

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

PRINTED: 02/28/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/10/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CADIA REHABILITATION CAPITOL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1225 WALKER ROAD</b> <b>DOVER, DE 19904</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced complaint survey was conducted at this facility from January 7, 2020 through January 10, 2020. 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 eight (108). The survey sample totaled eight (8).</p> <p>Abbreviations used in this report are as follows:            Activities of daily living (ADLs) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing;            Antipsychotic - drug to treat psychosis and other mental/emotional conditions (e.g. Risperdal, Seroquel);            Anxiety - feeling worry, nervous or restless;            BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15.                13-15: Cognitively intact                8-12: Moderately impaired                0-7: Severe impairment            Blanchable - skin loses redness/turns white when pressed with finger (better than non-blanchable);            Boggy - abnormal texture of tissue characterized by sponginess / mushiness, usually due to high fluid content. A pressure ulcer / injury may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler compared to the surrounding tissue;            Braden Scale - test used to determine risk for developing pressure ulcers;            Centimeter - a metric measurement of length; 1 centimeter = 0.39 inches;            CNA - Certified Nurse's Aide;</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>01/31/2020</b>
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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 Dementia - loss of mental functions such as memory and reasoning that interferes with a person's daily functioning; Dependence / Dependent - full staff performance every time of activity performed; DON - Director of Nursing; Extensive Assistance - resident involved in activity, staff provide weight-bearing support; HeelZup device - a foam-filled cushion that elevates heels a minimum of one inch off of the bed surface, while supporting the lower leg from the ankle area to the knee to prevent pressure injury to the heel; Hospice - service that provides care to residents who are terminally ill; Ischium - bony areas on the bottom of each buttock; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; Offloading / Offload - removal of pressure from an area; Pain Scale - rating of pain severity on a 0 to 10 scale with 0 meaning no pain and 10 meaning the worst pain; Pressure injury / pressure ulcer - damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The ability of the soft tissue to tolerate pressure and shear may also be affected by microclimate (temperature, moisture of area), nutrition, perfusion (blood supply), co-morbidities (disease, illness) and condition of the soft tissue. - Stage 1 Pressure Injury: Intact red skin often	F 000			

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F 000	Continued From page 2 over a boney area that does not turn white / light (does not blanche - non-blanchable) when pressed; which may appear differently in darkly pigmented skin. Blanchable is better than non-blanchable. - Stage 2 Pressure Injury: Blister or shallow open sore with red/pink color. Deeper tissues/fat, granulation tissue, slough and eschar are not present. - Stage 3 Pressure Injury: Open sore that goes into the tissue under below the skin. How deep it is depends on the amount of tissue under the skin. Fat, granulation tissue and rolled edges are often present. Little slough and/or eschar may be visible but does not hide the extent of tissue loss. - Stage 4 Pressure Injury: Open sore so deep that muscle, tendons, ligaments, cartilage or bone can be seen. Rolled edges, undermining, tunneling often occur. Slough or eschar may be visible. - Unstageable: Actual depth of the ulcer cannot be determined due to the presence of slough (yellow, tan, gray, green or brown soft dead tissue) and/or eschar (hard dead tissue that is tan, brown or black. Eschar is worse than slough. Once slough/eschar removed, a Stage 3 or 4 injury will be revealed. - Deep Tissue Pressure Injury (DTI): Intact or non-intact deep red, maroon, purple discoloration that does not turn white/light when pressed or skin separation revealing a dark wound bed or blood filled blister. Pain and temperature change often appear before skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.	F 000			

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F 000	Continued From page 3 - Medical Device Related Pressure Injury: Pressure from a medical device used for diagnostic or therapeutic purpose results in an injury that generally conforms to the pattern or shape of the device. The injury should be staged using the staging system. <a href="http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/">http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/</a> PRN - as needed; Psychosis - loss of contact/touch with reality; RN - Registered Nurse; Sacrum - large triangular bone at base of spine; Santyl - ointment to help remove dead tissue; Severe Cognitive Impairment - unable to make own decisions; Shear/Shearing Force - friction with reduced blood flow to the tissue under the skin from sliding down in, or being pulled across, the bed; Slough - yellow, tan, gray, green or brown dead tissue; UM - unit manager; x - times.	F 000			
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 and interview it was determined that the facility failed to conduct	F 684	1. a.) R5 was not negatively impacted by	2/24/20	

