



HEALTH
L SERVICES

Care Quality
in Care
by Professionals

DHSS - DHCO
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
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STATE SURVEY REPORT

Page 1 of 1

NAME OF FACILITY: Cadia Rehabilitation Renaissance

DATE SURVEY COMPLETED: August 17, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Complaint survey was conducted at this facility from August 10, 2026, through August 17, 2026. The deficiencies contained in this report are based on observations, interviews, a review of clinical records and a review of other facility documentation as indicated. The facility census on the first day of the survey was one hundred and twelve (112). The survey sample totaled thirty-one (31) residents.	Cross-refer to the CMS 2567 survey completed August 17, 2026: F552, F605, F658, F695, F730, F759, F812, F880.	
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: Cross-refer to the CMS 2567 survey completed August 17, 2026: F552, F605, F658, F695, F730, F759, F812, F880.		

10/1/26

Provider's Signature

Title

NHA

Date

9/4/26

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 08/17/2026
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION RENAISSANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 In accordance with 42 CFR 483.73, an Emergency Preparedness survey was conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility from August 10, 2026 through August 17, 2026. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		10/01/2026
F0000	INITIAL COMMENTS An unannounced Annual and Complaint survey was conducted at this facility from August 10, 2026, through August 17, 2026. The deficiencies contained in this report are based on observations, interviews, a review of clinical records and a review of other facility documentation as indicated. The facility census on the first day of the survey was one hundred and twelve (112). The survey sample totaled thirty-one (31) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; COTA - Certified Occupational Therapy Assistant CNA - Certified Nurse's Aide; DON - Director of Nursing; EMR - Electronic Medical Record; LPN - Licensed Practical Nurse; NHA – Nursing Home Administrator; PPE - Personal Protective Equipment; RN - Registered Nurse; UM - Unit Manager; Anti-anxiety Medication – medication used to treat any of several disorders that cause nervousness,	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 fear, apprehension and worrying; Anti-coagulant – medication that works to prevent the coagulation (clotting) of blood; Anti-psychotic- class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions; Brief Interview for Mental Status (BIMS) – assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15. 0-7: Severe impairment (never/rarely made decisions) 08-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); Care Plan- outlines the plan of action that will be implemented during a patient's medical care; Cognitively intact - alert and oriented enough to make one's own decisions; Continuous positive airway pressure (CPAP) – machine for breathing assistance during sleep; Depression – mental disorder with feelings of sadness or a mood disorder that causes a persistent feeling of sadness and loss of interest that affects how you feel, think and behave; Electronic Medical Record (EMR) - a systematized collection of patient and population electronically stored health information in a digital format; Enhanced Barrier Precautions (EBP) - infection control guidelines used in nursing homes to stop the spread of dangerous germs; Extended-spectrum beta-lactamase (ESBL) - a type of multidrug-resistant organism; Insomnia – sleep disorder that is characterized by difficulty falling and/or staying asleep; Medication Regimen Review (MRR) - monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist;	F0000		

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F0000	Continued from page 2 Methicillin-resistant Staphylococcus aureus (MRSA) - a type of bacteria that is resistant to certain antibiotics; Minimum Data Set (MDS) – standardized assessment forms used in nursing homes; PEG tube - a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate; Personal Protective Equipment (PPE) - is the specialized gear worn to create a physical barrier between a person and dangerous germs, chemicals, or hazards; Psychotropic (medication) - any medication capable of affecting the mind, emotions and behavior.	F0000		
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: Based on observation and interview it was determined that the facility failed to ensure food was stored, prepared, and served in a manner that prevents food borne illness to the residents.	F0812	A. The Food Service Director (FSD) immediately evaluated the refrigerator. The refrigerator was repaired and subsequently verified to maintain an appropriate temperature. Food potentially exposed to unsafe temperatures was discarded. B. All residents have the potential to be affected by this deficient practice. The Food Service Director (FSD), Certified Dietary Manager (CDM), or designee will review all food-storage refrigeration units, including reach-in refrigerators, freezers, and walk-in refrigeration units, to verify that food is maintained at established safe temperatures and that food freshness and safety are maintained. If any refrigerator or freezer is found to be outside the established safe temperature range, the FSD/CDM or designee will immediately evaluate the unit, recheck and document the temperature, notify Maintenance and the FSD/CDM, and determine whether potentially affected food must be discarded. Food will not be served until the safety and suitability of the food has been determined. The refrigerator/freezer will be repaired or otherwise corrected as needed, and the temperature will be rechecked and documented to verify that the unit has returned to the established safe range. Future residents will be protected from this deficient practice through the corrective actions and	10/01/2026

