

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

#### **STATE SURVEY REPORT**

Page 1 of 1

NAME OF FACILITY: Cadia Rehabilitation Pike Creek

DATE SURVEY COMPLETED: February 17, 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 complaint survey was conducted at this facility from February 11, 2025, through February 17, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 148. The investigative sample totaled six residents.		
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.		
3	This requirement is not met as evidenced by:	žų	
	Cross Refer to the CMS 2567-L survey completed February 17, 2025: F684, F695 and F773.	Cross Refer to the CMS 2567-L Survey completed February 17, 2025: F684, F695, and F773.	4/7/2025

Provider's Signature Brandi Wilson Title NHA

PRINTED: 04/25/2025 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		085054	B. WING			1	С	
NAME OF I	PROVIDER OR SUPPLIER	083034	B. WING		TREET ARRESTOR OF A CONTROL OF	02	/17/2025	
	EHABILITATION PIKE	CREEK		38	TREET ADDRESS, CITY, STATE, ZIP CODE 540 THREE LITTLE BAKERS BLVD VILMINGTON, DE 19808			
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F 000	INITIAL COMMEN	ΓS	F 0	000				
	conducted at this fathrough February 1 contained in this reposervations, intervolutional records and documentation as in on the first day of the investigative sample. Abbreviations/definial follows:  CNO - Chief Nursing G-Tube - a tube instituted in the stomach; Hypoxia - not enought issues; LPN - Licensed Prance Certain (nervous system); MD - Medical Direct MAR - Medication ANHA - Nursing Hommas - Respiratory system respiratory system respiratory system in causing respiratory and assist breathing. Quality of Care CFR(s): 483.25	views, review of residents' review of other facility indicated. The facility census he survey was 148. The e totaled six residents.  itions used in this report are  g Officer; erted through the abdomen of the oxygen reaching the body inctical Nurse; in consists of a physical tify signs of disorders in spinal cord and nerves tor; in Administration Record; in e Administrator; in consists of a physical tify signs of disorders in the properties of the properties	F 6	84			4/7/25	
	Quality of care is a	fundamental principle that						
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE	
	ically Signed						03/14/2025	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

03/14/2025

	ICATION NUMBER		PLE CONSTRUCTION  G		E SURVEY PLETED
	085054	B. WING _		02/1	1 <b>7/2025</b>
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	UZI	1772025
CADIA REHABILITATION PIKE CREEK			3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808		
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applies to all treatment and ca facility residents. Based on the assessment of a resident, the that residents receive treatme accordance with professional practice, the comprehensive pcare plan, and the residents of This REQUIREMENT is not not by:  Based on interview and recordetermined that for two (R1 arresidents sampled for falls, the ensure that each resident recesservices in accordance with phyprofessional standards of pracassessments. For R1, the faci and document current vital signafter alert charting was initiate monitoring of the resident. For failed to ensure the resident was fall which included seizure a include:  The facility's policy and proceed Charting, last reviewed 1/3/25, policy to utilize alert charting experiencing changes in condition heightened observation as definitionally assessments and assessments into nursing notes. Incidents the placing a resident on alert charting are as nurse each shift and assessments into nursing notes. Incidents the placing a resident on alert charare not limited to; resident falls objective data related to the refine, vital signs".	e comprehensive facility must ensure int and care in standards of erson-centered hoices. The facility failed to eview, it was and R3) out of three erfacility failed to eview care and evice for post-fall lity failed to obtain ins (VS) every shift d for increased in R3, the facility as monitored after ctivity. Findings  Hure entitled Alert is stated, " It is the for residents it in that warrant ermined through its essessed by the ent data entered in the may warrant intring include; but s Document sident's condition	F 68	F684 #1  1. R1 no longer resides in the facility was not negatively impacted by this deficient practice.  2. All residents who are placed on a charting have the potential to be imby this deficient practice. Further residents will be protected from this deficient practice by measures outlisection 3.  