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

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Silverside

DATE SURVEY COMPLETED: April 27, 2026

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 annual and complaint survey was conducted at this facility from April 20, 2026, through April 27, 2026. The deficiencies contained in this report are based on interviews, observations, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was one hundred eight (108). The sample size was thirty-four (34).		
3201	**Regulations for Skilled and Intermediate Care Facilities**	Cross refer to the CMS 2567-L survey completed 4/27/2026: F550, F558, F561, F580, F658 and F689.	6/11/2026
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 was not met as evidenced by:		
	Cross Refer to the CMS 2567 – L survey completed April 27, 2026: Cross refer to the CMS 2567-L survey completed April 27, 2026: F550, F558, F561, F658, and F689.		

Provider's Signature Nichole Nolan Title NHA Date 5/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION SILVERSIDE	3322 SILVERSIDE ROAD , WILMINGTON, Delaware, 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
E0000	Initial Comments In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		06/25/2026
F0000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from April 20, 2026, through April 27, 2026. The deficiencies contained in this report are based on interviews, observations, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was one hundred eight (108). The sample size was thirty-four (34). Abbreviations and Definitions: Anticoagulant – medication that works to prevent the coagulation (clotting) of blood; BIMS - Basic Inventory of Mental status, a structured assessment tool aimed at evaluating cognition in the elderly. BIMS score of 0-7 is reflective of severe cognition deficit, 8-12 reflects moderate cognition deficit and 13-15 score is reflective of normal cognition; Craniotomy - a surgical procedure in which a portion of the skull is temporarily removed to access the brain for treatment of tumors, blood clots, aneurysms, or other brain conditions; Cerebral Infarction - stroke in the brain; CN - Corporate Nurse; CNA - Certified Nurse's Aide; Compression Fracture - collapse of a vertebra that may be due to trauma or due to weakening of the vertebra due to other conditions;	F0000		06/25/2026

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 reverse for further 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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F0000	Continued from page 1 COO - Chief Operating Officer; CT Scan - imaging test that takes detailed pictures of the inside of the body; DON - Director of Nursing; Hoyer Lift - sling-type hydraulic lift; L2 Vertebra - found in the lower back, crucial for supporting body weight, enabling spinal movement and protecting spinal nerves; L3 Vertebra - centrally located in the lower back, provides weight bearing support, spinal stability and enables lower back mobility; LPN - Licensed Practical Nurse; MD - Medical Director; MDS - Minimum Data Set/a federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; NHA - Nursing Home Administrator; NP - Nurse Practitioner; Pain Scale – 1-10. The most common scale for pain. The patient to identify their pain between one to ten, with ten being the worst pain imaginable and one being no pain at all. Rheumatoid Arthritis - a chronic progressive disease that causes joint inflammation and results in painful deformity and immobility, especially in the fingers, wrists, feet and ankles; RN - Registered Nurse; SD - Staff Development;	F0000		06/25/2026
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F0689	1.R12 still resides at the facility. R12 sustained a right ankle fracture status post fall from bed to floor. The resident was sent to the hospital and returned to the facility with orders for rest, ice, and elevating ankle. 2.All residents have the potential to be impacted by this deficient practice. A review of all risk management incidents in the last 30 days was conducted and determined that no other residents were affected by this deficient practice.	06/11/2026