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F0812 SS = F	Continued from page 3 Findings include: 8/10/26 9:17 AM - During the initial kitchen tour, an observation of the refrigerator was reading 43 degrees Fahrenheit. 8/11/26 11:20 AM - During an interview, E23 (FSD) stated that the refrigerator was being repaired on 8/10/26 and was fixed that morning. The refrigerator was running and holding at 36 degrees Fahrenheit. Based on the interview with E23, no presumptive actions were taken to preserve the food at the correct temperature of 41 degrees Fahrenheit or lower during that time frame. 8/11/26 11:30 AM - Findings were discussed with E23. 8/11/2026 2:35 PM - Findings were discussed with E1 (NHA).			F0812	Continued from page 3 system/process changes outlined in Section C. C. The Food Service Director (FSD), Certified Dietary Manager (CDM), or designee will audit food storage, including refrigerators, freezers, reach-in units, and walk-in refrigeration units. Temperature records, food freshness, expiration/use-by dates, food condition, and equipment functionality will be reviewed. Food potentially exposed to unsafe temperatures will be identified and discarded as indicated. A Root Cause Analysis was completed and determined that although the refrigerator was being repaired, the facility failed to ensure that food was maintained at appropriate temperatures and that the safety/freshness of food was monitored during the equipment issue. As a system/process change, the facility will implement a Refrigeration Temperature and Food Freshness Monitoring Process. Dietary staff will monitor and document the temperature of all food-storage refrigeration units according to the facility's established schedule and whenever there is a concern regarding equipment functionality. The designated dietary staff member responsible for each shift will verify the recorded temperatures and food-storage conditions. The revised process will require dietary staff to: Check and document refrigeration temperatures according to the facility's established schedule. Recheck the temperature immediately if a reading is outside the established safe range. Notify the Food Service Director (FSD)/Certified Dietary Manager (CDM) and Maintenance Director or designee immediately when a refrigeration unit is outside the established safe range or is not functioning properly. Evaluate food stored in the affected unit for temperature exposure, freshness, expiration/use-by dates, and overall condition. Discard food when required based on temperature		10/01/2026

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F0812 SS = F		F0812	Continued from page 4 exposure, food condition, expiration/use-by dates, or facility policy. Relocate food to an appropriate functioning refrigeration unit when indicated. Document the corrective action taken and continue monitoring the affected unit until the established safe temperature is restored and verified. The FSD/CDM or designee will review refrigeration temperature logs daily to verify that required temperatures have been recorded and that corrective actions were taken for any out-of-range temperature. The Staff Development Coordinator/RN, FSD/CDM, or designee will provide education to all dietary staff regarding food temperature monitoring, food freshness and safe food storage, refrigeration procedures, and the required response to temperatures outside the established safe range. Education will emphasize immediate notification, evaluation of potentially affected food, appropriate disposal, documentation, and follow-up until the refrigeration unit is functioning within the established safe range. All newly hired dietary staff will receive education during orientation regarding the facility's food-storage temperature monitoring and food freshness process before independently performing food-storage duties. Completion of education will be documented in the employee's education/orientation record. D. The Food Service Director (FSD), Certified Dietary Manager (CDM), or qualified dietary designee will audit all food-storage refrigeration units and the corresponding temperature documentation to verify that temperatures are maintained within the facility's established safe range and that food freshness and safety are maintained. Audits will be conducted daily until 100% compliance is achieved for three consecutive days. Following achievement of 100% compliance for three consecutive days, audits will be conducted weekly for three consecutive weeks using a dedicated audit sample consisting of all food-storage refrigeration	10/01/2026

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F0812 SS = F				F0812	Continued from page 5 units and their corresponding temperature documentation during the audit period. Following achievement of 100% compliance for three consecutive weeks, audits will be conducted monthly using a dedicated audit sample consisting of all food-storage refrigeration units and their corresponding temperature documentation during the audit period until 100% compliance is maintained for one month. If any audit identifies a refrigeration unit outside the established safe temperature range, missing or incomplete temperature documentation, or food that may have been exposed to unsafe temperatures, immediate corrective action will be taken. Corrective action will include rechecking the temperature, notifying the FSD/CDM and Maintenance Director or designee, evaluating and discarding affected food as indicated, correcting the equipment issue, and documenting the corrective action. All audit results and corrective actions will be documented and reported to the Quality Assurance and Performance Improvement (QAPI) Committee for continued monitoring, review, and follow-up. Once 100% compliance has been achieved and maintained according to the monitoring schedule above, the deficient practice will be considered corrected. The facility will continue to monitor compliance through its established QAPI process.		10/01/2026
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of			F0552	F552 A. R6 continues to reside in the facility. The psychotropic medication informed consent was completed on 8/12/26. B. All residents receiving psychotropic medications have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice through the corrective actions outlined in Section C. The Staff Development Coordinator or RN designee will conduct an audit of all residents who have been prescribed psychotropic medications within the previous 30 days to verify that informed consent has been obtained. If any residents are identified as not having informed consent on file, informed consent will be obtained at that time.		10/01/2026

