STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085054	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Pike Creek	3540 Three Little Bakers Blvd Wilmington, DE 19808

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure residents either had an advanced directive in place or failed to provide the residents and/or their resident representatives (RR) written information of the right to accept or refuse medical or surgical treatment and/or formulate an advance directive for four of 13 residents (Resident (R) 9, R77, R6, and R161) reviewed for advanced directives out of a total sample of 55 residents. This failure created the potential the residents' wishes would not be followed if the residents were unable to speak for themselves. Findings include:1. Review of R9's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R9 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of R9's EMR revealed no documentation that R9 had an advance directive or that the facility provided written information to the resident, or the resident representative (RR) concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. 2. Review of R77's admission Record, located under the Profile tab of the EMR, revealed R77 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of R77's EMR revealed no documentation that R77 had an advance directive or that the facility provided written information to the resident, or the RR concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. During an interview on 05/14/26 at 8:40 AM, the Administrator stated, I don't have any record of them being given information about advance directives, only that it was discussed. 3. Review of R6's admission Record, located under the Profile tab of the EMR, revealed R6 was admitted to the facility on [DATE]. Review of the Social Services Assessment, dated 03/31/26, provided by the Administrator, revealed the section titled Advance Directives was incomplete and did not indicate whether the family was offered or desired assistance formulating an advance directive. During an interview on 05/14/26 at 8:40 AM, the Administrator stated that the Social Service Assessment did not indicate whether the resident had an advance directive or whether the family would like assistance to formulate one. The Administrator indicated that she spoke with the Social Worker (SW) who stated that he spoke to the resident's family member regarding advance directives, and that the family was unsure if the resident had one and would look into it, and that he planned to follow up with the family during the next care conference. The Administrator indicated that they (continued on next page)

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needed to improve their process to obtain advance directives and help formulate one when they did not have one. During an interview on 05/14/26 at 1:30 PM, the Social Worker (SW) stated that R6 was non-verbal and that on 03/31/26, while completing the Social Services Assessment, he asked the family whether R6 had an advance directive, power of attorney, or living will. The family said they were unsure. The SW further stated that he asked whether they wanted information on how to establish one, but they stated that they were unsure. The SW acknowledged that he did not provide the family with information on how to create an advance directive or document the conversation because he became sidetracked when the family expressed greater concern about getting the resident back home. The SW also stated that R6 was in a vegetative state and was unlikely to be discharged home due to the level of care required. 4. Review of Resident 161's admission Record, located under the Profile tab of the EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, Multiple Sclerosis, acute and chronic respiratory failure, paraplegia, and a need for assistance with personal care. The EMR further indicated the resident's code status as Full Code. Review of the admission Documentation, located under the Profile Summary tab in the EMR confirmed the resident's code status was documented as Full Code, and the Advanced Directive section was marked as completed. However, the facility was unable to provide supporting documentation demonstrating that the resident was informed of advanced directives or provided education regarding advanced directive rights at the time of admission or thereafter. During an interview on 05/12/26 at 2:24 PM, the Administrator indicated that advance directive information was typically provided during the admission process; however, staff were unable to produce documentation or provide specific confirmation that R161 or the resident representative were educated on advance directives or offered the opportunity to complete or review such documentation. Review of the facility's policy titled, Advance Directives, dated 01/07/26, revealed, . Policy: It is the policy of Cadia Healthcare to offer residents assistance with creating or modifying Advance Directives. Purpose: To establish a process for education and informing residents of their right to create, modify, or revoke an Advance Directive. Procedure: Prior to or upon admission, the facility will identify