3. A facility wide sweep of all reside who are currently on Alert Charting completed and no other residents waffected by this deficient practice. A root cause analysis was conducted it was determined that the licensed failed to obtain current vital signs we charting on R1. The Staff Developer/designee will educate the licensed nursing staff on obtaining ovital signs each shift while the residing on alert charting.  4. The Director of Nursing/designee audit five random residents who are alert charting to ensure that current signs are obtained each shift of the charting process. The audit process will be conducted times weekly until compliance is	alert pacted  alert pacted  alert pacted  alert pacted  alert alert alert  alert alert alert	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		085054	B. WING _			C <b>17/2025</b>
	PROVIDER OR SUPPLIER	CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808	•	
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F 684	1/28/25 4:47 PM - A "Resident was foun front of his bed N initiated."  1/28/25 - The follow entered in R1's recopost] fall x [times] 3  According to the fact 1/28/25, the facility day shift (7 AM to 3 to 11:30 PM); and n  The Alert Charting of following: - E7 (LPN) docume 01/29/2025 04:51 [A Charting for Fall. Vin 156/74 - 1/28/2025 [Temperature] 98.2   77 - 1/28/2025 22:36 (9 - 1/28/2025 22:36   % - 1/28/2025 22:36   % - 1/28/2025 22:36   % - 1/28/2025 22:36   Charting for S/p [sta 145/66 - 1/29/2025 1/29/2025 21:20 Falled to current vital signs.  - E8 (LPN) docume 01/30/2025 11:49 [1 Alert Charting for s/ Alert Charting	A nurse's note documented, d by staff lying on the floor in euro checks and alert charting ving physician's order was ord: "Alert Charting s/p [status days, every shift for 3 days." cility's daily staff posting on has three shifts for nurses: :30 PM); evening shift (3 PM ight shift (11 PM to 7:30 AM). notes in R1's record were the nted, "Effective Date: 4:51 AM] Resident is on Alert tals:BP [Blood Pressure] 22:36 [10:36 PM] T - 1/28/2025 22:36 P [Pulse] 6 R [Respirations] 18.0 - D2 [Oxygen Saturation] 94.0 6". E7 failed to obtain and	F 68	consistently reached 100% of the during three consecutive audits. The followed by audits performed on week until compliance is consister achieved over three consecutive verically, a monthly audit will be contoned determine on-going compliance compliance is not achieved, reassessment of ongoing issues a corrective action will be taken. If compliance is achieved, corrective measures will be noted as success results will be brought through the meetings.  F684 #2  1. R3 still resides in the facility and not negatively impacted by this depractice. 2. All residents who are readmitted facility following an evaluation at the emergency room after experiencing in the facility have the potential to impacted by this deficient practice. Further residents will be protected this deficient practice by measures outlined in section 3. 3. A facility wide sweep of all resid who have been readmitted to the following an emergency room visit following a fall in the facility was completed and no other residents affected by this deficient practice. A root cause analysis was conduct it was determined that the licensed failed to obtain current vital signs of conduct an assessment on R3. The Developer/designee will educate the protection of the	this will nce a ntly veeks. ducted a life and life sful. All QAPI life and life sful. All QAPI life and life sful and life and life and life and life and life sfacility life staff and life staff life staff life staff life staff life staff life and life and life staff life staff life staff life and life staff life staf	

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	085054	B. WING _			17/2025	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
CADIA REHABILITATION PIKE C	REEK		3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808			