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F0552 SS = D	Continued from page 6 the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that, for one (R6) out of six residents sampled for medication review, the facility failed to discuss the risks and benefits of proposed care. Findings include: R6's clinical record revealed: 5/15/26 – R6 was admitted to the facility. 5/18/26 – An annual MDS assessment documented that R6 had a BIMS score of 6, indicating severe cognitive impairment. Discussions of R6's care and consents were had with her spouse. 5/18/26 – A review of a physician's progress note listed medication orders, including haloperidol lactate, an anti-psychotic medication, which was ordered and administered. Seroquel, a psychotropic medication, was also ordered and administered, and lorazepam, an anti-anxiety medication. There was no evidence of any discussions with family regarding risks versus benefits of medications. 7/30/26 – A psychiatric provider consult note documented a plan to continue Seroquel 100 mg at bedtime for agitation and lorazepam 0.5 mg in the morning and 1.5 mg at bedtime for anxiety, with lorazepam 1 mg every 2 hours as needed for breakthrough anxiety or acute agitation. The order for haloperidol had previously been discontinued. The plan noted that the medications would be continued because the benefits outweighed the risks. Diagnoses listed included dementia with behavioral disturbances and anxiety. 8/11/26 – During survey facility psychotropic consent form for lorazepam was completed. 8/12/26 – During survey, a facility psychotropic consent forms for the lorazepam and Seroquel were completed. 8/13/26 1:03 PM – During an interview, E26 (RN/Unit Manager) stated that the expectation was to discuss psychotropic medications with the resident/responsible party, including the risks and benefits, adverse outcomes, and alternative treatments, prior to the provider implementing the medications. E26 also stated that the same form was	F0552	Continued from page 6 C. A Root Cause Analysis was completed and determined that the process for obtaining and documenting informed consent was not consistently followed, particularly for residents admitted or readmitted to the facility while already receiving psychotropic medications. Staff understood that informed consent was required; however, staff did not appropriately document. The Staff Educator will provide re-education to all licensed nurses regarding residents receiving psychotropic medications upon admission or readmission and whenever a psychotropic medication is initiated or increased an informed consent must be completed. This education was added to New Hire Orientation to ensure all staff hired moving forward is educated. New orders for psychotropic medications will be reviewed in daily clinical meeting to ensure informed consent has been obtained, if indicated. D. The Director of Nursing or RN designee will audit residents prescribed new or increased psychotropic medications to ensure informed consent has been completed. Audits will be performed daily until 100 percent compliance is achieved for three consecutive days. Audits of all residents prescribed psychotropics will then be conducted weekly until 100 percent compliance is achieved for three consecutive weeks. Audits will subsequently continue monthly until 100 percent compliance is maintained for one month. Once 100 percent compliance has been achieved and maintained as outlined above, the deficient practice will be considered resolved. All audit results will be reviewed by the Quality Assurance Committee for continued monitoring and follow-up.	10/01/2026

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F0552 SS = D	Continued from page 7 to be completed upon admission, even when residents were admitted while already receiving psychotropic medications. E26 stated that, if the aforementioned topics were discussed with the responsible party, a progress note and consent form would be completed. 8/17/26 2:45 PM – Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0552				10/01/2026	
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity, The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any ... chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must... §483.12(a)(2) Ensure that the resident is free from ... chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. 	F0605	F605 A. R51 continues to reside in the facility. R51's order to monitor for target behaviors was corrected to clarify the specific behaviors staff should monitor for and not the resident's diagnosis. B. All residents receiving psychotropic medications have the potential to be affected by this deficient practice. The Staff Development Coordinator or RN designee will audit current residents receiving psychotropic medications to ensure that their monitoring orders are for behaviors exhibited by the resident and not a diagnosis. Any issues will be corrected at that time. Future residents will be protected from this deficient practice through the implementation of the corrective actions outlined in Section C. C. A Root Cause Analysis was completed and determined that staff did not recognize the difference between a diagnosis and a target behavior. Staff documented monitoring against diagnoses rather than observable behaviors. Staff Development Coordinator educated licensed nurses on psychotropic target behavior monitoring and documentation of observable behaviors instead of diagnoses. This education was added to New Hire Orientation to ensure all staff hired moving forward is educated. New orders for psychotropic medications will be reviewed in daily clinical meeting to ensure monitoring orders are in place for behaviors exhibited by the resident and not a diagnosis. D. The Director of Nursing or RN designee will audit all residents receiving psychotropic medications to			10/01/2026	

