STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 04/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION SILVERSIDE	3322 SILVERSIDE ROAD WILMINGTON, DE 19810

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from April 2, 2019 through April 5, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 113. The survey sample size was 7. Abbreviations/definitions used in this report are as follows: ADL - Activities of daily living; ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; Debility - physical weakness; DON - Director of Nursing; Exploitation - taking advantage of another for personal gain; LPN - Licensed Practical Nurse; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); Misappropriation - the intentional, illegal use of the property or funds of another person for one's own use or other unauthorized purpose; NHA- Nursing Home Administrator; Psychotropic (medication)- any medication capable of affecting the mind, emotions and behavior; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator;	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but	F 561		7/1/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/02/2019

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.

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F 561	Continued From page 1 not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R1) out of 3 sampled residents the facility failed to provide the necessary services to ensure that showers were received as scheduled, based on the residents preference. Findings include: Review of R1's clinical record revealed: 2/28/18- R1 was admitted to the facility. 3/1/18- A care plan was developed stating that R1 required staff assistance with ADL's due to debility and for being at high risk for falls.	F 561	1. 1. R1 did not receive showers as per his preference. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected by measures outlined in #3. 3. Residents shower preferences will be established upon admissions and updated Quarterly during Quarterly care conferences per MDS schedule. C.N.A. Participation Questionnaire Form will be updated to include bathing preferences: time/day of the week/type. 4. DON/designee will audit 5 random 2nd	

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F 561	Continued From page 2 Approaches included that R1's shower days were Tuesday and Friday, and it was important to R1 to choose what type of bath he/she received; R1 preferred showers. 3/1/19- 4/3/19- Review of R1's Point of Care history (where CNA's documented R1's showers) revealed that out of 10 opportunities, R1 only received a shower 3 times. For the other opportunities, R1 received partial bed baths, which were not his/her bathing preference. 4/3/19 2:57 PM- During an interview, R1 stated that his/her shower days were supposed to be Tuesday and Friday, but the facility had not given him a shower for at least two weeks. The facility failed to ensure that R1 received showers twice weekly per his/her care planned preference. 4/5/19 approximately 1:30 PM- During the exit conference, findings were reviewed with E1 (NHA) and E3 (ADON).	F 561	floor residents and 5 random 1st floor residents CNA documentation for adherence to resident preferences daily x 3 days or until 100% compliance is met. Then audit 3 x per week for 3 weeks or until 100% compliance is met. Then will audit 1 x weekly x 3 weeks or until 100% compliance is met. Then once in one month if 100% compliance is achieved then the problem will be considered resolved.	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced	F 607		7/1/19

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F 607	Continued From page 3 by: Based on record review, interview, and review of other facility documentation as indicated, it was determined that for one (R7) out of four sampled residents reviewed for abuse, the facility failed to implement the facility's policy to prevent and prohibit abuse. Findings include: The facility's policy entitled, Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime, last revised 3/14/19, stated, "Physical abuse is unnecessarily inflicting pain or injury to a resident ...Witnessed or suspected incidents of abuse or reasonable suspicions of a crime are to be reported immediately. A witness who fails to report abuse, neglect, mistreatment, misappropriation of resident property, exploitation, or suspicions of crime is considered to be as culpable as the accused." Review of facility documentation revealed: 11/7/18 approximately 1:00 PM- A resident concern form stated that a resident reported to E2 (DON) that E10 (LPN) had been verbally abusive to his/her roommate, R4, and other residents. It was documented that the concerned resident stated E10's tone was very condescending and his/her overall demeanor was very negative. When asked for specific examples the resident was unable to recall specific sentence structure, but was able to give the names of several staff members that had worked with E10 and had likely witnessed the inappropriate conduct. 11/7/18 3:30 PM- E2 (DON) interviewed E8 (CNA) and documented that E8 stated that E10 (LPN) was a little rough with residents. E8 stated	F 607	1. R7 received prophylactic psychiatric services and follow up to ensure he sustained no negative impact from deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected by measures outlined in #3. 3. E10 was terminated as a result of internal investigation. E8 and E9 are no longer employed. Staff Educator will reeducate all staff on the facility policy related to abuse, neglect, mistreatment, misappropriation, exploitation, and reasonable suspicion of crime and duty to report. Cadia Silverside policy is in alignment with State and Federal Regulations. 4. DON/designee will audit all investigations related to allegations of abuse, that investigations are complete, that staff statements are given timely related to resident complaints and are compliant with reporting guidelines. Audits will daily x 3 days or until 100% compliance is met. Then will audit 3x per week for 3 weeks or until 100% is met. Then will audit 1x weekly x 3 weeks or until 100% compliance is met. Then once in one month if 100% compliance is achieved then problem will be considered resolved.	