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current vital signs.  - E9 (LPN) documente 01/30/2025 22:46 [10: Alert Charting for s/p f 1/29/2025 21:20 [9:20 21:20 P 81 - 1/29/20 1/29/2025 21:20 O2 21:20". E9 failed to current vital signs.  - E7 (LPN) documente 01/31/2025 03:03 [3:0 Charting for Fall. Vitals 21:20 [9:20 PM] T 9 81 - 1/29/2025 21:20 O2 93.0 % - 1 to obtain and documente 01/31/2025 10:16 [10: Alert Charting for Fall. 1/29/2025 21:20 [9:20 21:20 P 81 - 1/29/20 21:20 P 81 - 1/29/20 21:20 P 81 - 1/29/20 21:20" E8 failed to current vital signs.  2/1/25 - R1 was placed signs/symptoms (s/s) included the following: - E7 (LPN) documente 02/1/2025 06:00 [6:00 Charting for S/S OF Files.	225 21:20 R 18.0 - 2 93.0 % - 1/29/2025 obtain and document R1's  ed, "Effective Date: 246 PM] Resident is on fall. Vitals: BP 145/66 - 2 PM] T 97.9 - 1/29/2025 025 21:20 R 18.0 - 2 93.0 % - 1/29/2025 obtain and document R1's  ed, "Effective Date: 3 AM] Resident is on Alert s: BP 145/66 - 1/29/2025 7.9 - 1/29/2025 21:20 P R 18.0 - 1/29/2025 7.9 - 1/29/2025 21:20 P R 18.0 - 1/29/2025 1/29/2025 21:20". E7 failed nt R1's current vital signs.  ed, "Effective Date: 16 AM] Resident is on Vitals: BP 145/66 - 1 PM] T 97.9 - 1/29/2025 025 21:20 R 18.0 - 93.0 % - 1/29/2025 obtain and document R1's  d on Alert Charting for of FLU/COVID/RSV, which	F 68	licensed nursing staff on obt vital signs and complete an a on residents who are readmit facility following an emergen after experiencing a fall the factor of Nursing/data audit all residents who are refrom an emergency room visifall, to ensure that current vital assessments are obtained ethe alert charting process. The audit process will be contimed weekly until compliance consistently reached 100% of during three consecutive audits perform week until compliance is contachieved over three consecutive audits of the determine on-going compliance is not achieved, reassessment of ongoing issecorrective action will be taked compliance is achieved, corresults will be brought through meetings.	assessment		

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION AND MADED		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		085054	B. WING _		II.	C / <b>17/2025</b>	
	PROVIDER OR SUPPLIER  EHABILITATION PIKE	CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808			
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F 684	18.0 - 1/31/2025 21 21:46". E7 failed tourrent vital signs.  2/17/25 at 12:46 PN Surveyor reviewed acknowledged that obtained and docur 2/17/25 2:00 PM - E were reviewed with information was proceed to the series of R3's considered to the series of R3's series of	2:46 O2 93.0 % - 1/31/2025 to obtain and document R1's obtain an interview, with E12 (NP) and E12 current vital signs were not nented by nursing staff.  Ouring an interview, findings E3 (CNO). No further vided to the Surveyor.  Inical record revealed:  Admitted to the facility with acute and chronic respiratory of reder, ventilator dependence, tative state.  Fur care plan (revised 2/15/23 ented, "At risk for falls r/t d/o [disorder] & involuntary sident is on hypnotic for obtained MDS documented, lent on staff for all activities of R3's clinical records ceived order to send resident	F 68	4			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	NG	l` cor	
	,	085054	B. WING		02	C 2/17/2025
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F 684	lasted about 5 minuresident was first foturned on her back  1/27/25 1:44 AM - Fhospital.  The facility lacked eclinical assessment done on for 1/27/25  2/3/25 6:26 PM - Threport submitted to Resident noted with  2/14/25 12:00 PM - E5 (RN supervisor) room and saw their back on the floor. His shaking. Her arms with blood pressure had surveyor asked E5 stated, "No, but her 12/14/25 12:30 PM with E3 (CNO.)	itesCNA reported that ound on her face then was	F 68	84		
	(CNO), E10 (Corp. Nurse). Respiratory/Trached CFR(s): 483.25(i)	Nurse) and E11 (Corp.	F 69	95		4/7/25
	The facility must en	tory care, including and tracheal suctioning. sure that a resident who are, including tracheostomy				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  3		(X3) DATE SURVEY COMPLETED	
		085054	B. WING		1	1 <b>7/2025</b>	
	PROVIDER OR SUPPLIER REHABILITATION PIKE	CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808			
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F 695	care and tracheal s care, consistent with practice, the compricare plan, the reside and 483.65 of this series This REQUIREMENDY:  Based on observative review, it was deter R4, R5, and R6) our respiratory care, the respiratory care, increspiratory mouth of with professional structure comprehensive per Findings include:  1. Review of R2's considered and trached on the staff for all and 8/4/23 - R2's respirative good oral considerations included Provide good oral considerations.  8/4/23 - R2's respirative record documented mouth care every sides A review of R2's respirative following:  6/6/24 7:00 PM - R2 following:	uctioning, is provided such h professional standards of ehensive person-centered ents' goals and preferences, subpart.  