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F 684	<p>Continued From page 4</p> <p>neurological assessments for one (R5) out of three residents sampled for neglect. Findings include:</p> <p>Review of R5's clinical record revealed:</p> <p>12/13/17 - A care plan was initiated for the potential for falls (last reviewed 1/7/20) and included multiple fall prevention interventions and the following more recently added measures ..."2/15/19 concave mattress; 5/20/19 landing strips x 2 (fall mat on each side of the bed) while in bed; 9/23/19 take turns providing increased staff monitoring; .</p> <p>12/13/17 - A care plan for potential for bleeding or bruising related to anticoagulant (blood thinner) therapy (last reviewed 1/7/20) was developed. R5 was on a blood thinner to prevent clots from an abnormal heart rhythm (atrial fibrillation).</p> <p>6/1/18 - The facility document entitled Neurological Flow Sheet included that neurological checks were to be performed every 30 minutes for 1 hour, then every 1 hour for 4 hours, then every 8 hours for 9 shifts. Based on this frequency, 18 separate assessments should be performed and documented.</p> <p>The purpose of neurological assessments was to monitor for signs of bleeding in the brain by assessing the level of consciousness, speech, hand grasps, movement, pupil size / reaction and vital signs (blood pressure, heart rate, respiration rate and temperature).</p> <p>The review of R5's nursing progress notes, neurological flow sheets and facility fall investigations showed that R5 was at increased</p>	F 684	<p>this deficient practice. There was no corrective action immediately taken for the affected resident as the timeframes to complete the neurological assessments had passed.</p> <p>b.) All residents who are receiving neurological assessments have the potential to be affected by this deficient practice. Residents will be protected from this deficient practice by taking the corrective actions outlined below in #1c.</p> <p>c.) The facility will conduct focused education for all licensed nursing staff responsible for initiating and conducting neurological checks with a focus on the importance of adhering to the frequency as outlined on the neurological flow sheet. Additionally, Unit Managers and/or Shift Supervisors have been in-serviced and are now required to monitor flow sheets each shift to ensure completion of neuro checks as indicated. In November 2019 it had been identified during a random audit done by the DON that there was missed documentation of one scheduled neurological assessment, upon conducting a root cause analysis it was identified that the neurological assessment had been done but not documented and there was no systemic issue with the process. Because the assessment results were not documented on the flow sheet, the decision was made to have the flow sheets reviewed each shift by nurse management to ensure that conducting of and documentation of neurological assessments were through</p>		

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F 684	<p>Continued From page 5</p> <p>risk for bleeding in the brain from falling. There were multiple times when R5 was found sitting / laying on the fall mat next to her bed and neurological assessments were not performed as directed. Out of 18 assessments for each unwitnessed fall, the following neurological assessments were not performed:</p> <ul style="list-style-type: none"> <li>- 6/24/19: missing 7 assessments (June 26 day and night shift; June 27 day, evening and night shifts; and June 28 day and evening shifts) along with 5 nurses' initials on completed assessments.</li> <li>- 8/1/19: missing 2 assessments (August 2 and 5 day shift) along with 10 nurses' initials on completed assessments.</li> <li>- 9/16/19: missing 8 assessments (September 17 day, evening and night shifts; September 18 evening and night shifts; September 19 night shift; and September 20 day and evening shifts) along with 2 nurses' initials on completed assessments.</li> </ul> <p>1/10/20 (around 11:55 AM) - During an interview with E1 (NHA) and E2 (DON), E2 confirmed the missing neurological assessments. E1 stated that the facility had previously identified missing neurological assessments and had recently implemented that unit managers / shift supervisors would monitor each shift the completion of neuro checks on all residents with them implemented. Report on the status of neurological assessments were provided to E1 and E2 during morning meeting. When asked if any training was provided to staff, E1 responded that education had not been provided outside of instruction for the unit managers and shift supervisors.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 1/10/20 during the exit conference</p>	F 684	<p>and complete. Operational change that is now in place to ensure the problem does not recur includes increased focus and depth of reviewing for completion. Each shift supervisor or Unit Manager will review all flow sheets for that shift to ensure completion of all neurological assessments as ordered by physician. DON/ADON will now review flow sheets daily to ensure all neurological assessments for past 24 hours were completed. By implementing this additional review process any potential opportunities for missing assessments will be mitigated.</p> <p>d.) The Director of Nursing (DON)/designee will audit all neurological flow sheets for residents who have orders for neurological checks, a physicians order is in place any time neurological assessments are initiated. The audit will be conducted daily until 100% compliance is achieved for 5 consecutive days. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive weeks. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive weeks. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.</p>		