if the resident has or wishes to create an advance directive. A resident has the option to execute an advance directive if he/she does not have one but will not be required to do so. Further review of the policy revealed the policy failed to document the facility providing written information to the residents, or the resident representative concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 facility policy review, the facility failed to ensure kitchen staff thoroughly cleaned and air-dried pots and pans prior to storage. In addition, the facility failed to ensure staff with facial hair wore a beard guard for facial hair. These failures increased the risk of foodborne illness by allowing wet pots and pans to be stored before fully drying and by failing to cover facial hair. This had the potential to affect 103 of the 152 residents receiving dietary services. Findings include:During an observation and interview on 05/11/26 at 9:30 AM, [NAME] (C) 1 was observed prepping food for lunch. C1 was observed to have a goatee that was approximately 0.25 – 0.50 inches in length and was not wearing a beard guard. C1 stated, I didn't think it was long enough to need to be covered. The Regional Food Service Director (RFSD) was present at the time and confirmed C1 was not wearing a beard guard and provided him with one. During an observation and interview on 05/11/26 at 9:35 AM, the Food Service Director (FSD) confirmed two pans, 6 inches by 12 inches by 4 inches; seven pans, 6 inches by 6 inches by 6 inches; five pans, 12 inches by 18 inches by 3 inches cleaned and stacked for use, were still wet. The pans had been stacked while still wet and were not given adequate time to air-dry before stacking. The FSD stated, They [pans] should be dry before they are stacked for use. Being wet increases the risk of contamination. Review of the facility's policy titled, Personnel Adherence to Sanitary Procedures, dated 01/07/26, revealed, Policy: . food services and dietary personnel will be required to adhere to the following sanitary standards. a. Hair nets, caps, beard nets, approved hats, or other effective hair restraints which cover all of the hair, must be worn at all times while on duty in order to keep hair from contacting food and food contact surfaces . Review of the facility's policy titled, Washing Pots and Pans, dated 01/07/26, revealed, . Remove pots and pans from sanitizer and place on drying rack in dish room to air dry. Remove pots and pans in dish room after they dry and move to pan rack in kitchen .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to ensure ordered pressure ulcer treatments were completed and/or newly identified skin changes were reported for three of five sampled residents (Resident (R) 182, R37, and R20) reviewed for pressure ulcers out of a total sample of 55. Failure to complete wound treatments as ordered and report changes in skin integrity placed the residents at increased risk of infection and wound deterioration. Findings include:Findings include: 1. Review of R182's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R182 was admitted to the facility on [DATE]. R182's pertinent diagnoses included spinal muscular atrophy, pneumonia, acute and chronic respiratory failure with hypoxia, severe sepsis with septic shock, severe protein-calorie malnutrition, hypotension, polyneuropathy, and generalized muscle weakness. Review of R182's 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/26/25 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. The resident did not exhibit behaviors or rejection of care during the review period. R182 required total dependence on staff for bed mobility, transfers, bathing, toileting, and toileting hygiene, and required substantial to maximum assistance with eating and oral hygiene. R182 was always incontinent with bowel and bladder. R182 was at risk for pressure ulcer development and had three unstageable pressure ulcers present on admission. R182 utilized pressure-reducing devices for both the bed and wheelchair and received pressure ulcer/injury care during the review period. Review of R182's Care Plan, dated 10/31/25 and located under the Care Plan tab of the EMR, revealed R182 had unstageable pressure ulcers to his left buttock, right buttock, and right great toe that were present upon admission and a reddened area to the sacrum. The pertinent interventions directed staff to administer treatments as ordered and monitor for effectiveness. Review of R182's Physician Orders, dated 10/2025 through 11/2025, located under the Orders tab of the EMR, revealed the following pertinent orders: -10/21/25: Santyl External Ointment 250 Unit/ gram (GM) (collagenase). Apply to bilateral buttocks topical one time a day for wound maintenance. Discontinued 11/12/25. -10/22/25: Cleanse left buttock with normal saline, pat dry, apply Santyl, cover with calcium alginate, and dry dressing one time day for wound maintenance. Discontinued 11/12/25. -10/22/25: Cleanse right buttock with normal saline, pat dry, apply Santyl and cover with calcium alginate and cover with a dry dressing one time day for wound maintenance. Discontinued 11/12/25. -11/03/25: Cleans sacrum with normal saline, pat dry, apply Santyl, cover with calcium alginate, and a dry dressing one time a day for skin integrity. Discontinued 11/12/25 -11/12/25: Cleanse left buttock with normal saline, pat dry, apply Silvadene, calcium alginate and cover with a dry dressing one time day for wound maintenance. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11/12/25: Cleanse right buttock with normal saline, pat dry, apply Silvadene, calcium alginate, and cover with a dry dressing one time a day for wound maintenance. -11/12/25: Cleanse sacrum with normal saline, pat dry, apply Silvadene, cover with calcium alginate, and a dry dressing one time day for skin integrity. Review of the Wound Treatment Administration Record (WTAR), dated 11/2025, located under the Orders tab of the EMR, revealed staff failed to document completion of wound treatments to R182's right and left buttock on 11/02/25 and 11/15/25, and to the sacrum on 11/15/25, as ordered. Review of R182's Progress Notes, dated 11/02/25 through 11/15/25 and located under the Progress Notes tab of the EMR, revealed no documentation indicating the ordered wound treatments to R182's right and left buttock and sacrum were completed on 11/02/25 and 11/15/25, nor was there documentation providing a clinical rational for the missed treatments. During an interview on 05/15/26 at 12:30 PM, Assistant Director of Nursing (ADON) 2 stated that R182 was admitted to the facility with multiple wounds, including the sacral wound (redness) and bilateral buttocks. ADON2 reviewed the 11/2025 WTAR and acknowledged that the wound treatments to R182's right and left buttock and sacrum were not signed off as completed on 11/02 and 11/15/25. ADON2 stated that the Unit Managers were responsible for monitoring the treatment records to ensure they were completed. ADON2 stated that if the wound treatments were not documented, then they were not done. During an interview on 05/15/26 at 12:59 PM, Unit Manager (UM) 3 stated nursing staff and leadership were responsible for monitoring the treatment records to ensure they were completed. UM3 reviewed the 11/2025 WTAR and acknowledged that the wound treatments for R182 were not signed off as completed on 11/02 and 11/15/25. UM3 stated that if the treatments were not signed off as completed, then they were not done. UM3 could not recall if the treatments for R182 were reviewed or if they identified any issues with them not being completed. 2. Review of R37's admission Record, located under the Profile tab of the EMR, revealed R37 was admitted to the facility on [DATE] and readmitted on [DATE]. R37's pertinent diagnoses included chronic respiratory failure with hypoxia, persistent vegetative state, ventilator dependent, cognitive communication deficit, non-traumatic subarachnoid hemorrhage, peripheral vascular disease, anemia, moderate protein-calorie malnutrition, hypotension, neuropathy, and generalized muscle weakness. Review of R37's quarterly MDS, with ARD of 03/11/26 and located under the MDS tab of the EMR, revealed R37 was in a vegetative state due to anoxic brain injury and was ventilator dependent. R37 was dependent on staff for assistance with all activities of daily living. R37 was always incontinent with bowel and bladder. R37 was at risk for developing pressure ulcers, had one unhealed stage 4 pressure ulcer that was present upon admission, and received pressure ulcer/injury care during the review period. Review of R37's Care Plan, last revised on 03/23/26 and located under the Care Plan tab of the EMR, revealed R37 had a stage 4 sacral pressure ulcer. The pertinent interventions directed staff to administer treatment as ordered and monitor for effectiveness. Review of the Order Summary Report, dated 02/01/26 through 05/15/26 revealed the following pertinent orders: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-02/06/26: Cleanse sacral wound with Vashe (wound solution), lightly pack with Vashe soaked gauze, cover with ABD [Abdominal pad] and secure with tape. Discontinued 02/09/26 -02/09/26: Cleanse sacral wound with normal saline, pat dry, apply hydrofera blue and cover with dry dressing one time a day every Monday, Wednesday, and Friday for wound management. Discontinued 03/30/26 -03/23/26: Cleanse sacrum with normal saline and apply alginate and dry dressing (dd) one time a day every Monday, Wednesday, and Friday for wound care. Discontinued 03/25/26 -03/25/26: Cleanse sacrum with normal saline and apply alginate and dd one time a day every Monday, Wednesday, and Friday for wound care. Discontinued 03/30/26 -03/31/26: Cleanse sacral wound with normal saline, pat dry, apply hydrofera blue and cover with dry dressing one time a day every Monday, Wednesday, and Friday for wound management. Review of the WTARs, dated 02/2026 through 05/2026 and located under the Orders tab of the EMR, revealed staff failed to document completion of ordered wound treatments to R37's sacral pressure ulcer on 02/08/26, 03/24/26, 04/08/26, and 04/17/26. Review of R37's Progress Notes, dated 02/01/26 through 05/15/26 and located under the Progress Notes tab of the EMR, revealed no documentation indicating the ordered wound treatments to