

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

PRINTED: 02/03/2021
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 11/20/2020
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION CAPITOL			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 WALKER ROAD DOVER, DE 19904		
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced COVID-19 Focused Infection Control and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection, which began on November 13, 2020 and ended on November 20, 2020. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census on the first day of the survey was 95. The survey sample totaled six (6).</p> <p>Abbreviations and Definitions used in this report are as follows:</p> <p>CNA - Certified Nurse's Aide; DON - Director of Nursing; HCP - Healthcare Provider; ICP - Infection Control Preventionist; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RN - Registered Nurse; RNC - Regional Nurse Consultant; UM (Unit Manager) - manager of a nursing unit.</p> <p>ADL (Activities of daily living) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Asymptomatic - without symptoms; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15: 13-15 - cognitively intact. 08-12 - moderately impaired. 00-07 - severe impairment;</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

12/16/2020

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 - brain disorder with memory loss, poor judgement, personality changes and disorientation; CDC - Centers for Disease Control and Prevention; Cloth face covering - Textile (cloth) covers that non-direct care facility staff may wear and are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. They are not PPE; CMS - Centers for Medicare & Medicaid Services; Cognitively intact - fully oriented and able to make appropriate decisions; COVID-19 (Coronavirus) - a respiratory illness that can be spread person to person; DPH - The State Agency Division of Public Health; Face masks - they are PPE and are often referred to as surgical or procedure masks; they are required to be worn by staff providing direct care to residents during the COVID-19 pandemic; Immediate Jeopardy (IJ); MDS (Minimum Data Set) - an assessment tool used for residents in nursing homes; PPE (Personal Protective Equipment) - specialized clothing or equipment worn by an employee for protection against infectious materials, such as a mask, gloves, goggles and gowns; PUI - person under investigation for COVID-19 infection because of symptoms or awaiting test results; Positive - +; SARS-Cov-2 - Corona virus; s/sx - signs and symptoms; SOB - shortness of breath; Source control - use of cloth face coverings or facemasks to cover a person's mouth and nose to prevent the spread of respiratory secretions	F 000			

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F 000	Continued From page 2	F 000		
F 880 SS=J	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions</p>	F 880		12/22/20

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F 880	<p>Continued From page 3</p> <p>to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the CDC's (Centers for Disease Control) guidance, it was determined that the facility failed to follow the CDC's recommendations during a COVID-19 facility outbreak for one (R1) out of five sampled, COVID-19 positive residents. The facility failed to ensure adherence to isolation precautions after</p>	F 880	<p>#1</p> <p>1. R1 was not negatively impacted by this deficient practice. R1 was moved to the designated COVID unit on 11/13/20. R1 no longer resides in the facility. 2. All residents and staff have the potential to be affected by this deficient practice.</p>		

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F 880	<p>Continued From page 4</p> <p>R1, a COVID-19 positive resident, was observed in the hallway of the non-designated COVID-19 unit without a mask. Residents and employee's were potentially exposed to COVID-19 which could result in the likelihood of a serious outcome if COVID-19 was transmitted from this failure to isolate a COVID-19 positive resident with a history of dementia and wandering into other resident rooms. An immediate jeopardy was called on 11/13/2020 at 4:00 PM and was abated on 11/16/2020 at 1:00 PM. Additionally, the facility failed to send employees home after screening questions yielded responses consistent with signs and symptoms of COVID-19. Lastly, the facility failed to ensure signs related to COVID-19 precautions were placed outside of the door for one (R4) out of five sampled COVID-19 positive residents. Findings include:</p> <p>1. Review of the CDC's webpage entitled Preparing for COVID-19 in Nursing Homes, last updated 11/20/2020, indicated the following: " Implement Source Control Measures. -Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. -If a resident requires a higher level of care or the facility cannot fully implement all recommended infection control precautions, the resident should be transferred to another facility that is capable of implementation. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html."</p> <p>Review of the CDC's web page entitled Responding to COVID-19 Considerations for the Public Health Response to COVID-19 in Nursing Homes, last updated 4/30/2020, indicated the following:</p>	F 880	<p>3. A root cause analysis was conducted by the facility and it was determined that R1, who was COVID-positive, was found to have exited his room, stood outside of his room for three minutes, and returned to his room on his own. R1 was also found not to be wearing a mask while in the hallway. The facility determined that the resident should have been prioritized for placement on the designated COVID unit or transferred to a sister facility's designated COVID unit. Facility staff will be educated by the Director of Nursing or designee on redirecting COVID-positive residents who are found out of their room and not wearing a mask on a non-designated COVID unit back to their rooms. Education began immediately. All COVID-positive residents, not residing on a designated COVID unit, will be assessed/reassessed for wandering risk. Facility staff will also be educated on prioritizing placement of COVID-positive residents on a designated COVID unit in the facility or transferring them to a designated COVID unit at a sister facility.</p> <p>4. Director of Nursing (DON) or designee will conduct an audit on all COVID positive residents who are at risk for wandering to assure they are redirected back to their room. Director of Nursing or designee will conduct an audit of all newly diagnosed COVID positive residents for placement on a designated COVID unit or transfer to sister facility. The audits will be conducted daily until 100% compliance is achieved for five consecutive days. Then the audits will be conducted 3 times a week until 100%</p>		