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F 684	Continued From page 6 beginning around 2:45 PM.	F 684			
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 record review, observation and interview it was determined that the facility failed to implement care and services in a manner that promoted healing and / or prevented pressure injury in two (R1 and R5) out of three residents investigated for neglect. Findings include:  A facility policy (last revised 1/16/19) entitled Pressure Ulcer Prevention and Management included interventions for dependent residents may include, but are not limited to: "Turning and repositioning every two hours; Use of pillows to aid positioning; Offloading heels while in bed; When possible, keeping the head of the bed lower than 30 degrees..."  1. Review of R1's clinical record revealed:	F 686	1. a. R1 has noted improvement to L buttock wound. Right heel remains stable despite arterial duplex lower extremity doppler impression on 1/16/20 indicated resident suffers from severe PVD of bilateral lower extremities with no blood flow beneath the knee of the right leg. Upon being made aware of the deficient practice R1 was turned and repositioned and is now being turned and repositioned as per order every two hours. HeelZup cushion was placed under heels as ordered and is being used per physician order while resident is in bed.  b. All residents have the potential to be impacted by this deficient practice. Future	2/24/20	

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F 686	<p>Continued From page 7</p> <p>5/24/11 - R1 was admitted to the facility with Alzheimer's dementia.</p> <p>12/4/19 - An annual MDS documented that R1 was dependent on staff for activities of daily living, and was unable to complete a BIMS assessment due to R1 being severely cognitively impaired.</p> <p>12/4/19 - R1's Braden Scale score was 14 indicating that R1 was at moderate risk for developing pressure ulcers.</p> <p>12/17/19 - R1 was admitted to the hospital for repair of a broken right thigh bone.</p> <p>12/22/19 - R1 was readmitted to the facility with the following pressure-related skin injuries: - Redness: (L) great (big) toe and (L) heel; - Stage 1: sacrum; - Stage 2: (R) heel and (R) great toe.</p> <p>12/22/19 - The physicians' order included: Turn and reposition every two hours.</p> <p>12/23/19 - R1's Braden Scale documented a score of 9, which now reflected that R1 was at very high risk for developing pressure ulcers.</p> <p>12/23/19 - A physician's order included: Offload heels with HeelZup cushion while in bed.</p> <p>The HeelZup heel suspension cushion is s 3.25 inch foam cushion with raised sides to prevent the legs from falling off and is used to raise the heels off of the bed to prevent heel pressure ulcers. The HeelZup cushion is required be positioned under the calves (and not the knees) to effectively prevent the heels from pressing into</p>	F 686	<p>residents will be protected from this deficient practice by taking the correct actions outlined in 1c.</p> <p>c. DON/Designee will complete an in-service for all nursing staff on proper offloading of heels including, when ordered, usage of HeelZup cushion. Including in this training will be education on the importance of maintaining appropriate elevation of bed for each individual resident to prevent shear injury to the buttocks and sacrum.</p> <p>d. DON/Designees will conduct audits of 20 residents who are at moderate to high risk for developing pressure ulcers. Audits will be conducted utilizing a resident rounding tool to ensure proper offloading of heels and bed elevation per each resident's individual plan of care. The audit will be conducted daily until 100% compliance is achieved for 5 consecutive days. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive weeks. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive weeks. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.</p> <p>2. a. R5 heels are intact with no skin issues. Immediately upon being made</p>		

