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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Renaissance	26002 John J Williams Highway Millsboro, DE 19966

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview it was determined that for one (R123) out of four residents reviewed for abuse the facility failed to ensure an allegation of misappropriation of resident property was reported to the state agency within the required time frame. Findings include: 1. The facility policy on abuse last updated January 3, 2025, indicated, All alleged incidents involving misappropriation shall be reported to the NHA/designee immediately .Incidents involving reasonable suspicion of criminal conduct are reported to the applicable state agency within eight hours or withing two hours if the conduct causes serious bodily harm. 1. Review of R123's clinical record revealed: 7/20/25 11:30 AM - A statement written by E12 (LPN) documented, At 10:45 AM I counted .however six [purple tablets] were missing. I recognized the discrepancy. Nursing supervisor [E9 (RN)] was immediately made aware, and she immediately made E2 (former DON) aware. 8/7/25 - E2 (former DON) submitted an incident report to the state agency that alleged [R123] bought in home medications upon admission .six purple pills noted on count sheet. It was noted that the six purple pills were missing. The incident report documented that the incident occurred on 7/19/25 nineteen days prior to the day the allegations were reported. 8/21/25 11:36 AM - During an interview, E9 (RN supervisor) stated, On July 20th on a Sunday and [E12(LPN)] said the count was incorrect, she said the six purple pills weren't there. E9 then confirmed that she notified E2 (DON) and that E2 was the person responsible for reporting. 8/21/25 11:45 AM - During an interview, E2 (former DON) confirmed recognizing the incident as an allegation of misappropriation of resident property and stated, I was delayed in reporting it because I was doing the investigation. 8/21/25 12:59 PM - During an interview, E1 (NHA) confirmed the delayed reporting. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (CO), and E11 (CNO) during the exit conference.

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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview, and record review it was determined that for two (R118 and R120) out of nine residents sampled for discharge and hospitalization the facility failed to send the required notification to the Ombudsman of transfer discharge. Findings include:1. A review of R118's clinical record revealed: 6/16/25 - R118 was admitted to the facility with diagnoses including complete obstruction of the intestines and acute kidney failure. 7/22/25 10:55 AM - Review of R118's progress note documented R118 was admitted to the hospital. 8/22/25 12:20 PM - During an interview E17 (SW) reported the Ombudsman was notified quarterly of resident discharges and transfers. E17 then stated, I was out on medical leave, and my assistant was not sending them out so now I am sending it out for July and August prior to me going out on medical leave I was sending them out monthly. Surveyor requested documentation of required notification for the previous months. 8/22/25 1:15 PM - E11 confirmed the required notification of R118's transfer to the hospital was not submitted to the Ombudsman. 2. A review of R120's clinical record revealed: 4/14/25 R120 was admitted to the facility with diagnoses including lower back stress fracture and left rib fracture. 7/23/25 - R120's clinical record documented R120 was discharged to home. 8/22/25 12:20 PM - An interview with E17 (SW) revealed there was no notification to the Ombudsman for R120's planned discharge to home from the facility. 8/22/25 1:15 PM - E11 (CNO) confirmed that the required notification to the Ombudsman for R120's discharge to home was not sent. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview, and record review it was determined for one (R10) out of four residents sampled for PASARR review the facility failed to ensure a referral for a new PASARR Level I and II screening occurred by or before the sixth (60) day. R10 remained in the facility beyond the authorization time frame. Findings include:Review of R10's clinical record revealed: 6/5/25 - A review of R10's Notice of PASARR Level I Screen Outcome documented PASARR Level Determination Convalescence Categorical Approval Period 60 days. Suspected or confirmed PASARR Condition(s): (MH) Mental Health Disability. A 60 day or less stay in the NF is authorized rescreening must occur by or before the 60 days if the individual is expected to remain in the NF (Nursing Facility) beyond the authorization timeframe. 6/12/25 - R10 was admitted to the facility with diagnoses including but not limited to post traumatic stress disorder and anxiety. 8/22/25 10:02 AM - An interview with E17 (SW) confirmed R10's PASARR rescreening had not been submitted. E17 stated, I thought [R10's] approval was for ninety (90) days, so it needs to be submitted I'll initiate it. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review it was determined for one (R37) out of two residents sampled for care plans the facility failed to develop and implement a comprehensive person-centered care plan to address R37's refusal to wear a splint/brace for right hand/wrist contractures. A review of R37's clinical record revealed: 1/2/24 - R37 was admitted to the facility with diagnoses including but not limited to stroke and right-side weakness. 1/3/24 - A review of R37's orders documented splint/brace/device see RNP task for details. 10/8/24 - A review of R37's care plan for actual contractures and potential for further contractures related to decreased mobility, right spastic hemiplegia (stiff muscles and poor motor control) following stroke revealed the intervention resting right hand splint initiated 2/19/24. Review of R37's care plan lacked evidence of the resident refusing to wear the splint. 8/20/25 9:53 AM - E19 (CNA) was interviewed and reported R37 had weakness to the right arm but had never seen or known R37 to have a worn a splint. 8/20/25 2:00 PM - During an interview E18 (LPN) reported and stated, [R37] does not wear the splint [R37] always refuses to wear the splint. In addition, E18 confirmed R37 had not been care planned for refusing to wear the splint. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review it was determined that for one (R37) out of four sampled residents reviewed for ADL(s) the facility failed to provide nail care. Findings include: Review of R37's clinical record revealed: 1/2/24 - R37 was admitted to the facility with diagnoses including a stroke and right-side weakness. 4/1/25 - R37's care plan for self-care deficit documented assist with daily hygiene, eating, toileting, dressing, grooming and oral care as needed. R37's care plan lacked evidence of refusing nail care. 6/25/25 - A quarterly MDS assessment revealed R37 required moderate assistance for personal hygiene and grooming. 8/18/25 9:50 AM - An observation of R37's fingernails on both hands were very long with dark encrusted debris underneath each fingernail. 8/19/25 10:42 AM - A second observation revealed R37 had not been provided nail grooming. 8/20/25 9:34 AM - A third observation of R37's nails on both hands remained long in length with dark encrusted debris under the nails on both hands. 8/21/25 9:53 AM - A fourth observation revealed R37's nails were still long with dark debris underneath all fingernails on both hands. 8/21/25 10:16 AM - During an interview, E19 (CNA) confirmed that according to the shower record that R37 should have received nail care on 8/17/25 during the 3:00 PM to 11:00 PM shift. 8/21/25 2:05 PM - During an interview and observation E18 (LPN) confirmed R37's nails needed to be cut, filed and cleaned. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review it was determined for one (R37) out of three residents sampled for range of motion and mobility, the facility failed to provide a right wrist splint to prevent contractures for R37. Findings include: A facility policy titled Range of Motion Contracture Management revised 1/2/25 documented . To prevent the decline in range of (ROM), influencing a resident's ability to participate in functional activities Cross Refer F657 A review of R37's clinical record revealed: 1/2/24 - R37 was admitted to the facility with diagnoses including but not limited to stroke and right-side weakness. 1/3/24 - R37's documented splint/brace/device see RNP task for details. Review of the RNP task sheet revealed [R37's] splint is to be applied on the 7AM-3PM, 3PM-11PM and the 11PM-7AM shifts. 10/8/24 - R37's care plan for actual contractures and potential for further contractures related to decreased mobility, right spastic hemiplegia (stiff muscles and poor motor control) following stroke revealed the intervention resting right hand splint initiated 2/19/24. 2/25/25 - The facility range of motion assessment revealed R37's right wrist range was severe reduced range of motion reduction attributed to actual contracture and tone. 8/18/25 11:14 AM - R37 was observed lying in bed. R37's splint for the right/wrist and hand was laying in the resident's wheelchair. 8/19/25 10:00 AM - A second observation revealed R37 was in bed and was not wearing a splint. The splint was observed laying on R37's wheelchair. 8/20/25 9:53 AM - During an interview E19 (CNA) stated, since I have been working here, I have never seen [R37] with a brace I know that [R37's] is right arm is weak, but I have never seen him with a brace. 8/20/25 11:13 AM - R37's RNP task for splint placement was documented by E19 CNA that the splint had been applied. R37 was not wearing the splint during this observation. 8/20/25 11:15 AM - R37 was not wearing a splint to the right hand. R37's splint was laying on the wheelchair. 8/20/25 1:55 PM - R37 was not wearing the splint to the right hand. R37's splint was laying on the wheelchair. 8/20/25 2:00 PM - During an interview E18 (LPN) reported and stated, [R37] does not wear the splint. E18 reported [R37] always refuses to wear the splint. 8/21/25 2:05 PM - During the interview E18 observed and confirmed R37's splint was sitting on the wheelchair. E18 picked up the splint and applied it to R37's right wrist. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview it was determined that the facility failed to ensure accuracy of the medication reconciliation documentation for a controlled drug. Findings include: 8/3/25 - A controlled drug administration record for R123 documented that the facility received thirty morphine capsules from the pharmacy. 8/5/25 - The controlled drug administration record for R123's morphine revealed that E12 (LPN) administered one of the capsules to R123 and documented that twenty-nine capsules remained. 8/6/25 - The controlled drug administration record for R123's morphine indicated that E12 (LPN) witnessed E13 (RN) destroy a remaining amount of twenty-four of R123's morphine capsules. The controlled drug administration record had previously documented a remaining amount of twenty-nine capsules, a five-capsule deficit. The clinical record and drug administration record lacked clarification to account for the five-capsule deficit. 8/20/25 1:38 PM - During an interview, E11 (CNO) stated that the facility had not identified any medication reconciliation discrepancies regarding medications received from the pharmacy for R123. 8/20/25 1:45 PM - During an interview, E12 (LPN) denied knowledge of the five capsule deficit documented on the controlled drug medication administration record for R123's morphine capsules. When shown the record, E12 confirmed witnessing the destruction of the medications, and stated I don't remember there being an error. 8/20/25 1:53 PM - During an interview, E13 (RN) confirmed his signature on the controlled drug medication administration record for R123's morphine capsules. E13 confirmed the five capsule discrepancy and stated, I think it's just a typo. 8/20/25 2:26 PM - During an interview E11 (CNO) confirmed the discrepancy on the controlled drug administration record for R123's morphine and stated, it was a clerical error. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, it was determined for two (R20 and R61) out of five sampled residents for unnecessary medications, the facility failed to document a rationale for disagreeing on a monthly medication regimen review (MRR) recommendations. The Findings include:1.7/6/25 – R20 was admitted to the facility. The following recommendations were unanswered with a rationale: 12/31/24 – The pharmacist recommended: Could Trazodone GDR be considered with an insomnia diagnosis? The provider checked disagree, but no rationale was documented. 1/29/25 – The pharmacist noted: Clonazepam 0.5 mg tab order omits 0.5 mg tab = 2.5 mg. Neither agree nor disagree was selected, but documentation was noted. 3/30/25 – The pharmacist recommended: Could clozapine GDR be considered? Disagree was checked, but no rationale was documented. 4/28/25 – The pharmacist suggested monitoring for ASA/Clopidogrel for bruising/bleeding. Disagree was checked, with no rationale provided. 5/4/25 – The pharmacist recommended: Please evaluate resident tolerability to Amoxicillin with penicillin allergy. Please evaluate resident tolerability to Aspirin with Excedrin allergy. Neither agree nor disagree was selected, but documentation was noted. 7/6/25 – The pharmacist recommended: Please evaluate resident tolerability of Aspirin with allergy to Excedrin, and please clarify diagnosis of 'psych disorder' per CMS. There was no documentation from the provider in response. 7/25/25 – The pharmacist recommended: 7/6 olanzapine psyche disorder dx will trigger MDS inappropriate use on the quality indicator report. Please review dx and usage in considering a GDR. Risk vs. benefit analysis suggested with methocarbamol per Beers. Neither agree nor disagree was checked, but no rationale was documented. 8/22/25, 10:02 AM – During an interview, E7 (NP) confirmed she reviews the pharmacist's recommendations. E7 stated she consults the pharmacist when a GDR is suggested. For psychiatric medication changes, she contacts E27 (Psych NP) to discuss whether changes are appropriate. E7 also confirmed that when a provider disagrees with a recommendation, a rationale should be documented. 8/22/25, 2:25 PM – During an interview, E11 (CNO) confirmed that the facility attending physician failed to document the action taken or not taken in response to identified irregularities. 2.Review of R61's clinical record revealed: 10/13/23 – R61 was admitted to the facility. 7/1/25 - A MRR for R61 documented, lorazepam that a dose reduction GDR be considered. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/1/25 – A MRR for R61 documented lorazepam 0.5 mg tab by mouth two times a day, should be considered for GDR. There was no rational documented. 8/22/25 10:15 AM - During an interview with E7, (NP) stated she reviews the monthly GDR recommendations. E7 discusses the findings with the psychiatric nurse practitioner. E7 then documents her rationale on the pharmacy GDR form and in the electronic medical record. 8/22/25 1:45 PM - During an interview, E3 (DON) stated that quarterly reviews of the Medical Record Review (MRR) are conducted. Following these reviews, the findings are discussed with the medical director. E3 confirmed that the medical director did not include a rationale for lorazepam. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined that for two out of three medication carts reviewed the facility failed to ensure opened medications were labeled with an open date. For one out of three medication carts reviewed the facility failed to ensure that insulin was stored in accordance with manufacturer's instructions regarding temperature. Lastly, the facility failed to ensure that medications in the facility were labeled in accordance with currently accepted professional principles when they accepted and stored unidentifiable medications then failed to ensure safe and secure storage of those medications. Findings include: 1a. 7/13/25 - A controlled substance record was created for R123 by E23 (RN) and E24 (RN) that documented six purple pills were received from R123. 7/20/25 11:30 AM - A statement written by E12 (LPN) documented, At 10:45 AM I counted .however the six [purple tablets] were missing. I recognized the discrepancy. Nursing supervisor [E9 (RN)] was immediately made aware, and she immediately made E2 (former DON) aware. 8/7/25 - E2 (former DON) submitted an incident report to the state agency that alleged [R123] bought in home medications upon admission .six purple pills noted on count sheet. It was noted that the six purple pills were missing. 8/20/25 1:38 PM - During an interview, E11 (CNO) stated We implemented a new medication from home sheet for counting medications from home. They are counted then placed into the cart until the DON takes possession, then they are counted again and placed in the locked drawer in the DON office. E11 stated that E2 (former DON) was interviewed regarding the six missing tablets and that E2 reported she may have left the keys on her desk at times. 8/20/25 2:01 PM - During an interview, E24 (RN) confirmed that R123 bought in six purple pills to the facility. E24 stated, E23 (RN) asked me to be a witness. R123 had multiple bottles of medications. After a few days we got tired of counting them and we gave them to [E2 (former DON)]. 8/21/25 11:45 AM - During an interview, E2 (former DON) denied knowledge of the whereabouts of the missing six purple pills. E2 stated, The staff bought me meds in a Ziplock bag inside was pill bottles and said that her family would pick them up. I put them in my drawer and locked them up. I never counted them. Later the staff said they [R123's family] wanted them and came in on a Saturday to get them but they didn't get them. At no time did I touch the pills, open them, or count them I just locked them in my office drawer. When [E12 (LPN)] returned them, she said there was some purple pills missing. I asked [E12] for a statement. She did verbally tell me there were purple pills in the bottle and they were not there at that point. Everyone has access to my office. My keys are always in my top desk drawer so anyone can go in. So, what happened to the pills I have no clue. The six purple pills bought to the facility from home by R123 were stored by the facility. The facility was unable to safely secure the medications as evidenced by the medications were unable to be located as of 7/20/25. 1b. 7/13/25 - A controlled substance record was created for R123 by E24 (RN) who hand wrote Morphine 30 mg six purple pills were received from R123. 8/20/25 1:45 PM - During an interview, E12 (LPN) confirmed visualizing the medications accepted and stored by the facility from R123 and that the six purple pills were unlabeled. E12 stated, There were three bottles of Percocet, and one bottle had six morphine mixed in with the Percocet. When asked how staff identified the six purple pills, E12 stated, By visually identifying and at the time she was on the same medication from the pharmacy, same color and size. 8/20/2025 2:01 PM - During an interview, E24 (RN) confirmed the facility accepted and stored unlabeled medications from R123. E24 stated, I believe it was all labeled oxy but [R123] had a card of morphine from our pharmacy, and we visually matched the six purple pills and they were an identical match when we looked at them. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/20/25 2:26 PM - During an interview, E11 (CNO) confirmed the facility accepted and stored unlabeled medications from R123. E11 stated, we can't assume what they [the medications] are but we can't get rid of them because they are the residents property. 8/21/25 11:32 AM - During an interview, E25 (LPN) confirmed the facility received and stored six purple pills from R123. E25 stated, There were six purple pills mixed in with the bottle of oxycodone. We took them for safety; we counted the medications in front of [R123]. When asked how staff determined what the six purple pills were due to the bottle being unlabeled E25 stated, [R123] was cooperative and telling us what the medication was. The facility accepted and stored unidentifiable/unlabeled medication as evidenced by the acceptance of six purple pills not in their original container received from R123. 2. 8/19/25 10:48 AM - During inspection of a [NAME] unit medication cart, one opened bottle of aspirin, and one opened bottle of Colace were observed without open dates. E21 (LPN) immediately confirmed the finding. 8/19/25 12:27 PM - During inspection of a [NAME] unit medication cart, one opened bottle of aspirin, and one open bottle of Tylenol were observed without open dates. E16 (LPN) immediately confirmed the finding. 