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F 880	<p>Continued From page 5</p> <p>"Response to Newly Identified SARS-CoV-2-infected HCP or Residents Resident with new-onset suspected or confirmed COVID-19</p> <p>-Ensure the resident is isolated...</p> <p>-If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit. https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html."</p> <p>Review of the facility policy for COVID-19, last updated 11/10/2020, indicated the following: "Person Under Investigation/COVID-19 confirmed:</p> <p>-The resident will be immediately placed in isolation with contact/droplet precautions...</p> <p>-The resident should wear a facemask to contain secretions, if tolerated.</p> <p>Outbreak management: The facility will establish a separate COVID unit with a separate entrance and exit and dedicated staff where possible. If a sister facility has an established COVID unit, COVID positive residents in previously naive (no suspected or COVID 19 positive residents) facility may be transferred to the organizations designated COVID unit."</p> <p>Review of the facility policy on recommendations for Terminal COVID-19 Isolation Room/Unit Cleaning, last updated 5/20/2020, indicated to wait 24 hours before cleaning or disinfecting, if 24 hours was not feasible wait as long as possible.</p> <p>Review of R1's clinical record revealed:</p> <p>10/7/2020 - A care plan for socially inappropriate</p>	F 880	<p>compliance is achieved for 3 consecutive weeks. Then the audits will be conducted weekly until 100% compliance is achieved for 3 consecutive weeks. Then additional audits will be conducted in a month. If 100% compliance is achieved, the deficiency will be considered resolved. The results of the audits will be presented and discussed at the facility Quality Assurance Performance Improvement (QAPI) Meeting.</p> <p>#2</p> <ol style="list-style-type: none"> 1. No residents were negatively impacted by this deficient practice. E10 and E6 were sent home to quarantine. 2. All residents and staff have the potential to be affected by this deficient practice. 3. It was determined through root cause analysis that facility personnel failed to follow the existing policy on the employee screening process. Cadia Healthcare policy, "Employee Screening for COVID-19," is in alignment with CDC and State guidelines. CMS mandated consulting firm, LW, provided education on COVID-19 infection control practices on 12/14/20. All staff will be educated on the "Employee Screening for COVID-19" policy related to identifying signs and symptoms of COVID-19 and quarantining appropriately. 4. Director of Nursing or designee will audit employee screening logs for any positive signs or symptoms to ensure the employee was sent home as needed. The audit will be conducted daily until 100% compliance is achieved for five 		