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F0689 SS = G	Continued from page 2 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of other documentation as indicated, it was determined that for three (R12, R63, and R76) out of three residents sampled for accidents, the facility failed to ensure that the residents received adequate assistance and supervision to prevent accidents to the extent possible. R12, a completely dependent resident, sustained a fall from the bed to the floor while a staff member was providing care and sustained a right ankle fracture. R63, a resident who required extensive assistance for transfers, sustained L2 and L3 fractures during a transfer from the shower bed to the bed and was sent emergently to the hospital. R76, a resident who was completely dependent on staff for transfers, sustained an injury to the top of his head during a transfer from a mechanical lift to his motorized wheelchair. R76 was sent emergently to the hospital and received three staples to his scalp. Findings include: Cross Refer F658 1. R12's clinical record revealed: 1/2/19 – R12 was admitted to the facility with the following diagnoses, including, but not limited to, anoxic brain injury, abnormal posture, multiple contractures of the upper and lower limbs and idiopathic progressive neuropathy. 10/1/25 – A review of R12's quarterly MDS documented "R12 required substantial maximum assistance to roll left and right in the bed. 12/30/25 – A review of R12's quarterly MDS documented "R12 required substantial maximum assistance to roll left and right in the bed. 12/3/25 1:00 AM – A facility reported incident to the division documented "[R12] sustained fall 12/3/25 complaint of ankle pain later in day. Xray obtained, results unclear. Repeat film obtained on 12/5/25. 12/3/25 8:24 AM – A review of R12's post fall assessment documented by E29 (ADON) "What was	F0689	Continued from page 2 Further residents will be protected by this deficient practice by measures outlined in Section 3. 3. A root cause analysis was conducted, and it was determined that C.N.A failed to provide the proper level of assistance during care while inspecting residents' linen to determine what supplies were needed. Staff Developer/designee will educate all nursing staff on following the residents' plan of care for the level of assistance required with bed mobility. The facility will continue to provide lift academy in new hire orientation and complete safe patient handling competency for all nursing staff. 4. The ADON/designee will conduct random observation of staff providing ADL care/bed mobility to validate proper level of assistance is used. The audit process will be 5 observations daily times three days if 100% compliance is achieved, then 5 observations weekly for three weeks until 100% compliance is achieved, then 5 observations monthly for 3 months to determine ongoing compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings. 1.R76 still resides at the facility. R76 was transferred to the hospital and returned to the facility with 3 staples to his scalp. 2. All residents have the potential to be impacted by this deficient practice. A review of all risk management incidents in the last 30 days was conducted and determined that no other residents were affected by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section 3. 3. Root cause analysis was conducted, and it was determined that nursing staff failed to utilize Hoyer lift properly due to staff competency. All mechanical lifts were inspected to ensure equipment is properly functioning per manufacturer's guidelines. All nursing staff will complete the facility's lift academy to ensure proper use of Hoyer lift equipment while transferring residents between multiple surfaces. The staff developer/designee will educate all nursing staff utilizing a Hoyer lift properly for transfers. The facility will continue to provide lift academy in new hire orientation and complete safe patient handling competency for all nursing staff. 4. The ADON/designee will conduct random	06/11/2026

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F0689 SS = G	Continued from page 3 resident doing just prior to fall.... Care being provided. Additional comments on R12's post fall assessment documented "Proper positioning of resident." 12/3/25 8:33 AM – A progress note authored by E18 (LPN UM) documented "Therapy reported to nursing R12 reported sliding out of bed when care was being provided. E18 also documented [R12] stated, "Slid out of bed and was in a seated position on R12's bottom." 12/4/25 11:15 AM – A review of R12's initial right ankle Xray report addendum documented "This is a limited study. There is a question of a fracture at the tip of medial malleolus seen on the AP view. Recommend follow up films including oblique views to see if a fracture is present or not. 12/5/25 12:48 PM – A review of R12's right ankle Xray findings documented "Compared to study performed on 12/4/25 concluded stable fracture." 12/5/25 2:37 PM – A progress note documented Xray to right ankle completed and noted with stable fracture. Reviewed with E19 (NP) new order received to send [R12] to hospital for evaluation. FM2 made aware and in agreement. 12/5/25 11:07 PM – A progress not documented [R12] received back for the hospital at 10:48 PM as per hospital report, resident has a fracture to ankle, rest, ice, elevate ankle to help it heal. Ibuprofen or Tylenol to be taken as needed for pain. 12/12/25 – A facility five day follow up report to the division documented "Through interviews with staff members it was determined that at approximately 1:00 AM, while resident was receiving care, R12 was sliding off the side of the bed and was lowered onto the floor in a seated position. 4/21/26 2:13 PM – A care plan for R12 initiated 4/1/20 documented "[R12] is at high risk for falls related to cognitive impairment, contractures urinary and bowel incontinence, psychotropic and opioid medications and history of actual falls."	F0689	Continued from page 3 observations to ensure correct technique/supervision/assistance is being safely provided to residents while using the Hoyer lift. The audit process will be 5 observations daily times three days until 100% compliance is achieved, then 5 times weekly for three weeks until 100% compliance is achieved, then 5 observations monthly for 3 months to determine ongoing compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings. 1. R63 still resides at the facility. R63 was sent to the hospital and returned with diagnosis of acute L2 and L3 vertebra compression fractures. 2.All residents that use shower beds have the potential to be impacted by this deficient practice. All shower beds were inspected to ensure proper functionality and good condition. All beds in the facility were also inspected to ensure proper functionality and good condition. A bariatric shower bed was also purchased by the facility to increase bed boundaries. A review of all risk management incidents in the last 30 days was conducted and determined that no other residents were affected by this deficient practice. 3. The facility conducted a root cause analysis, and it was determined that while the CNA was providing the proper level of assistance for bed mobility, the fall may have been prevented if the side rail had not been lowered until the CNA was ready to transfer the resident. Education was conducted with all nursing staff on proper use of shower bed to include not disengaging the siderail until resident is ready to transfer and that all locks are engaged. Education was completed on 5/6/2025. The findings were submitted to QAPI on 5/6/2025. The facility will continue to provide lift academy in new hire orientation and complete safe patient handling competency for all nursing staff. 4. The DON or designee will conduct audits of shower bed usage to validate safety. Maintenance Director or designee will conduct audits of shower beds to validate functionality. The audits will be performed weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Performance Improvement Committee.	06/11/2026

