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

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Healthcare Silverside **DATE SURVEY COMPLETED:** December 12, 2022

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 December 8, 2022 through December 12, 2022. The deficiency contained in this report is based on interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 107. The survey sample size was one.		
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 the CMS 2567-L survey completed December 12, 2022: F842.	Cross refer to the CMS 2567-L survey completed December 12, 2022: F842	2/3/2023

Provider's Signature Laura L. Dittmer Title NHA Date 1/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION SILVERSIDE	3322 SILVERSIDE ROAD WILMINGTON, DE 19810

(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 December 8, 2022 through December 12, 2022. The deficiency contained in this report is based on interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 107. The survey sample size was one. Findings include: Abbreviations used in this report are as follows: CNA- Certified Nursing Assistant; CPR- Cardiopulmonary Resuscitation; DON- Director of Nursing; ED- Emergency Department; LPN- Licensed Practical Nurse; NHA- Nursing Home Administrator; 02- Oxygen; Pt- Patient; RN- Registered Nurse. Auscultated- To listen; Bibasilar- Base of right and left lungs; Crackles- Abnormal lung sounds; EMT- Emergency Medical Technician; Liter- Unit of measurement; Paramedic- A specially trained medical technician licensed to provide a wide range of emergency services beyond what an EMT does; Pulse Ox (Pulse Oximetry)- A method of measuring the oxygen in blood using a small electronic device placed on the finger. Normal measurements are generally between 95% and 100%.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		2/3/23

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

Electronically Signed | 01/04/2023

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 842	Continued From page 1 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

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F 842	Continued From page 2 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R1) out of one resident sampled for a change in condition, the facility failed to ensure accurate and complete records. Findings include: Review of R1's clinical record revealed: 11/10/22- R1 was admitted to the facility. 11/26/22 7:12 PM- A nurses note in the electronic medical record (EMR), documented by E4 (LPN	F 842	A. R1 was sent out 911. She passed away in transit to the hospital. B. All residents who code have the potential to be affected. A facility wide sweep was conducted of the last 7 days and no further residents were identified to be impacted by this deficient practice. C. A new Rapid Response Team/Code Blue record form (attached) (RRT/CBR) to be implemented to capture accurate and timely documentation of the events surrounding clinical emergencies and	

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F 842	Continued From page 3 Supervisor) stated, "This nurse made aware by floor nurse that patient had emesis x (vomit times) 2 while CNA was performing care. Upon further assessment patient noted pale in color, with decreased o2 patient placed on facemask 6 liters (per minute- lpm). Auscultated lung sounds noted with bibasilar crackles. Notified On call of condition change in patient order to send out to ED, son aware and at bedside. EMT arrived pt condition deteriorated CPR initiated and once stable transferred by stretcher to (name of hospital) with EMT/paramedics." 12/12/22 11:15 AM- During an interview, E4 (LPN Supervisor) stated that vital signs (measurements of respiratory rate, pulse, body temperature, pulse ox and blood pressure) were obtained on R1 during R1's 11/26/22 observed change in respiratory condition. E4 stated that the only vital sign that appeared abnormal was R1's pulse ox that measured 88%. E4 stated that R1 was then administered oxygen with a facemask at 2 lpm, and the oxygen was subsequently increased to 4 lpm. E4 further stated that R1's pulse ox reading did not rise above 91% during the administration of oxygen. 12/12/22 11:45 AM- During an interview, E5 (RN) stated that she was alerted by the CNA caring for R1 at approximately 5:30 PM that R1 had vomited twice. E5 stated that she went to R1's room to check on her and E5 observed R1 to be pale in color, breathing rapidly and with difficulty. E5 raised the head of the bed to aid R1's breathing. E5 stated that vital signs were obtained and a face mask was applied to deliver oxygen at 2 lpm. Review of R1's EMR revealed incomplete	F 842	Code Blue situations. Without this new template, nurses were randomly and inconsistently not documenting comprehensive, consistent, and thorough vital signs and assessments of residents during clinical emergencies/Code Blue situations. Staff Educator to in-service all licensed nurses on the new form and process to accurately capture and record emergent clinical events. Verbal report will be provided to EMT personnel as well as a copy of Rapid Response Team/Code Blue record. RRT/CBR form will be scanned into EHR (electronic health record). D. DON/Designee to audit all Code Blue and clinical emergencies to ensure that RRT/CBR forms are completed thoroughly and accurately. Audits will continue until 100% compliance is achieved over a 3 month period. If 100% compliance is achieived over 3 consecutive months, problem will be considered resolved. Results of audits to be presented at QAPI meeting.	

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F 842	Continued From page 4 documentation related to R1's 11/26/22 change in condition. The times of R1's observed change in condition, the nursing responses to R1's change in condition, including R1's vital signs, R1's response to oxygen placement, R1's height of bed adjustment and the time of the call placed to the on-call Physician were not documented in the EMR. Additionally, the times of the 911 calls placed by E4 (LPN Supervisor), what nursing report was given to 911, to the paramedics/ EMT and responses to their actions, were not documented in the EMR. These findings were reviewed during the exit conference on 12/12/22, beginning at 3:30 PM, with E1 (CNO), E2 (NHA), E3 (DON) and E5 (Corporate Nurse).	F 842		