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F 686	<p>Continued From page 8 the mattress. (HeelZup.com).</p> <p>12/29/19 10:16 AM - A nursing progress note documented: "Blister to left buttock is now open, 3.2 x 3.8 cm." R1's clinical record lacked evidence as to when R1 developed the left buttock blister, a Stage 2 pressure injury.</p> <p>12/30/19 - A physician's order included: Heel boots to bilateral heels at all times. May remove for hygiene.</p> <p>12/30/19 - R1's revised care plan for pressure ulcer included interventions: heel booties to bilateral heels; offload heels with (HeelZup) cushion while in bed; skin checks every two hours and as needed; turn and reposition every two hours and as needed."</p> <p>12/31/19 11:44 AM- A nursing progress note included: "Left ischial (lower part of buttock) area noted with unstageable pressure ulcer with 100% slough...measures 2 cm x 3.1 cm..."</p> <p>1/9/20 - R1 was observed in bed on her back with her heels not elevated off of the bed: 11:51 AM; 11:57 AM; and 12:50 PM.</p> <p>1/9/20 2:20 PM - During an interview and observation, E5 (CNA) confirmed that R1 was positioned on her back with the HeelZup cushion (with a pillow on top) under R1's knees and not offloading her heels from the bed. E5 reported, "R1 likes to mainly stay on her back, especially after the broken leg." E5 added, "We are supposed to turn her every two hours, but we don't move her as much because of the leg fracture."</p>	F 686	<p>aware of this deficient practice R5 was repositioned and heels were offloaded. R5 is now being repositioned and heels are being offloaded as per her plan of care.</p> <p>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 correct actions outlined in 2c.</p> <p>c. DON/Designee will complete an in-service for all nursing staff on proper offloading of heels and the importance of turning and repositioning according to each resident's plan of care.</p> <p>d. DON/Designee will conduct audits of 20 residents who are at moderate to high risk of developing pressure ulcers. Audits will be conducted utilizing a resident rounding tool to ensure proper offloading of heels and adherence to turning and repositioning orders per each residents individual plan of care. The audit will be conducted daily until 100% compliance is achieved for 5 consecutive days. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive weeks. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive weeks. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.</p>		

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F 686	<p>Continued From page 9</p> <p>1/10/20 9:05 AM - During an observation it was noted that R1 was in bed on her back with the head of the bed elevated at 45 degrees. R1's left heel boot was off, and the right heel boot was half of the way off. The HeelZup device was positioned under R1's knees and her heels were not elevated off the bed.</p> <p>To prevent shear injury [to the buttocks and sacrum], maintain the head of the bed at the lowest level of elevation and for the shortest period of time. (<a href="https://quizlet.com/201460280/pressure-ulcer-assessment-and-care-flash-cards">https://quizlet.com/201460280/pressure-ulcer-assessment-and-care-flash-cards</a>).</p> <p>1/10/20 9:11 AM - During an interview and observation, E6 (CNA) confirmed that R1's head of the bed was at 45 degrees, her heel boots and HeelZup device were not properly placed, and that R1's heels were pressing against the bed.</p> <p>The facility failed to provide care and services to promote healing of R1's pressure ulcers and to prevent the development of further pressure injuries.</p> <p>2. Review of R5's clinical record revealed:</p> <p>1/14/16 - R5 was admitted to the facility with multiple diagnoses including dementia.</p> <p>12/13/17 - A care plan for the potential for pressure ulcers (last reviewed / edited 1/7/20) related to decreased functional mobility, incontinence, friction, impaired cognition: (R5) chooses not to have her heels offloaded at times. Interventions included: Braden risk assessment as ordered; Encourage / offload heels when in bed; Encourage / turn and reposition every 2</p>	F 686		

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F 686	<p>Continued From page 10</p> <p>hours and PRN; Ensure measures are taken to prevent / reduce potential shearing or friction during transfers, repositioning, etc.; Skin checks every 2 hours and PRN; Weekly skin assessments. Report abnormal conditions to MD (physician).</p> <p>11/18/19 - A Braden Scale documented R5 was at risk for skin breakdown with a score of 16.</p> <p>11/25/19 - A significant change MDS assessment, completed when R5 was discharged from hospice, documented that R5 required extensive assistance of two staff for bed mobility. Pressure injury prevention treatments included pressure reducing mattress and wheelchair cushion and turning / repositioning program.</p> <p>June - December 2019 - Review of nursing progress notes documented R5 experienced a pathological fracture of the bottom of the left thigh bone (femur) and wore a knee immobilizer (brace) on the left leg from 8/19/19 through 12/5/19.</p> <p>1/7/20 - The weekly skin check documented that R5 had no new skin conditions.</p> <p>1/9/20 (9:30 AM - 2:10 PM) - The surveyor observed R5 on her back with pillows under her thighs, knees bent and both heels pressing into the mattress at 9:30 AM, 10:30 AM, 11:00 AM, 12:50 PM and 2:10 PM.</p> <p>1/9/20 (2:20 PM) - During an interview, E3 (RN, UM) confirmed R5's heels were pressing into mattress and both heels were boggy (soft and mushy) after the surveyor informed E3 that R5 had been observed on her back in same position</p>	F 686			