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F0689 SS = G	Continued from page 4 4/22/26 11:47 AM – During an interview E13 (LPN) reported "[R12] required two person assistance total care and has always been a two person assist with care and transfers. 4/23/26 12:39 PM – During an interview with E25 (OT) reported "[R12] reported rolling out of the bed to E25 during care. E25 stated, "[R12] is dependent for bed mobility." E25 also stated, "[R12] would not have been able to roll or slide off the bed and does not have the ability to do that [R12] is dependent for bed mobility. 4/23/26 12:45 PM – During an interview E19 (NP) reported "[R12] was complaining of pain and when they did a further investigation it was founded [R12] had fallen out of bed during care. 4/23/26 3:11 PM – During a phone interview E24 (CNA) reported "[R12's] call light was on I went in the room [R12] had thrown up, I was looking around to see if towels were in the room, I wasn't really paying attention, but I was standing on the right side of the bed and then [R12] started sliding off the bed to the left. I ran to try to catch [R12] but it was too late, so I lowered [R12] on the floor in a seated position. I ran to the door and called E14 (LPN). We put [R12] back in bed with the Hoyer lift." 4/23/26 3:30 PM – During an interview E29 (CNA) reported "I have to physically assist [R12] to turn in bed [R12] is not able to move in the bed without help [R12's] legs don't move they just are there laying on top of the bed [R12] is total care." 4/24/26 9:40 AM – During an interview E15 (ADON) reported "[E24] went into [R12's] room and [R12] had thrown up. [E24] was trying to clean up [R12] and had a towel under the resident's neck [R12] started sliding off the bed [E24] was on the other side of the bed and ran over to try to catch [R12] but ending up placing [R12] on the floor. E15 then stated, "I'm thinking [R12] was too far over on the left side of the bed." 4/27/26 1:11 PM – During a phone interview E14 (LPN) reported "I was called by E24 and told [R12] had fell I assessed [R12] and then assisted E24 with transferring the resident back to bed and with care. I wasn't there when the fall happened, I just wrote	F0689	Continued from page 4 All results will be brought through QAPI meetings. Definitions: Lift Academy: Training class that goes over safe patient handling, transfers, bed mobility, and use of mechanical lifts. Risk Management is an internal incident report system.	06/11/2026

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F0689 SS = G	Continued from page 5 on the witness statement what E24 said happened. The facility failed to ensure R12 received adequate hands on assistance and supervision for a resident that required substantial maximum assistance with bed mobility when R12 slid out of the bed and had to be lowered to the floor and sent to the hospital for treatment and evaluation for a right ankle fracture. 2. R76's clinical records revealed: 6/2/22 – R76 was admitted to the facility with diagnoses, including but not limited to, brain bleed, seizure disorder and craniotomy which resulted in left sided paralysis. 6/13/22 – R76's transfer care plan documented, "The resident requires Mechanical Lift (Hoyer) with 2 staff assistance for transfers." 9/3/24 – R76's care plan (revised 9/4/24) documented, "[R76] is on anticoagulant therapy…monitor for bleeding…" 9/28/24 – R76's medications included Xarelto 10 mg (anticoagulant) daily for deep vein thrombosis. 3/3/26 – R76's quarterly MDS assessment documented a BIMS score of 15, indicating a completely intact cognitive status, and a complete dependance on staff for all bathing and transfer needs. 3/31/26 5:00 PM – R76's clinical record included, "Notified by the CNA that during two persons transfer with Hoyer lift in the shower room, the top of the lift made contact with his head. He has a small laceration to the top of his head, and c/o [complained of] neck pain 9/10… Resident stated, "Hoyer lift came down on top of his head during transfer." 4/1/26 1:00 AM – R76's physician's record documentation included, "… Sustained a head strike from a Hoyer lift. Patient states that he was being lifted out of the shower back into his wheelchair when the Hoyer lift collapsed onto his head. It struck him on the top of his head. He did not lose consciousness. He did not sustain any other injuries. Since the injury he has had pain on the top of his head … He endorses pain here along with neck pain…Given concern for intracranial hemorrhage [brain bleed] and particular because of his Xarelto use, CT head and C-spine was completed…"	F0689		06/11/2026

