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

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

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Pike Creek

DATE SURVEY COMPLETED: March 21, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 03/18/24 to 03/21/24. Survey Census: 161 Sample Size: 49 Supplemental Residents: 0	Please see POC.	5.12.24
3201	Regulations for Skilled and Intermediate Care Nursing Facilities		
3201.1.0	Scope		
3201.1.2	Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed March 21, 2024: F584, F641, F657, F692, F697, F699 and F755.		

Provider's Signature [signature] Title Administrator Date 4.16.24

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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
E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality, on 03/18/24 to 03/21/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 03/18/24 to 03/21/24. Survey Census: 161 Sample Size: 49 Supplemental Residents: 0	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		5/12/24

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

Electronically Signed | 04/12/2024

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.

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 584	Continued From page 1 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to provide a safe, clean, comfortable, and homelike environment. Specifically, the facility failed to ensure a homelike environment for five of 49 sampled residents (Resident (R) 85, R90, R25, R40, and R98). Findings include: 1. Review of R85's "Admission Record" located	F 584	a. The areas identified that failed to provide a homelike environment for 5 residents were repaired and cleaned. b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. A root cause analysis was completed	

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 584	Continued From page 2 under the "Profile" tab of the electronic medical record (EMR), indicated the resident was admitted to the facility on 04/19/22. Review of R85's quarterly "Minimum Data Set (MDS)" located under the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 01/22/24 titled "Brief Interview for Mental Status (BIMS)" score, indicated staff was unable to determine the resident's cognition. An observation was conducted on 03/21/24 at 11:01 AM in R85's room. The Manager of Housekeeping (MH) was present. The resident's privacy curtain was partially detached from the track (attached to the ceiling) which surrounded the resident's bed. The ends of the curtain were broken. The MH confirmed the observation. 2. Review of R90's "Admission Record" located under the "Profile" tab of the EMR, indicated the resident was admitted to the facility on 10/15/22. Review of R90's quarterly "MDS" located under the "MDS" tab of the EMR with an ARD of 01/23/24, indicated the staff was unable to determine the resident's BIMS score. During an observation on 03/19/24 at 4:15 PM, the ceiling over R90's bed had two reddish stains on the ceiling. When the privacy curtain was pulled around the resident, the privacy curtain exposed a large water stain. An observation was conducted on 03/21/24 at 11:01 AM in R90's room with the MH present. The resident's privacy curtain was partially detached from the track (attached to the ceiling) which surrounded the resident's bed. The ends of the	F 584	and it was found that environmental rounds need to be done more frequently and thoroughly. All direct care staff (nurses, aides, therapy) will be in-serviced by Staff Development on the importance of timely reporting of any environmental issues that prevent a safe, homelike environment for residents via maintenance orders or notifying a supervisor as soon as identified. Training will include but not be limited to the need to ensure privacy curtains are clean and in good condition, floors, walls and ceilings are clean, free of stains and in good repair and hvac units are clean with no dust or debris. Maintenance Director and Housekeeping Director will conduct daily environmental rounds of center. d. The NHA or designee will randomly audit 10 residents rooms to ensure that there are no items in disrepair or needing cleaning. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 584	Continued From page 3	F 584		

curtain were broken. The curtain had stains on the privacy curtain and the ceiling had two reddish stains located over the resident's bed. The MH confirmed this observation.

3. Review of R25's "Admission Record" located under the "Profile" tab of the EMR, indicated the resident was admitted to the facility on 04/07/23.

Review of R25's annual "MDS" located under the "MDS" tab of the EMR with an ARD of 01/17/24, indicated the resident had a "BIMS" score of 15 out of 15 which revealed the resident was cognitively intact.

During an observation on 03/18/24 at 2:12 PM, R25's room was observed with trash on the floor and a towel was on the floor, under the head of his bed. The resident's floor had dark marks under his bed and under the ventilation system.

During an observation conducted on 03/19/24 at 10:26 AM, R25 still had a towel under his bed located at the head of the resident's bed. On the windowsill, there were two spoons, multiple medical supplies, and a land line phone with beard/hair trimmings that covered the top of the handle. The air conditioning unit had a thick layer of dust and yellow stains. The resident's television stand had dust on the base.

During an interview conducted on 03/21/24 at 12:20 PM, MH confirmed the observations of R25's room which included the towel on the floor, items on the windowsill, the dust and stains on the air conditioner unit, and dust on the television stand base.