R37's sacral pressure ulcer was completed on 02/0826, 03/24/26, 04/08/26, and 04/17/26, nor was there documentation providing a clinical rationale for the missed treatments. During an interview on 05/15/26 at 12:30 PM, ADON2 stated that R37 had a pressure ulcer on her sacrum and one on her left heel. ADON2 reviewed the 02/2026 through 05/2026 WTARs and acknowledged that the wound treatments to R37's sacral pressure ulcer were not signed off as completed on 02/08/26, 03/24/26, 04/08/26, and 04/17/26. ADON2 stated that if the wound treatments were not documented, then they were not done. During an interview on 05/15/26 at 6:00 PM, the Director of Nursing (DON) stated that staff are expected to document on the WTARs when they complete wound treatments. The DON stated that she was unsure if the wound nurse was off on those days or if the lack of documentation was an oversight. The DON stated that if the wound treatments were not signed off as completed, then it was not done. 3. Review of R20's Face Sheet, located under the Profile tab in the EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage, acute chronic respiratory failure, and heart failure. Review of R20's quarterly MDS, with an ARD of 05/01/26, and located in Internet Quality Improvement and Evaluation System (IQIES), revealed R20 had a BIMS score of 00 out of 15, which indicated the resident was severely cognitively impaired. It was recorded R20 was at high risk for the development of pressure ulcers and had no current skin concerns. It was recorded R20 was dependent on staff for all activities of daily living (ADLs) and required a two-person assist with a Hoyer lift for transfers. Review of the R20's Care Plan, revised on 01/28/26, and located under the Care Plan tab in the EMR, revealed interventions to prevent skin breakdown and promote skin integrity. Interventions included (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completion of Braden risk assessments, a wheelchair cushion, pressure redistribution mattress, offloading heels while in bed, and skin checks every two hours and as needed. During an interview on 05/14/26 at 1:35 PM, R20's family member (F) 1 stated after assisting with incontinence care earlier in the day (on 05/14/26), she observed a discoloration of the skin on R20's right upper buttocks. During an interview on 05/14/26 at 1:57 PM, Certified Nursing Assistant (CNA) 13 stated he was assigned to R20 and provided incontinence care at approximately 8:30 AM and again at 1:02 PM. CNA13 revealed he observed a red area on the resident's right buttock at 8:30 AM. CNA13 stated that the area appeared unchanged in size and condition during the subsequent care provided at 1:02 PM. CNA13 stated he did not report the identified new red area on the R20's right buttock to his charge nurse, as directed by facility protocol. During an interview on 05/14/26 at 4:24 PM, Unit Manager (UM) 4 confirmed CNAs were expected to report any observed skin changes. UM4 stated R20's newly identified skin change was identified at approximately 9:00 AM on 05/14/26. UM4 reviewed R20's Kardex and stated the documentation indicated no skin concerns were observed or noted. Review of a Progress Note, dated 05/15/26 at 11:57 AM and located under the Progress Notes tab in the EMR, revealed R20 was noted to have an open area to the upper right buttock measuring approximately 0.5 centimeters (cm). During an interview on 05/15/26 at 5:45 PM, the Administrator confirmed staff should adhere to ordered care interventions to ensure early identification of changes in a resident's condition. Review of the facility's policy titled, Pressure Ulcer Prevention and Management, last revised 01/17/23, revealed, It is the policy of Cadia Healthcare to promote skin integrity in residents through the recognition, treatment and prevention of pressure ulcers . Residents will have a plan of care developed and updated as needed. Interventions implemented are added to the resident's plan of care .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to safeguard controlled medications used in facility stock and failed to safeguard controlled medications and/or ensure the availability of physician ordered medications for two of 55 sampled residents (Resident (R)178 and R5). These failed practices placed residents at risk for medication diversion, unmanaged symptoms, and failure to receive medications as prescribed. Findings include:1. Review of a Pharmacy Delivery Manifest, dated 09/10/25, provided by the Director of Nursing (DON), revealed one pill of Oxycodone IR (an immediate release narcotic pain medication) 5 milligrams (mg) was delivered to the facility for a stock replacement order in the Omnicell (a secured automated medication dispensing cabinet). The Pharmacy Delivery Manifest for 09/10/25 had a delivery time of 7:28 AM and was signed by Licensed Practical Nurse (LPN)10. During an interview on 05/13/26 at 10:00 AM, the DON stated she received an email from the pharmacy on 09/15/25 informing the facility the Oxycodone IR 5 mg replacement pill for the Omnicell, delivered on 09/10/25, was never placed into the Omnicell. The DON stated she then checked the Omnicell, and the