NT is not met as evidenced that for five (R2, R3, tof five residents reviewed for efacility failed to ensure that cluding tracheostomy care and are, was provided consistent andards of practice and the son-centered care plan.  Initical record revealed:  mitted to the facility with acute respiratory failure with costomy. R2 was dependent ctivities of daily living.  atory care plan documented, has a tracheostomy." The ed, "Trach care per order	F 695	1. R2 no longer resides in the facility was not negatively impacted by this deficient practice.  2. All residents who have a trached have the potential to be impacted to deficient practice. Further residents protected from this deficient practice measures outlined in section 3.  3. A facility wide sweep of all reside who have a tracheostomy was composed to ensure that tracheostomy and or was provided per the physician so and documented. No other resident affected by this deficient practice. A root cause analysis was conduct it was determined that the licensed respiratory staff failed to document tracheostomy and oral care were completed. The Staff Developer/dewill educate the licensed respirator on ensuring that residents with a tracheostomy receive tracheostomy oral care every shift as ordered and ensure that the provided care is documented.  4. The Director of Respiratory Therapy/designee will audit five rar residents who have a tracheostomy ensure that tracheostomy and oral have been provided as ordered and ensure that tracheostomy and oral have been provided as ordered and ensure that tracheostomy and oral have been provided as ordered and ensure that tracheostomy and oral have been provided as ordered and ensure that tracheostomy and oral have been provided as ordered and ensure that tracheostomy and oral have been provided as ordered and ensure that tracheostomy and oral have been provided as ordered and ensure that tracheostomy and oral have been provided as ordered and ensure that tracheostomy and oral have been provided as ordered and ensure that tracheostomy and oral have been provided as ordered and ensure that tracheostomy and oral have been provided as ordered and ensure that tracheostomy and oral have been provided as ordered and ensure that tracheostomy and oral have been provided as ordered and ensure that tracheostomy and oral have been provided as ordered and ensure that tracheostomy and oral have been provided as ordered and ensure that tracheostomy and oral have been provided as ordered and	estomy by this s will be ce by ents apleted ral care order ts were ed, and that esignee y staff y and		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′			(X3) DATE SURVEY COMPLETED	
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PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	UL,	1172020
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6/9/24 7:00 PM - R2 evidence of trached care.  The facility failed to respiratory mouth copportunities.  2. Review of R3's citalized to respiratory mouth copportunities.  2. Review of R3's citalized to respiratory experience diagnoses including failure, seizure diso and persistent vege completely depended daily.  2/16/23 - R3's respiratory Failurely experience and persistent is very to Respiratory Failurely experience and provided to respiratory experience and provided to respiratory mouth care.	2's respiratory TAR lacked obtomy and respiratory mouth provide tracheostomy and are for two out of 24 provided inical record revealed:  admitted to the facility with gracute and chronic respiratory refer, ventilator dependence, stative state. R3 was ent on staff for all activities of pratory care plan documented, atiliator dependent r/t [related are." The interventions reper order."  Tratory treatment record pratory to perform mouth care, affit."  A review of R3's respiratory pollowing:  B's respiratory TAR lacked estomy and respiratory mouth provide tracheostomy and	F 6	95	documented. The audit process will be conducted times weekly until compliance is consistently reached 100% of the tiduring three consecutive audits. The followed by audits performed on week until compliance is consistent achieved over three consecutive we Finally, a monthly audit will be conducted to determine on-going compliance. compliance is not achieved, reassessment of ongoing issues are corrective action will be taken. If compliance is achieved, corrective measures will be noted as success results will be brought through the meetings.  