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F 880	<p>Continued From page 6</p> <p>behaviors as evidenced by wandering in and out of others rooms was initiated with a goal that R1 will have less than 3 incidents of wandering in and out of other residents rooms for 90 days. Interventions included to calmly redirect resident out of other's rooms, and re-direct and discourage behavior when noted.</p> <p>11/2/2020 - A quarterly MDS assessment documented R1 was severely cognitively impaired with a BIMS score of 4 and a diagnosis of dementia. R1's functional ability included having balance during transitions, walking steady at all times and the ability to walk in the corridor with no physical help from staff and no devices.</p> <p>11/12/2020 1:49 PM - A nurses note documented, "spoke with resident's son and informed them that R1 has tested positive for COVID 19...".</p> <p>11/12/2020 - An order was written for contact isolation secondary to COVID 19 for 14 days.</p> <p>11/12/2020 -A care plan for R1 testing positive for COVID-19 was initiated and updated 11/13/2020 with a goal of recovering from the illness in 30 days. Interventions for this care plan included: maintain droplet precautions, monitor food/fluid intake, refer to dietary as needed, monitor vital signs and for signs and symptoms related to COVID-19. Notify MD/NP for any changes.</p> <p>11/12/2020- An additional COVID-19 care plan was initiated with the goal that R1 would not have any complications by the review date and included interventions such as to elevate the head of the bed for comfort and lung expansion, give medications as ordered, monitor for side effects and effectiveness, maintain precautions,</p>	F 880	<p>consecutive days. Then the audit will be conducted 3 times a week until 100% compliance is achieved for 3 consecutive weeks. Then the audit will be conducted weekly until 100% compliance is achieved for 3 consecutive weeks. Then another audit will be conducted in a month. If 100% compliance is achieved, the deficiency will be considered resolved. The results of the audits will be presented and discussed at the facility Quality Assurance Performance Improvement (QAPI) Meeting.</p> <p>#3</p> <ol style="list-style-type: none"> 1. R4 was not negatively impacted by this deficient practice. Contact/droplet precautions were maintained. 2. All residents and staff have the potential to be affected by this deficient practice. 3. The facility determined through root cause analysis that there was no central location identified for staff to locate isolation precautions signage. Isolation precaution signage will now be available in Central Supply along with required Personal Protective Equipment. Director of Nursing or designee will provide education on proper signage/equipment needed for contact/droplet isolation precautions. 4. Director of Nursing or designee will audit resident rooms requiring isolation precautions for proper signage. The audit will be conducted daily until 100% compliance is achieved for five consecutive days. Then the audit will be conducted 3 times a week until 100% 		

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F 880	<p>Continued From page 7</p> <p>isolation - Contact and Droplet, monitor vital signs and any s/sx related to COVID-19 (i.e. fever, SOB, cough), notify MD/NP for any changes, and perform hand hygiene before and after resident care. There was no evidence that R1's care plan for wandering was updated to reflect his/her isolation status.</p> <p>11/12/2020 3:03 PM - A progress note documented, "R1 evaluated via telehealth video, assisted by facility NP, roommate tested positive for COVID. R1 was noted with temperature of 99.4 (slightly elevated/low grade temperature) early this morning. +COVID on rapid testing today. Temperature down to 97.8 after Tylenol... Resident is currently otherwise asymptomatic."</p> <p>11/13/2020 12:22 AM - A nurses note documented "resident is on droplet/isolation precautions due to + COVID testing. R1 complied with staying in his/her room this shift, was observed standing at the door and was able to be redirected back to his/her side of the room."</p> <p>11/13/2020 7:00 AM - During the entrance conference with E5 (DON), it was reported that the facility had a designated 30 bed COVID-19 unit and that "some of our COVID positive residents and PUI's are on the non-designated COVID-19 unit as well because of overflow, we ran out of room."</p> <p>11/13/2020 at 9:20 - 9:23 AM - R1 was observed leaving his room without a mask, then walking toward the beginning of the hall, in the direction of the nurses station. R1 stood for several minutes, then returned to his room without any staff intervention. E15 (CNA) was at the nurses station</p>	F 880	<p>compliance is achieved for 3 consecutive weeks. Then the audit will be conducted weekly until 100% compliance is achieved for 3 consecutive weeks. Then another audit will be conducted in a month. If 100% compliance is achieved, the deficiency will be considered resolved. The results of the audits will be presented and discussed at the facility Quality Assurance Performance Improvement (QAPI) Meeting.</p>		

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F 880	<p>Continued From page 8 and stated, "R1's COVID -19 positive, but they can't make (R1) stay in their room."</p> <p>11/13/2020 9:34 AM - A nurses note documented, "attempted to encourage R1 to stay in room and wear mask due to COVID Positive, R1 continues to walk in hallway with no mask, and becomes agitated when asked to wear mask or to return to room."</p> <p>11/13/2020 9:35 AM - R1 was again observed leaving his room without a facemask. R1 walked toward the beginning of the hall and stood for several minutes. E15 (CNA) walked toward R1 and ushered R1 back into his room.</p> <p>11/13/2020 11:45 AM - E8 (LPN) reported that R1 was transported to the facility's designated COVID-19 unit.</p> <p>During an interview on 11/13/2020 at 11:10 AM with E14 (LPN), when asked if E14 observed R1 going into other residents rooms, E14 stated, "we usually catch R1 before that happens."</p> <p>11/13/2020 2:55 PM - A progress note for R1 documented, "yesterday [temperature] at 99.4°F, afebrile (no elevated temperature) since, with stable sats [oxygen levels] in the mid 90's on room air and unchanged activity tolerance. Severe cognitive deficit, has left isolation unit on multiple occasions, wander guard (bracelet worn by residents that are at risk for wandering ; alerts staff with audible alarm when resident is near an alarmed door) in place...resident educated and placed in isolation with droplet precautions for a minimum of 14 days...High risk for elopement - close monitoring advised." There was no evidence of additional monitoring.</p>	F 880		

