

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2025
NAME OF PROVIDER OR SUPPLIER Cadia Rehabilitation Renaissance		STREET ADDRESS, CITY, STATE, ZIP CODE 26002 John J Williams Highway Millsboro, DE 19966	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, it was determined that the facility failed to report an allegation of abuse to the state agency for one of one resident (R15) reviewed for abuse.</p> <p>Findings include:</p> <p>A facility policy titled Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime, revised January 12, 2023, indicated, .Allegations of resident abuse shall be reported to the appropriate state regulatory authority within two hours .the named person accused of the act will be immediately suspended pending outcome of the investigation .</p> <p>Review of R15's clinical record revealed:</p> <p>1/15/25 - R15 was admitted to the facility with diagnoses including Alzheimer's disease and Dementia with unspecified severity of behavioral disturbance.</p> <p>1/21/25 - An admission MDS documented a BIMS score of 00, indicating R15 was severely cognitively impaired.</p> <p>5/16/25 at approximately 9:10 PM - A facility investigation documented that E8 (CNA) informed E11 (LPN, supervisor) that E10 (CNA) had pushed R15. E11 instructed E8 to write a statement and place it under the DON's door.</p> <p>5/29/25 1:55 PM - During a telephone interview, E8 stated she saw E10 in the doorway between two units. E8 reported that R15, who wears a wander guard bracelet and frequently sets off the alarmed door, was grabbed by E10, turned around, and pushed.</p> <p>5/30/25 8:50 AM - During a telephone interview, E9 (CNA) stated she witnessed E10 push R15 away from the door. E9 wrote a statement and was also told by E11 to place it under the DON's door.</p> <p>5/30/25 9:05 AM - During an interview, E7 (RN/UM) stated she was on call on 5/17/25. Upon arriving at the facility, she was informed of the incident by E8. E7 notified E2 (DON), who arrived at the facility at approximately 3:00 PM and began an investigation.</p> <p>5/30/25 9:10 AM - During an interview, E2 (DON) stated she became aware of the incident the previous evening and came to the facility the next day (Saturday) to investigate. E2 stated, I didn't know it wasn't reported.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5/30/25 approximately 2:00 PM - During a telephone interview, E11 confirmed that E8 had reported the allegation to her and that she instructed E8 to write a statement and leave it under the DON's door. E11 acknowledged she had not read the statement and did not report the allegation to the state agency. E11 further confirmed that the accused staff member was allowed to continue working on the unit.</p> <p>5/30/25 3:02 PM - During an interview, E10 (CNA) stated he was sitting between the units and continually redirecting R15. E10 stated, I didn't push him. I was trying to re-direct him away from the door.</p> <p>There was no evidence the facility reported R15's allegation of abuse.</p> <p>6/2/25 2:45 PM - Findings were reviewed with E1 (NHA), E2, E3 (CNO), and E4 (COO) during the exit conference.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on observation, interview, and record review, it was determined that for one (R15) out of one resident reviewed for abuse, the facility failed to protect residents by not suspending the accused staff member pending the outcome of the investigation. Findings include:</p> <p>A facility policy titled Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime, revised January 12, 2023, indicated, .Allegations of resident abuse shall be reported to the appropriate state regulatory authority within two hours .the named person accused of the act will be immediately suspended pending outcome of the investigation .</p> <p>Review of R15's record revealed:</p> <p>5/16/25 at approximately 9:10 PM - A facility investigation documented that E8 (CNA) informed E11 (LPN, supervisor) that E10 (CNA) had pushed R15. E11 instructed E8 to write a statement and place it under the DON's door.</p> <p>5/17/25 - The facility provided investigation packet documented the following: a statement written by E10 accused, wrote the accusation of rough is untrue. statement written by E18 (RN part time supervisor) wrote R15 was thoroughly checked by from head to toe and there were no bruising/skin issues noted. statement written by E11 wrote that at the time of the incident she was providing care to a resident on another unit and remembers E8 telling her about the allegation. Interviews and skin checks performed on R15 and the other residents that were assigned to E10 the evening prior by E2. No issues or concerns were noted.</p> <p>5/30/25 - at approximately 2:00 PM - During a telephone interview, E11 confirmed the accused was not immediately suspended pending outcome of the investigation.</p> <p>5/30/25 9:10 AM - During an interview, E2 (DON) stated she was made aware of the incident the following day and went to the facility to conduct an investigation about the allegation of abuse. E2 stated I completed the investigation, E10 wasn't suspended because it was determined there was no abuse. E10 was allowed to continue to work his scheduled shifts providing resident care the remainder of the shift on 5/16/25 following the allegation without suspension and continues to work at the facility.</p> <p>6/2/25 2:45 PM - Findings were reviewed with E1 (NHA), E2, E3 (CNO), and E4 (COO) during the exit conference.</p>