F 695 #2  1. R3 still resides in the facility and not negatively impacted by this defipractice. 2. All residents who have a tracheo have the potential to be impacted by deficient practice. Further residents protected from this deficient practice measures outlined in section 3. 3. A facility wide sweep of all reside who have a tracheostomy was comto ensure that tracheostomy and or was provided per the physician so and documented. No other resident affected by this deficient practice. A root cause analysis was conducted it was determined that the licensed	me is will ce a tly eeks. lucted If ad ful. All QAPI was cient stomy y this s will be e by ents pleted al care order ts were ed, and	
	linical record revealed:			tracheostomy and oral care were		
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTE RESPIRATORY MOUTH OF COMPONING TAILURE RESPIRATORY FAILURE RESPIRATORY FAILUR	PROVIDER OR SUPPLIER  EHABILITATION PIKE CREEK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  6/9/24 7:00 PM - R2's respiratory TAR lacked evidence of tracheostomy and respiratory mouth care.  The facility failed to provide tracheostomy and respiratory mouth care for two out of 24 opportunities.  2. Review of R3's clinical record revealed:  12/17/22 - R3 was admitted to the facility with diagnoses including acute and chronic respiratory failure, seizure disorder, ventilator dependence, and persistent vegetative state. R3 was completely dependent on staff for all activities of daily.  2/16/23 - R3's respiratory care plan documented, "The resident is ventilator dependent r/t [related to] Respiratory Failure." The interventions included, "Trach care per order."  9/26/23 - R3's respiratory treatment record documented, "Respiratory treatment record documented, "Respiratory to perform mouth care, Trach care every shift."  12/14/25 12:15 PM - A review of R3's respiratory TAR revealed the following:  6/9/24 7:00 PM - R3's respiratory TAR lacked evidence of tracheostomy and respiratory mouth care  The facility failed to provide tracheostomy and respiratory mouth care for one out of a total of 60 opportunities.	DENTIFICATION NUMBER:  085054  B. WING  PROVIDER OR SUPPLIER  EHABILITATION PIKE CREEK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  6/9/24 7:00 PM - R2's respiratory TAR lacked evidence of tracheostomy and respiratory mouth care.  The facility failed to provide tracheostomy and respiratory mouth care for two out of 24 opportunities.  2. 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The interventions included, "Trach care per order."  9/26/23 - R3's respiratory treatment record documented, "Respiratory trach care very shift."  2/14/25 12:15 PM - A review of R3's respiratory TAR lacked evidence of tracheostomy and respiratory mouth care for one out of a total of 60 opportunities.  The facility failed to provide tracheostomy and respiratory mouth care for one out of a total of 60 opportunities.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		085054	B. WING			C <b>17/2025</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CADIA R	EHABILITATION PIKE	CREEK		3540 THREE LITTLE BAKERS BLVD		
O/IDIA I	ENABIENATION	OKEEK		WILMINGTON, DE 19808		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 695	Continued From pa	ge 8	F 695	will educate the licensed respirat	ony etaff	
	diagnoses including post stroke, chronic	dmitted to the facility with gleft sided paralysis status crespiratory failure and was dependent on staff for alling.		on ensuring that residents with a tracheostomy receive tracheosto oral care every shift as ordered a ensure that the provided care is documented.  4. The Director of Respiratory	my and	
	" Has a tracheos included, "Monitor/o	ratory care plan documented, stomy" The interventions locument respiratory rate, Check and document q [every]		Therapy/designee will audit five r residents who have a tracheostor ensure that tracheostomy and or have been provided as ordered a documented.  The audit process will be conductive to the conductive tracking the conductive tracking the conductive tracking the conductive tracking tracking the conductive tracking trac	ny to al care nd	
		ician's orders documented, hift, Respiratory to perform hift."		times weekly until compliance is consistently reached 100% of the during three consecutive audits. be followed by audits performed to	time This will	
	A review of R4's res following:	spiratory TAR revealed the		week until compliance is consiste achieved over three consecutive Finally, a monthly audit will be co	ntly weeks.	
