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 Rehab Capitol Healthcare

DATE SURVEY COMPLETED: January 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 January 20, 2026, through January 27, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was ninety-five (95). The investigative sample totaled twenty-five (25) residents.		
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 was not met as evidenced by:** Cross Refer to the CMS 2567 – L survey completed January 27, 2026: F609, F628, F644, F695, F756, F760 and F842.	Cross Refer to the CMS 2567 for F tags F609, F628, F644, F695, F756, F760 and F842.	3/13/26

Provider's Signature _____ Title NHA Date 2/10/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085048	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION CAPITOL	**1225 WALKER ROAD , DOVER, Delaware, 19904**

(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 conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility from January 20, 2026 through January 27, 2026. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		03/13/2026
F0000	INITIAL COMMENTS An unannounced annual, and complaint survey was conducted at this facility from January 20, 2026 through January 27, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was ninety-five (95). The investigative sample totaled twenty-five (25) residents. Abbreviations/definitions used in this report are as follows: AA - Activity Aide; AD - Activity Director; ADON - Assistant Director of Nursing; AMA - against medical advice; BIPAP- bi-level positive airway pressure; CNA - Certified Nursing Assistant; DON - Director of Nursing; EpiPen - an injection to treat severe allergic reactions; FSD - Food Service Director; Long-Term Care Ombudsman Transfer Log; notification to the Ombudsman of resident discharges and transfers;	F0000		03/13/2026

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 MAR - Medication Administration Record; Morphine - an opioid or narcotic pain medication used to treat moderate to severe pain; MS Contin (Morphine) is an opioid pain medication; MRR - Monthly Medication Review, a pharmacist review of resident's medication; NHA - Nursing Home Administrator; NP - Nurse Practitioner; Ombudsman - resident representative who investigates reported complaints and helps to achieve agreement between parties; PASARR - Preadmission Screening and Resident Review, a multi-level screening test performed on residents to determine least restrictive setting their mental well-being; PRN - as needed; SW - Social Worker.	F0000		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations	F0609	R108 no longer resides in the facility and was not negatively impacted by this deficient practice. The allegation of abuse was reported to Division of Healthcare Quality (DHCQ) upon becoming aware of the allegation. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined in #3. A root cause analysis was conducted and it was determined that the facility failed to report abuse within the 2-hour time frame. A facility wide sweep was conducted and all other incidents were reported within the appropriate timeframe. Education will be conducted by the Director of Nursing with nursing staff on the 2-hour reporting requirements for abuse allegations. The Director of Nursing/Designee will conduct Daily audits of all clinical notes three times a week until 100% compliance, then weekly until 100% compliance is achieved for 3 consecutive audits, then monthly until 100% compliance is achieved and at that time the deficient practice will be considered resolved. Compliance will be considered achieved after clinical documentation shows that the facility took all	03/13/2026

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F0609 SS = D	Continued from page 2 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 interview and record review, it was determined that for two (R30 and R108) out of nine residents sampled for abuse, the facility failed to report an allegation of abuse to the state agency within two hours. Findings include: 2. Review of R108's clinical record revealed: 10/26/25 - E7 (CNA) documented in a written statement, "On October 25, 2025...around 11:15 PM I went to check on all my patients. When I got to [R108] she stated that 'the CNA that had her torn her clothes and was rough with her...". 10/26/25 11:08 AM - The facility submitted an allegation of staff to resident abuse incident involving R108 to the state agency, greater than two hours after R108's initial report to the facility. 1/23/26 10:19 AM - During an interview E7 (CNA) confirmed the aforementioned written statement and that R108's allegation of abuse was reported to a nurse on 10/25/25. 1/23/26 1:57 PM - During an interview E3 (ADON) confirmed the finding. E3 stated, "I found out through reading notes and things that it happened on the 25th but no one made leadership aware." 1/27/26 5:45 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON). The facility policy on abuse last updated 1/9/26 indicated, "Allegations of abuse shall be reported to the appropriate state regulatory authority within two hours." 1. A review of R30's clinical record revealed: 1/6/19 – R30 was admitted to the facility. 10/25/25 7:15 PM – R30 reported E4 (CNA) was rough with care. 10/27/25 11:09 AM – The facility reported an allegation	F0609	Continued from page 2 necessary steps to report abuse timely. The clinical notes audit will assist the facility when conducting an alleged abuse investigation based on timing of the documentation versus when the allegation of abuse occurred. All audit findings will be brought through the facility's quarterly QA Meeting for review. R30 was not negatively impacted by this deficient practice. The allegation of abuse was reported to the Division of Healthcare Quality (DHCQ) upon becoming aware of the allegation. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined in #3. A root cause analysis was conducted and it was determined that the facility failed to report abuse within the 2-hour time frame. A facility wide sweep was conducted and all other incidents were reported within the appropriate timeframe. Education will be conducted by the Director of Nursing with nursing staff on the 2-hour reporting requirements for abuse allegations. The Director of Nursing/Designee will conduct Daily audits of all clinical notes three times a week until 100% compliance, then weekly until 100% compliance is achieved for 3 consecutive audits, then monthly until 100% compliance is achieved and at that time the deficient practice will be considered resolved. Compliance will be considered achieved after clinical documentation shows that the facility took all necessary steps to report abuse timely. The clinical notes audit will assist the facility when conducting an alleged abuse investigation based on timing of the documentation versus when the allegation of abuse occurred. All audit findings will be brought through the facility's quarterly QA Meeting for review.	

