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: August 25, 2025

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 Annual, Complaint and Emergency Preparedness survey was conducted at this facility from August 18, 2025, through, August 25, 2025. The deficiencies contained in this report are based on observation, interview, review of clinical records and other facility documentation, as indicated. The facility census on the first day of the survey was one hundred and sixteen (116). The survey sample size was forty-four (44) residents.		10/9/25
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 August 25, 2025: F609, F628, F645, F657, F677, F688, F755, F756, F761, F773, and F812.	Cross refer to the CMS 2567-L completed August 25th,2025: F609, F628, F645,F657,F688 F755, F756, F761, F773 AND F812	

Provider's Signature Mary Catherine R Title NHA Date 9/19/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085052	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION RENAISSANCE	**26002 JOHN J WILLIAMS HIGHWAY , MILLSBORO, Delaware, 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
E0000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility from August 18, 2025 through August 25, 2025. The facility census was one hundred and sixteen (116) on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		
F0000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from August 18, 2025 through, August 25, 2025. The deficiencies contained in this report are based on observation, interview, review of clinical records and other facility documentation, as indicated. The facility census on the first day of the survey was one hundred and sixteen (116). The survey sample size was forty-four (44) residents. Abbreviations/definitions used in this report are as follows: CG - Caregiver; CNA - Certified Nursing Assistant; CNO - Chief Nursing Officer; COO - Chief Operating Officer; DON - Director of Nursing; LPN - Licensed practical nurse; MD - Doctor of medicine; NHA - Nursing Home Administrator; NP - Nurse practitioner;	F0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0000	Continued from page 1 RN - Registered nurse; SW - Social worker; UM - Unit Manager; Activities of daily living (ADLs) - Tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Alzheimer's disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Amoxicillin - antibiotic used to treat various bacterial infections; ARD (Assessment Reference Date) - The specific end point of look-back periods in the MDS assessment process; Assessment - An evaluation of a condition or resident; ASA - aspirin; Baseline - A minimum or starting point used for comparisons; BIMS - (Brief Interview for Mental Status) - Assessment of the resident's mental status. The total possible BIMS Score ranges form 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions 8-12: Moderately impaired (decisions poor; cues/supervision required 13-15: Cognitively intact (decisions consistent/reasonable); Bipolar Disorder - Mood disorder; Clonazepam - medication that can be used to treat seizures, panic disorder, and anxiety; Clopidogrel - medication used to prevent blood clots from forming in order to reduce the risk of heart attack and stroke; CO2 - Carbon Dioxide; Continence - Control of bladder and bowel function;	F0000		

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F0000	Continued from page 2 COPD - Chronic obstructive pulmonary disease; CVA - stroke; Dementia - A severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation or loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Dialysis - Cleansing of the blood by artificial means when the kidneys have failed; DM - Diabetes; Incontinence - Loss of control of bladder and/or bowel function; ETA - Estimated time of arrival; Excedrin - medication used for headaches and migraine; GRA - gradual dose reduction; GM - Gram; DX - diagnosis; L - Liter; Laceration - A cut or tear in the skin caused by blunt trauma, such as stretching, shearing, or tearing forces; MAR - Medication administration record; MDS - minimum data set, standardized assessment forms used in nursing homes; Meds - Medications; Methocarbamol - medication used to treat muscle spasms and pain; MG - Milligrams; Min - Minute; MRR - Monthly Regimen Review; Medi-honey - Natural, non-toxic agent that has been used to treat wounds;	F0000		

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F0000	Continued from page 3 Minimum Data Set (MDS) assessment - Federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; Nasal cannula - tube inserted into nasal passage to secure an open airway; O2 - Oxygen; Olanzapine - medication used to treat mental disorders including schizophrenia and bipolar disorder; OOB - Out of bed; Pain level - Pain is identified between zero (0) to 10, with 10 being the worst pain imaginable and 0 being no pain; PRN - As needed; Psychotic Disorder - severe mental disorders that cause abnormal thinking and perceptions; Q - Every; Schizoaffective Disorder - Condition in which a person experiences a combination of schizophrenia symptoms such as hallucinations or delusions and mood disorder symptoms such as mania and depression; SQ - Subcutaneously; Traumatic brain injury - brain dysfunction caused by an outside force, violent blow to the head, severe sports injury or a car accident; Trazadone - antidepressant medication; Treatment Administration Record (TAR) - List of daily/weekly/monthly treatments to be performed.	F0000		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and	F0609	F609 R123 no longer resides in the facility. The incident of alleged misappropriation of resident property was reported to the State Agency, documentation was completed, and the resident/family and police were notified. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by implementing the	10/09/2025

