meal times. Have to wait. End up using the bathroom on yourself." During an interview on 7/8/19 at 11:16 AM A3 stated there was "not enough help. You see 3 or 4 CNA's standing around doing nothing. Doesn't make you feel too good. I waited 2 hours to get a pain pill." During an interview on 7/8/19 at 12:17 PM A1 stated that the facility was "short staffed	F 725	The facility reviewed its staffing levels and staff assignments determining that staff was sufficient but not utilized in a proactive manor to assure adequate and timely response to resident needs. System changes being implemented to improve the resident perception of sufficient staffing include: 1) Rounding 2 times per shift by the Unit Manager/Supervisor/Designee; 2)Re-education of interdisciplinary staff related to Customer Service in order to address resident needs and concerns in a timely manner. D. The Activities Director/designee will conduct 5 resident interviews daily until 100% compliance is achieved for 3 consecutive days, then once weekly or until 100% compliance is achieved, then monthly until 100% compliance is achieved for one month. At that time the deficiency will be considered resolved. Audit results will be reviewed at monthly QA meeting for 3 months.	

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F 725	Continued From page 15 especially at night... spread thin. They are busy tending to whatever emergency and then not enough staff to help." During an interview on 7/9/19 at 11:10 AM A2 stated that the facility was short staffed "mostly with 11-7 shift, they turned my bell off when I was concerned I was going to have bowel movement this morning, no one comes on midnight shift." 7/11/19 2:00 PM - During a resident council meeting the following anonymous statements were given in response to the question "Do you get the care and the help you need without having to wait a long time?" A6 stated, "No, its about two hours sometimes for help." A7 stated, "I wait at least 40 minutes at night." These findings were reviewed with E1 (NHA) and E2 (DON) on 7/12/19 at 2:00 PM.	F 725		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		9/10/19

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F 812	Continued From page 16 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to store and prepare food in accordance with professional standards for food safety by stacking wet dishes and storing food uncovered. Findings include: The following observations were made during tours of the facility kitchen: 7/8/19 8:30 AM - On the shelf overtop of the dishwashing station four deep stainless serving trays were stacked with moisture between two of them. E16 (FSD) immediately took these dishes out of service. 7/12/19 1:34 PM - Two trays of cake, stored in the walk-in refrigerator, were unlabeled and uncovered. This finding was confirmed by E16 (FSD) at 2:50 PM on 7/12/19. Findings were reviewed with E1 (NHA) and E2 (DON) on 7/15/19 during the exit conference beginning at 11:10 AM.	F 812	A. No residents were negatively impacted by this deficient practice. Food Service Director immediately took the dishes out of service and removed the cake from the refrigerator. B. All residents have the ability to be impacted by this deficient practice. C. Food Service Director/designee will re-educate the dietary staff on proper procedure for food storage and prevention of wet-nesting pans. System changes to be implemented are as follows: 1) to provide additional drying space areas to allow for quicker drying time. 2) Cakes removed from oven will be immediately placed on a covered cooling rack. D. Food Service Director will audit pans and refrigerators daily for 3 days until 100% compliance is achieved on 3 consecutive days, then 3 times weekly until 100% compliance is achieved, then monthly until 100% compliance is achieved. At that time the deficiency will be considered resolved. Audit results will be reviewed at monthly QA meeting for 3 months.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Renaissance **DATE SURVEY COMPLETED: July 15, 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, complaint and emergency preparedness surveys were conducted at this facility from July 8, 2019 through July 15, 2019. The deficiencies contained in this report were based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 117. The survey sample totaled forty-eight (48) plus one (1) additional FRI (facility reported incident) resident	Please refer to the Plan of Correction on CMS-2567 Report dated 7/15/19 for: F609 F641 F644 F684 F693 F725 F812	
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 July 15, 2019: F609, F641, F644, F684, F693, F725, F761 and F812.		

Provider's Signature Sue Sheridan Title NHA Date 8/12/19

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NAME OF FACILITY: Cadia Rehabilitation Renaissance **DATE SURVEY COMPLETED: July 15, 2019**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE

Provider's Signature Sue Shenton Title NHA Date 8/12/19

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3201	**Regulations for Skilled and Intermediate Care Facilities**	F609 F641 F644 F684 F693 F725 F812	
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 July 15, 2019: F609, F641, F644, F684, F693, F725, F761 and F812.		

Provider's Signature Sue Sheridan Title NHA Date 8/12/19

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Provider's Signature Jane Thornton Title NHA Date 8/12/19