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F 686	Continued From page 11 on numerous occasions today.  The facility failed to reposition R5 and offload her heels according to the plan of care.  1/10/19 (around 11:50 AM) - During an interview with E1 (NHA) and E2 (DON) to review the aforementioned observations, E2 stated that she "will take care of that now."  1/10/19 (12:41 PM) - A nursing progress note documented R5 was "evaluated for redness noted to bilateral heels. In house (NP) and this writer in to evaluate with bilateral healing having blanchable erythema. Resident is palliative care, diabetic, with appetite fair with resident needing assist with meals...New orders to use (HeelZup) cushion while in bed and continue to off load while in recliner chair with pillows. New orders to cleanse bilateral heels with NSS (normal saline solution - salt water), pat dry, apply skin prep q (every) shift and as needed. No sign of pain noted at this time..."	F 686			
F 697 SS=D	Pain Management CFR(s): 483.25(k)  §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 697		2/24/20	

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F 697	<p>Continued From page 12</p> <p>Based on record review and interview it was determined that one (R5) out of two residents with a fracture investigated for neglect the facility failed to assess pain intensity (severity) before / after PRN pain medication and failed to determine R5's acceptable (comfortable) pain rating intensity. Findings include:</p> <p>April 2002 - The American Geriatrics Society pain management standards included: Appropriate assessment and management of pain; Assessment in a way that facilitates regular reassessment and follow-up; Same quantitative pain assessment scales should be used for initial and follow up assessment; Set standards for monitoring and intervention; and Collect data to monitor the effectiveness and appropriateness of pain management.</p> <p>The review of the facility policy entitled Pain Management (last reviewed 1/2/10) included: "Pain scales (numerical or behavioral) are utilized to quantify resident's pain and the effectiveness of pain interventions. All residents will be assessed / monitored every shift for new onset of pain, and/or the effectiveness of current pain management measures. Pre and post pain medication administration assessments are performed and documented in the electronic medication administration record (eMAR)."</p> <p>Review of R5's clinical record revealed:</p> <p>12/13/17 - A care plan for pain was initiated (last revised 1/7/20) related to "pain in shoulder...healing fx (fracture) of the lateral (outer) aspect of the distal left femur (bottom of the left thigh bone)" with the goal that R5's "pain will be controlled to a level that is comfortable."</p>	F 697	<p>1. a. R5 was not negatively impacted by the cited deficient practice. R5's orders were reviewed immediately following upon identification of deficient practice and pre and post pain indicators were added to order for pain medications. A facility sweep of all orders for PRN pain medication has been completed to ensure both pre and post pain indicators are associated with the order for pain medication.</p> <p>b. All residents that we administer pain medications to, have the potential to be affected by this deficient practice. Residents will be protected by taken the action outlined in 1c.</p> <p>c. All nurses who administer medication will be educated on the appropriate utilization and documentation of pre and post pain indicators when administering PRN pain medication.</p> <p>d. DON/Designee will conduct medication administration record audit to ensure that nurses are following medicine administration procedure as it relates to monitoring effectiveness of current pain management measures. The audit will be conducted daily until 100% compliance is achieved for 5 consecutive days. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive weeks. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive weeks. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the</p>		