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F0609 SS = D	Continued from page 4 misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for one (R123) out of four residents reviewed for abuse the facility failed to ensure an allegation of misappropriation of resident property was reported to the state agency within the required time frame. Findings include: 1. The facility policy on abuse last updated January 3, 2025, indicated, "All alleged incidents involving misappropriation shall be reported to the NHA/designee immediately...Incidents involving reasonable suspicion of criminal conduct are reported to the applicable state agency within eight hours or withing two hours if the conduct causes serious bodily harm." 1. Review of R123's clinical record revealed: 7/20/25 11:30 AM - A statement written by E12 (LPN) documented, "At 10:45 AM I counted...however six [purple tablets] were missing. I recognized the discrepancy. Nursing supervisor [E9 (RN)] was immediately made aware, and she immediately made E2 (former DON) aware." 8/7/25 - E2 (former DON) submitted an incident report to the state agency that alleged "[R123] bought in home medications upon admission...six purple pills noted on count sheet. It was noted that the six purple pills	F0609	Continued from page 4 corrective actions listed in #3. The Nursing Home Administrator or designee audited all allegations of misappropriation of resident property in the last 60 days, and no additional unreported allegations were identified. A root cause analysis was completed and determined that the Director of Nursing failed to report the allegation timely to the Delaware Department of Health and Social Services, Division of Health Care Quality, within the required two-hour timeframe. The Staff Developer or designee will re-educate nursing administration on reporting allegations of misappropriation of resident property within the required time. The Staff Educator or designee will conduct audits of all allegations of abuse and misappropriation of funds and residents' property to ensure that these are reported within the required two-hour timeframe. recommendation. The audits will be performed daily until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly until 100% compliance is achieved for three consecutive weeks. Audits will then continue monthly until 100% compliance is achieved for three consecutive months. Once 100% compliance is maintained, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee for ongoing process improvement.	

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F0609 SS = D	Continued from page 5 were missing." The incident report documented that the incident occurred on 7/19/25 nineteen days prior to the day the allegations were reported. 8/21/25 11:36 AM - During an interview, E9 (RN supervisor) stated, "On July 20th on a Sunday and [E12(LPN)] said the count was incorrect, she said the six purple pills weren't there." E9 then confirmed that she notified E2 (DON) and that E2 was the person responsible for reporting. 8/21/25 11:45 AM - During an interview, E2 (former DON) confirmed recognizing the incident as an allegation of misappropriation of resident property and stated, "I was delayed in reporting it because I was doing the investigation." 8/21/25 12:59 PM - During an interview, E1 (NHA) confirmed the delayed reporting. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (CO), and E11 (CNO) during the exit conference.	F0609		
F0628 SS = E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing	F0628	R18 and R120 no longer reside in the facility so the facility was unable to correct. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by implementing the corrective actions listed in #3. The Social Services Director or designee reviewed all transfers and discharges in the past 30 days, and no additional missing notifications were identified. 3. A root cause analysis was completed, and it was determined that the social services department failed to complete the transfer and discharges to the ombudsman due to no social worker out on medical leave. In the future the facility will find coverage to complete transfers and discharges to the ombudsman An in-service will be conducted by the Staff Developer or designee to educate the Social Services Department on notifying the Ombudsman of transfers/discharges in a timely manner. The Nursing Home Administrator or designee will audit	10/09/2025

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F0628 SS = E	Continued from page 6 care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F0628	Continued from page 6 notifications of Ombudsman transfers and discharges for residents. The audits will be performed daily until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly until 100% compliance is achieved for three consecutive weeks. Audits will then continue monthly until 100% compliance is achieved for three consecutive months. Once 100% compliance is maintained, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee for ongoing process improvement.	

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F0628 SS = E	Continued from page 7 (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as	F0628		

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F0628 SS = E	Continued from page 8 practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:	F0628		

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F0628 SS = E	Continued from page 9 (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview, and record review it was determined that for two (R118 and R120) out of nine residents sampled for discharge and hospitalization the facility failed to send the required notification to the Ombudsman of transfer discharge. Findings include: 1. A review of R118's clinical record revealed: 6/16/25 - R118 was admitted to the facility with diagnoses including complete obstruction of the intestines and acute kidney failure. 7/22/25 10:55 AM - Review of R118's progress note documented "R118 was admitted to the hospital. 8/22/25 12:20 PM - During an interview E17 (SW) reported the Ombudsman was notified quarterly of resident discharges and transfers. E17 then stated, "I was out on medical leave, and my assistant was not sending them out so now I am sending it out for July and August prior to me going out on medical leave I was sending them out monthly." Surveyor requested documentation of required notification for the previous months. 8/22/25 1:15 PM - E11 confirmed the required notification of R118's transfer to the hospital was not submitted to the Ombudsman. 2. A review of R120's clinical record revealed:	F0628		