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F 880	Continued From page 9 11/13/2020 3:20 PM - A nurse's note documented "this nurse arrived to the unit this morning and noted resident to be out in the hallway. Staff reports he is COVID positive and they redirect R1 as needed. I went to the resident and was able to get R1 back in his room without difficulty. Later in the morning I noted R1 was in the hallway again while I was helping on the unit. I asked R1 to come back into his room and R1 yelled he was fine where he was. I told R1 there was something on TV to watch and R1 did go into the room and sit down. I finished the task at hand and left the unit. When I returned early afternoon I noted that R1 was no longer on the unit." E8 (LPN) confirmed to the surveyor that R1 was transported to the COVID unit at 11:45 AM. 11/13/2020 at 4:00 PM - An immediate jeopardy (IJ) was called. E1(NHA) began drafting an abatement plan that included education of staff, immediately after notification of the IJ. 11/1/2020- 11/15/2020 - Review of R1's behavior monitoring flowsheet for socially inappropriate behavior evidenced by wandering in and out of residents rooms revealed absence of documentation of monitoring from the overnight shift on 11/11 through the day and evening shift on 11/12 and three episodes of wandering during the day shift on 11/13. During an interview on 11/16/2020 at 8:10 AM, E5 (DON) reported that R1 was not moved to the designated COVID -19 unit upon positive diagnosis due to "availability, we had to clean the room and we needed other's [COVID-19 positive residents] moved out."	F 880			

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F 880	<p>Continued From page 10</p> <p>11/16/2020 - Review of the census list for the facility's designated COVID-19 unit for 11/12/2020 revealed resident rooms 106 and 107 were empty and rooms with COVID positive residents were available for cohorting.</p> <p>During an interview on 11/16/2020 at 11:15 AM, E8 (LPN), E20 (LPN) and E16 (CNA) confirmed receiving education in accordance to the abatement plan upon arrival for their shift.</p> <p>During an interview on 11/16/2020 at 11:30 AM, E4 (former NHA) reported 32/90 nursing employees had received the education indicated in the abatement plan. E4 stated, "we are working on something for those who are out of work and off, that accounts for our numbers, either telephone [education] or virtual."</p> <p>11/16/2020 - The IJ was abated at 1:00 PM.</p> <p>During an interview on 11/17/2020 at 7:50 AM, E19 (LPN) confirmed receiving education related to the abatement was completed upon entry to work.</p> <p>2. Review of the CDC's webpage entitled "Preparing for COVID-19 in Nursing Homes", last updated 11/20/2020 in the Core practices section indicated the following: "Evaluate and Manage Healthcare Personnel. - Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that support HCP to stay home when ill. - Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19. -Actively take their temperature and document</p>	F 880			

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

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F 880	<p>Continued From page 11</p> <p>absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html."</p> <p>"Symptoms of Coronavirus, last updated 5/13/2020: People with COVID-19 have had a wide range of symptoms reported - ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19: -Fever or chills -Cough -Shortness of breath or difficulty breathing -Fatigue -Muscle or body aches -Headache -New loss of taste or smell -Sore throat -Congestion or runny nose -Nausea or vomiting -Diarrhea</p> <p>This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19. https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html."</p> <p>Review of the CDC's webpage entitled Considerations for Use of SARS-CoV-2 Antigen Testing in Nursing Homes, last updated 10/23/2020 indicated: "Considerations for interpreting antigen test results in nursing homes:</p>	F 880			