4. Review of R40's "Admission Record" located

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 584	Continued From page 4 under the "Profile" tab of the EMR, indicated the resident was admitted to the facility on 05/04/20. Review of R40's quarterly "MDS" located under the "MDS" tab of the EMR with an ARD of 02/05/24, indicated the resident had a BIMS score of 15 out of 15 which revealed the resident was cognitively intact. During an interview and observation on 03/19/24 at 10:37 AM, R40 stated the facility did not clean under her bed. Observations included a privacy curtain with multiple spatter stains. The netting was damaged and there were large holes in the top section of the privacy curtain. The ceiling had brown spatter stains. During an observation conducted on 03/21/24 at 11:04 AM, the MH confirmed the splatters, and the torn netting of the privacy curtain. The MH confirmed the brown spots under the resident's bed. 5. Review of R98's "Admission Record" located under the "Profile" tab of the EMR, indicated the resident was admitted to the facility 08/22/23. Review of R98's quarterly "MDS" located under the "MDS" tab of the EMR with an ARD of 02/19/24, indicated the resident had a "BIMS" score of 15 out of 15 which revealed the resident was cognitively intact. During an observation and interview on 03/18/24 at 11:04 AM, R98 pointed to red spatter marks, on the ceiling, over her bed. R98 stated they have been there since she was first admitted. During an observation on 03/21/23 at 11:00 AM,	F 584		

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 584	Continued From page 5 the MH confirmed R98's privacy curtain was partially detached from the track (attached to the ceiling) which surrounded the resident's bed. The ends of the curtain were broken. The MH confirmed the splatter on the ceiling over her bed. During an interview on 03/21/24 at 10:56 AM, the MH stated deep cleaning was completed daily and MH was able to produce a cleaning schedule. The MH stated privacy curtains were checked once a week and if they were damaged, she would let the Maintenance Director know so the curtains could be replaced. The MH stated for the ceiling stains, housekeeping would have attempted to wash. The MH stated if the department could not get the stain out, then she would alert Maintenance of the issue, so that the department could paint over the area. During an interview on 03/21/24 at 11:27 AM, the Maintenance Director stated he attempted to repair concerns for residents as soon as possible. The Maintenance Director stated Housekeeping did not alert him to the concerns of the residents and the environmental issues. During an interview on 03/21/24 at 6:25 PM, the Director of Nursing (DON) stated the facility completed environmental checks on residents' rooms once a week.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		5/12/24

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 641	Continued From page 6 Based on record review and interview, the facility failed to accurately code the "Minimum Data Set (MDS)" assessment for one of 49 sampled residents (Resident (R) 142) reviewed for "MDS" assessments. This deficient practice increased the potential for missed opportunities of care or services. Findings include: Review of R142's undated "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab, indicated an admission date of 12/05/23 and diagnoses of respiratory insufficiency, muscle weakness, and difficulty in walking. Review of R142's discharge "MDS" with an Assessment Reference Date (ARD) of 01/23/24, located in the EMR under the "MDS" tab, revealed the resident was discharged, return not anticipated, due to an acute hospitalization. Review of R142's "Progress Notes" located in the EMR under the "Progress Note" tab, revealed R142 did not discharge to the hospital as indicated on the 01/23/24 "MDS;" however was a planned discharge home. During an interview on 08/17/22 at 4:00 PM, the Minimum Data Set Coordinator (MDSC) stated the "MDS" on 01/23/24 was coded incorrectly with the discharge to hospital and it should have been coded as discharge to home/community. The MDSC also stated the facility did not have a specific policy for following the MDS, the MDS nurses followed the MDS manual for coding.	F 641	a. R142 MDS was modified on 3/20/24 to include discharged to home with home health. b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. A root cause analysis was completed and it was found that RNAC had the correct discharge disposition but erroneously choose the wrong code when completing MDS. Corporate RNAC will conduct a focus review of the last 30 days since survey exit to ensure accurate coding of discharge MDS assessments and identify trends. Education will be provided to facility RNACs by Corporate RNAC on importance of completing accurate discharge assessments in MDS. d. Corporate RNAC or designee will conduct random selection audits of 3 MDS assessments to ensure they contain accurate discharge MDS assessments. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 657	Continued From page 7	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to provide one Resident (R) 16 advance notice of their care plan meetings and ensure one resident (R25) was invited to participate in his quarterly care plan meeting of 49 sampled residents.	F 657	a. All residents with care plans occurring after date of survey have received advance notice of scheduled care conference. b. All residents have the potential to be affected by this deficient practice. Future	5/12/24