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F0628 SS = E	Continued from page 10 4/14/25 R120 was admitted to the facility with diagnoses including lower back stress fracture and left rib fracture. 7/23/25 - R120's clinical record documented R120 was discharged to home. 8/22/25 12:20 PM - An interview with E17 (SW) revealed there was no notification to the Ombudsman for R120's planned discharge to home from the facility. 8/22/25 1:15 PM - E11 (CNO) confirmed that the required notification to the Ombudsman for R120's discharge to home was not sent. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.	F0628		
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-	F0645	F645 R10 still resides in the facility. The PASRR was re-screened by the licensed social worker. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by implementing the corrective actions listed in #3. A PASRR audit was conducted to determine if there were any additional residents who did not have their PASRR completed before the 60th day. There were no additional concerns. A root cause analysis was completed and determined that the Social Services Department did not have a process in place for tracking PASRR completion prior to the 60th day. A tracking process has been implemented to validate PASRRs are completed on time. The Staff Developer or designee will educate the Social Services Department on completing the PASRR before the 60th day. The Nursing Home Administrator or designee will audit all PASRRs to ensure that they are completed before the 60th day. The audits will be performed daily until 100%	10/09/2025

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F0645 SS = D	Continued from page 11 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on interview, and record review it was determined for one (R10) out of four residents sampled for PASARR	F0645	Continued from page 11 compliance is achieved for three consecutive days. Random audits will continue once weekly until 100% compliance is achieved for three consecutive weeks. Audits will then continue monthly until 100% compliance is achieved for three consecutive months. Once 100% compliance is maintained, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee for ongoing process improvement.	

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F0645 SS = D	Continued from page 12 review the facility failed to ensure a referral for a new PASARR Level I and II screening occurred by or before the sixth (60) day. R10 remained in the facility beyond the authorization time frame. Findings include: Review of R10's clinical record revealed: 6/5/25 - A review of R10's "Notice of PASARR Level I Screen Outcome" documented.... "PASARR Level Determination Convalescence Categorical Approval Period 60 days. Suspected or confirmed PASARR Condition(s): (MH) Mental Health Disability. A 60 day or less stay in the NF is authorized rescreening must occur by or before the 60 days if the individual is expected to remain in the NF (Nursing Facility) beyond the authorization timeframe." 6/12/25 - R10 was admitted to the facility with diagnoses including but not limited to post traumatic stress disorder and anxiety. 8/22/25 10:02 AM - An interview with E17 (SW) confirmed R10's PASARR rescreening had not been submitted. E17 stated, "I thought [R10's] approval was for ninety (90) days, so it needs to be submitted I'll initiate it." 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.	F0645		
F0657 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.	F0657	F657 R37 still resides in the facility. Care plan updated; alternative interventions implemented; physician/OT/family involved. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by implementing the corrective actions listed in #3.The facility audited all residents with splints/braces to ensure that refusals were documented, and care plans updated accordingly. 3. A root cause analysis determined that the Unit Manager failed to document a care plan for R37's splint refusal. The Staff Developer or designee will educate the nursing staff on care planning refusals when residents decline treatment.	10/09/2025

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F0657 SS = D	Continued from page 13 (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 observation, interview and record review it was determined for one (R37) out of two residents sampled for care plans the facility failed to develop and implement a comprehensive person-centered care plan to address R37's refusal to wear a splint/brace for right hand/wrist contractures. A review of R37's clinical record revealed: 1/2/24 - R37 was admitted to the facility with diagnoses including but not limited to stroke and right-side weakness. 1/3/24 - A review of R37's orders documented "splint/brace/device see RNP task for details." 10/8/24 - A review of R37's care plan for actual contractures and potential for further contractures related to decreased mobility, right spastic hemiplegia (stiff muscles and poor motor control) following stroke revealed the intervention "resting right hand splint initiated 2/19/24." Review of R37's care plan lacked evidence of the resident refusing to wear the splint. 8/20/25 9:53 AM - E19 (CNA) was interviewed and reported R37 had weakness to the right arm but had never seen or known R37 to have a worn a splint. 8/20/25 2:00 PM - During an interview E18 (LPN) reported and stated, "[R37] does not wear the splint	F0657	Continued from page 13 The Rehab Director or designee will audit residents with splints to ensure that refusals are documented, and care plans updated. The audits will be performed daily until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly until 100% compliance is achieved for three consecutive weeks. Audits will then continue monthly until 100% compliance is achieved for three consecutive months. Once 100% compliance is maintained, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee for ongoing process improvement.	

