

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/23/2019
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NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 WALKER ROAD DOVER, DE 19904
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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
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F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from May 21, 2019 through May 23, 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 one hundred sixteen (116). The survey sample totaled six (6). Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; MDS - Minimum Data Set-standardized assessment forms used in nursing homes; R/T-related to.	F 000		
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 ...	F 676		6/30/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
05/31/2019

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 676	<p>Continued From page 1</p> <p>§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:</p> <p>§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,</p> <p>§483.24(b)(2) Mobility-transfer and ambulation, including walking,</p> <p>§483.24(b)(3) Elimination-toileting,</p> <p>§483.24(b)(4) Dining-eating, including meals and snacks,</p> <p>§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 observation, interview and review of facility documentation it was determined that for one (R2) out of six residents sampled the facility failed to provide the necessary care and services to ensure effective communication between staff and R2, who had a hearing impairment. Findings include: Review of R2's clinical record revealed: 11/27/14 - R2 was admitted to the facility with multiple diagnoses including unspecified hearing loss. 4/9/19 - A quarterly MDS assessment documented R2 as having moderately impaired</p>	F 676	<ol style="list-style-type: none"> 1. A portable hand held white board with dry erase markers has been provided to R2 to use for communication purposes in addition to the notebook and pen that she currently has. 2. Any residents with a diagnosis of Hearing Loss have the potential to be impacted by this deficient practice. Current and future residents will be protected by taking the corrective actions outlined in section 3. 3. DON will ensure all residents with a diagnosis of Hearing Loss are identified and their medical records are reviewed to ensure appropriate orders and care plans are in place. Staff educator will in-service 	
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F 676	<p>Continued From page 2 hearing.</p> <p>4/29/19 - A consultation note documented testing revealed "no hearing in any frequency in either ear".</p> <p>R2's care plan problem for alteration in communication related to hearing loss last updated 5/16/19, documented that R2 was completely deaf; unable to respond to ENT (Ear/Nose/Throat) Doctor upon examination, and that for R2 to be able to effectively communicate basic needs and wants to staff, the use of a word board was needed for communicating.</p> <p>During an interview/observation on 5/22/19 at 4:45 PM in R2's room, the surveyor observed a plastic dry erase board above wheelchair height, an estimated five feet that had various black writing such as "Aug 12, April 2, ratchet etc.(and so forth)" and was almost completely covered with various scribbling's. When the surveyor asked permission to erase the writing to communicate for the interview, R2 stated "that [the writing/scribbling] has been here, it doesn't erase" R2 then handed the surveyor the scrap piece of paper to write on. There was no dry erase marker in the room, only a permanent black marker. With R2's permission the surveyor attempted to wipe the board clean, and the writing was not erasable with use of a tissue.</p> <p>During an interview on 5/23/19 at 10:30 AM E4 (CNA) confirmed that communication between staff and R2 included use of the communication board.</p> <p>On 5/23/19 at 11:20 AM E3 (RN) accompanied the surveyor to R2's room along with E5 (CNA)</p>	F 676	<p>Care Staff on the importance of ensuring communication care plans are being followed to allow for ease of communication between resident and staff/visitors.</p> <p>4. DON or designee will identify all residents who have a care plan for a communication board and will audit daily to ensure that they have a communication board that is accessible, functional and has erasable markers. The audits will be conducted daily until 100% compliance over 3 consecutive days occurs. Audits will then continue three times weekly until 100% success at 3 consecutive weekly audits. Documentation audits will then be done once a week until 100% success over 3 consecutive weekly audits. Finally, in 30 days from the final audit a single audit will be done and if it is 100% compliant deficiency will be considered resolved. Results will be reviewed at the QAPI meeting.</p>		

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F 676	<p>Continued From page 3</p> <p>who explained that the "communication boards are to be erased and present day information added by the 11-7 shift. R2's board had been accidentally written on with permanent marker a long time ago so we all use paper." E3 then stated "I know a trick from my old job, that may help" then began to re-write over top the permanent marker then re-erase until clean. E3 stated that "R2 can't reach the board anyway cause of the wheelchair, I just use pen and paper".</p> <p>The communication board in R2's room was not of accessible height for a person in a wheelchair, did not have dry erase markers or eraser, was not updated to reflect current date, or assigned healthcare staff and had permanent marker covering the board almost in its entirety, prohibiting use by staff and visitors to communicate with R2.</p> <p>These findings were reviewed with E1(NHA) and E2 (DON) during the exit conference meeting on 5/23/19 at 2:15 PM.</p>	F 676			



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Capitol

DATE SURVEY COMPLETED: May 23, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced complaint survey was conducted at this facility from May 21, 2019 through May 23, 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 one hundred sixteen (116). The survey sample totaled six (6).</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by the following: Cross refer to CMS 2567-L survey completed May 23, 2019; F676.</p>	<p>CMS 2567 corrections will be electronically submitted on ePOC.</p>	<p>5/31/19</p>

Provider's Signature *J. Proctor* Title Administrator Date 5/31/19