STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085054	A. Building B. Wing	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Pike Creek	3540 Three Little Bakers Blvd Wilmington, DE 19808

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46448 Based on observations and interview, it was determined that the facility failed to ensure a call bell was in reach for one (R105) out of five residents reviewed. Findings include: Review of R105's clinical record revealed: 11/18/22 - R105 was admitted to the facility with a past medical history including paralysis and weakness of his right side following a stroke, a tracheostomy (small surgical opening that is made through the front of the neck into the windpipe), and dependence on a ventilator (machine that moves air in and out of your lungs). 2/14/23 11:28 AM - During an interview with R105, the Surveyor observed his call bell not within reach as it was hanging off the right side of R105's bed. The Surveyor asked the resident if this happens often and he stated, Sometimes. They just changed my linen. The Surveyor picked the call bell up to test the device and left it within reach of resident. 2/14/23 3:47 PM - During an observation, R105 was observed lying in bed with eyes closed. R105's call bell was lying off of the right side of his bed about 2 inches from the floor. 2/21/23 10:00 AM - The Surveyor observed R105's call bell hanging from the right side of his bed underneath the bedrail hanging a few inches from the floor. R105 was awake and watching television. E19 (LPN) confirmed that R105's call bell was out of reach and stated, Oh, sorry sometimes it just takes me long to get down here. 2/23/23 11:19AM - Findings were reviewed with E1 (CNO) and E2 (NHA).

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.

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47621 Based on record review, interview and other facility information as indicated, it was determined that for one (R223) out of three residents reviewed for the beneficiary protection notification, the facility failed to obtain R223's signature or to document R223's refusal to sign the Notice of Medicare Non-Coverage (NOMNC) when the resident was discharged from Medicare Part A Services and transferred to an assisted living facility. Findings include: Review of R223's clinical record revealed: 12/8/22 - R223 was admitted to the facility. 12/15/22 - R223's MDS assessment documented that R223 was independent and able to make decisions that are consistent and reasonable. 1/25/23 - R223 was discharged from Medicare Part A services and transferred to an assisted living facility. 2/20/23 - Review of R223's NOMNC notice which was provided with the completed SNF (skilled nursing facility) beneficiary protection notice worksheet revealed that R223 did not sign the statement acknowledging that she received and understood the NOMNC. 2/21/23 at 9:53 AM - During an interview with E22 (SW) and E23 (SW) regarding the NOMNC process, E23 confirmed that R223's family member (F1) was called and notified the end date of Medicare Part A services. E23 confirmed that R223 was not asked to sign the NOMNC notice. 2/23/23 11:19AM - Findings were reviewed with E1 (CNO) and E2 (NHA).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46134 Based on record reviews and interviews, it was determined that the facility failed to develop a comprehensive person-centered care plan for two (R102 and R619) out of 35 residents sampled for review of care plans. Findings include: 1. Review of R619's clinical record revealed the following: 12/25/22 - R619 was admitted to the facility with multiple diagnoses, including respiratory failure and asthma. 12/28/22 - A Physician's order was written for Ipratropium-Albuterol Solution 3 ml inhale orally every 6 hours as needed for shortness of breath. 12/28/2022 - A Physician's order was written for Continuous Positive Airway Pressure (CPAP) breathing machine use at bedtime. 12/29/22 - A Physician's order was written for Montelukast Sodium 1 tablet by mouth one time a day for asthma. Review of R619's comprehensive person-centered care plan revealed a lack of evidence regarding the respiratory care for CPAP and treatment to be provided to R619. 2/20/23 at 12:13 PM - During an interview, E5 (Respiratory Therapist) acknowledged that R619's comprehensive person-centered care plan did not contain evidence regarding the respiratory care and treatment to be provided to R619. 46448 2. Review of R102's clinical record revealed: 11/6/22 - R102 was admitted to the facility with a past medical history including traumatic brain injury, dysphagia following a brain hemorrhage, and contractures of the left hip and knee. 11/13/22 - R102's comprehensive MDS assessment revealed that he was a totally dependent (requiring full staff performance every time during a 7-day period) in the following activities of daily living (ADL) care areas: dressing, eating, toileting, and personal hygiene. Record review lacked evidence of an ADL care plan for R102. 2/20/23 11:09 AM - During an interview, E21 (RNAC) was asked for a copy of R102's ADL care plan. E21 looked through R102's care plan and stated, I don't see one in here for him. The Surveyor asked who initiates the care plans? E21 replied, The CAA (Care Area Assessment) will trigger . the resident did not trigger for ADLs. We do what the CAA triggers, if not it's up to nursing to make that decision . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy on Care Planning revised on 1/12/23 documented, A comprehensive care plan should be developed to address medical, nursing, nutritional, and psychosocial needs within 7 days of completion of the comprehensive assessment. A comprehensive care plan must be prepared by an interdisciplinary team . Care plans should include: Services furnished to maintain highest practical well-being . The facility failed to develop and implement a comprehensive ADL care plan for R102. 2/23/23 11:19 AM - Findings were reviewed with E1 (CNO) and E2 (NHA).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 20835 Based on record review and interview, it was determined that for one (R97) out of 35 sampled residents for care plan investigation, the facility failed to ensure that the required interdisciplinary team (IDT) members attended or otherwise participated in the care plan meeting. Findings include: Review of the facility's policy and procedure titled Care Planning, with a revision date of 1/12/23, stated that the comprehensive care plans should be reviewed and revised by the interdisciplinary team (IDT) after each assessment. The following was reviewed in R97's clinical record: 10/2/22 - R97 was admitted to the facility. 10/19/22 -An admission MDS (Minimum Data Set) assessment was completed. 10/19/22 - Review of the Care Conference Participation Form lacked evidence of participation by R97's Attending Physician and the assigned CNA. 1/5/23 - A quarterly MDS assessment was completed. 1/5/23 - Review of the Care Conference Participation Form lacked evidence of participation by R97's Attending Physician and the assigned CNA. 2/17/23 12:00 PM - An interview with E22 (SW) confirmed that the facility was unable to provide evidence that R97's Attending Physician or the assigned CNA participated in the above two Care Conference Meeting's on 10/19/22 and 1/5/23. 2/23/23 2:15 PM - Finding was reviewed during the Exit Conference with E1 (CNO), E2 (NHA) and E3 (DON).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 40163 Based on observation, interview and review of the clinical record, it was determined that for one (R108) out of four residents reviewed for urinary catheters/urinary tract infection (UTI), the facility failed to ensure that R108 received appropriate treatment and services to prevent the risk of infection UTI when R108's urinary catheter bag was observed lying on a visibly soiled floor. Findings include: The following was reviewed in R108's clinical record: 12/17/22 - R108 was admitted to the facility with a neurogenic bladder and required a foley catheter (a tube in the bladder to drain urine). 12/21/22 - A Physician's order included indwelling catheter care every shift. 2/14/23 10:14 AM - During a random observation, R108's foley catheter drainage bag was noted to be hooked to the left side of R108's bed, approximately one half full of urine and lying on the floor. Beneath R108's catheter drainage bag the floor was observed to be visibly soiled with dried spill-like soiled areas beneath it. 2/14/23 10:36 AM - During an interview, E30 (CNA) confirmed that R108's catheter drainage bag was on a visibly soiled floor. The facility failed to prevent the risk for R108 to acquire a bladder infection related to placement of the catheter drainage bag on a visibly soiled floor. 2/23/23 at 2:15 PM - The finding was reviewed during the Exit Conference with E1 (CNO), E2 (NHA) and E3 (DON) during the exit conference.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46134 Based on observations and interviews, it was determined that the facility failed to ensure that medications were stored and labeled properly in two out of five medication carts and in one out of two medication rooms reviewed. Findings include: The facility policy on storage of medications, last updated 1/31/23, indicated, .When opening a multi-dose container, place the date on the container . 2/16/23 - During a medication storage review of the first floor the following was observed: 2/16/23 10:30 AM- The [NAME] Clay 3 medication cart had one opened vial containing Olopatedine (used for allergies) that did not have an open date. E19 (LPN) confirmed the finding. 2/16/23 11:00 AM - The [NAME] Clay 1 medication cart had one opened bottle of Keppra (used for seizures) that did not have an open date. E19 confirmed the finding. 2/16/23 11:30 AM - The [NAME] Clay medication room had a refrigerated bottle of Omeprazole (used for acid reflux) liquid that did not have an open date. E9 (RN) confirmed the finding. 2/23/23 2:15 PM - Findings were reviewed during the Exit Conference with E1 (CNO), E2 (NHA) and E3 (DON).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36017 Based on observations and interview, it was determined that the facility failed to ensure that the kitchen's handwashing stations were properly maintained. Findings include: The following were observed on 2/13/23 from 8:45 AM to 9:30 AM during the initial kitchen tour: 1. The cleaning supplies were stored on top of the handwashing sink in the dishwashing room, blocking access to the handwashing sink. 2. No handwashing sign was present designating handwashing only at the handwashing sink outside of the Dietary Director's office. 2/13/23 at approximately 10:10 AM - Findings were reviewed and confirmed with E29 (Food Service Director).

