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

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

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Pike Creek

DATE SURVEY COMPLETED: August 18, 2021

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced COVID-19 Focused Infection Control and complaint survey was conducted at this facility from August 17, 2021 through August 18, 2021. The deficiency contained in this report is based on interviews and review of facility documentation. The facility census on the first day of the survey was one hundred eight (108).	1. No residents were affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected by the action outlined below in #3. 3. During a facility COVID outbreak, nursing staff either became COVID positive or were identified as PUI's. Due to this, they were removed from the schedule per state/federal/CDC guidelines. Existing contracted staffing agencies were unable to provide clinical staff, therefore, several days failed to meet minimum staffing levels. New staffing agency contracts were obtained and have been successful in providing clinical staff and maintaining a daily PPD of 3.28. New scheduler has been educated on Eagle's Law and the minimum staffing requirements in the state of Delaware.	
3201	**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.,	**Nursing Staffing:**		
1162	**(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level re-quired to provide 3.28 hours of direct care per resident per**		

Provider's Signature Mg Ellen B Title N H A Date 9/2/21

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	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 weekly shift ratios:** **RN/LPN CNA*** **Day - 1 nurse per 15 res. 1 aide per 8 res.** **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 under this chapter shall be one (1) week.** 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 August 18, 2021. 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 two (8/7/2021 and 8/8/2021) out of seven days reviewed, the facility failed to provide a staffing level of at least 3.28 hours of direct care per resident per day (PPD). Findings include: Review of facility staffing worksheets, completed and signed by the Nursing	4. DON/Designee will audit daily staffing sheet to ensure that the minimum PPD of 3.28 is always maintained. Audits will be daily or until 100% compliance is reached for 3 consecutive days. Audits will then be three times weekly or until 100% compliance is reached for three consecutive weeks. Audits will continue at once per week until three consecutive weeks are 100% complaint. If a random sample of 3 staffing sheets are 100% compliant in one month, the deficiency will be considered resolved. Results of interviews will be presented at QA committee meeting.	

Provider's Signature [signature] Title NHA Date 9/2/21

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	Home Administrator on August 18, 2021 covering the period of 8/2 – 8/8/2021 revealed the following: 8/7/2021 – PPD = 2.90 8/8/2021 – PPD = 3.19 The facility failed to maintain the minimum PPD staffing requirement of 3.28. 8/30/21 at 4:00 PM - Findings were communicated to E1 (NHA) via email. 8/30/21 at 4:37 PM – Findings were confirmed by E1 via email.		

Provider's Signature Mary Ellen R Title NHA Date 9/2/21

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 08/18/2021

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 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from August 17, 2021 through August 18, 2021. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations 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 one hundred eight (108).	F 000		

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

Electronically Signed | 09/01/2021

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.