Oxycodone IR 5 mg pill was not in the Omnicell. The DON stated she then interviewed LPN10, who signed for the Oxycodone delivery on 9/10/25. The DON stated LPN10 verified she did accept and sign for the Oxycodone IR 5 mg pill from the pharmacy on 09/10/25. The DON stated she was told LPN10 and LPN3 attempted to put the pill into the Omnicell upon receipt, but the Omnicell was not working at the time. Both LPN10 and LPN3 contacted their Registered Nurse Unit Manager (RN-UM)1 and gave the Oxycodone IR 5 mg pill to RN-UM1 until the Omnicell was working. The DON stated RN-UM1 was interviewed on 09/15/25 and could not locate the Oxycodone IR 5 mg pill. The DON stated RN-UM1 verified she never placed the pill into the Omnicell. The DON stated all medication rooms and carts in the facility were searched without success in locating the pill. The DON stated the police were called, and a report was filed, and RN-UM1 was terminated on 09/15/25. The DON stated the Oxycodone IR 5 mg pill should have been double locked in the medication storage cart until the Omnicell was working. During an interview on 05/15/26 at 9:30 AM, LPN10 revealed one Oxycodone IR 5 mg pill was delivered to the facility on [DATE]. LPN10 stated she signed for the medication and took LPN3 to the medication room for a witness to insert the pill into the Omnicell. LPN10 stated the Omnicell was not working at the time. LPN10 stated she and LPN3 then informed RN-UM1 about the pill being delivered and the Omnicell not working. LPN10 stated RN-UM1 then took the Oxycodone IR 5 mg pill and RN-NM1 stated she would put it into the Omnicell once it was working. LPN10 stated she never heard anything else about the Oxycodone until 09/15/25 when the DON informed her the pill was missing. During an interview on 05/15/26 at 9:45 AM, LPN3 revealed she was with LPN10 on 09/10/25 when they attempted to place the Oxycodone IR 5mg pill into the Omnicell. LPN3 verified the Omnicell was not working, and the pill was immediately given to RN-UM1 who stated she would take possession of the pill until the Omnicell was working. Review of the facility policy titled, Controlled Medication Storage and Disposal, with a revision date of 01/09/2026, revealed Schedule II-V medications (Oxycodone IR is a Schedule II drug with a high potential for abuse with use potentially leading to severe psychological or physical dependence) were to be stored in a double-locked, permanently affixed compartment separate from all other non-narcotic medications. The nurse on duty maintained possession of the key to the controlled medication storage (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	area. 2. Review of R178's admission Record, and located under the Profile tab in the electronic medical record (EMR), revealed the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia (total or near total loss of voluntary movement (paralysis) on one side of the body) and hemiparesis (partial weakness or loss of strength on one side of the body) following cerebral infarction (occurs when a blood vessel in the brain is blocked or restricted), aphasia (language disorder caused by damage to the brain's language center), and seizures (a sudden, uncontrolled burst of abnormal electrical activity in the brain). Review of R178's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/08/25, and located under the MDS tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15 which indicated severe cognitive impairment. Review of R178's Physician Orders, and located under the Orders tab in the EMR, revealed an order, dated 08/02/25, for Lorazepam (an antianxiety medication) 0.5 mg to be given every eight hours for anxiety as needed. Review of R178's Controlled Drug Administration Record, and located under the Misc tab in the EMR, revealed on 09/19/25 at 7:00 AM the shift change count for Lorazepam 0.5 mg was nine tablets. This 7:00 AM count occurred with on-coming LPN10 and off-going LPN9. On 09/19/25 at 3:00 PM, the shift change count for Lorazepam 0.5 mg was eight tablets. This 3:00 PM count occurred between off-going LPN10 and on-coming LPN6. During an interview on 05/15/26 at 9:30 AM, LPN10 revealed she was the nurse who cared for R178 from 7:00 AM to 3:00 PM on 09/19/25 and conducted the count for Lorazepam 0.5 mg at 7:00 AM with an off-going nurse and at 3:00 -PAM with an on-coming nurse. LPN10 stated on 09/19/25 at 7:00 AM there were nine Lorazepam 0.5 mg tablets and at 3:00 PM there were eight. LPN10 stated she did not give R178 any Lorazepam during her shift. LPN10 stated she had no idea what happened to the pill, but it may have possibly fallen out of the pill pack when she was cleaning the medication cart. LPN10 stated she immediately reported the missing pill to the DON. LPN10 stated she, along with the DON and Assistant Director of Nursing (ADON), looked in the cart, medication room, and on the unit for the missing pill but were unable to locate it. Review of the 09/19/25 Medication Administration Record (MAR), and located under the Orders tab in the EMR, revealed R178 was not administered Lorazepam 0.5 mg on 09/19/25. During an interview on 05/13/26 at 10:20 AM, the DON revealed there was a missing Lorazepam 0.5 mg pill reported to her and the ADON by LPN10 on 09/19/25 at 3:00 PM. The DON stated on 09/19/25 there were nine pills at 7:00 AM during shift change narcotic count and on 09/19/25 at 3:00 PM there were eight pills of Lorazepam 0.5 mg for R178. The DON stated that she and the ADON searched the medication cart, medication room, and the unit where R178 was located, and the pill was not located. The DON stated the police were called, and a report was filed, and LPN10 was terminated. 