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F 697	<p>Continued From page 13</p> <p>Approaches included to "administer non-pharmacological and pharmacological pain interventions as ordered and report effectiveness to physician; Assess for verbal and non-verbal pain indicators to include: facial grimacing...constant shifting in bed, moaning or groaning, restlessness and agitation..." No pain intensity rating had been identified as R5's comfort level in order to determine effectiveness of pain interventions.</p> <p>November - December 2019 - Review of R5's nursing progress notes and eMAR revealed that R5 received 18 doses of PRN pain medication: - only 1 dose included an initial pain severity rating before the PRN medication: November 24 (5:38 PM). - all 18 doses did not include a pain intensity rating after the PRN medication to evaluate effectiveness: November 2 (4:53 AM), 8 (10:43 AM), 9 (2:11 PM), 10 (9:59 AM), 14 (3:28 PM), 19 (6:39 PM), 20 (12:54 AM), 22 (4:36 AM), and 24 (5:38 PM); and December 3 (5:21 PM), 4 (8:03 PM). December 7 (1:12 AM), 8 (6:32 PM), 10 (5:07 PM), 13 (6:58 PM), 17 (8:08 PM), 20 (3:48 PM) and 22 (3:41 PM).</p> <p>1/10/20 (10:44 AM) - During an interview E3 (RN, UM) confirmed the missing pain severity ratings. E3 stated that the order was entered in the computer without the pre and post pain indicators. E3 added that, for R5, the pain scale to be used would be the non-verbal or faces (behavioral scale).</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 1/10/20 during the exit conference beginning around 2:45 PM.</p>	F 697	<p>audits will be presented and discussed at the facility QA Meeting.</p>		

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F 756 SS=D	<p>Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)</p> <p>§483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>§483.45(c)(2) This review must include a review of the resident's medical chart.</p> <p>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.</p>	F 756		2/24/20	

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F 756	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to identify irregularities during medication regimen reviews for one (R5) out of three residents investigated for neglect. Findings include:</p> <p>A review of the facility policy entitled Psychoactive Medications (last revised 1/2/20) included: "PRN orders for antipsychotic medications expire upon physician discontinuation or in 14 days, whichever is first. To continue the medication beyond 14 days, the provider is required to re-evaluate the resident and write a new prescription; this process is required every 14 days as long as the medication is ordered for the resident."</p> <p>Cross Refer F758 Review of R5's clinical record revealed:</p> <p>9/6/19 - The physicians' orders included an antipsychotic medication (Haldol) to be given every 4 hours PRN for increased anxiety / behaviors.</p> <p>October 2019 - December 2019 - Review of consultant pharmacist's medication regimen review documentation from October 24, November 25 and December 19 revealed that the pharmacist did not identify that the PRN order for Haldol expired and was never re-written.</p> <p>1/10/19 (around 11:50 AM) - During an interview with E1 (NHA) and E2 (DON) to review the aforementioned findings, E2 agreed that the pharmacist should have identified this issue.</p> <p>Findings were reviewed with E1 (NHA) and E2</p>	F 756	<p>1.</p> <p>a.) R5 was not negatively impacted by this deficient practice. Immediately upon identifying deficient practice R5's record was reviewed. As of 1/10/20 there was no longer an order for Haldol for R5, nor was the medication being administered therefore no further corrective action was needed.</p> <p>b.) All residents who have orders for PRN antipsychotic medicine have the potential to be affected by this deficient practice. A sweep of all residents with PRN antipsychotic orders has been completed to ensure there are stop dates entered for 14 days from original order. Residents will be protected from this deficient practice by taking the corrective actions outlined below in #1c.</p> <p>c.) The pharmacy will conduct focused education for all pharmacists responsible for conducting medication regimen reviews. Education will be reflective of the following: need to identify and report to the facility <input type="checkbox"/>s Attending Physician, Medical Director and Director of Nursing when PRN antipsychotic orders have expired and have not been discontinued; prescribing practitioner needs to evaluate resident, identify if the order should be extended beyond 14 days and document rationale in resident <input type="checkbox"/>s medical record indicating duration for the PRN order; the written report from the pharmacist must at a minimum include the resident <input type="checkbox"/>s name,</p>		

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F 756	Continued From page 16 (DON) on 1/10/20 during the exit conference beginning around 2:45 PM.	F 756	the relevant drug and the irregularity identified.		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)  §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehensive assessment of a resident, the facility must ensure that---  §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758	d.) The pharmacy designee will audit all prn antipsychotic orders. The audit will be conducted 3 times weekly until 100% compliance is achieved for 3 consecutive weeks. Then, the audit will be conducted weekly until 100% compliance is achieved for three consecutive weeks. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.	2/24/20	