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F0605 SS = D	Continued from page 8 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic	F0605	Continued from page 8 ensure psychotropic target behavior monitoring orders are in place with observable behaviors and not diagnoses. The audits will be performed daily or until 100% compliance is achieved for three consecutive days. Audits of all residents receiving psychotropic medications will continue once weekly or until 100% compliance is achieved for three consecutive weeks. Audits will continue monthly until 100% compliance is achieved for one month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	10/01/2026

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F0605 SS = D	Continued from page 9 drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that for one (R51) of six residents sampled for unnecessary medications, the facility failed to ensure residents receiving psychotropic medications therapy were monitored for targeted behaviors following initiation and during continued use of the medications. Findings include: Review of R51's clinical record revealed: 3/24/26 - R51 was admitted to the facility. 3/24/26 - A physician's order documented risperidone (anti-psychotic) 2 mg give 1.5 tablet by mouth at bedtime for depression/mood. 3/24/26 - A physician's order documented venlafaxine (anti-depressant) 150 mg give one capsule by mouth at bedtime for depression. 3/24/26 - A physician's order documented lorazepam (anti-anxiety) 0.5 mg give one tablet every four hours as needed for anxiety for 14 days. 3/25/26 - A physician's order documented lorazepam 0.5 mg give one tablet by mouth at bedtime for insomnia, anxiety, agitation, and dementia with behavioral disturbance. 3/27/26 - A physician's order documented "Psychotropic target behavior: depression/anxiety.	F0605		10/01/2026

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F0605 SS = D	Continued from page 10 At the end of each shift note: frequency - number of times behavior occurred; interventions ...; outcome ..." every shift for monitoring. 4/7/26 - A care plan documented R51 had a mood problem related to anxiety with the following interventions: "monitor, record, report to MD acute episodes of sadness, loss of pleasure or interest in activities, change in appetite/eating habits, and change in sleep patterns; monitor/record/report to MD risk for harming others, increased anger, agitation, feels threatened by others, and possession of weapons to harm self or others; administer medications as ordered, monitor/document side effects and effectiveness; psychiatry consult as needed." The aforementioned physician's order was unclear regarding target behaviors the staff should monitor R51 for. 8/17/26 10:00 AM - A review of the MAR/TAR for 3/24/26 to 8/17/26 lacked evidence of monitoring for increased anger, agitation, sleeplessness or periods of sadness. The MAR/TAR documented staff was monitoring for depression and anxiety which is not a target behavior. 8/17/26 11:06 AM - During an interview, E20 (LPN) stated the expectation was for the nurse to monitor adverse effects and behaviors for any resident taking psychotropic medications. E20 stated the provider will add a monitoring order into EMR (electronic medical record) and staff should be documenting if those behaviors or adverse effects were noted. E20 confirmed the monitoring order for R51 stated depression/anxiety which was not behaviors exhibited by resident. 8/17/26 2:50 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0605		10/01/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was	F0658	F658 A. Resident R13 continues to reside in the facility. B. All residents that sustained a fall have the potential to be affected by this deficient practice. An audit of all post fall evaluations completed in the last 30 days was conducted by the Director of Nursing to ensure it was completed by an RN. No deficiencies	10/01/2026