8/19/25 3:03 PM - During inspection of a Rehoboth unit medication cart, an unused Humalog insulin pen was observed in a medication cart. The pharmacy labeled the insulin pen with manufacturer's instructions that directed the insulin pen to be refrigerated until opened. E24 (RN) immediately confirmed the finding. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on record review and interview, it was determined that for one (R106) out of one resident reviewed for lab services, the facility failed to promptly notify the ordering medical practioner of abnormal laboratory results. Findings include:Review of R106's clinical record revealed: 6/6/25 - R106 was admitted to the facility. 7/10/25 5:50 AM - A nursing progress note documented for R106 that a urine sample was collected and a dipstick resulted in positive blood and leukocytes. The nursing note further documented that a lab order to do urinalysis (UA) and culture and sensitivity (C&S) was placed, waiting to be picked up and that the NP was notified in the book. 7/10/25 12:01 PM - A physician's progress note documented that R106 complained of burning with urination, an in-house urine dipstick was positive for blood and leukocytes, and the lab picked up the urine in the morning, awaiting a culture and sensitivity. 7/12/25 1:19 PM - The lab results revealed the urine culture was positive for a urinary tract infection (UTI) with a positive growth of greater than 100,000 colony forming units of Escherichia coli (a type of bacteria). 7/12/25, 7/13/25 and 7/14/25 - The clinical record lacked evidence that R106's UTI was addressed for three days after the positive results were available. 7/15/25 11:34 AM - A physician's order was written for cefuroxime axetil (antibiotic) 500 mg, give 500mg by mouth stat for UTI. 7/15/25 9:00 PM - The medical administration record for R106 documented cefuroxime as not available. 7/16/25 9:00 AM - The medical administration record for R106 documented cefuroxime as administered. 7/16/25 9:54 AM - A nursing progress note documented for R106 that the pharmacy did not process the cefuroxime due to a resident's allergy. Two doses of cefuroxime were sent to a local pharmacy for the facility to pick up.There was an additional one day delay making it four days before the urine culture results were reviewed and R106 received antibiotics. 8/22/25 10:10 AM - During an interview, E22 (LPN) stated that the outside lab urine culture results are automatically uploaded into a resident's chart, and staff need to be aware to keep checking the chart for the results. When the results appear in the chart, they notify the provider. 8/22/25 10:15 AM - During an interview, E18 (LPN) stated that the outside lab will call the facility for a positive lab result and during weekend hours, the facility will contact the on-call provider. 8/25/25 11:23 AM - During an interview, E23 (UM) stated that the outside lab urine culture results are uploaded to the resident's charts. The outside lab generally does not call for positive urine culture results. E23 confirmed that there was a delay in notifying the provider about the culture results for R106. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Renaissance	26002 John J Williams Highway Millsboro, DE 19966

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and review of facility documents it was determined that the facility failed to ensure dishes and utensils were cleaned under sanitary conditions. Additionally, the facility failed to ensure cleanliness of food storage areas and properly store items in facility unit refrigerators. Findings include: 1. 8/19/25 9:36 AM - 9:41 AM - During a follow up visit to the kitchen, the dish washer was observed as having a water temperature of 135 degrees during the wash cycle. The digital screen that displayed the dish cycle temperatures, flashed red and [alarmed] kitchen staff that the temperature was below 150 degrees. 8/19/25 9:43 AM - During an interview, E15 (FSD) confirmed the wash cycle for the temperature did not meet the minimum 150 degrees. E15 stated, I just saw the alarm, so I went and talked to maintenance, and they think one of the boilers temperatures was turned down. 8/19/25 10:00 AM - Review of the facilities dish machine temperature logs revealed the following dates when dish washing temperatures failed to meet the minimum of 150 degrees:June 2025 - 6/5, 6/26 and 6/29.July 2025 - 7/5, 7/11, 7/15, 7/16, 7/27 and 7/28.August 2025 - 8/1, 8/2, 8/3, 8/8, 8/9 and 8/14. 8/19/25 11:26 AM - During an interview, E15 (FSD) confirmed the temperature logs and stated that they had a contractor out on 8/12/25 and the temperatures met requirements that day. 2. 8/19/25 10:35 AM - During inspection of the facilities unit refrigerators a plastic food storage container that contained rice and broccoli was observed on the shelf, unlabeled and undated. The finding was immediately confirmed by E14 (unit clerk). 3. 8/19/25 11:23 AM - During a follow up visit to the kitchen, an area of fuzzy, black spotted substance was observed on the wall surrounding the light switch of the dry storage room. E15 (FSD) immediately confirmed the finding. 8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (COO) and E11 (CNO) during the exit conference.