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F0657 SS = D	Continued from page 14 [R37] always refuses to wear the splint." In addition, E18 confirmed R37 had not been care planned for refusing to wear the splint. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.	F0657		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review it was determined that for one (R37) out of four sampled residents reviewed for ADL(s) the facility failed to provide nail care. Findings include: Review of R37's clinical record revealed: 1/2/24 - R37 was admitted to the facility with diagnoses including a stroke and right-side weakness. 4/1/25 - R37's care plan for self-care deficit documented "assist with daily hygiene, eating, toileting, dressing, grooming and oral care as needed." R37's care plan lacked evidence of refusing nail care. 6/25/25 - A quarterly MDS assessment revealed R37 required moderate assistance for personal hygiene and grooming. 8/18/25 9:50 AM - An observation of R37's fingernails on both hands were very long with dark encrusted debris underneath each fingernail. 8/19/25 10:42 AM - A second observation revealed R37 had not been provided nail grooming. 8/20/25 9:34 AM - A third observation of R37's nails on both hands remained long in length with dark encrusted debris under the nails on both hands.	F0677	F677 R37 still resides in the facility. Nails assessed and care provided; care plan updated with frequency and responsible staff. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by implementing the corrective actions listed # 3. A facility-wide audit of nail/foot care was completed to ensure that all residents were provided with nail care. There were no additional concerns. A root cause analysis determined that the CNAs failed to provide nail care for R37 because they were not aware of the tracking tool. The Staff Developer or Designee educated the nursing staff on proper nail care and a tracking tool to verify that nail care was completed. The Director of Nursing or designee will audit residents' nails to ensure that proper nail care is provided. The audits will be performed daily until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly until 100% compliance is achieved for three consecutive weeks. Audits will then continue monthly until 100% compliance is achieved for three consecutive months. Once 100% compliance is maintained, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee for ongoing process improvement.	10/09/2025

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F0677 SS = D	Continued from page 15 8/21/25 9:53 AM - A fourth observation revealed R37's nails were still long with dark debris underneath all fingernails on both hands. 8/21/25 10:16 AM - During an interview, E19 (CNA) confirmed that according to the shower record that R37 should have received nail care on 8/17/25 during the 3:00 PM to 11:00 PM shift. 8/21/25 2:05 PM - During an interview and observation E18 (LPN) confirmed R37's nails needed to be cut, filed and cleaned. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.	F0677		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review it was determined for one (R37) out of three residents sampled for range of motion and mobility, the facility failed to provide a right wrist splint to prevent contractures for R37. Findings include:	F0688	F688 The facility failed to provide a right wrist splint for R37. R37 still resides in the facility. Splint was immediately applied; care plan updated; alternative interventions added. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by implementing the corrective actions listed in #3. An audit was completed to review all residents with orders for right wrist splints to ensure compliance. A root cause analysis identified that staff lacked understanding of splint protocols. The Staff Developer or designee will in-service the nursing staff on validating that splints are applied correctly and according to orders. The Rehab Director or designee will audit residents with splints to ensure they are applied appropriately The audits will be performed daily until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly until 100% compliance is achieved for three consecutive weeks.	10/09/2025

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F0688 SS = D	Continued from page 16 A facility policy titled "Range of Motion Contracture Management revised 1/2/25 documented... To prevent the decline in range of (ROM), influencing a resident's ability to participate in functional activities...." Cross Refer F657 A review of R37's clinical record revealed: 1/2/24 - R37 was admitted to the facility with diagnoses including but not limited to stroke and right-side weakness. 1/3/24 - R37's documented "splint/brace/device see RNP task for details." Review of the RNP task sheet revealed [R37's] splint is to be applied on the 7AM-3PM, 3PM-11PM and the 11PM-7AM shifts. 10/8/24 - R37's care plan for actual contractures and potential for further contractures related to decreased mobility, right spastic hemiplegia (stiff muscles and poor motor control) following stroke revealed the intervention "resting right hand splint initiated 2/19/24." 2/25/25 - The facility range of motion assessment revealed R37's right wrist range was "severe reduced range of motion reduction attributed to actual contracture and tone." 8/18/25 11:14 AM - R37 was observed lying in bed. R37's splint for the right/wrist and hand was laying in the resident's wheelchair. 8/19/25 10:00 AM - A second observation revealed R37 was in bed and was not wearing a splint. The splint was observed laying on R37's wheelchair. 8/20/25 9:53 AM - During an interview E19 (CNA) stated, "since I have been working here, I have never seen [R37] with a brace I know that [R37's] is right arm is weak, but I have never seen him with a brace." 8/20/25 11:13 AM - R37's RNP task for splint placement	F0688	Continued from page 16 Audits will then continue monthly until 100% compliance is achieved for three consecutive months. Once 100% compliance is maintained, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee for ongoing process improvement.	

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F0688 SS = D	Continued from page 17 was documented by E19 CNA that the splint had been applied. R37 was not wearing the splint during this observation. 8/20/25 11:15 AM - R37 was not wearing a splint to the right hand. R37's splint was laying on the wheelchair. 8/20/25 1:55 PM - R37 was not wearing the splint to the right hand. R37's splint was laying on the wheelchair. 8/20/25 2:00 PM - During an interview E18 (LPN) reported and stated, "[R37] does not wear the splint. E18 reported [R37] always refuses to wear the splint." 8/21/25 2:05 PM - During the interview E18 observed and confirmed R37's splint was sitting on the wheelchair. E18 picked up the splint and applied it to R37's right wrist. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.	F0688		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). 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	F0755	F755 1. R123 no longer resides in the facility and was not adversely affected by this deficient practice. Discrepancy was determined to be a clerical error. 2. Residents on controlled substances have the potential to be affected by this practice. Future residents will be protected from this deficient practice by implementing the corrective actions listed in number three. 3. The root cause analysis revealed that the two nurses incorrectly documented the number of capsules that were wasted. DON/Designee will educate nursing administration on the facility's Controlled Substance Storage and disposal Policy to include documenting the amount wasted accurately. 4. The Director of Nursing (DON) and/or designee will audit controlled substances log of medications wasted to validate accuracy. The audits will be performed daily until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly until 100% compliance is achieved for three consecutive weeks. Audits will then continue monthly	10/09/2025