	6/6/24 7:00 PM - R4 evidence of tracheo	t's respiratory TAR lacked stomy care.		to determine on-going complianc compliance is not achieved, reassessment of ongoing issues	e. If	
	6/9/24 5:00 PM - R4 evidence of respirat tracheostomy care a	t's respiratory TAR lacked ory mouth care, and at 7:00 PM.		corrective action will be taken. If compliance is achieved, corrective measures will be noted as successesults will be brought through the	e ssful. All	
		R4's respiratory TAR lacked ory mouth care, and at 7:00 PM.		meetings. F695 #3		
	6/18/24 5:00 PM - R	24's respiratory TAR lacked ory mouth care, and		1. R4 still resides in the facility an not negatively impacted by this depractice.      2. All residents who have a trache	ficient	
	evidence of respirat	24's respiratory TAR lacked ory mouth care. provide tracheostomy and		have the potential to be impacted deficient practice. Further resider protected from this deficient practime measures outlined in section 3.	by this ts will be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		.E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		005054	B. WING			C	
		085054	D. WING	=		02/	17/2025
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CADIAD	ELIADII ITATION DIVE	CDEEK		3	540 THREE LITTLE BAKERS BLVD		
CADIA R	EHABILITATION PIKE	CREEN		٧	VILMINGTON, DE 19808		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
F 695	Continued From pa	ge 9	F6	95			
	respiratory mouth copportunities.	are for four out of 60 out of			A facility wide sweep of all reside who have a tracheostomy was com	pleted	
	4. Review of R5's cl	linical record revealed:			to ensure that tracheostomy and or was provided per the physician □s of	order	
					and documented. No other residen	ts were	
		dmitted to the facility with			affected by this deficient practice.	مط جحط	
	diagnoses including	chronic obstructive			A root cause analysis was conducted it was determined that the licensed		
	tracheostomy.	ocute respiratory failure, and			respiratory staff failed to document		
	tracricostority.				tracheostomy and oral care were	uiui	
	2/23/24 - R5's care	respiratory care plan			completed. The Staff Developer/de	signee	
	documented, "Ha	as a tracheostomy" The			will educate the licensed respirator	y staff	
		ed, " Trach care per orders			to ensure that residents with a		
	11 2 (6) (8)				tracheostomy receive tracheostom		
	0/4/04 DEL	-1			oral care every shift as ordered and	1	
	documented, "Track	atory treatment record			ensure that the provided care is documented.		
		orm mouth care two times a			The Director of Respiratory		
	day."	om moun out two united a			Therapy/designee will audit resider have a tracheostomy to ensure that		
	A review of R5's res	spiratory TAR revealed the			tracheostomy and oral care have b		
	following:				provided as ordered and document		
					The audit process will be conducted	d three	
		5's respiratory TAR lacked			times weekly until compliance is		
		stomy and respiratory mouth			consistently reached 100% of the ti		
	care.				during three consecutive audits. The be followed by audits performed on		
	6/0/24 7:00 PM - RF	5's respiratory TAR lacked			week until compliance is consistent		
		estomy and respiratory mouth			achieved over three consecutive w		
	care.	storry and respiratory mean			Finally, a monthly audit will be cond	lucted	
	0/47/04 7 00 514	Office and minutes of TAB 4			to determine on-going compliance.	If	
		R5's respiratory TAR lacked			compliance is not achieved,	24	
		stomy and respiratory mouth			reassessment of ongoing issues ar corrective action will be taken. If	iu	
	care.				compliance is achieved, corrective		
	The facility failed to	perform tracheostomy and			measures will be noted as success	ful. All	
		are for three out of total 60			results will be brought through the meetings.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		085054	B. WING			1	7/0005
NAMEOFI	PROVIDER OR SUPPLIER	000004	D. WING		TREET ARRESTS OF THE STATE OF T	02/	17/2025
NAIVIE OF I	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CADIA R	EHABILITATION PIKE	CREEK		3	540 THREE LITTLE BAKERS BLVD		
				V	VILMINGTON, DE 19808		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	<	(EACH CORRECTIVE ACTION SHOULD	ŖΕ	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
					DEI IGIENGT)		
/							
F 695	Continued From pa	ge 10	F 69	95			
	5. Review of R6's c	linical record revealed:			F695 #4		
					, , , , , , , , , , , , , , , , , , , ,		
	12/6/22 - R6 was ad	dmitted to the facility with			1. R5 still resides in the facility and	was	
		anoxic brain damage,			not negatively impacted by this defi		
		e state, acute and chronic			practice.		