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F0689 SS = G	Continued from page 6 R76's medication administration record from 4/1/26 to 4/19/26 revealed the use of pain medications for 17 out 39 opportunities for complaints of head and neck pain at a level between 7 and 9. 4/21/26 9:00 AM – During an interview, R76 stated, "After my shower, the two aides used the lift to move me from the shower bed (in the shower room) to my chair. The hooks of the lift were not properly hooked to the bars, and this caused the front of the lift to become unbalanced and tilt backwards and I was dropped onto the chair. I was glad that the chair was there, or I would have fallen to the floor. This movement caused the bars of the lift to fall on top of my head. This is where I had the craniotomy." He indicated the top of his head and stated, "My head and neck hurt now, and I have been taking pain medicine." The Surveyor asked the resident about other times when he was showered and how he got back into the chair. R76 stated, "They usually bring me back into the room in the shower bed and transfer me to the bed and get me dressed in the bed. This has never happened to me before. I don't think the lift was operated correctly because the lift was not moving when they tried to put me in the chair and the bars fell on my head." 4/22/26 1:30 PM – During a telephone interview, E5 (CNA) stated, "I helped [E6] (CNA) get [name of resident] from the wheelchair onto the shower bed. We used the purple lift. I left to do my work and then went back to check on the resident and [E6] a little later and saw that the resident had received his shower, was dressed and ready to get into the wheelchair. The sling was hooked up to the lift and [E6] was using the control to guide the lift. I was holding the sling to help guide him to the wheelchair. [E6] started to move the lift, it came above the wheelchair, and it looked like it was stuck because it wouldn't move. The way the lift was positioned, it looked like it was going sideways to the wheelchair. I told [6] that this does not look right and tried to pull him [R76] back to correct it, but the lift came upwards, and the bar hit him on his head. We got him into the chair and got the nurse." 4/22/26 3:30 PM – During an interview, E6 stated, "I have worked at the facility for about 3 months now. I showered and dressed [R76] and hooked the sling up to the Hoyer lift. [E5] came in to help me get him into the chair. [E5] was guiding the resident in the sling, and I was using the control and moving the lift. I lifted him up and was putting him in the chair and his weight shifted causing the lift to tip back and the bar hit him on top of his head. I put him in	F0689		06/11/2026

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F0689 SS = G	Continued from page 7 the chair and told the nurse." 4/23/26 10:00 AM – The facility provided the Surveyor with a facility report dated, 4/1/26, and entitled "Inspection Report – ARJO HOYER LIFT." A review of the document revealed that the lift was rated to use safely with patients up to 500 lbs. The lift was inspected and was found to be in proper working condition and met all operational and safety requirements, no repairs were required at that time. 4/23/26 11:00 AM – During an interview, the Surveyor asked E30 (PT) who makes the determination for the residents' transfer statuses. E30 stated, "Therapy evaluates residents and writes the order for their transfer status based on what equipment and how much help they need to move from the bed to the wheelchair or the wheelchair to the bed and other surfaces. [R76] was not able to bear weight on his feet, and the Hoyer lift was determined to be safe to use for his transfers." The Surveyor asked E30 if it was likely that R76's head injury could have been caused during the transfer because his weight shifted. E30 stated, "Not if the lift was used properly." R76's weight was 167.8 lbs. on 3/28/26. 4/24/26 2:00 PM – During an interview E3 (COO) stated, "It is the facility's position that the incident occurred when the resident's weight shifted during the transfer. We reviewed the incident and the staff involved received education and training on safe transfers. It was an unavoidable accident." 4/27/26 2:15 PM: The facility provided the Surveyor with a document entitled, "April 2026", entitled, "Facility Position on Mr. [initial of R76's last name.]" The document included, "…The facility met all four key elements to minimize accident hazards, and the accident was UNAVOIDABLE…. [Name of resident] weight shifted during at the last moment while transitioning from a supine to a sitting position in the sling of the mechanical lift. The facility utilized the proper equipment and personnel. A root cause analysis concluded, after gathering witness statements, return demonstrations by staff on proper Hoyer use, and satisfactory inspection of the equipment, that this last-minute weight shift caused him to bump his head, therefore was UNAVOIDABLE." The facility failed to ensure R76 received adequate assistance and supervision for a transfer from the Hoyer lift to the wheelchair resulting in an injury to the top of his head.	F0689		06/11/2026

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F0689 SS = G	Continued from page 8 3. Review of R63's clinical record revealed: 9/23/24 – R63 was admitted to the facility with diagnoses including cerebral infarction and rheumatoid arthritis. 3/4/25 2:31 PM – An order entered in R63's clinical record documented, "...Bed Mobility: extensive assist of one [staff person]...". 4/24/25 – A quarterly MDS assessment documented R63 had a BIMS score of 11, indicating moderately impaired cognition. The assessment also documented that R63 required maximal assistance to roll from lying on her back to the left side or right side and for upper and lower body dressing. 4/29/25 12:10 PM – A facility incident report documented, "...[R63] had been given a shower and was brought back to her room...[E7, CNA] lowered the side rail and pushed the shower bed against [R63]'s bed...[E7] prepped [R63] by turning her on her side and pulling the bath sheet out from under [R63] and started pushing the Hoyer pad underneath it...[R63] rolled over and fell between the 2 beds to the floor...[R63] was crying and very anxious." 4/29/25 12:47 PM – A Nurse's Note was entered in R63's clinical record documented, "[R63] fell from shower bed to floor...[R63] transported to hospital." 4/29/25 – A facility document entitled, "Education Note" documented, "...Employee Name: [E7] Education Provided: When using the shower bed, do not disengage the side railing until you are ready to transfer the resident and that all locks are engaged...". 4/29/25 – A facility document entitled, "Point of Inspection Review" documented, "...Equipment to be Inspected: Shower Beds...No repairs or maintenance issues were identified during the inspection...shower beds are in proper working order with secure locking and braking mechanisms...". 4/29/25 9:25 PM – A hospital radiology report documented that R63 underwent a CT scan that revealed acute L2 and L3 vertebra compression fractures. 4/22/26 2:03 PM – During an interview, (E7) stated, "I was getting [R63] ready to transfer back to her bed from the shower bed. I must have forgotten to lock the wheels on the shower bed. I rolled [R63] to put the Hoyer lift pad under her. The shower bed	F0689		06/11/2026