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. 20835 Based on observations, interviews and reviews of clinical records, facility documentation and other sources as indicated, it was determined that the facility failed to maintain an infection prevention and control program to protect the residents against an outbreak of norovirus (a highly contagious infection that can cause a sudden onset of severe vomiting and diarrhea) and they failed to have a system in place to control a contagious disease to residents, staff and visitors. For three (R52, R167 and R417) out of nine sampled residents, the facility failed to actively adhere to contact precautions and hand hygiene among healthcare personnel, residents, and visitors in patient care areas affected by outbreaks of norovirus gastroenteritis, including a process to identify the residents who were symptomatic with signs and symptoms of norovirus as per CDC guidance. The facility's system failure put all residents, including R52, R167 and R417 at immediate jeopardy (IJ) of a serious adverse outcome by not having a method of identifying residents that required contact precautions as it relates to Norovirus, not providing staff the necessary education and PPE (Personal Protective Equipment) to use for contact precautions while delivering resident care and lack of evidence of staff surveillance as per CDC guidance. The IJ was identified on 2/16/23 at 4:11 PM and was abated on 2/20/23 at 10:19 AM. In addition, the facility failed to use infection control precautions for R29 during wound care. Findings include: The facility policy titled, Standard and Transmission Based Precautions, effective June 2013 and revised 1/27/23 documented, 'Contact Precautions' -applies to all residents infected or colonized with a MDRO (multidrug-resistant organisms or bacteria that resist treatment with more than one antibiotic) in the following situations: presence of acute diarrhea . c. diff (or clostridium difficile, a bacterial overgrow that releases toxins that attack the lining of the intestines) . norovirus . Special Situations: Organisms likely to have spores like Clostridium difficile and some diseases with ongoing transmission like Norovirus and Influenza may require special contact precautions. In addition to contact precautions, perform hand hygiene using soap and water and use a hypochlorite solution (e.g., bleach) for environmental cleaning . Resident Care Equipment and Articles - cleaned and disinfected after use . The CDC's Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, last updated 2/15/17, documented, . The Summary of Recommendations includes recommendations organized into the following categories: -Patient Cohorting and Isolation Precautions . Avoid exposure to vomitus or diarrhea . During outbreaks, place patients with Norovirus gastroenteritis on Contact Precautions for a minimum of 48 hours after the resolution of symptoms to prevent further exposure of susceptible patients . Consider longer periods of isolation or cohorting precautions for complex medical patients (e.g., those with cardiovascular, autoimmune, immunosuppressive, or renal disorders) as they can experience protracted episodes of diarrhea and prolonged viral shedding. Patients with these or other comorbidities have the potential to relapse, and facilities may choose longer periods of isolation based on clinical judgment . Staff who have recovered from recent suspected norovirus infection associated with an outbreak may be best suited to care for symptomatic patients until the outbreak resolves . (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Hand Hygiene . Actively promote adherence to hand hygiene among healthcare personnel, patients and visitors in patient care areas affected by outbreaks of norovirus gastroenteritis . During outbreaks, use soap and water for hand hygiene after providing care or having contact with patients suspected or confirmed with norovirus gastroenteritis . -Personal Protective Equipment . If norovirus infection is suspected, adherence to PPE use according to Contact and Standard Precautions is recommended for individuals entering the patient care area (i.e. gowns and gloves upon entry) to reduce the likelihood of exposure to infectious vomitus or fecal material . Use a surgical or procedure mask and eye protection or a full face shield if there is an anticipated risk of splashes to the face during the care of patients, particularly among those who are vomiting . -Education . Provide education to staff, patients, and visitors, including recognition of norovirus symptoms, preventing infection, and modes of transmission upon the recognition and throughout the duration of a norovirus gastroenteritis outbreak . -Active Case-Finding . Begin active case-finding when a cluster of acute gastroenteritis cases is