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F0658 SS = D	Continued from page 11 determined that for one (R13) out of forty-five residents in the investigative sample, the facility failed to provide services that meet professional standards of quality by having Licensed Practical Nurses (LPN) complete post fall assessments. Findings include: "Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2024... RN... Post Fall Assessment & Documentation... updated 10/11/24." Review of R13's clinical record revealed: 3/17/26 - R13 was admitted to the facility. 6/24/26 11:20 AM - A facility reported incident documented that R13 had a witnessed fall when standing up from wheelchair, lost balance, and fell making contact with a chair on the left side and shoulder while outside on the patio with activities. 6/24/26 11:20 AM - A witness statement documented that R13 was sitting on the ground on the patio with left side leaning against an outdoor chair. The statement further documented that R13 was assessed by E20 (LPN) for range of motion (ROM), vital signs and neurological checks were initiated. 6/24/26 12:13 PM - A post fall assessment was completed by E20 in the EMR (electronic medical record). There was no evidence in the clinical record that the RN on duty was called to assess the resident. 6/24/26 1:00 PM - A provider progress note documented that E8 (NP) assessed R13 post fall. The progress note documented that R13 was complaining of pain in the left shoulder and had limited ROM. The progress note further documented that E8 ordered an x-ray of R13's left shoulder. 8/13/26 12:40 PM - During an interview, E20 stated she completed the post fall assessment on 6/24/26 after R13 fell outside on the patio. E20 stated the expectation is for the LPN to complete the assessment if assigned to the resident and notify the RN Unit Manager if they are available. 8/13/26 1:00 PM - During an interview, E12 (RN) stated the expectation was the post fall assessment could be started by an LPN but an RN should be present during assessment and cosign the assessment upon completion. E12 confirmed that E20 completed the aforementioned assessment.			F0658	Continued from page 11 were noted. Future residents will be protected from this deficient practice through the implementation of the corrective actions outlined in Section C. C. A root cause analysis determined that the post-fall assessment was completed by a Licensed Practical Nurse (LPN). The RN Unit Manager that reported to the fall did assess the resident but failed to document her assessment. The Staff Development Coordinator will educate licensed nurses on the requirement to notify the RN to complete the post-fall assessment and documentation in the medical record. All falls will be reviewed in daily clinical meeting to ensure the post-fall assessment was completed by an RN. D. The Assistant Director of Nursing or RN designee will audit post-fall assessments to ensure that each assessment is completed by a Registered Nurse (RN). Audits will be performed daily until 100% compliance is achieved for three consecutive days. Audits of all residents who experience falls will then continue weekly until 100% compliance is achieved for three consecutive weeks. Audits will subsequently continue monthly until 100% compliance is maintained for one month. Once 100% compliance has been achieved and sustained according to the monitoring schedule above, the deficient practice will be considered resolved. All audit results will be reviewed by the Quality Assurance Committee.		10/01/2026

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F0658 SS = D	Continued from page 12 8/17/26 2:50 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0658		10/01/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for two (R16 and R27) out of two residents reviewed for respiratory care, the facility failed to ensure the respiratory equipment was stored in plastic bagging when not in use. Findings include: 1. R16 was admitted to the facility with the following diagnoses, including but not limited to, pneumonia, shortness of breath, and chronic obstructive pulmonary disease. 7/23/26 – A review of R16's physician's orders documented Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/3 mL, to be inhaled orally every eight hours as needed for wheezing/shortness of breath for 14 days, and 3 mL to be inhaled orally three times a day for shortness of breath/wheezing. 8/10/26 at 9:25 AM – An observation revealed R16's nebulizer machine sitting on the nightstand, with the nebulizer mask attached to the tubing. The mask was dated and lying in the drawer, with the drawer closed. A plastic bag was observed lying next to the nebulizer machine. 8/11/26 at 10:41 AM – A second observation revealed R16's nebulizer mask and tubing stored in a plastic bag. 8/12/26 at 10:11 AM – A third observation revealed R16's nebulizer mask lying on the bedside table and not enclosed in a plastic bag. 8/12/26 at 10:17 AM – During an interview and	F0695	F695 A. Residents R16 and R27 continue to reside in the facility. Their respiratory equipment was placed in proper storage bags. B. All residents utilizing respiratory equipment have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice through the implementation of the corrective actions outlined in Section C. C. The Director of Nursing and/or RN designee will audit residents receiving nebulizer treatments and CPAP treatments in the last 30 days. The audit will include direct observation of respiratory equipment when it is not in use to verify that the equipment is stored appropriately. A root cause analysis was completed and determined that nursing staff failed to properly store nebulizer masks and tubing, as well as CPAP masks and tubing, in a plastic bag after use. The Staff Development Coordinator will educate nursing staff regarding proper storage and protective bagging of respiratory equipment when not in use, including equipment used for nebulizer treatments and CPAP treatments. This education was added to New Hire Orientation to ensure all staff is educated moving forward. D. The Director of Nursing and/or RN designee will conduct direct observational audits of residents receiving nebulizer treatments and CPAP to verify that respiratory equipment is properly stored when not in use. The audits will be performed daily until 100% compliance is achieved for three consecutive days. Audits of all residents who receive nebulizer treatments or use a CPAP will then continue weekly until 100% compliance is achieved for three	10/01/2026