		and tracheostomy. R6 was			2. All residents who have a trached	stomy	
		ent on staff for all activities of			have the potential to be impacted by		
	daily living.				deficient practice. Further residents		
					protected from this deficient practic		
	12/6/22 - R6's respi	ratory care plan documented,			measures outlined in section 3.	·,	
	"Resident has a t	racheostomy r/t [related to]			3. A facility wide sweep of all reside	ents	
	impaired breathing	mechanic" The			who have a tracheostomy was com		
		ed, "Suction as necessary.			to ensure that tracheostomy and or		
	Trach care per orde				was provided per the physician □s o		
	·				and documented. No other residen		
	4/24/24 - R6's respi	ratory TAR documented,			affected by this deficient practice a		
		hift, and respiratory to perform			documented.		
	mouth care 2 times	a shift."			A root cause analysis was conducted	ed. and	
					it was determined that the licensed	,	
	A review of R6's res	piratory TAR revealed the			respiratory staff failed to document	that	
	following:				tracheostomy and oral care were		
					completed. The Staff Developer/de	signee	
	6/6/24 7:00 PM - R6	S's respiratory TAR lacked			will educate the licensed respirator		
	evidence of tracheo	stomy and respiratory mouth			on ensuring that residents with a		
	care.				tracheostomy receive tracheostomy	/ and	
					oral care every shift as ordered and	1	
	6/9/24 7:00 PM - R6	S's respiratory TAR lacked			ensure that the provided care is		
	evidence of tracheo	stomy and respiratory mouth			documented.		
	care.				4. The Director of Respiratory		
					Therapy/designee will audit residen	ts who	
	6/17/24 7:00 PM - F	R6's respiratory TAR lacked			have a tracheostomy to ensure that		
	evidence of tracheo	stomy and respiratory mouth			tracheostomy and oral care have be	∍en	
	care.				provided as ordered and document		
					The audit process will be conducted		
		R6's respiratory TAR lacked			times weekly until compliance is		
		stomy and respiratory mouth			consistently reached 100% of the ti	me	
	care.				during three consecutive audits. Th	is will	
					be followed by audits performed on	ce a	
	The facility failed pro	ovide tracheostomy and			week until compliance is consistent		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
085054		B. WING			C 02/17/2025				
NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION PIKE CREEK				STREET ADDRESS, CITY, STATE, ZIP CODE  3540 THREE LITTLE BAKERS BLVD  WILMINGTON, DE 19808					
(X4) ID PREFIX TAG			ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 695	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F6			fucted If If If Ind If Ind If Ind If Ind If If Ind If			

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
085054		B. WING		C		
NAME OF I	PROVIDER OR SUPPLIER	000004	D. WING	CTREET APPRECA OITY OTATE TIP CORE	02/17/2025	
NAME OF	-NOVIDER OR SUFFLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CADIA R	EHABILITATION PIKE	CREEK		3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	
F 695	Continued From page 12		F 6:	Therapy/designee will audit resider have a tracheostomy to ensure that tracheostomy and oral care have be provided as ordered and document. The audit process will be conducted times weekly until compliance is consistently reached 100% of the tracked to the followed by audits performed on week until compliance is consistent achieved over three consecutive will be consistently, a monthly audit will be constituted to determine on-going compliance. compliance is not achieved, reassessment of ongoing issues an corrective action will be taken. If compliance is achieved, corrective measures will be noted as success results will be brought through the of meetings.	t een eed. d three me is will ce a tly eeks. lucted If	
SS=D	CFR(s): 483.50(a)(2) §483.50(a)(2) The f (i) Provide or obtain	,,,,,	F 77	73	4/7/25	
	practitioner or clinical accordance with Star practice laws.  (ii) Promptly notify the physician assistant, nurse specialist of law outside of clinical rewith facility policies notification of a pracephysician's orders.	al nurse specialist in ate law, including scope of the ordering physician, nurse practitioner, or clinical aboratory results that fall ference ranges in accordance				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		085054	B, WING			C 02/17/2025	
			3, ,,,,,,		STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	1772025
NAME OF I	PROVIDER OR SUPPLIER						
CADIA R	EHABILITATION PIKE	CREEK	- 1	_	540 THREE LITTLE BAKERS BLVD		
				٧	VILMINGTON, DE 19808		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 773	Continued From pa	age 13	F 7	73			