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F 758	<p>Continued From page 17 in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure a PRN antipsychotic medication was prescribed for no more than 14 days for one (R5) out of three residents investigated for neglect. Findings include:  Review of the facility policy entitled Psychoactive Medications (last revision 1/2/20) included: "PRN</p>	F 758	<p>1. a.) R5 was not negatively impacted by this deficient practice. As of 1/10/20 R5 did not have an order for Haldol nor was Haldol being administered therefore no immediate corrective action was taken.</p> <p>b.) All residents who have orders for PRN antipsychotic medicine have the potential</p>		

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F 758	<p>Continued From page 18</p> <p>orders for antipsychotic medications expire upon physician discontinuation or in 14 days, whichever is first. To continue the medication beyond 14 days, the provider is required to re-evaluate the resident and write a new prescription; this process is required every 14 days as long as the medication is ordered for the resident."</p> <p>Review of R5's clinical record revealed:</p> <p>1/14/16 - R5 entered the facility with multiple diagnoses including dementia.</p> <p>9/5/19 - R5 was admitted to [name of hospice].</p> <p>9/6/19 - R5's physicians' orders included an antipsychotic medication (Haldol) to be given every 4 hours PRN for increased anxiety / behaviors.</p> <p>September 2019 - December 2019 - Review of physicians' progress notes, physicians' orders and hospice documentation revealed:</p> <ul style="list-style-type: none"> <li>- 9/17/19: E7 (NP) note included the plan for "Unspecified Psychosis: Haldol recently initiated for management of symptoms. No GDR (gradual dose reduction) at this time as benefit outweighs the risk."</li> <li>- 9/20/19: A new order was not written for Haldol on the 14th day after the original order.</li> <li>- 9/23/19 - 11/29/19: E8 (NP) documented four separate progress notes.</li> <li>- 10/4/19, 10/18/19, 11/1/19, and 11/29/19: A new order was not written for Haldol.</li> <li>- 12/3/19 - R5 was discharged from hospice, Haldol discontinued and R5 continued to live in the facility.</li> <li>- R5 received over 20 doses of Haldol PRN on an order that expired 9/20/19.</li> </ul>	F 758	<p>to be affected by this deficient practice. A sweep of all residents with PRN antipsychotic orders has been completed to ensure there are stop dates entered for 14 days from original order. Residents will be protected from this deficient practice by taking the corrective actions outlined below in #1c.</p> <p>c.) Upon conducting a root cause analysis it was identified that the reason the medication was not re-evaluated by provider within appropriate time frame was because our process was not followed to enter a stop date in the original order. The facility will conduct focused education for prescribing providers as well as all licensed nursing staff responsible for entering orders for PRN antipsychotic medication to include the need to limit the order to 14 days by entering a stop date on the original order and that it cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.</p> <p>d.) The Director of Nursing (DON)/designee will audit all prn antipsychotic orders. The audit will be conducted daily until 100% compliance is achieved for 5 consecutive days. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive weeks. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive weeks. Then, another audit will be conducted in one month. If 100%</p>		

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/10/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>CADIA REHABILITATION CAPITOL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1225 WALKER ROAD</b> <b>DOVER, DE 19904</b>		
(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 758	Continued From page 19  The facility failed to ensure that the provider re-evaluated the PRN Haldol. The PRN antipsychotic order remained in effect for more than 14 days.  1/9/19 (10:48 AM) - During an interview, E3 (RN, UM) confirmed the PRN Haldol was never re-ordered while R5 was on hospice and that a hard-stop (discontinuation date) was not entered in the computer for the PRN Haldol.  Findings were reviewed with E1 (NHA) and E2 (DON) on 1/10/20 during the exit conference beginning around 2:45 PM.	F 758	compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.		



**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Health Care Quality

Office of Long Term Care Residents Protection

DHSS - DHCQ  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 421-7400

**STATE SURVEY REPORT**

NAME OF FACILITY: Cadia Rehab. Capitol

DATE SURVEY COMPLETED: January 10, 2020

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201  3201.1.0  3201.1.2	<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 January 7, 2020 through January 10, 2020. 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 eight (108). The survey sample totaled eight (8).</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>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.</b></p> <p><b>This requirement is not met as evidenced by:</b> Cross Refer to the CMS 2567-L survey completed January 10, 2020: F684, F686, F697, F756 and F758.</p>	<p>Please cross reference electronic PO C in epoc system.</p>	<p>2/24/20</p>

Provider's Signature: [Signature] Title: Administrator Date: 1.27.2020