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F0695 SS = D	Continued from page 13 observation, E12 (RN, UM) confirmed that R16's nebulizer mask was not placed in protective bagging. The surveyor asked E12, "What is the facility's policy for respiratory equipment when not in use?" E13 stated, "It should be in a bag. I will speak to the nurse; this will be taken care of." 2. R27's clinical record revealed: 7/30/26 – R27 was admitted to the facility. 7/30/26 7:24 PM – A physician's order for R27 documented to apply the CPAP at bedtime and as needed for naps. 8/2/26 – An admission Minimum Data Set (MDS) documented R27 as cognitively intact with a BIMS score of 14. 8/10/26 10:54 AM – An observation revealed R27's CPAP mask and tubing lying on the bedside table, on top of the CPAP machine. R27 stated that she did not receive a bag for storing the mask. 8/10/26 11:07 AM – During an interview, E6 (RN) stated that respiratory equipment, including a CPAP mask, goes into a clear, gallon-sized bag. 8/10/26 11:10 AM – During an interview, E17 (CNA) confirmed that the CPAP was lying on the bedside table and was not placed in a storage bag. 8/17/26 2:50 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0695	Continued from page 13 consecutive weeks. Audits will subsequently continue monthly until 100% compliance is achieved and maintained for one month. Once 100% compliance has been achieved and sustained according to the monitoring schedule above, the deficient practice will be considered resolved. All audit results will be reviewed by the Quality Assurance Committee.	10/01/2026			
F0730 SS = D	Nurse Aide Perform Review – 12Hr/Year In- service CFR(s): §483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for two (E9 and E10) out of five CNA's reviewed for annual performance reviews, the facility failed to ensure that the annual performance	F0730	A. The facility identified that the annual performance reviews for Nurse Aides E9 and E10 were not completed within the required twelve-month timeframe. The overdue performance reviews were completed. The facility recognizes that all nurse aides must receive a documented performance review at least annually, in accordance with applicable regulatory requirements and facility policy. B. All residents have the potential to be affected by this deficient practice. The Human Resources Director (HRD), or a qualified	10/01/2026			

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F0730 SS = D	Continued from page 14 review was completed at least once every twelve months. Findings include: Review of CNA Performance Evaluation's revealed: 1. 1/29/25 - E9 was hired at the facility. 4/17/26 - An annual performance evaluation for E9 was completed. 2. 3/1/25 - E10 was hired at the facility. 6/2/26 - An annual performance evaluation for E10 was completed. 8/12/26 - During an interview, E11 (HR) confirmed that the annual performance evaluations for E9 and E10 were not completed within 12 months. 8/17/26 2:50 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0730	Continued from page 14 Human Resources designee, will audit the personnel files of all current nurse aides to identify any nurse aide whose annual performance review was not completed within the required twelve-month timeframe. Any overdue performance review identified during this 100% review will be completed as soon as possible. Any identified performance or competency concerns will be addressed through appropriate education, competency validation, and/or supervisory intervention, as indicated. Future nurse aides will be protected from this deficient practice through the corrective actions and system changes outlined in Section C. C. A Root Cause Analysis was completed and the facility determined that it did not have an effective centralized tracking and notification process to ensure that annual nurse aide performance reviews were completed within the required twelve-month timeframe. As a system/process change, the facility will establish a Nurse Aide Annual Performance Review Tracking System. The tracking system will include each nurse aide's date of hire, date of the most recent performance review, and next performance review due date. The Human Resources Director (HRD), or a qualified Human Resources designee, will review the tracking system monthly in collaboration with the Director of Nursing (DON), or Registered Nurse (RN) designee. Advance reminders will be provided to the appropriate department manager before a performance review becomes due. The department manager will be responsible for ensuring the performance review is completed and submitted to Human Resources within the required timeframe. The Human Resources Director (HRD), or qualified Human Resources designee, will provide education to all managers responsible for completing nurse aide performance reviews regarding the required twelve-month timeframe and the facility's Nurse Aide Annual Performance Review Tracking System. All newly appointed or newly assigned managers responsible for completing nurse aide performance reviews will receive education regarding the annual performance review requirements and use of the tracking system as part of their orientation to the	10/01/2026			

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F0730 SS = D				F0730	Continued from page 15 role and prior to assuming responsibility for completing performance reviews. Completion of education will be documented and maintained in accordance with facility policy. D. The Human Resources Director (HRD), or a qualified Human Resources designee, will conduct ongoing monitoring using the Nurse Aide Performance Review Audit Tool. The Section B/C audit is the facility's initial 100% review of all current nurse aide personnel files to identify and correct any overdue performance reviews and establish accurate information in the Nurse Aide Annual Performance Review Tracking System. The Section D audits are the facility's ongoing monitoring process to ensure that the corrective action remains effective and that nurse aide performance reviews continue to be completed within the required twelve-month timeframe. The HRD or qualified Human Resources designee will conduct a 100% audit of all current nurse aide personnel files initially to establish baseline compliance and verify that all nurse aides have a current performance review within the required twelve-month timeframe. Following achievement of 100% compliance, audits will be conducted weekly for three consecutive weeks using a dedicated sample of nurse aide personnel files with performance reviews due or completed during the audit period. The audit will verify that the performance review was completed within the required twelve-month timeframe and that the completion date is accurately reflected in the tracking system. Following achievement of 100% compliance for three consecutive weeks, audits will be conducted monthly using a dedicated sample of nurse aide personnel files with performance reviews due or completed during the audit period until 100% compliance is maintained for one month. If an audit identifies an overdue or missing performance review, the performance review will be completed as soon as possible, the tracking system will be corrected, and the responsible manager will receive re-education regarding the required timeframe and tracking process.		10/01/2026