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F 607	Continued From page 4 the other night he/she was giving R7 a shower and asked E10 to re-apply dressings to R7's buttocks. E10 touched R7's buttocks without ointment and R7 stated, "who is poking my butt? It hurts!" and E10 "replied to the resident 'that wasn't poking your butt, this is poking you' and then began to poke her finger aggressively into the resident's butt and hip area." 11/7/18 3:50 PM- E2 (DON) interviewed E9 (CNA) and documented that E9 stated the other night E10 (LPN) was putting paste on R7's bottom after a shower and was really rough. E9 stated that the look on R7's face during the incident was that he/she was uncomfortable and E10 told R7 to suck it up. E10 was poking his/her finger into R7's bottom and side really hard saying "this is poking you!" 11/8/18- The resident concern form stated that the response to the concern was that the allegation was investigated and substantiated. This resulted in E10 (LPN) being terminated. 4/4/19 3:28 PM- During an interview, E12 (staff developer) stated that there was no education provided to E8 (CNA) and E9 (CNA) after it was found that they did not immediately report witnessed abuse to R7. The facility failed to implement the facility's policy to prevent and prohibit abuse as evidenced by E8 (CNA) and E9 (CNA) not immediately reporting witnessed abuse. 4/5/19 approximately 1:30 PM- During the exit conference, findings were reviewed with E1 (NHA) and E3 (ADON).	F 607		
F 610	Investigate/Prevent/Correct Alleged Violation	F 610		7/1/19

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F 610 SS=D	Continued From page 5 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility documents, clinical record review, and interviews, it was determined that for one (R2) out of four sampled residents for abuse, the facility failed to complete a thorough investigation of an alleged abuse for R2 by not doing a physical assessment of R2 after an allegation of sexual abuse. Findings include: Review of the facility documents revealed: A facility policy titled, Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime, with an effective date of October 21, 2010 and a revision date of March 14, 2019, stated, "Assessment of the alleged victim will be conducted for signs and symptoms of injury (physical and/or psychosocial).	F 610	1. R2 was sent to hospital for evaluation and abuse was unsubstantiated. 2. All residents with allegations of abuse have the potential to be impacted by this deficient practice. Future residents will be protected by measures outlined in #3. 3. Staff Educator to educate all nurses on how to conduct a thorough investigation related to allegations of sexual abuse including physical assessment. New checklist created as a reference to nurses to guide them through thorough completion of a resident abuse allegation and investigation. 4. DON/designee to audit all allegations of sexual abuse for thoroughness of investigation and completion. Audits will be done daily x 3 days or until 100%	

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F 610	Continued From page 7 meeting. Remeron restarted at this time. 9/24/18 - A nurse's progress note, written by E7 (RN), stated, R2 expressed he/she was feeling anxious but denied pain. Allowed R2 to express his/her feelings...Rechecked 30 minutes later and R2 stated he/she felt calmer. 9/26/18 - A nurse's progress note written by E11 (RN) stated, CNA told this nurse that R2 was crying during getting ready for the day. Emotional support given by CNA with due relief. 4/3/19 3:40 PM - During an interview, E2 (DON) stated E6 (LPN) called E2 at home to tell her about R2's allegation. E2 stated that she reported the incident to the state agency and called and suspended the accused staff member. E2 stated the nurse who was suspended fit the description given by R2 to a tee, and that the nurse had worked the 11-7 shift. E2 stated that R2 was sent to the hospital on 9/26/18 because his/her story regarding the abuse changed, to include the nurse putting her finger in R2's vagina. 4/4/19 9:20 AM - During an interview with E3 (ADON), it was revealed that there was no documentation of a physical assessment of R2's vaginal area on 9/24/18 when R2 first made an allegation of sexual abuse, or on 9/26/18 when R2 changed his/her story regarding the abuse. Findings were reviewed with E3 (ADON) on 4/4/19 at 9:30 AM.	F 610		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Silverside

DATE SURVEY COMPLETED: April 5, 2019

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 April 2, 2019 through April 5, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 113. The survey sample size was 7.		
3201	**Regulations for Skilled and Intermediate Care 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.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey completed April 5, 2019: F561, F607, and F610.	Cross refer to CMS 2567-L survey completed April 5, 2019: F561, F607, F610.	July 1, 2019

Provider's Signature Laurie L. Dittmar Title NHA Date 5/1/19