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F0755 SS = D	Continued from page 18 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 record review and interview it was determined that the facility failed to ensure accuracy of the medication reconciliation documentation for a controlled drug. Findings include: 8/3/25 - A controlled drug administration record for R123 documented that the facility received thirty morphine capsules from the pharmacy. 8/5/25 - The controlled drug administration record for R123's morphine revealed that E12 (LPN) administered one of the capsules to R123 and documented that twenty-nine capsules remained. 8/6/25 - The controlled drug administration record for R123's morphine indicated that E12 (LPN) witnessed E13 (RN) destroy a remaining amount of twenty-four of R123's morphine capsules. The controlled drug administration record had previously documented a remaining amount of twenty-nine capsules, a five-capsule deficit. The clinical record and drug administration record lacked clarification to account for the five-capsule deficit. 8/20/25 1:38 PM - During an interview, E11 (CNO) stated that the facility had not identified any medication reconciliation discrepancies regarding medications received from the pharmacy for R123. 8/20/25 1:45 PM - During an interview, E12 (LPN) denied knowledge of the five capsule deficit documented on the controlled drug medication administration record for R123's morphine capsules. When shown the record, E12 confirmed witnessing the destruction of the medications, and stated "I don't remember there being	F0755	Continued from page 18 until 100% compliance is achieved for three consecutive months. Once 100% compliance is maintained, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee for ongoing process improvement.	

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F0755 SS = D	Continued from page 19 an error." 8/20/25 1:53 PM - During an interview, E13 (RN) confirmed his signature on the controlled drug medication administration record for R123's morphine capsules. E13 confirmed the five capsule discrepancy and stated, "I think it's just a typo." 8/20/25 2:26 PM - During an interview E11 (CNO) confirmed the discrepancy on the controlled drug administration record for R123's morphine and stated, "it was a clerical error." 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.	F0755		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no	F0756	F756 Drug regimen Review 1. R20 and R61, currently reside in the facility and were not adversely affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by implementing the corrective actions listed in number three. 3. Root cause analysis revealed the medical provider failed to document a rationale when disagreeing with a Monthly drug regimen review. DON/Designee will educate the medical providers on facility's Pharmacy Monthly Drug Review to include documenting reason for rejecting recommendation. 4. The Director of Nursing (DON) and/or designee will audit all medication regimen reviews to validate medical provider document rationale when rejecting a recommendation. The audits will be performed monthly until 100% compliance is achieved for three consecutive months. Once 100% compliance is maintained, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee for ongoing process improvement.	10/09/2025

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CADIA REHABILITATION RENAISSANCE	**26002 JOHN J WILLIAMS HIGHWAY , MILLSBORO, Delaware, 19966**

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F0756 SS = D	Continued from page 20 change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined for two (R20 and R61) out of five sampled residents for unnecessary medications, the facility failed to document a rationale for disagreeing on a monthly medication regimen review (MRR) recommendations. The Findings include: 1.7/6/25 – R20 was admitted to the facility. The following recommendations were unanswered with a rationale: 12/31/24 – The pharmacist recommended: "Could Trazodone GDR be considered with an insomnia diagnosis?" The provider checked "disagree," but no rationale was documented. 1/29/25 – The pharmacist noted: "Clonazepam 0.5 mg tab order omits 0.5 mg tab = 2.5 mg." Neither "agree" nor "disagree" was selected, but documentation was noted. 3/30/25 – The pharmacist recommended: "Could clozapine GDR be considered?" "Disagree" was checked, but no rationale was documented. 4/28/25 – The pharmacist suggested monitoring for "ASA/Clopidogrel for bruising/bleeding." "Disagree" was checked, with no rationale provided. 5/4/25 – The pharmacist recommended: "Please evaluate resident tolerability to Amoxicillin with penicillin allergy. Please evaluate resident tolerability to Aspirin with Excedrin allergy." Neither "agree" nor "disagree" was selected, but documentation was noted. 7/6/25 – The pharmacist recommended: "Please evaluate resident tolerability of Aspirin with allergy to Excedrin, and please clarify diagnosis of 'psych disorder' per CMS." There was no documentation from the	F0756		