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F0689 SS = G	Continued from page 9 separated from [R63]'s bed and [R63] fell in between the two beds. [R63] won't take a shower anymore since the accident. [R63] will only take bed baths now." 4/23/26 9:39 AM – During an interview, (E2, DON) stated, "Staff is trained on shower bed transfers during onboarding." The Surveyor asked if it was re-education for shower bed transfers that was provided to E7 on 4/29/25? E2 stated, "Yes." 4/23/26 12:58 PM – Facility provided documentation of a QAPI meeting held on 4/29/25 to address R63's fall from shower bed, Nursing and CNA staff in-service shower bed transfer safety education completed on 4/29/25 and 5/6/25, and weekly audits of shower bed safety and CNA safe resident transfers conducted from 5/5/25 to 7/7/25. E2 confirmed that a Safe Patient Handling Competency training is completed by new staff upon hire and by existing staff during annual in-service training. 4/23/26 1:28 PM – Interviews were conducted with E8 (CNA), E9 (CNA), E10 (CNA), E11 (CNA) and E12 (CNA) to confirm that shower bed transfer safety education and Safe Patient Handling Competency training had been completed. 4/23/26 3:13 PM – Finding was reviewed with E1 (NHA) and E2. 4/27/26 1:35 PM - Finding was reviewed during the exit conference with E1, E2, E3 (COO), E16 (CN) and E17 (CN).	F0689		06/11/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F0550	1.R23 still resides at this facility. R23 was not negatively impacted by this deficient practice. R23 was observed during subsequent meals to ensure care was provided respectfully and in accordance with resident rights and facility policy. 2. All residents requiring feeding assistance have the potential to be affected by this deficient practice. An audit of residents requiring feeding assistance was completed by nursing management to ensure staff were providing meal assistance in a dignified manner consistent with resident rights and facility expectations. Further residents will be protected by this deficient practice by measures outlined in Section 3. 3. Root cause analysis was conducted and revealed that the C.N.A failed to provide feeding assistance at proper eye level due to knowledge deficit. The C.N.A was educated on the proper feeding procedures and	06/11/2026

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F0550 SS = D	Continued from page 10 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined that for one (R23) out of thirty-four residents sampled for resident rights the facility failed to ensure R23 was provided with a dignified dining experience during lunch. Findings include: R23's clinical record revealed: 6/13/22 - R23 was admitted to the facility. 4/22/26 12:39 PM – During an observation R23 was in bed, E27 (CNA) entered the resident's room with R23's lunch tray. E27 placed the lunch tray on the overbed table and then began assisting R23 to eat while standing. E27 remained standing during the time frame that R23 was being assisted with the lunch meal. 4/22/26 1:00 PM – During an interview E27 reported "[R23] needs assistance with eating. The surveyor asked E27 "If you were in the dining room and assisting a resident with their meal would you be sitting or standing" E27 stated, "I would be sitting" E27 then stated and confirmed, "I was standing I know that I should have been sitting down, I'm sorry."	F0550	Continued from page 10 resident rights. The Staff Developer will re-educate all nursing staff, including CNAs and nurses, on resident rights, dignity, and respectful dining assistance practices, including sitting at resident eye level during feeding assistance when feasible, promoting resident dignity, and respect during meals. The facility's new hire orientation will be revised to include residents' rights related to dining services for all licensed nurses and C.N.A's. 4. The Director of Nursing or designee will complete random meal assistance audits to validate staff are providing feeding assistance at eye level. Audits will be completed for 3 observations daily for 3 days or until 100% compliance achieved, then 3 observations weekly for 3 weeks or until 100% compliance achieved, then monthly for 3 months or until 100% compliance is achieved. Results of audits will be reviewed in the Quality Assurance and Performance Improvement (QAPI) meeting quarterly. Additional education or corrective action will be implemented as indicated.	06/11/2026