detected in the healthcare facility. Use a specified case definition, and implement line lists to track both exposed and symptomatic patients and staff. Collect relevant epidemiological, clinical, and demographic data as well as information on patient location and outcomes . -Communication and Notification . Provide timely communication to personnel and visitors when an outbreak of norovirus gastroenteritis is suspected and outline what policies and provisions need to be followed to prevent further transmission . (https://www.cdc.gov/infectioncontrol/guidelines/norovirus/) According to the facility's completed form entitled Gastroenteritis Data Collection Line Listing for Patients, from 1/31/23 to 2/15/23, 46 residents were documented with gastrointestinal (GI) symptom(s) on both floors of the facility. Observations and clinical record reviews of three current residents with recent GI symptoms identified on the GI Line Listing revealed: 1a. Review of R167's clinical record revealed the following: 2/9/23 - R167 was admitted to the facility. 2/13/23 5:47 PM - Review of the Electronic Medication Administration Record (eMAR) revealed that R167 was administered a medication to treat diarrhea and another medication to treat nausea and vomiting. Subsequently, the eMAR documented that these medications were effective in treating the diarrhea, as well as the nausea and vomiting. 2/14/23 8:45 AM - A Physician Order was written to chart GI symptoms, which included to monitor for nausea, vomiting, and diarrhea every shift for three days. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/15/23 3:30 PM - An interview with R167 revealed that he had nausea yesterday on 2/14/23, but denied nausea, vomiting and/or diarrhea today. An observation of the exterior door into R167's room revealed that there was no signage indicating that R167 was on contact precautions and there was no PPE hanging on his door for staff and visitors to apply prior to entering the room. 2/16/23 3:40 PM - An interview with the assigned nurse E8 (LPN) revealed that R167 was not on contact precautions. The facility failed to ensure R167 had contact precautions implemented (including PPE and signage) and the facility failed to ensure that staff were aware of the precautions to follow during an outbreak in the facility. 46134 1b. Review of R417's clinical record revealed the following: 2/8/23 - R417 was admitted to the facility. 2/14/23 3:26 PM - A progress note by E24 (NP) stated that R417 was experiencing loose stools and had orders for medications to treat diarrhea and nausea and vomiting. 2/15/23 3:45 PM - An interview was done with E6 (CNA) and E7 (CNA). E6 stated that a stomach bug is growing and growing and it is hard to make sure that you don't catch it. E6 and E7 both stated they do not know when residents are positive for a stomach virus and that they ask the Nurses to find out information about residents because the Nurses do not automatically tell them. E6 and E7 added that it is hard to tell who has a stomach virus because some residents are on laxatives and it is hard to know the difference when the residents have loose stools. 2/16/23 9:00 AM - A review of the facility's infection control tracking document for gastroenteritis documented that R417's last episode of diarrhea was on 2/15/23 at 2:00 PM. 2/16/23 11:00 AM - An observation of R417's exterior room door lacked evidence of contact precautions signage and the presence of PPE for staff and visitors to apply prior to entering R417's room. 1c. Review of R52's clinical record revealed the following: 12/23/22 - R52 was admitted to the facility. 2/14/23 3:15 AM - A nurses note in the electronic medical record (EMR) revealed that R52 was being monitored for GI symptoms. 2/14/23 2:00 PM - A nurses note in the EMR revealed that R52 was experiencing loose stools and a new order was received for a medication to treat R52's diarrhea. R52's onset of diarrhea was noted on the facility's Gastroenteritis: Data Collection Line Listing. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/16/23 11:00 AM - While PPE was present outside of R52's door as the resident was already on enhanced barrier precautions, an observation of R52's exterior door revealed the absence of contact precautions signage to inform staff and visitors to apply the PPE prior to entering the room. According to the facility's Gastroenteritis: Data Collection Line Listing, R52's last episode of diarrhea was on 2/16/23 at 8:30 AM. 2/16/23 4:11 PM - Based on observations, interviews, review of facility documentation and other sources, an Immediate Jeopardy was called and reviewed with facility leadership including E1 (CNO), E2 (NHA), E3 (DON) and E26 (VPO). 