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F0756 SS = D	Continued from page 21 provider in response. 7/25/25 – The pharmacist recommended: "7/6 olanzapine psyche disorder dx will trigger MDS inappropriate use on the quality indicator report. Please review dx and usage in considering a GDR. Risk vs. benefit analysis suggested with methocarbamol per Beers." "Neither agree nor disagree" was checked, but no rationale was documented. 8/22/25, 10:02 AM – During an interview, E7 (NP) confirmed she reviews the pharmacist's recommendations. E7 stated she consults the pharmacist when a GDR is suggested. For psychiatric medication changes, she contacts E27 (Psych NP) to discuss whether changes are appropriate. E7 also confirmed that when a provider disagrees with a recommendation, a rationale should be documented. 8/22/25, 2:25 PM – During an interview, E11 (CNO) confirmed that the facility attending physician failed to document the action taken or not taken in response to identified irregularities. 2.Review of R61's clinical record revealed: 10/13/23 – R61 was admitted to the facility. 7/1/25 - A MRR for R61 documented, lorazepam that a dose reduction GDR be considered. 7/1/25 – A MRR for R61 documented lorazepam 0.5 mg tab by mouth two times a day, should be considered for GDR. There was no rational documented. 8/22/25 10:15 AM - During an interview with E7, (NP) stated she reviews the monthly GDR recommendations. E7 discusses the findings with the psychiatric nurse practitioner. E7 then documents her rationale on the pharmacy GDR form and in the electronic medical record. 8/22/25 1:45 PM - During an interview, E3 (DON) stated that quarterly reviews of the Medical Record Review (MRR) are conducted. Following these reviews, the findings are discussed with the medical director. E3 confirmed that the medical director did not include a rationale for lorazepam. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.	F0756		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F0761	F761- Labeling of Drugs and Biologicals.	10/09/2025

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F0761 SS = D	Continued from page 22 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined that for two out of three medication carts reviewed the facility failed to ensure opened medications were labeled with an open date. For one out of three medication carts reviewed the facility failed to ensure that insulin was stored in accordance with manufacturer's instructions regarding temperature. Lastly, the facility failed to ensure that medications in the facility were labeled in accordance with currently accepted professional principles when they accepted and stored unidentifiable medications then failed to ensure safe and secure storage of those medications. Findings include: 1a. 7/13/25 - A controlled substance record was created for R123 by E23 (RN) and E24 (RN) that documented "six purple pills" were received from R123. 7/20/25 11:30 AM - A statement written by E12 (LPN) documented, "At 10:45 AM I counted...however the six [purple tablets] were missing. I recognized the discrepancy. Nursing supervisor [E9 (RN)] was	F0761	Continued from page 22 R123 no longer resides in the facility and was not adversely affected by this deficient practice. Identified medication carts were corrected and medications not dated and stored at proper temperature were removed and destroyed. All residents have the potential to be affected by this deficient practice. The facility did an audit of all medications carts to ensure compliance. Future residents will be protected from this deficient practice by taking the corrective actions outlined in section 3. A root cause analysis revealed that nursing staff failed to follow guidelines related to medication reconciliation, storage, and dating of medications upon opening. DON/designee will educate licensed nurses on Medication Storage to include dating of house stocks upon opening and refrigerating unopened insulin. Facility implemented a new form for home medication inventory. DON/designee will educate licensed nurses on use of the home medication inventory sheet. The Unit Manager/designee will audit all medication carts to validate that house stocks are dated upon opening and that insulin is stored properly. DON/designee will audit any home medication to validate inventory sheet is completed and medication is stored properly. The audits will be performed daily until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly until 100% compliance is achieved for three consecutive weeks. Audits will then continue monthly until 100% compliance is achieved for three consecutive months. Once 100% compliance is maintained, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee for ongoing process improvement.	

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F0761 SS = D	Continued from page 23 immediately made aware, and she immediately made E2 (former DON) aware." 8/7/25 - E2 (former DON) submitted an incident report to the state agency that alleged "[R123] bought in home medications upon admission...six purple pills noted on count sheet. It was noted that the six purple pills were missing." 8/20/25 1:38 PM - During an interview, E11 (CNO) stated "We implemented a new medication from home sheet for counting medications from home. They are counted then placed into the cart until the DON takes possession, then they are counted again and placed in the locked drawer in the DON office." E11 stated that E2 (former DON) was interviewed regarding the six missing tablets and that E2 reported "she may have left the keys on her desk at times." 8/20/25 2:01 PM - During an interview, E24 (RN) confirmed that R123 bought in six purple pills to the facility. E24 stated, " E23 (RN) asked me to be a witness. R123 had multiple bottles of medications. After a few days we got tired of counting them and we gave them to [E2 (former DON)]. 8/21/25 11:45 AM - During an interview, E2 (former DON) denied knowledge of the whereabouts of the missing six purple pills. E2 stated, "The staff bought me meds in a Ziplock bag inside was pill bottles and said that her family would pick them up. I put them in my drawer and locked them up. I never counted them. Later the staff said they [R123's family] wanted them and came in on a Saturday to get them but they didn't get them. At no time did I touch the pills, open them, or count them I just locked them in my office drawer. When [E12 (LPN)] returned them, she said there was some purple pills missing. I asked [E12] for a statement. She did verbally tell me there were purple pills in the bottle and they were not there at that point. Everyone has access to my office. My keys are always in my top desk drawer so anyone can go in. So, what happened to the pills I have no clue." The six purple pills bought to the facility from home by R123 were stored by the facility. The facility was unable to safely secure the medications as evidenced by the medications were unable to be located as of 7/20/25.	F0761		