F 773			F 7	773	1. R1 no longer resides in the facili was not negatively impacted by this deficient practice. 2. All residents who have a physici order to obtain laboratory services the potential to be impacted by this deficient practice. Further residents protected from this deficient practice measures outlined in section 3. 3. A facility wide sweep of all reside who have a physician's order to oblaboratory services was completed ensure that the laboratory services obtained per physician's orders an results were received. No other reswere affected by this deficient practic was determined that the nursing management team failed to ensure the physician ordered laboratory sewere obtained, and results were rethe physician ordered laboratory sewere obtained, and results were rethe Staff Developer/designee will the nursing management team on ensuring that laboratory services a obtained per the physician's order, the results are received. 4. The Director of Nursing/designe audit ten random residents who had order to obtain laboratory services ensure that the laboratory services obtained per the physician's order results are received. The audit process will be conducted times weekly until compliance is	an's have so will be be by ents tain to were do sidents tice. ed, and ethat ervices ceived. educate re and e will ve an to are and the dothree dothree dothree dothree	
		ppra Levels every night shift arting on the 25th"			consistently reached 100% of the t during three consecutive audits. The be followed by audits performed or	nis will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		085054	B. WING			C 02/47/2025		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
CADIA REHABILITATION PIKE CREEK				3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808				
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 773	page			73	-4			
	Lab draw was scheduled for 10/25/24 on the 11-7 shift. R3's clinical records (lab records) documented that the labs were drawn on 10/28/24.			week until compliance is consi achieved over three consecutive Finally, a monthly audit will be to determine on-going compliance is not achieved,	ve weeks. conducted			
	2/12/25 11:00 AM - A review of R3's clinical records failed to show evidence of the antiseizure medications laboratory results from 10/28/24. During an interview, E3 (Unit Manager) stated, "I will check for the results." E3 confirmed with the Surveyor that the lab results were not available in R3's clinical record.			reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.  F773 #2				
		Phenobarbital results of 33.2 uploaded into R3's clinical		R3 still resides in the facility was drawn on February 13, 20 was within normal limits.				
	The clinical record for Keppra was obt	lacked evidence that the labs ained.		2. All residents who have a phy order to obtain laboratory servi the potential to be impacted by	ces have			
	that the lab results	- R3's clinical record revealed were reviewed by the NP onths after the labs were		deficient practice. Further reside protected from this deficient promeasures outlined in section 3. A facility wide sweep of all rewho have a physician's order to	lents will be actice by esidents			
		obtain antiseizure sults per physician's orders for agnosis of seizure disorder.		laboratory services was comple ensure that the laboratory serv obtained per physician's orders results were received. No othe	eted to ices were and			
	with E3 (CNO.)	- Findings were confirmed		were affected by this deficient   A root cause analysis was condit was determined that the nurs	ducted, and ing			
	the exit conference	Findings were reviewed during with E1 (NHA), E2 (DON), E3 Nurse) and E11 (Corp.		management team failed to en the physician ordered laborator were obtained per physician's cresults were received. The Star Developer/designee will educa licensed nursing staff on ensur laboratory services are obtained	ry services orders and ff te the ing that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		085054	B. WING			C <b>02/17/2025</b>		
NAME OF PROVIDER OR SUPPLIER  CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE  3540 THREE LITTLE BAKERS BLVD  WILMINGTON, DE 19808					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF COR IX (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE	
F 773	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	physician's order and the rescreceived.  4. The Director of Nursing/de audit ten random residents worder to obtain laboratory seensure that the laboratory seensure that the laboratory seensults are received.  The audit process will be contimes weekly until compliant consistently reached 100% of during three consecutive audits be followed by audits perform week until compliance is conachieved over three consecutived in a monthly audit will be to determine on-going complicompliance is not achieved, reassessment of ongoing iss corrective action will be taked compliance is achieved, corresults will be brought through meetings.	esignee /ho have rvices to rvices to rvices order and aducted e is f the tillits. The need on sistent tive we e cond iance. ues and n. If ective iccessi	e will ve an to are and the d three is will ce a dly eeks. lucted If		