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F0550 SS = D	Continued from page 11 4/22/6 1:12 PM – Findings were confirmed with E28 (RN).	F0550		06/11/2026
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews it was determined for one (R23) out of thirty four residents sampled for accommodations the facility failed to ensure R23's call light was within reach. Findings include: R23's clinical record revealed: 6/13/22 – R23 was admitted to the facility. 4/22/26 10:39 AM – During an observation R23 was sitting up in the wheelchair near the left side of the foot of the bed. The call light cord was wrapped around the left side enabler at the head of the bed with the call light dangling near the floor. 4/22/26 11:52 AM – A second observation revealed R23 sitting up in the wheelchair in the same position and the call light was not within reach. 4/22/26 11:57 AM – During an observation E27 (CNA) and another staff CNA entered R23's room with a Hoyer lift to transfer R23 back to the bed. 4/22/26 12:06 PM – R23 was observed in bed the call light remained wrapped around the enabler and not within the resident's reach. 4/22/26 12:28 PM – E27 was observed in R23's room at this time and then exited the room. Call light remained not within R23's reach. 4/22/26 12:43 PM – E27 observed leaving R23's room with the resident's lunch tray. R23's call light was not within reach. 4/22/26 1:00 PM – During an interview E27 was asked by the surveyor "If you have transferred a resident from the bed to the wheelchair and or from the wheelchair to the bed what would be the most	F0558	1. R23 still resides at this facility. R23 was not negatively impacted by this deficient practice. The call light was placed within residents' reach upon identification. 2. All residents who utilize call lights have the potential to be affected by this deficient practice. An audit of all resident rooms was completed by nursing management to verify call lights were operational, accessible, and within reach of residents. Any identified concerns will be corrected immediately. 3. A root cause analysis was conducted and revealed after interview with identified staff member that the C.N.A failed to ensure the call light was within reach after providing care for the resident. The C.N.A was educated on validating placement of call light within residents' reach after each encounter. The Staff Developer will re-educate licensed nurses and CNAs on proper placement and accessibility of call lights, including avoiding tying, securing, or placing call lights in inaccessible locations. Nursing supervisors and unit managers will monitor compliance during daily rounds. The facility's new hire orientation will be revised to include ensuring the call bell is within reach after each resident encounter. Avoid tying, securing, or placing call lights in inaccessible locations such as tying them to enablers, grab bars, clipping them to curtains, or placing in nightstands. 4. The Unit Manager/or designee will conduct random audits of residents' call light accessibility. Audits will be completed on 10 resident observations daily for 3 days or until 100% compliance is achieved, then 10 resident observations weekly for 3 weeks or until 100% compliance is achieved, then 10 resident observations monthly for 3 months or until 100% compliance is achieved Audit findings will be reviewed during the Quality Assurance and Performance Improvement (QAPI) meetings monthly. Additional education and corrective action will be implemented as indicated.	06/11/2026

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F0558 SS = D	Continued from page 12 important thing that you would do before leaving the resident." E27 stated, "I would make sure the call light was within reach." Surveyor, "then asked E27 is R23's call light within reach." E27 then stated, "No, I'm sorry I apologize." E27 unwrapped the call light from the enabler and placed it within R23's reach. 4/22/26 1:12 PM – Findings were confirmed with E28 (RN).	F0558		06/11/2026
F0561 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 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 observation, interview, record review, and other documentation as indicated, it was determined that one (R76) out of three residents sampled for choices, the facility failed to ensure that R76, a resident who was completely dependent on the staff for showers, received showers per his preference to	F0561	1. R76 still resides at this facility. R76 was not negatively impacted by this deficient practice. Resident was interviewed to obtain shower/bath preferences and plan of care updated. 2. All residents with scheduled showers have the potential to be affected by this deficient practice. A root cause analysis was conducted and determined that the facility failed to review and obtain updated preferences for bathing due to residents' history of preferring bed baths. An audit of resident shower schedules and residents with shower/bed bath preferences were reviewed for accuracy. 3.The Staff Developer will re-educate all nursing staff, including CNAs and licensed nurses, on resident rights regarding bathing preferences, accurate documentation of showers provided, proper documentation of refusals, and re-approaching residents after refusals. The facility's new hire orientation includes review of residents' right to choose shower/bed bath preferences. 4. Unit Manager or designee will conduct audits of resident bathing documentation to validate residents are provided with showers/bed baths per schedule, any refusals were documented, and re-approaches were completed when indicated. Audits will be completed for 5 residents daily for 3 days or until 100% compliance is achieved, then 5 resident audits 3 times a week for 3 weeks or until 100% compliance is achieved, then 10 resident audits a month for 3 months or until 100% compliance is achieved. Results of audits will be reviewed at the Quality Assurance and Performance Improvement (QAPI) meeting. Additional education or corrective action will be implemented as indicated.	06/11/2026