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 657	Continued From page 8 Findings include: Review of facility's policy titled, "Care Planning," dated 01/03/24, indicated " ...Care Plan Meetings ...Care plan meetings will be held at least quarterly for each resident ...The facility must provide the resident and the resident representative, if applicable, with advance notice of care planning conferences to promote participation ..." 1. Review of R16's "Admission Record" located under the "Profile" tab of the electronic medical record (EMR), indicated the resident was admitted to the facility on 09/02/10. Review of R16's annual "Minimum Data Set (MDS)" located under the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 12/13/23, indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15 which revealed the resident was cognitively intact. Review of R16's care conference "Progress Notes" located under the "Prog (Progress)" tab of the EMR failed to include the resident was provided advance notice to participate in her care conference. There was evidence the resident had a care conference at bedside with her representative. During an interview on 03/18/24 at 10:33 PM, R16 stated the facility just showed up in her room to have a care conference and did not provide her with advance notice. 2. Review of R25's "Admission Record" located under the "Profile" tab of the EMR, indicated the	F 657	residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. c. A root cause analysis was conducted and it was found that verbally telling residents when their care conference is being held was not adequate. A process was put in place in addition to phone calls to Responsible Parties and verbal notification to residents of care conference date and time, all residents will receive a written reminder hand delivered to their room with the date and time of upcoming care conference. The social services director will train all social services staff of this new process to ensure compliance. d. The Social Services Director or designee will audit all residents who have scheduled care conference to ensure they have received written communication in their room of date and time the meeting is scheduled for. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 657	Continued From page 9 resident was admitted to the facility on 04/07/23. Review of R25's annual "MDS" located under the "MDS" tab of the EMR with an ARD of 01/17/24, indicated the resident had a "BIMS" score of 15 out of 15 which revealed the resident was cognitively intact. Review of R25's care conference "Progress Notes" located under the "Prog" tab of the EMR, indicated the resident's last care conference was on 11/09/23, in which he participated. During an interview on 03/18/24 at 2:28 PM, R25 stated he was not invited to his care conference. During an interview on 03/19/24 at 3:14 PM, the Social Services Director (SSD) stated a care conference would have been held with a resident and/or their family member from 14 to 21 days after the assessment. The SSD stated once the care conference was scheduled, the facility provided advance notice. The SSD stated the facility staff did not document the residents' invitation within the EMR. The SSD stated there was no evidence she could provide that showed R16 was provided advance notice or that R25 participated in his last quarterly care conference, February 2024. During an interview on 03/21/24 at 6:20 PM, the Director of Nursing (DON) stated residents should have been given advance notice and permitted to participate in their care conferences.	F 657		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		5/12/24

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 692	Continued From page 10 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to obtain a reweigh within 48 hours after a 26.3-pound weight loss for one of four residents (Resident (R) 104) reviewed for nutrition of 49 sampled residents. Findings include: Review of a facility policy titled, "Weight Tracking and Recording," revised 01/11/24 and provided by the facility, indicated "Policy: It is the policy ...to consistently take and record weight. Purpose: To attain and document weights in a timely manner to track resident at nutritional risk and clarifying possible false weight fluctuations ...Procedure...5. The re-weight will be documented by nursing	F 692	a. Resident was re-weighed and weight was documented and reviewed by Dietician and Provider. b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. A root cause analysis was done and it was found that the nurse that entered the weight did not follow process to initiate re-weigh. Dietician will educate all nursing staff members who weigh patients and enter weights into electronic medical record on facility policy of Weight Tracking	