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F0730 SS = D		F0730	Continued from page 16 The HRD or qualified Human Resources designee will also review the monthly tracking report to verify that upcoming performance reviews are identified in advance and that responsible managers have been notified. All audit results and corrective actions will be documented and reported to the Quality Assurance and Performance Improvement (QAPI) Committee for continued monitoring, review, and follow-up. Once 100% compliance has been achieved and maintained according to the monitoring schedule above, the deficient practice will be considered corrected. The facility will continue to monitor compliance through its established QAPI process.	10/01/2026
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure that it was free of medication error rate of 5 percent or greater. During medication pass observation on 8/14/26, two medication errors out of twenty-five opportunities were identified, resulting in a medication error of 8% and affecting one resident (R93). Findings include: Review of R93's clinical record revealed: 11/18/25 - A physician's order documented Midodrine (vasopressor) 10 mg give one tablet via PEG-tube three times a day for hypotension. 2/20/26 - A physician's order documented acetaminophen (pain reliever) liquid 160 mg/5 mL give 20 mL via PEG-tube every six hours as needed for pain. 8/14/26 1:14 PM - During a random medication pass observation, E6 (RN) administered the aforementioned medications orally to R93.	F0759	F759 A. Resident R93 continues to reside in the facility. Resident R93's medication orders were corrected to accurately reflect the prescribed route of administration. B. All residents receiving enteral medications have the potential to be affected by this deficient practice. The Director of Nursing and/or designee will identify residents who currently receive medications through a PEG tube to ensure the medication orders have the correct route of administration. Any issues will be corrected at that time. Future residents will be protected from this deficient practice through the implementation of the corrective actions outlined below in C. C. The facility determined root cause analysis was that the resident was able to take medications by both the oral and enteral route and the orders did not accurately reflect her preferences for which medications should be administered via which route. The Staff Development Coordinator will educate licensed nurses regarding medication administration and proper route per the provider's order. New medications orders will be reviewed in daily clinical meeting to ensure the route is appropriate.	10/01/2026

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F0759 SS = D	Continued from page 17 8/17/26 11:14 AM - During an interview, E7 (LPN) stated R93 takes medications orally and via PEG-tube. E7 stated R93 was able to take one pill orally but if multiple medications via PEG-tube. E7 confirmed the aforementioned medications should have been administered via PEG-tube. 8/17/26 11:19 AM - During an interview, E8 (NP) stated R93 takes medications via PEG-tube and orders should be written to reflect that route. E8 stated its expected for the nurse to follow the orders as written by the subscriber. 8/17/26 2:50 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.			F0759	Continued from page 17 D. The Director of Nursing and/or RN designee will audit all residents with enteral medication administration to ensure nurses are following the proper route of administration. These audits will be performed daily until 100% compliance is achieved for three consecutive days. Audits of all residents who have enteral medications will then continue weekly until 100% compliance is achieved for three consecutive weeks. Audits will subsequently continue monthly until 100% compliance is achieved and maintained for one month. Once 100% compliance has been achieved and sustained according to the monitoring schedule above, the deficient practice will be considered resolved. All audit results will be reviewed by the Quality Assurance Committee.		10/01/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify			F0880	F880 A. Residents R1 and R144 continue to reside in the facility. Unable to correct. B. All residents requiring Enhanced Barrier Precautions and Transmission-Based Precautions have the potential to be affected by this deficient practice. The Director of Nursing and/or RN designee will audit residents who are currently on Enhanced Barrier Precautions and Transmission-Based Precautions to ensure appropriate use of personal protective equipment (PPE). Any deficiency identified during the audit will be addressed and corrected immediately by having the staff member perform hand hygiene and don proper PPE. Future residents will be protected from this deficient practice through the implementation of the corrective actions outlined below in C. C. A root cause analysis was completed and the facility determined that its infection prevention and control process did not consistently ensure that staff correctly recognized and followed personal protective equipment practices necessary to prevent the transmission of infections. The Staff Development Coordinator RN will educate		10/01/2026