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F 880	<p>Continued From page 12</p> <p>Testing of symptomatic residents or HCP If an antigen test (POC) is presumptive negative, perform RT-PCR immediately (e.g., within 48 hours). -Symptomatic residents and HCP should be kept in transmission-based precautions or excluded from work until RT-PCR results return. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ong-term-care.html."</p> <p>Review of the facility policy for COVID-19, last updated 11/10/2020, indicated in the "Preventative Measures" section to perform "active screening of health care professionals for signs and symptoms of COVID-19."</p> <p>11/13/2020 6:45 AM - During an observation of facility screening practices for employee entry, E10 (supply clerk) entered the facility and was screened by E11 (LPN) who obtained E10's temperature and then proceeded to ask E10 screening questions related to symptoms of COVID-19. E10 answered "yes" to the following signs/symptoms of COVID-19 "fatigue, muscle aches, headaches, and GI symptoms nausea, vomiting, diarrhea." E10 then stated, "I feel like sh*t", to E11, who directed E10 to go see the nursing supervisor.</p> <p>During an interview on 11/13/2020 at 9:35 AM, E10 (supply clerk) confirmed that he/she was still having symptoms. E10 stated, "I waited in my office, they tested me [for COVID-19] and I was negative so now I'm out delivering supplies. E10 was observed on the Scott unit refilling PPE in carts. Immediately following the surveyor interview, E3 (RNC) was observed directing E10 to go home.</p>	F 880			

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F 880	<p>Continued From page 13</p> <p>Review of the 11/13/2020 day shift screening logs revealed that R6 (RN) answered "yes" to the following signs and symptoms of COVID-19 asked on the screening log "sore throat, fatigue, muscle aches, head ache, and GI symptoms nausea, vomiting, diarrhea."</p> <p>During an interview on 11/13/2020 at 3:04 PM, E6 (RN) confirmed the symptoms documented on the screening form and reported that prior to arriving at the facility for work, E6 spoke on the phone with both E5 (DON) and E4 (former NHA), relayed symptoms and was not told to stay home.</p> <p>During an interview on 11/13/2020 at 4:05 PM with E5 (DON) and E4 (former NHA), both confirmed that E6 (RN) reported symptoms prior to arriving to work. E5 stated, "I would have sent E10 (supply clerk) home if I had found out sooner, with E6 (RN), I thought it was only a headache."</p> <p>During an interview on 11/13/2020 at 4:09 PM with E2 (RDO), it was reported that since both E5 (RN) and E10 (supply clerk) tested negative for COVID-19 on their (POC) test that day, it was sufficient for them to continue working. E2 stated, "they were tested and that is sufficient, otherwise we would be sending everyone home, they could be sick from anything, people have other illnesses."</p> <p>3. Review of the CDC's webpage entitled Responding to Coronavirus (COVID-19) in Nursing Homes Considerations for the Public Health Response to COVID-19 in Nursing Homes, last updated 4/30/2020, indicated the following: "Place signage at the entrance to the COVID-19</p>	F 880		

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F 880	<p>Continued From page 14</p> <p>care unit that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms." https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html.</p> <p>Review of R4's clinical record revealed the following;</p> <p>11/12/2020 - An order was written for R4 to be on "isolation precautions Contact/Droplet secondary to Covid-19 for 14 days".</p> <p>11/13/2020 2:00 AM - A progress note documented, "late entry for 11/12/2020 at 2200 (10:00 PM). Resident who tested positive with the corona virus...".</p> <p>11/13/2020 - Review of the list of residents with confirmed or suspected cases of COVID-19 provided by the facility at the entrance conference indicated R4 was COVID-19 positive.</p> <p>11/13/2020 8:45 AM - During observation and a tour of the non-designated COVID-19 unit, which housed COVID-19 positive, COVID-19 naive and PUI residents, R4's room did not have signs instructing HCP of required PPE for entering R4's room. R4 was a COVID-19 positive resident.</p> <p>During an interview on 11/13/2020 at 8:49 AM, E7 (RN) confirmed that R4 was a COVID-19 positive resident and that there was no signage indicating the needed appropriate PPE outside of R4's room. E7 stated, "that's R12's (RN-ICP) responsibility."</p>	F 880			

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F 880	<p>Continued From page 15</p> <p>11/13/2020 8:56 AM - E17 (CNA) was observed leaving R4's room and confirmed knowing that R4 was COVID-19 positive. When asked how E17 was made aware of which residents were COVID-19 positive due to no sign outside of R4's door, E17 stated, "I ask when I come on the hall because they change rooms and residents and I want to be sure."</p> <p>During an interview on 11/19/2020 at 12:02 PM, E12 (RN-ICP) confirmed responsibility for placing signs outside of COVID-19 positive residents rooms. E12 then stated, "I usually do it, but anyone can do it, the signs are in the isolation carts on the unit. I was off, so the nurse should have placed it."</p> <p>These findings were reviewed with E1 (NHA) and E5 (DON) during the exit conference on 11/20/2020 at 10:00 AM.</p>	F 880			