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F0561 SS = D	Continued from page 13 maintain good grooming and hygiene. Findings include: R76's clinical records revealed: 6/2/22 – R76 was admitted to the facility with diagnoses, including but not limited to, brain bleed, seizure disorder and craniotomy which resulted in left sided paralysis. 6/13/22 – R76's activities of daily living care plan (revised 3/7/24) included, "... [R76] has an ADL [Activities of Daily Living] self-care performance deficit r/t [related to] CVA [cardiovascular accident] with left sided hemi [paralysis.]" The interventions included, "[R76] prefers to have afternoon or evening showers, he is scheduled for hair care/nail care and shower/bed bath weekly on Tuesday and Friday 3-11 shift, notify nurse if [R76] refuses...." 3/3/26 – R76's quarterly MDS assessment documented a BIMS score of 15, indicating a completely intact cognitive status, and a complete dependance on staff for all bathing and transfer needs. 3/31/26 – An incident report submitted to Division reporting department included, "[R76] stated that he has not taken a shower in 3 weeks and to beg for [one]..." 4/21/26 11:30 AM – During an interview, the Surveyor asked R76 what his bathing preference was. R76 stated, "I prefer to take showers." The Surveyor asked R76 when was the last time he received a shower. R76 stated, "It's been a long time, and I begged for one and got it on the evening when the lift fell on my head." 4/22/26 11:30 AM – During an interview, the Surveyor asked R76 if he received his shower that was scheduled for the previous evening. R76 stated, "No, I was not offered a shower." R76's scheduled shower record revealed: 2/26 – Five bed baths, one shower and three episodes of refusals. 3/26 – Five bed baths, one shower and three episodes of refusals. 4/3/26 to 4/19/26 – Four bed baths, 2 showers and 1 episode of refusal. 4/24/26 12:00 PM – During an interview, the	F0561		06/11/2026

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F0561 SS = D	Continued from page 14 Surveyor asked E4 (UM) what process should be followed if a resident refused a shower. E4 stated, "The aide will offer the shower again and try to arrange a time more suitable for the resident. The aide will then inform the nurse if the resident continued to refuse. The nurse will speak to the resident about the shower and if the resident still refuses, the unit manager will be informed. The unit will speak to the resident, and the refusal will be documented in the progress notes." The Surveyor asked E4 what would happen on the evening shift if the unit manager was not there. E4 stated, "The evening supervisor will be informed, and a note will be written in the resident's record." R76's clinical record lacked evidence that he was offered a shower on 21 out of 27 opportunities. 4/24/26 2:20 PM – Findings were confirmed with E1 and E3. 4/27/26 1:35 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (COO), E16 (CN) and E17 (CN).	F0561		06/11/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F0580	1. R43 still resides at this facility. R43 was not negatively impacted by this deficient practice. NP was notified of skin alteration on 4/1/2026 with no new orders. 2. All residents with new skin alterations have the potential to be affected by this deficient practice. An audit of new skin risk managements completed in the last 30 days will be reviewed to verify that the provider was notified in a timely manner. Any identified concerns will be addressed immediately. 3. Root cause analysis was conducted and determined that the nurse failed to document the skin alteration in the medical record upon discovery on 3/31/2026. Nurse completed the late entry risk management and notification on 4/1/2026. The identified nurse is no longer employed at the facility. The Staff Developer will re-educate all licensed nursing staff on completing a timely risk management upon identification of new skin alterations. Risk management includes Provider/Family notification. This process is reviewed in new hire orientation for nurses and C.N.A. The facility will review all new risk management in daily clinical meeting to verify completion. 4. Wound Nurse or designee will conduct audits of residents with skin alterations to validate documentation of timely notification to provider.	06/11/2026

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F0580 SS = D	Continued from page 15 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R43) out of three residents reviewed for accident hazards, the facility failed to notify the provider when a new skin alteration was identified after an earlier incident where R43 spilled coffee. Findings include: R43's record revealed: 3/5/26 - R43 was admitted to the facility. 3/11/26 - The admission MDS documented that R43 required set-up assistance for eating. 3/30/26 8:30 AM - A nurse's note by E21 (RN/SD) documented, "Resident placed his coffee on the bed railing after letting go of the cup it fell back onto his lap spilling onto his bilateral upper thighs. Resident	F0580	Continued from page 15 Audits will be completed daily x 3 days or until 100% compliance is achieved, then 5 audits weekly for 3 weeks or until 100% compliance is achieved, then 5 audits monthly for 3 months or until 100% compliance is achieved Results of audits will be reviewed during the Quality Assurance and Performance Improvement (QAPI) meeting monthly. Additional education and corrective action will be implemented as indicated.	06/11/2026