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F0880 SS = D	Continued from page 18 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record review, it was determined that for two (R1 and R144) out of seven residents reviewed for infection control, the facility failed to use appropriate infection prevention and control practices to prevent the transmission of infection. Findings include:	F0880	Continued from page 18 nursing staff and other clinical staff regarding Enhanced Barrier and Transmission-Based Precautions and appropriate selection and use of personal protective equipment. The Staff Development Coordinator will conduct monthly audits of PPE usage and report to monthly Antibiotic Stewardship Meeting. D. The Director of Nursing and/or RN designee will conduct audits of residents on Enhanced Barrier Precautions (EBP) and Transmission Based Precautions (TBP) with direct observations specifically verifying appropriate use of PPE. These audits will be performed daily until 100% compliance is achieved for three consecutive days. Audits of 10% of residents on EBP or TBP precautions will then continue weekly until 100% compliance is achieved for three consecutive weeks. Audits will subsequently continue monthly until 100% compliance is achieved and maintained for one month. Once 100% compliance has been achieved and sustained according to the monitoring schedule above, the deficient practice will be considered resolved. All audit results will be reviewed by the Quality Assurance Committee.	10/01/2026

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 08/17/2026	
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION RENAISSANCE				STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY , MILLSBORO, Delaware, 19966			
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F0880 SS = D	Continued from page 19 Review of the facility's policy and procedure titled, "Standard and Transmission-Based Precautions," last revised 6/4/26, documented, "... Enhanced Barrier Precautions ... PPE [personal protective equipment] - gloves and gown and/or face protection during high-contact resident care activities: i.e. dressing, bathing, transferring, providing hygiene...assisting with toileting...". 1. Review of R1's clinical record revealed: 10/31/25 - R1 was admitted to the facility with a diagnosis of urinary tract infection. 10/22/25 – R1's physician order documented enhanced barrier precautions (EBP) related to a history of extended-spectrum beta-lactamase (ESBL). 7/9/26 - R1's quarterly MDS documented a BIMS score of 12, indicating moderate cognitive impairment. 7/9/26 - A care plan for R1 documented EBP for ESBL in urine. 8/12/26 10:30 AM – An observation was made that E24 (CNA) entered R1's room and provided a bed bath without putting on a gown. 8/12/26 10:30 AM - During an interview, E24 confirmed that the resident was on EBP; however, she did not put on a gown while providing a bed bath. 8/12/26 10:35 AM - During an interview, E12 (RN) confirmed that she observed E24 providing a bed bath to the resident without wearing a gown. E12 acknowledged the concern and stated that she would re-educate the CNA regarding the appropriate use of PPE when providing care to a resident on EBP. 8/17/26 2:50 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference. 2. R144's clinical records revealed: 8/1/26 – R144 was admitted to the facility. 8/3/26 – A care plan documented that R144 was on enhanced barrier precautions due to having a urinary catheter and a history of MRSA, with interventions to initiate/maintain infection control			F0880			10/01/2026

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F0880 SS = D	Continued from page 20 precautions as per guidelines/protocol. 8/3/26 – A physician's order documented that R144 was to be cared for using enhanced barrier precautions due to having a urinary catheter and a history of MRSA. 8/6/26 – An admission MDS documented that R144 was cognitively intact with a BIMS score of 15 and was dependent on staff to transfer to the toilet and for toileting hygiene. 8/10/26 10:14 AM – An observation was made of R144 sitting in a wheelchair at the doorway of his room. R144's doorway had a cart with personal protective equipment (PPE) and signage for enhanced barrier precautions. E22 (RN, UM) approached R144 and asked him if he needed any assistance. R144 responded that he needed to use the bathroom. R144 performed hand hygiene, put on gloves and assisted R144 into the bathroom. 8/10/26 10:16 AM – An observation was made that E22 stepped out of R144's bathroom without a gown on and waited outside the closed bathroom door. 8/10/26 10:21 AM – An observation was made that E22 entered R144's bathroom without a gown on. 8/10/26 10:26 AM – An observation was made that E22 exited R144's bathroom without a gown on, removed the gloves and performed hand hygiene. 8/10/26 10:28 AM – During an interview, E22 stated that R144 is on enhanced barrier precautions because he has a catheter in place. E22 stated there are no gowns in the bathroom to put on; the gowns are in the cart outside the room. E22 stated that she transferred R144 to the toilet, provided peri-care and transferred him back to the wheelchair. E22 confirmed she should have been wearing a gown. 8/17/26 2:50 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0880		10/01/2026