2/16/23 7:02 PM - It was confirmed by Surveyors that the affected three resident rooms had contact precautions signage and PPE in place for staff and visitors on what was required prior to entering the rooms. The facility started staff education that was ongoing around the clock and through an electronic module available to staff. In addition, a CDC sign for norovirus was posted at the receptionist desk educating visitors on what precautions were required during the outbreak. 2/16/23 7:30 PM - E2 submitted an acceptable Abatement Plan signed, dated, and timed 2/16/23 at 7:29 PM. 2/17/23 4:00 PM - E1 was advised by the Surveyor to send via email evidence of staff education once completed. 2/17/23 5:40 PM - In an email correspondence, E2 sent proof of staff education status as of 2/17/23 at 5:30 PM and stated, continuing to educate staff. 2/20/23 10:19 AM - The date and time E2 stated that staff in-service was completed. 40264 2. The facility failed to provide evidence of an infection control surveillance program that included monitoring staff for GI signs and symptoms. The CDC's Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, last updated on 2/15/17, documented . The Summary of Recommendations includes recommendations organized into the following categories: -Staff Leave and Policy . Exclude ill personnel from work for a minimum of 48 hours after the resolution of symptoms. Once personnel return to work, the importance of performing frequent hand hygiene should be reinforced, especially before and after each patient contact . 2/14/23 12:17 PM - An interview with E9 (LPN) stated that a GI illness started on the second floor last weekend and then spread to the first floor residents. E9 stated that she believed a random test was done, but she was not sure if the residents were tested specifically for Norovirus. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/15/23 3:00 PM - E3 (IC/DON) provided the survey team with copies of the correspondence from the State of Delaware Department of Public Health (DPH). This included the Gastroenteritis Data Collection Line List. DPH recommended 2-3 resident stool samples for testing. E3 also stated that the official start of the outbreak was 2/8/23 when the facility received notification of a positive test for norovirus. 2/16/23 10:35 AM - A joint interview with E1 (CNO), E2 (NHA) and E3 revealed that DPH sent an email for the facility to call DPH to go over the results and recommendations when the positive norovirus test came back on 2/8/23. According to E1 and E3, the recommendations included to quarantine (resident) cases in their room .if .any more staff please exclude them until .(diarrhea) symptoms have resolved .isolating precautions .cohorting or exclusion for staff . 2/16/23 10:45 AM - An interview with E3 confirmed that an infection control line listing was not initiated for staff. It was further revealed there were sporadic staff cases based on who called out sick. E3 stated that symptomatic staff could not come back to work until they were without nausea, vomiting, diarrhea and/or fever for 48 hours. E3 stated that she'll start creating the staff line list using the DPH template. 47114 3. Review of the facility policy and procedure, revised 6/2/2021, titled Infection Control Hand Hygiene included, .it is the policy of Cadia Healthcare to help control the spread of infection through hand hygiene, wash hands thoroughly, using rigorous scrubbing action for at least 20 seconds . Review of When and How to Perform Hand Hygiene included .after touching a patient or the patient's immediate environment, after contact with blood, body fluids or a contaminated surface. https://www.cdc.gov/handhygiene/providers/index.html. 2/20/23 9:55 AM - During an observation, R29's breakfast tray and a urinal containing urine were on the bedside table. E14 (LPN) placed dressing supplies on the unclean bedside table and then picked up R29's breakfast tray and left the room. E14 then picked up the urinal from the bedside table and emptied it in the bathroom and washed her hands for five seconds. E14 placed a blue pad on the bedside table to create a clean field, then picked up the dressing supplies that had been placed on a dirty bedside table, and put them on the blue pad causing contamination of the clean field. E14 then put on clean gloves and opened the treatment supplies that had been contaminated causing the nurses gloves to no longer be clean. The nurse proceeded to complete the dressing change with gloved hands that were contaminated. 2/21/23 11:00 AM - The Surveyor asked E1 (CNO) for a policy and procedure for wound care, and E1 replied, No, we don't have a policy and procedure for wound care. 2/21/23 2:11 PM - During an interview with E14 she stated, I put the dressings on the table and put the dressings on top of the pad. 2/23/23 - Findings were reviewed with E1 (CNO), E2 (NHA) and E3 (DON) during the exit conference beginning at 2:15 PM.