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F0580 SS = D	Continued from page 16 was not wearing pants (sic) this nurse and CNA were about to assist resident with morning care. B/L [Bilateral] upper thighs nonblanchable redness all skin intact at this time. After morning care resident denied pain to the area...". 3/30/26 1:47 PM - A nurse's note by E20 (Wound Care RN) documented, "Evaluated skin to abdomen, thighs... No scalded skin present. PT [Patient] denies pain." 3/30/26 2:47 PM - A progress note by E19 (NP) documented under Physical Exam "... Skin: refer to skin assessment...". 3/31/26 12:00 AM - A late entry nurse's note by E22 (RN) was documented on 4/1/26 at 8:57 AM. The note stated, "during incontinence care by assigned CNA a right upper thigh broken blister... was noticed... Right upper thigh broken blister cleaned with saline pat dry and applied kin (sic) prep." Review of the facility's incident documentation revealed that E23 (MD) was notified of R43's blister on 4/1/26 at 8:38 AM, over 24 hours after the blister was identified. 4/23/26 2:17 PM - During an interview, E19 (NP) stated that she was notified of R43's coffee spill on 3/30/26. However, E19 reviewed the physician binder and confirmed that there was no evidence of R43's change of skin condition was communicated to a Provider as noted on 3/31/26. The facility failed to notify the on-call Provider when R43 had a change in skin condition after an incident where R43 spilled coffee on his skin. 4/27/26 1:35 PM - Finding was reviewed with E1 (NHA), E2 (DON), E3 (COO), E16 (Corp. Nurse) and E17 (Corp. Nurse).	F0580		06/11/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F0658	1. R12 still resides at this facility. R12 was not negatively impacted by this deficient practice. Resident was assessed by RN on following shift after fall. 2. All residents experiencing falls have the potential	06/11/2026

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(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
F0658 SS = D	Continued from page 17 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review and other facility documentation it was determined for one (R12) out of four residents sampled for falls the facility failed to ensure that an RN performed the initial post fall assessment and documentation after R12 slid off of the bed and was lowered to the floor on the 11 PM-7 AM shift. An RN post fall assessment was not performed until the 7 AM – 3PM shift. Findings include: Cross Refer F689 R12's clinical record revealed: 1/2/19 – R12 was admitted to the facility with the following diagnoses including but not limited to anoxic brain injury, abnormal posture, multiple contractures of the upper and lower limbs and idiopathic progressive neuropathy. 12/3/25 1:00 AM – A facility reported incident to the division documented "[R12] sustained fall 12/3/25 complaint of ankle pain later in day. Xray obtained, results unclear. Repeat film obtained on 12/5/25. 12/3/25 8:34 AM – A review of R12's initial post fall assessment was performed by E15 (ADON) on the 7 AM – 3 PM shift. [R12's] clinical record lacked evidence of an initial RN assessment until the next shift. 04/22/2026 2:30 PM - A review of a facility form titled, "Investigative Protocol Witness Summary Witness Written Summary by E14 (LPN) documented…. [R12] was in a seated position s/p (sic) fall denied any pain…. Assessed completed range of motion denied pain vss (sic) assisted CNA with care returned to bed. 4/23/26 1:38 PM – During an interview E2 (DON) stated, "the fall was not reported by the E24 (CNA) and E14 because they felt like it was not a fall because [R12] was assisted down to the floor." 4/27/26 1:11 PM During a phone interview E14 stated and confirmed "I was called by E24 saying [R14] fell we went in and provided care and assessed [R12]. I believe we called down to the RN, but I don't remember that was so long ago. I wrote	F0658	Continued from page 17 to be affected by this deficient practice. An audit of current resident falls occurring within the previous 30 days will be conducted to verify that a RN completed and documented the post fall assessment timely during the same shift if feasible. Any identified concerns will be addressed immediately. 3. Root cause analysis determined that the nurse failed to identify resident being assisted to the ground by C.N.A was considered a fall, therefore nurse did not notify the RN in the facility. Identified nurse was educated on 12/10/2025 by Staff developer on the definition of a fall and completion of risk management. The Staff Developer will re-educate all licensed nursing staff on definition of a fall and the requirement of a RN post fall head to toe and neurological assessment. New Hire orientation will be revised to include definition of fall and the need for RN assessment after a fall. The facility will review all new risk management in the daily clinical meeting to verify that post-fall assessment requirements are met. 4. The Director of Nursing or designee will conduct audits on Fall Risk Management to validate that the RN completed and documented the post fall head to toe and neurological assessment. Audits will be conducted for 3 falls daily x 3 days or until 100% compliance is achieved, then 5 falls weekly for 3 weeks or until 100% compliance is achieved, then 5 falls audited monthly for 3 months or until 100% compliance is achieved Results of audits will be reviewed during the Quality Assurance and Performance Improvement (QAPI) meeting monthly. Additional education and corrective action will be implemented as indicated.	06/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/27/2026

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F0658 SS = D	Continued from page 18 what E24 said on the incident report. I wasn't there when [R12] fell."	F0658		06/11/2026