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F0761 SS = D	Continued from page 24 1b. 7/13/25 - A controlled substance record was created for R123 by E24 (RN) who hand wrote "Morphine 30 mg six purple pills" were received from R123. 8/20/25 1:45 PM - During an interview, E12 (LPN) confirmed visualizing the medications accepted and stored by the facility from R123 and that the six purple pills were unlabeled. E12 stated, "There were three bottles of Percocet, and one bottle had six morphine mixed in with the Percocet." When asked how staff identified the six purple pills, E12 stated, "By visually identifying and at the time she was on the same medication from the pharmacy, same color and size." 8/20/2025 2:01 PM - During an interview, E24 (RN) confirmed the facility accepted and stored unlabeled medications from R123. E24 stated, "I believe it was all labeled oxy but [R123] had a card of morphine from our pharmacy, and we visually matched the six purple pills and they were an identical match when we looked at them." 8/20/25 2:26 PM - During an interview, E11 (CNO) confirmed the facility accepted and stored unlabeled medications from R123. E11 stated, "we can't assume what they [the medications] are but we can't get rid of them because they are the residents property." 8/21/25 11:32 AM - During an interview, E25 (LPN) confirmed the facility received and stored six purple pills from R123. E25 stated, "There were six purple pills mixed in with the bottle of oxycodone. We took them for safety; we counted the medications in front of [R123]." When asked how staff determined what the six purple pills were due to the bottle being unlabeled E25 stated, "[R123] was cooperative and telling us what the medication was." The facility accepted and stored unidentifiable/unlabeled medication as evidenced by the acceptance of six purple pills not in their original container received from R123. 2. 8/19/25 10:48 AM - During inspection of a Bethany unit medication cart, one opened bottle of aspirin, and	F0761		

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F0761 SS = D	Continued from page 25 one opened bottle of Colace were observed without open dates. E21 (LPN) immediately confirmed the finding. 8/19/25 12:27 PM - During inspection of a Fenwick unit medication cart, one opened bottle of aspirin, and one open bottle of Tylenol were observed without open dates. E16 (LPN) immediately confirmed the finding. 8/19/25 3:03 PM - During inspection of a Rehoboth unit medication cart, an unused Humalog insulin pen was observed in a medication cart. The pharmacy labeled the insulin pen with manufacturer's instructions that directed the insulin pen to be refrigerated until opened. E24 (RN) immediately confirmed the finding. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.	F0761		
F0773 SS = D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R106) out of one resident reviewed for lab services, the facility failed to promptly notify the ordering medical practioner of abnormal laboratory results. Findings include: Review of R106's clinical record revealed: 6/6/25 - R106 was admitted to the facility. 7/10/25 5:50 AM – A nursing progress note documented	F0773	F 773 Labs 1. R106 currently resides in the facility. Resident completed antibiotic treatment for urinary tract infection. Resident was not adversely affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected by measures taken below in number 3. 3. A facility-wide audit was conducted of all residents with a positive urine culture, and all labs have been reviewed by the provider. The root cause analysis determined that the lab did not call the facility with a positive urine culture result. The lab result was uploaded directly into the electronic health record. As a result, the RN supervisor was not aware of the abnormal result to call the provider. CNO will educate the lab director that all positive urine cultures are to be called to the facility. All positive urine results are to be called to the provider. Nursing management will be educated by Staff D to review the lab portal in the electronic health record at the beginning and ending of their shifts daily to ensure all positive urine cultures are addressed and provider notified. 4. The DON and/or designee will conduct audits of all urine lab results to ensure the results are reviewed timely and positive results are called to the provider.	10/09/2025

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F0773 SS = D	Continued from page 26 for R106 that a urine sample was collected and a dipstick resulted in positive blood and leukocytes. The nursing note further documented that a lab order to do urinalysis (UA) and culture and sensitivity (C&S) was placed, waiting to be picked up and that the NP was notified in the book. 7/10/25 12:01 PM – A physician's progress note documented that R106 complained of burning with urination, an in-house urine dipstick was positive for blood and leukocytes, and the lab picked up the urine in the morning, awaiting a culture and sensitivity. 7/12/25 1:19 PM – The lab results revealed the urine culture was positive for a urinary tract infection (UTI) with a positive growth of greater than 100,000 colony forming units of Escherichia coli (a type of bacteria). 7/12/25, 7/13/25 and 7/14/25 – The clinical record lacked evidence that R106's UTI was addressed for three days after the positive results were available. 7/15/25 11:34 AM – A physician's order was written for cefuroxime axetil (antibiotic) 500 mg, give 500mg by mouth stat for UTI. 7/15/25 9:00 PM – The medical administration record for R106 documented cefuroxime as not available. 7/16/25 9:00 AM – The medical administration record for R106 documented cefuroxime as administered. 7/16/25 9:54 AM – A nursing progress note documented for R106 that the pharmacy did not process the cefuroxime due to a resident's allergy. Two doses of cefuroxime were sent to a local pharmacy for the facility to pick up. There was an additional one day delay making it four days before the urine culture results were reviewed and R106 received antibiotics. 8/22/25 10:10 AM – During an interview, E22 (LPN) stated that the outside lab urine culture results are automatically uploaded into a resident's chart, and	F0773	Continued from page 26 The audits will be performed daily until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly until 100% compliance is achieved for three consecutive weeks. Audits will then continue monthly until 100% compliance is achieved for three consecutive months. Once 100% compliance is maintained, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee for ongoing process improvement.	

