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 Rehabilitation Renaissance **DATE SURVEY COMPLETED: July 13, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint and Focused Infection Control Survey was conducted at this facility from July 8, 2022, through July 13, 2022. The deficiencies contained in this report are based interviews and facility documentation as indicated. The facility census the first day of the survey was ninety-eight (98). The survey sample size was ten (10) residents. There were no deficiencies identified during the survey.	1. No resident was affected by deficient practice. 2. All residents have the potential to be affected by deficient practice, future residents will be protected by plan outlined in #3. 3. Daily staffing will be reviewed by NHA/designee, both projected PPD for current day and actual PPD for previous day, to assure adequate staffing and compliance with Delaware Nursing Home Staffing laws. On Fridays, projected staffing and PPD will be reviewed for upcoming weekend, and on Monday the actual PPD for Friday, Saturday and Sunday will be reviewed. 4. Daily staffing will be reviewed by NHA/designee daily for three consecutive weeks or until	9/1/2022
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:**		
16 Del. C. Chap. 11 §1162	**(c) By January 1, 2021, 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.** **Nursing staff must be distributed in order to meet the following minimum shift ratios:** **RN/LPN CNA*** **Day 1 nurse per 15 res 1 aide per 8 res.**		

Provider's Signature RRoath, Nha Title Administrator Date 7.25.22

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	Evening 1:23 **1:10** **Night 1:40** **1:20** ***or RN, LPN, or NAIT serving as a CNA.** **(g) The time period for review and determining compliance with the staffing ratios required under this chapter shall be (1) week.** A staffing audit was conducted by the State of Delaware Division of Long Care Residents Protection on July 8, 2022. The facility was found to be out of compliance with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities. Based on review of facility documentation it was determined that for 6 days out of 21 days reviewed, the facility failed to provide staffing at a level of at least 3.28 hours of direct care per patient care (PPD). Findings include: Review of the facility staffing worksheets, completed and signed by the Nursing Home Administrator, revealed the following: 6/13/22 = 3.22 6/17/22 = 3.20 6/18/22 = 3.02 6/19/22 = 3.05 6/25/22 = 2.82 6/26/22 = 3.10 7/12/22 2:32 PM – During an interview, E3 (Scheduler) confirmed that the facility was not meeting the 3.28 PPD required by the Eagles Law.	100% compliance is achieved. Then three times per week for three weeks or until 100% compliance is achieved. Then weekly for three weeks or until 100% compliance. If in one month, compliance is 100%, then deficient practice will be considered resolved.	

Provider's Signature C Roth, Nha Title Administrator Date 7.25.22

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	7/12/22 2:25 PM - During an interview, E2 (Corporate), also confirmed that the facility was not meeting the 3.28 PPD required by the Eagles Law. Findings were reviewed during the exit conference on 7/13/22 beginning at approximately 1:00 PM with E1 (NHA) and E2 (Corporate).		

Provider's Signature A Plotts, Nhs Title Administrate Date 7.25.22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085052	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION RENAISSANCE	26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced COVID-19 Focus Infection Control Survey and Complaint Survey were conducted by the State of Delaware Division of Healthcare Quality, Office of Long Term Care Residents Protection from July 8, 2022 through July 13, 2022. The facility was found to be in compliance with 42 CFR §483.80 and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The facility census on the first day of the survey was ninety-eight (98). The survey sample size totaled ten (10). There were no deficiencies identified during the survey.	F 000		

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

Electronically Signed | 07/25/2022

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.