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 692	Continued From page 11 within 48 hours ...6. Once the weight fluctuation has been confirmed, the Dietician or designee will be notified." Review of R104's "Order Summary Sheet," dated 01/01/24 through 03/21/24, located in R104's electronic medical record (EMR) under the "Orders" tab, indicated the resident was re-admitted to the facility on 01/17/24 with diagnoses which included gastroesophageal reflux disease (GERD), enterocolitis due to clostridium difficile, Parkinsons, tracheostomy, ventilator dependent, and dysphagia (difficulty in swallowing). Review of a quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/23/24 located in the resident's EMR under "MDS" tab, indicated R104 was 67 inches tall with a weight of 203 pounds, had no significant weight gain or loss, and received nutrition through a feeding tube. Review of "Weights," located in the EMR under "Vital Signs" tab, indicated the following weights: 203 pounds on 01/19/24; 202.8 pounds on 02/29/24; 179.5 pounds on 03/13/24- with 11.5 percent loss; and 176.5 pounds on 03/20/24- reweight during survey, with additional weight loss present. Review of a "Nutrition/Dietary Note," dated 02/27/24 and located in the EMR under "Progress Notes" tab, revealed "Resident is at risk for malnutrition related to being dependent on tube feeding and ...Res [resident] not tolerating current TF (tube feeding) formula and would be changed from Osmolite to Vital."	F 692	and Recording. Audit was done to identify any residents triggering for significant weight loss to ensure no re weighs were warranted. d. The dietician or designee will audit 5 weights for residents with significant weight loss to ensure that reweights are done within 48 hours and dietician was notified accordingly. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 692	Continued From page 12 Review of the "Medication Administration Record (MAR)," dated "February 2024," under the "Orders" tab of the EMR, indicated R104 was receiving Osmolite 1.5 (feeding formula) via G-tube (tube in stomach) at 65 mL/hr. (milliliters per hour) for 20 hours. On 02/24/24, the formula was changed to Osmolite 1.2 at 60mL/hr. for 20 hours. On 02/27/24, the formula was changed to Vital 1.5 at 50 mL/hr. for 20 hours. R104 was also receiving 30 mL of liquid protein supplement three times a day. Review of the "MAR," dated March 2024, under "Orders" tab of the EMR, indicated the resident was receiving Vital 1.5 via G-tube at 40 mL/hr. for 20 hours per day from 03/01/24 through 03/20/24 and 30 mL liquid protein supplement three times a day without interruption or holding of tube feed. Review of an "Encounter" note, dated 03/12/24, located in the resident EMR under "Progress Note," documented "Pt being seen lying in bed in no acute distress.. Staff reporting that the patient has had one episode of vomiting in the last 24 hours. Orders given to hold TF. Pt [patient] with VSS (vital signs stable) and mildly distended abdomen with enteral tube patient...Weight 202.8 pounds; 02/29/2024 2:28 PM ...BMI 31.8." During an interview on 03/20/24 at 9:55 AM, the RD stated R104 was not tolerating his formula, so it was changed from Osmolite (with fiber) to Vital (no fiber) on 02/27/24. The RD stated she was not aware of the significant weight loss. The RD stated she would ask for the resident to be weighed "right now." She stated all residents were on monthly weights unless they were at high risk for malnutrition.	F 692		

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 692	Continued From page 13 During an interview on 03/20/22 at 10:00 AM, Licensed Practical Nurse (LPN) 10 confirmed she entered the resident's weight into the EMR on 03/13/24 but did not remember asking for a reweight. During an interview on 03/20/24 at 3:37 PM, LPN10 stated she would ask for a reweigh the same day if a resident had a significant weight loss and if it was accurate, the RD would be notified. Review of a "Physician Progress" note, located in the EMR under "Progress Note" tab, dated 03/20/24, revealed "Note Text: Reviewed weight loss-patient had been steadily and slowly declining due to respiratory failure and advanced Parkinson?s [sic] disease. Severe gastroparesis is also contributing to it. Due to intolerance of higher volume of tube feed, He is receiving maximum amount of nutrition that his gastric capacity can take. We hvave [sic] been following him last 2 months in our high-risk meeting. Cont (continue) current care. Reduce Carbidopa/ Levodopa (medication for Parkinsons) as pt [patient] is fairly immobile and bedbound to see if that helps reduce some of the distressing symptoms of Gastro paresis (a condition that affects the stomach muscles from properly emptying)." Review of a "Nutrition/Dietary" note, located in the EMR under "Progress Note" and dated 03/20/24, revealed "Note Text: NUTRITION/TF FOLLOW-UP, SIGNIFICANT WEIGHT LOSS ...Updated Nutrition Goal: to receive and tolerate enteral feeds ...stabilizing calculated body weight of 176 plus or minus five pounds." The RD note continued to indicate resident was at risk for	F 692		

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 692	Continued From page 14 Malnutrition related to not tolerating TF, multiple hospitalizations, and necessity to hold formula. During an interview on 03/21/24 at 10:12 AM, the LPN10 did not know if the family had been notified of weight loss or why there was no documentation.	F 692		
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: Based on observation, interview, record review, and facility policy review, the facility failed to ensure narcotic pain medications were delivered in a timely manner, failed to offer additional non-pharmacy interventions or medications, and recognize there was an issue with pharmacy delivery for one of one resident (Resident (R) 73) reviewed for pain management of 49 sampled residents. This resulted in the resident missing multiple doses of pain medication and unresolved pain. Findings include: Review of the facility's policy titled, "Medication Administration," revised on 03/31/23, did not address ordering of medications, specifically controlled substances or what the process was regarding pharmacy not delivering medications. The Administrator confirmed on 03/20/24 at 4:00	F 697	a. Pain medicine was ordered and delivered and is available for resident. Resident is not currently experiencing unresolved pain. Process for ordering controlled substances has been reviewed to ensure timely delivery of all controlled substances. b. b. All residents with orders for controlled substances have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. A root cause analysis was done and it was found that medication did not arrive at scheduled delivery time. Collaborative training and education with Pharmacy and	5/12/24