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F0773 SS = D	Continued from page 27 staff need to be aware to keep checking the chart for the results. When the results appear in the chart, they notify the provider. 8/22/25 10:15 AM – During an interview, E18 (LPN) stated that the outside lab will call the facility for a positive lab result and during weekend hours, the facility will contact the on-call provider. 8/25/25 11:23 AM – During an interview, E23 (UM) stated that the outside lab urine culture results are uploaded to the resident's charts. The outside lab generally does not call for positive urine culture results. E23 confirmed that there was a delay in notifying the provider about the culture results for R106. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.	F0773		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by:	F0812	F812 Facility Response All dishes and utensils were rewashed and sanitized in the three-compartment sink until the dishwasher was repaired and confirmed to reach required sanitization temperatures. All unlabeled and undated food items were discarded immediately. The wall surrounding the light switch was thoroughly cleaned and sanitized the same day. A complete audit of kitchen food storage areas, dishwashing equipment, and kitchen surfaces was conducted. Any items out of compliance were corrected immediately. All residents had the potential to be affected by this deficient practice. Residents will be protected from this deficient practice by implementing the corrective actions listed in #3. A root cause analysis was completed and determined that the kitchen staff failed to ensure the dishes and utensils were cleaned under sanitary conditions. It was determined the dietary staff need to be re-educated on reporting malfunctioning dishwasher temps. The staff also failed ensure cleanliness of food storage areas and items properly stored in facility unit refrigerators. The staff development and/or designee re-educated the	10/09/2025

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F0812 SS = F	Continued from page 28 Based on observation, interview and review of facility documents it was determined that the facility failed to ensure dishes and utensils were cleaned under sanitary conditions. Additionally, the facility failed to ensure cleanliness of food storage areas and properly store items in facility unit refrigerators. Findings include: 1. 8/19/25 9:36 AM - 9:41 AM - During a follow up visit to the kitchen, the dish washer was observed as having a water temperature of 135 degrees during the wash cycle. The digital screen that displayed the dish cycle temperatures, flashed red and [alarmed] kitchen staff that the temperature was below 150 degrees. 8/19/25 9:43 AM - During an interview, E15 (FSD) confirmed the wash cycle for the temperature did not meet the minimum 150 degrees. E15 stated, "I just saw the alarm, so I went and talked to maintenance, and they think one of the boilers temperatures was turned down." 8/19/25 10:00 AM - Review of the facilities dish machine temperature logs revealed the following dates when dish washing temperatures failed to meet the minimum of 150 degrees: June 2025 - 6/5, 6/26 and 6/29. July 2025 - 7/5, 7/11, 7/15, 7/16, 7/27 and 7/28. August 2025 - 8/1, 8/2, 8/3, 8/8, 8/9 and 8/14. 8/19/25 11:26 AM - During an interview, E15 (FSD) confirmed the temperature logs and stated that they had a contractor out on 8/12/25 and the temperatures met requirements that day. 2. 8/19/25 10:35 AM - During inspection of the facilities unit refrigerators a plastic food storage container that contained rice and broccoli was observed on the shelf, unlabeled and undated. The finding was immediately confirmed by E14 (unit clerk). 3. 8/19/25 11:23 AM - During a follow up visit to the kitchen, an area of fuzzy, black spotted substance was observed on the wall surrounding the light switch of the dry storage room. E15 (FSD) immediately confirmed the finding.	F0812	Continued from page 28 Dietary staff on: Proper monitoring and documentation of dishwasher sanitizing temperatures before each meal service Labeling and dating of all food items upon storage Daily cleaning procedures and reporting requirements for unclean surfaces. A posted cleaning schedule was implemented. The Food Service Director who is Serve safe certified or designee Serve safe certified will: audit dishwasher sanitizing temperatures, before meal service to validate temperature are 150 or above audits of food storage for proper labeling/dating of facility unit refrigerators Complete environmental rounds in the kitchen The audits will be performed daily until 100% compliance is achieved for three consecutive days. Random audits will continue once weekly until 100% compliance is achieved for three consecutive weeks. Audits will then continue monthly until 100% compliance is achieved for three consecutive months. Once 100% compliance is maintained, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee for ongoing process improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085052	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0812 SS = F	Continued from page 29 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.	F0812		