DELAWARE HEALTH AND SOCIAL SERVICES

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

STATE SURVEY REPORT

NAME OF FACILITY: **Cadia Capitol**

DATE SURVEY COMPLETED: **November 20, 2020**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced COVID-19 Focused Infection Control and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection, which began on November 13, 2020 and ended on November 20, 2020. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census on the first day of the survey was 95. The survey sample totaled six (6).</p> <p>Regulations for Skilled and Intermediate Care Facilities</p>	<p>1. No residents affected by deficient practice.</p> <p>2. All residents have the potential to be affected by deficient practice. Future residents will be protected by action plan outlined below in #3.</p> <p>3. During a facility covid outbreak, Nursing staff either became covid Positive or were identified as PUIs, Therefore were removed from the Schedule per state requirements. Existing contracted staffing agencies Were unable to provide clinical staff Immediately therefore several days Failed to meet minimum staffing Levels. New staffing agency contract Obtained and was successful in providing Clinical staff. New DON to Capitol will Educated on minimum staffing hppd Of 3.28 to maintain and monitor adequate Staffing levels in the Scheduler's absence.</p>	12/31/2020
3201.1.0	Scope		
3201.1.2	<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:</p>	<p>4. One week's worth of staffing will be reviewed by NHA/designee daily for one week or until 100% compliance is achieved. Then three times per week for one week or until 100% compliance. Then one time a week for one week or until 100% compliance. If in 3 weeks, compliance is 100%, then deficient practice will be considered resolved.</p>	

Provider's Signature John Hupp Title CNO Date 12/14/2020



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<p>16 Del. C., 1162</p>	<p>Cross Refer to the CMS 2567-L survey completed November 20, 2020: F880</p> <p>Nursing Staffing:</p> <p>(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.</p> <p>Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:</p> <table border="0" data-bbox="277 1197 821 1386"> <tr> <td></td> <td>RN/LPN</td> <td>CNA*</td> </tr> <tr> <td>Day</td> <td>1 nurse per 15 res. per 8 res.</td> <td>1 aide</td> </tr> <tr> <td>Evening</td> <td>1:23</td> <td>1:10</td> </tr> <tr> <td>Night</td> <td>1:40</td> <td>1:20</td> </tr> </table> <p>* or RN, LPN, or NAIT serving as a CNA.</p> <p>(g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week.</p> <p>A desk review staffing audit was conducted by the State of Delaware, Division of Health Care Quality, Office of Long Term Care Residents Protection on November 30, 2020. The facility was found to be out of compliance with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities.</p>		RN/LPN	CNA*	Day	1 nurse per 15 res. per 8 res.	1 aide	Evening	1:23	1:10	Night	1:40	1:20	<p>Dec. 31, 2020</p> <p>Cross Refer to CMS 2567-L Survey completed November 20, 2020: F880</p>	
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Provider's Signature Michael John Hepp Title CWO Date 12/14/2020



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	<p>Based on review of facility documentation it was determined that for two, out of three weeks reviewed, the facility failed to provide staffing at a level of at least 3.28 hours of direct care per resident per day (PPD). Findings include:</p> <p>Review of facility staffing worksheets, completed and signed by the Nursing Home Administrator on 11/13/2020, revealed the following:</p> <p>10/20/2020 PPD = 3.16 10/23/2020 PPD= 3.05 10/24/2020 PPD= 3.22 10/25/2020 PPD =2.99 10/26/2020 PPD= 2.84 10/27/2020 PPD=3.04 10/28/2020 PPD= 3.11 10/29/2020 PPD= 3.14 10/30/2020 PPD= 3.04 10/31/2020 PPD= 3.15 11/1/2020 PPD= 2.91</p> <p>12/3/2020 – E21 (interim NHA) submitted an email to the state agency confirming a failure to meet staffing requirements. E21 email indicated the following “You are correct for Oct 19 -25 and Oct 26-Nov 1. The hours for nurses and aides was short of the required hours due to COVID 19 and the staffing challenges created.”</p> <p>The facility failed to maintain the minimum PPD staffing requirement of 3.28.</p>		

Provider's Signature

Michael J. [Signature]

Title

CNO

Date

12/14/2020



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Provider's Signature John Hugg Title CNO Date 12/14/2020



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Provider's Signature *Michael John Hepp* Title *CWO* Date *12/14/2020*



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Provider's Signature Michael Steyer for John Hupp Title CNO Date 12/14/2020