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 697	Continued From page 15 PM, the facility did not have a policy on ordering medications. Review of "Order Summary Report," dated 01/01/24 through 03/31/24, located under the "Orders" tab of the resident's electronic medical record (EMR) indicated an admission date of 08/25/23. The resident had diagnoses which included chronic pain, polyneuropathy, anxiety disorder, major depression, and post-traumatic stress disorder. Review of R73's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/26/24, revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated the resident was cognitively intact. The assessment of pain management revealed the resident was on a pain management program and received narcotic medications. The assessment also revealed R73 had not received any non-medication interventions for pain. The resident had reported her pain was almost constant at a level of five out of 10. Review of R73's "Care Plans" located in the EMR under "Care Plans" tab, initiated on 08/25/24 and revised 03/12/24, indicated "Problem ...Potential for pain r/t [related to] chronic pain syndrome, polyneuropathy ...Goal ...The resident will not have an interruption in normal activities due to pain through the review date ...Interventions ...Administer analgesia as per orders, Evaluate the effectiveness of pain interventions." The Care Plan failed to include non-pharmacy interventions. During an interview on 03/18/24 at 2:47 PM, R73	F 697	Facility Staff will be done to review how to prevent issues due to untimely delivery of pain medication. Education will also address that controlled substances are available in the onsite locked supply and can be pulled with a code provided by pharmacy in the event they are not available in house at time administration is scheduled. d. The DON or designee will audit 10 residents to ensure that narcotic pain medications are delivered in a timely manner, there is no issue with the pharmacy delivery, and that the residents are offered additional nonpharmacy interventions or medications. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audit will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits shall be reviewed by quality Assurance Committee.	

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 697	Continued From page 16 stated she must go without pain medications frequently because the nurses did not order them in a timely manner. She stated the pharmacy only sent a small number each time. R73 stated the facility told her it was because the insurance would not pay for it. R73 stated she offered to pay for it herself and the facility told her no. She stated she got short of breath easily because of her rare lung disease and if she was in pain, made it worse and she began to get anxious. Review of "Order Summary Report," dated 01/01/24 through 03/31/24 and located under the "Orders" tab of the resident's EMR, revealed the following orders for pain medication: -"Acetaminophen (Tylenol) tablet 325 MG (milligram) every six hours as needed for mild to moderate pain. Scale of 1-3 and not to exceed 3000 MG in a 24-hour period." - "Oxycodone HCL [Hydrochloric acid] Oral Tablet 10 MG (Oxycodone HCL) Give 10 mg by mouth every 4 hours for pain-Start Date-03/21/24 0900." -"Gabapentin Oral Capsule 400 MG (Gabapentin) Give 2 capsules by mouth every 6 hours for neuropathy-Start Date-08/25/2023." -"Ibuprofen Oral Tablet 400 MG (Ibuprofen) Give 400 mg by mouth every 6 hours as needed for pain-Start Date- 01/27/2024." Review of the "Medication Administration Record (MAR)," dated January 2024 through March 2024 and located in the EMR under "Orders" tab, revealed the following missed doses of Oxycodone: -01/01/24 at 3:37 AM. The nurse documented the resident's pain at seven. The nurse failed to offer Tylenol or any other non-pharmacy interventions. The Ibuprofen was not an active order at that time.	F 697		

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 697	Continued From page 17	F 697		

01/05/24 at 3:29 AM. The nurse documented the resident's pain at seven. The nurse failed to offer Tylenol or any other non-pharmacy interventions.
-02/14/24 at 9:00 AM and 1:00 AM and documented the medication was effective (E). The nurse did not administer Tylenol or Ibuprofen.
-02/21/24 at 6:00 PM. The nurse did not administer Tylenol or Ibuprofen.
-01/19/24 at 9:37 PM. The nurse documented the resident's pain at level seven. The nurse failed to administer Tylenol.
-03/17/24 at 5:00 AM and 9:00 AM. Nurse did not administer Tylenol or Ibuprofen.
-03/19/24 at 9:00 PM. Nurse did not administer Tylenol or Ibuprofen.
-03/20/21 at 1:00 AM and 5:00 AM. Nurse did not administer Tylenol or Ibuprofen.

Review of an "Administration Note," dated 03/19/24 at 10:18 PM, located in the EMR under "Orders" tab, revealed Licensed Practical Nurse (LPN) 4 documented "Oxycodone HCL Oral Tablet 10 MG Give 10 mg by mouth every 4 hours for pain, Awaiting overnight delivery from pharmacy, per pharmacist."

