

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 08/25/2025
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 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 within two hours if the conduct causes serious bodily harm. 1. Review of R123's clinical record revealed:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>8/21/25 12:59 PM - During an interview, E1 (NHA) confirmed the delayed reporting.</p> <p>8/25/25 2:10 PM - Findings were reviewed with E1 (NHA), E10 (CO), and E11 (CNO) during the exit conference.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>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.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**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.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p>		