3. Review of R5's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R5 was admitted to the facility on [DATE]. R5's pertinent diagnoses included constipation, irritable bowel syndrome (IBS), and a history of fecal impaction. Review of R5's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085054	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Pike Creek	3540 Three Little Bakers Blvd Wilmington, DE 19808

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/10/26 and located under the MDS tab of the EMR, revealed R5 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. It was recorded R5 was frequently incontinent of their bowels and did not have constipation during the review period. Review of R5's Care Plan, dated 04/05/26 and located under the Care Plan tab of the EMR, revealed the resident had constipation, IBS, a history of fecal impaction, and was non-compliant with bowel protocol. The care plan directed staff to follow facility bowel protocol for bowel management, monitor/report as needed signs and symptoms of complications related to constipation, and to record bowel movement patterns each day. Review of R5's Physician Order, dated 04/05/26 and located under the Orders tab of the EMR, revealed an order for naloxegol oxalate (medication used to treat opioid-induced constipation) 25 milligram (mg), give one tablet orally each morning for constipation. Review of R5's Medication Administration Record (MAR), dated 05/2026 and located under the Orders tab of the EMR, revealed staff documented a 9 indicating the medication was not administered on 05/09/26, 05/10/26, 05/11/26, 05/12/26 and 05/13/26. Review of R5's Progress Notes, dated 05/09/26 through 05/13/26 and located under the Progress Notes tab of the EMR, revealed that on 05/09/26, staff did not administer naloxegol oxalate to the resident because it was pending delivery from the pharmacy and that the Nurse Practitioner (NP) was aware. On 05/10/26, 05/11/26, 05/12/26, and 05/13/26, staff noted that the medication was still on order. Further review revealed no documented evidence staff contacted the provider to notify them that the medication was still unavailable. During an interview on 05/12/26 at 9:56 AM, R5 stated that he did not receive his naloxegol oxalate for the last four days and did not know why, but any constipation at this time. During a combined observation and interview on 05/14/26 at 8:55 AM, Registered Nurse (RN) 2 verified that the pharmacy had not delivered R5's naloxegol oxalate. RN2 then called the pharmacy to inquire about the medication and was told that the medication would be delivered that evening. RN2 stated the nurses were responsible for ordering medications when supplies run low, and that if a medication was not available, they were to contact the pharmacy and physician and obtain an order to hold the medication or replace it with one that is available. RN2 stated that she did notify the NP and noted that she was aware the medication was not available but did not obtain an order to hold the medication until it was available. During a telephone interview on 05/14/26 at 10:45 AM, the Quality Assurance Pharmacist stated that on 04/22/26 at 9:26 AM, the pharmacy delivered a 14-day supply of naloxegol oxalate to the facility, and that the pharmacy did not receive the next refill request from the facility until 05/14/26 at 9:00 AM, and it was scheduled for delivery that evening. An attempt to interview the NP on 05/14/26 at 2:47 PM was unsuccessful. A message was left for the NP to return the call; however, the NP did not return the call prior to the survey exit. During an interview on 05/15/26 at 6:41 PM, the Director of Nursing stated that if a medication was unavailable, staff were to notify the pharmacy and notify the provider to see if they wanted to substitute the medication with another available medication or obtain an order to place the medication (continued on next page)

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	085054	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on hold until it was available. The DON stated that all nurses were responsible for ordering medications and this was missed. Review of the facility policy titled, Medication Unavailable, last revised on 01/12/23, indicated, . When a medication is unavailable through the pharmacy, nursing may check the backup supply for the medication. If the medication is not available from the backup supply, notify the physician for additional or alternative orders. If the provider is not available, contact the Medical Director for directions and or orders. Document provider or Medical Director notification and orders in the resident's medical record .