During an interview on 03/20/24 at 9:35 AM, LPN10 stated there was an issue with insurance paying for the medications. She stated the dose was changed recently to better control the resident's pain. LPN10 confirmed there were missed doses last evening. LPN10 stated she reordered the Oxycodone yesterday, 03/19/24, and was told by the pharmacist the Oxycodone would be sent in the evening. The pain medication was not delivered until 8:00 AM on 3/21/24.

During an interview and observation on 03/20/24

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 697	Continued From page 18 at 9:30 AM, R73 stated she was "miserable" all night and had a pain level of 10. She stated the nurse was aware she was crying in pain. R73 stated she kept telling staff she needed pain medication all night. R73 stated she had an abscessed tooth, and it was causing additional pain in her right cheek and jaw. She stated she had a dental appointment for 04/05/24. R73's right cheek was observed to be very swollen. She stated the Nurse Practitioner (NP) had been collaborating with her to find a good schedule for managing her pain. During an interview on 03/21/24 at 10:16 AM, Certified Nursing Assistant (CNA) 7, assigned to R73, stated on 03/19/24, the resident was complaining she had pain in her tooth and was asking for pain medication all evening. During an interview on 03/20/24 at 2:22 PM, the Director of Quality at the facilities pharmacy provider stated the cutoff for getting a same day delivery was 1:00 PM. She stated if the medication was ordered after 1:00 PM, it would be delivered the following day. During an interview on 03/20/24 at 2:47 PM, LPN8 stated the pharmacy had only been sending 12 Oxycodone pain medications at a time. LPN8 stated she was not aware the pharmacy had a 1:00 PM cutoff time for same day delivery.	F 697		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent,	F 699		5/12/24

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 699	Continued From page 19 trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure that trauma survivors received trauma-informed, culturally competent care accounting for residents' experiences and preferences to avoid triggers (psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening) leading to potential re-traumatization for two of two residents (Resident (R) 63 and R110) of 49 sampled residents. Findings include: Review of the facility's policy titled, "Trauma-Informed Care," dated 01/11/24, revealed "Policy: It is the policy of [Facility Name] to provide trauma-informed care to all residents. Purpose: To address the trauma in the lives of the residents served by [Facility Name]; to promote the understanding of trauma and its impact; to eliminate or mitigate triggers that may cause re-traumatization. Procedure: The facility works to ensure that residents receive culturally competent, trauma-informed care in accordance with standards of practice. The facility strives to eliminate or mitigate triggers that may cause re-traumatization of the resident. Screening: ...A positive screen will warrant further evaluation by the provider. Resources and referrals to outside organizations will be made available. Care Planning: Care planning will be person-centered	F 699	a.Both residents were reviewed by Provider on 3/25 and identified to have a positive trauma screen but to not have an actual diagnosis of PTSD. Both residents were provided a consultation with Psychological Care Provider to evaluate any further needs related to positive trauma screen. Care plans were updated to reflect positive trauma screen interventions. b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. A root cause analysis was conducted and it was found that care plans did not reflect identified interventions related to positive trauma screen. All residents who have a positive trauma screen were reviewed to ensure that their care plan reflected resident□s triggers and providing trauma-informed care, culturally competent care to avoid triggers leading to re-traumatization. Social Service department and MDS coordinators will be educated on the importance of ensuring comprehensive care plan is in place for all active conditions.	

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 699	Continued From page 20 and incorporate the resident's experiences and preferences. Trauma specific interventions may include: ...Resident-specific techniques to eliminate or mitigate triggers." 1. Review of R63's undated "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed R63 was admitted to the facility on 10/05/22 with diagnoses including type two diabetes mellitus and additional diagnoses added of Parkinson's disease and post-traumatic stress disorder (PTSD). Review of R63's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/04/24, revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated R63 was cognitively intact. Further review of R63's record revealed a care plan for PTSD dated 01/09/24. The care plan failed to specifically identify any triggers related to PTSD or how to address them. There were no specific traumatic event(s) identified. The effects of the trauma on R63's mental, physical, social, emotional, and spiritual well-being were not addressed. There was no trauma-informed care approach (delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma) to providing care to R63. There were no triggers identified that may cause R63 to be re-traumatized. 2. Review of R110's undated "Admission Record," located in the EMR under the "Profile" tab, revealed R110 was admitted to the facility on 07/22/23 with diagnoses which included aphasia,	F 699	d. The Director of Nursing or designee will randomly audit 3 care plans for residents with PTSD or positive trauma screen to ensure that there are resident identified triggers and trauma-informed care interventions. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 699	Continued From page 21 cognitive communication deficit, and PTSD. Review of R110's quarterly MDS with an ARD of 01/22/24, revealed the resident had a BIMS score of zero out of 15, which indicated R110 was severely cognitively impaired. Further review of R110's record revealed a care plan for having a post trauma screen dated 03/11/24. The care plan failed to specifically identify any triggers related to trauma or how to address them. There were no specific traumatic event(s) identified. The effects of the trauma on R110's mental, physical, social, emotional, and spiritual well-being were not addressed. There was no trauma-informed care approach (delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma) to providing care to R110. There were no triggers identified that may cause R110 to be re-traumatized. During an interview on 03/21/24 at 1:45 PM, the Director of Nursing (DON) stated, "We did a complete audit of care plans for trauma. R63 was identified due to having issues with a previous care giver and R110 was identified due to having "family loss." During an interview on 03/21/24 at 2:20 PM, the DON stated, "The diagnosis is correct for both residents and the care plan is not adequate for either resident because it fails to identify the triggers for either resident."	F 699		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		5/12/24

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 755	Continued From page 22 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to identify issues related to timely delivery of pain medications for one of one resident (Resident (R) 73) reviewed for pain management of 49 sampled residents. The facility also failed to collaborate with the pharmacy to ensure a process was in place for	F 755	a. Pain medicine was ordered and delivered and is available for resident. Resident is not currently experiencing unresolved pain. Process for ordering controlled substances has been reviewed to ensure timely delivery of all controlled substances.	

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 755	Continued From page 23 ordering controlled substances. This resulted in R73 having unresolved pain. Findings include: Review of the facility's policy titled, "Medication Administration," revised on 03/31/23, did not address ordering of medications, specifically controlled substances or what the process is regarding pharmacy not delivering medications. The Administrator confirmed on 03/20/24 at 4:00 PM the facility did not have a policy on ordering medications. Review of "Order Summary Report," dated 01/01/24 through 03/31/24 and located in the resident's electronic medical record (EMR) indicated an admission date of 08/25/23. The resident had diagnose which included chronic pain, polyneuropathy, anxiety disorder, major depression, and post-traumatic stress disorder. Review of R73's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/26/24, revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated the resident was cognitively intact. The assessment of pain management revealed the resident was on a pain management program and receiving narcotic medications. During an interview on 03/18/24 at 2:47 PM, R73 stated she must go without pain medications frequently because the nurses did not order them in a timely manner. She stated the pharmacy only sent a small number each time. R73 stated the facility told her it was because the insurance would not pay for it.	F 755	b. b. All residents with orders for controlled substances have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. A root cause analysis was done and it was found that medication did not arrive at scheduled delivery time. Collaborative training and education with Pharmacy and Facility Staff will be completed to review how to prevent issues due to untimely delivery of pain medication. Education will also address that controlled substances are available in the onsite locked supply and can be pulled with a code provided by pharmacy in the event they are not available in house at time administration is scheduled. d. The DON or designee will audit 10 residents to ensure that narcotic pain medications are delivered in a timely manner, there is no issue with the pharmacy delivery, and that the residents are offered additional nonpharmacy interventions or medications. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audit will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient	

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 755	Continued From page 24 Review of "Order Summary Report," dated 02/01/24 through 03/31/24 located under the "Orders" tab of the resident's EMR indicated the following one-time orders written by the provider for Oxycodone. -"Oxycodone HCL [Hydrochloric acid] Oral Tablet 10 MG [milligram] (Oxycodone HCL) Give 1 tablet by mouth every 4 hours for acute pain ...Prescriber Entered." The start date was 02/01/24 and end date was 02/01/24. The start date was 02/19/24 and end date was 02/19/24. The start date was 02/21/24 and end date was 02/22/24. The start date was 02/21/24 and end date was 02/21/24. -"Oxycodone HCL Oral Tablet 20 MG (Oxycodone HCL) Give 1 tablet by mouth every 8 hours as needed for Pain ...Prescriber entered." The start date was 01/29/24 and the discontinued date was 01/29/24. -"Oxycodone HCL Oral Tablet 5 MG (Oxycodone HCL) Give 2 tablets by mouth every 8 hours as needed for Pain ...Prescriber entered." The start date was 01/28/24 and the discontinued date was 01/28/24. -"Oxycodone HCL Oral Tablet 5 MG (Oxycodone HCL) Give 4 tablets by mouth one time only for pain 1 Day ...Verbal." The start day was 01/29/24 and the end date was 01/30/24. -"Oxycodone HCL Oral Tablet 10 MG (Oxycodone HCL) Give 2 tablets by mouth every 8 hours as needed for pain ...Prescriber Entered." The start date was 01/14/24 and end date was 01/14/24. -"Oxycodone HCL Oral Tablet 10 MG (Oxycodone HCL) Give 2 tablets by mouth every 4 hours for pain Discontinue order when 10mg arrives. To pull back up supply ... Prescriber (Physician or [Nurse Practitioner] NP) entered." The start date was 03/01/24 and the discontinued date was	F 755	practice will be considered resolved. All audits shall be reviewed by quality Assurance Committee.	

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 755	Continued From page 25 03/01/24. The start date was 03/06/24 and the end date was 03/07/24." -"Oxycodone HCL Oral Tablet 10 MG (Oxycodone HCL) Give 1 Tablet by mouth every 4 hours for pain ...Prescriber Entered." The start date was 03/20/24 and the end date was 03/21/24. Review of an "Administration Note," dated 03/19/24 at 10:18 PM, located in the EMR under "Orders" tab, revealed Licensed Practical Nurse (LPN) 4 documented "Oxycodone HCL Oral Tablet 10 MG Give 10 mg by mouth every 4 hours for pain, Awaiting overnight delivery from pharmacy, per pharmacist." Review of the "Medication Administration Record (MAR)," dated 01/24 through 03/24 and located in the EMR under "Orders" tab, revealed the following missed doses of Oxycodone: -01/01/24 at 3:37 AM. -01/05/24 at 3:29 AM. -02/14/24 at 9:00 AM and 1:00 AM. -02/21/24 at 6:00 PM. -01/19/24 at 9:37 PM. -03/17/24 at 5:00 AM and 9:00 AM. -03/19/24 at 9:00 PM. -03/20/21 at 1:00 AM and 5:00 AM. Missed doses of medications were reviewed with Chief Nursing Officer on 03/21/24 at 1:00 PM and he stated he would have to review it. During an interview on 03/20/24 at 9:35 AM, LPN10 stated there was an issue with insurance paying for the medications. She stated the dose was changed recently to better control the resident's pain. LPN10 confirmed there were missed doses last evening. She stated the nurse did not call the pharmacy for a code to pull the	F 755		

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 755	Continued From page 26	F 755		

medication from the onsite locked supply. LPN10 stated at times the pharmacy would give the nurses the code to pull the Oxycodone if they called the physician for a one-time order, then at other times the pharmacy would tell nursing staff that a new prescription was needed. She stated her expectation, as the unit manager, was that staff would call the NP to get an order or figure out how to get a script. LPN10 stated she reordered the Oxycodone (Narcotic pain med) yesterday, 03/19/24, and was told by the pharmacist the Oxycodone would be sent in the evening. The pain medication was not delivered until 8:00 AM on 03/21/24.

During an interview on 03/20/24 at 10:56 AM, the Director of Nursing (DON) stated the facility had already gotten a prior authorization and sent the paperwork to obtain pain medications for R73. He stated the insurance has nothing to do with the pharmacy not sending the medication. The DON stated he would check into it.

During an interview on 03/20/24 at 9:30 AM, R73 stated she was "miserable" all night and had a pain level of 10. She stated the nurse was aware she was crying in pain. R73 stated she kept telling staff she needed pain medication all night.

During an interview on 03/20/24 at 2:22 PM, the Director of Quality at the facilities pharmacy provider stated the cutoff for getting a same day delivery was 1:00 PM. She stated if the medication was ordered after 1:00 PM, it would be delivered the following day. She stated once the pharmacy had delivered the number of pills ordered by the physician, the provider must obtain a new prescription. She stated the nurses could not pull narcotics from onsite until the

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 _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 755	Continued From page 27 pharmacy received a new script. She stated if the physician ordered a 20 MG dose, the nurses could only pull a 20 MG tablet and not two 10 MG tablets. She agreed to send the facility the policy and procedure for ordering Narcotics, but it was never received. During an interview on 03/20/24 at 2:47 PM, LPN8 stated the pharmacy had only been sending 12 Oxycodone at a time. LPN8 was not aware the pharmacy had a 1:00 PM cutoff time for same day delivery. During an interview on 03/21/24 at 11:39 AM, LPN4, the nurse assigned to R73 on 03/19/24 on the evening shift, stated she called the pharmacy, and they told her the medication was on its way to the facility. LPN4 stated she spoke to the night shift nurse after she left the facility and she stated the pharmacy told her the same thing, that the medication was "on its way." She stated the pharmacy told her something different each time she called for the delivery of R73's pain medication. LPN4 stated she did not understand why the pharmacy would not give a 30-day supply.	F 755		