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F0609 SS = D	Continued from page 3 of abuse to the State agency. 1/22/25 11:07 AM – During an interview with E3 (DON), it was confirmed that the allegations of abuse must be reported within two hours. 1/22/25 12:00 PM – During an interview with E1 (NHA), it was confirmed that the alleged abuse was not reported within two hours. The facility failed to report the allegation of abuse to the State Agency within the designated timeframe of two hours. 1/27/26 5:45 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0609		
F0628 SS = A	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F0628		03/13/2026

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F0628 SS = A	Continued from page 4 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section	F0628		

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F0628 SS = A	Continued from page 5 must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term	F0628		

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F0628 SS = A	Continued from page 6 Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of	F0628		

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F0628 SS = A	Continued from page 7 the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interviews and review of other facility documents it was determined that resident that for one (R107) out of two residents sampled for discharge the facility failed to report R107's discharge to the Ombudsman. R107 left the facility AMA (Against Medical Advice) on 11/24/25. The facility reported the discharge to the Ombudsman on 1/21/26 two months later. Findings include: A review of R107's clinical record revealed: 11/15/25 - R107 was admitted to the facility. 11/24/25 8:12 AM - A social services progress note documented "Received email this weekend from staff that [R107] wished to be discharged on Monday 11/24/25. Spoke with [R107] at bedside with resident who stated "arranging for family to pick him up this morning. Discussed if there were any changes that could be made [R107] reports that care was good during his stay." 11/24/25 12:07 PM - A review of R107's progress note documented "[R107] decided to leave the facility today all attempts at encouraging R107 to stay and continue therapy failed. Prescriptions were obtained from the provider even though R107 said they were not needed. [R107] was picked up by family about noon with all belongings and discharged paperwork. 1/22/26 3:15 PM - During an interview E6 (SW) was asked to provide notification for [R107's] discharge status of AMA to the Ombudsman. 1/23/26 8:46 AM - During an interview E1 (NHA) stated, "E6 did not notify the Ombudsman [R107] discharged from the facility on 11/24/25." A facility fax to the Ombudsman titled "Long-Term Care Ombudsman Transfer Log" dated 1/21/26 confirmed notification of the discharge occurred two months after the date of discharge. 1/27/26 5:45 PM - Findings were reviewed at the exit conference with E1(NHA) and E2 (DON).	F0628		
F0644 SS = D	Coordination of PASARR and Assessments	F0644	R5 was not negatively impacted by this deficient practice. The resident's Preadmission Screening and	03/13/2026

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F0644 SS = D	Continued from page 8 CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R5) out of three residents reviewed for PASRR (Preadmission Screening and Resident Review), the facility failed to refer R5 for a PASRR evaluation as required when a resident experiences a significant change in mental health status. Findings include: Review of R5's clinical record revealed: 2/6/23 - R5 was re-admitted to the facility. 11/13/23 - R5's Notice of PASRR Level II Outcome indicated that R5 had the following mental health diagnoses: -Adjustment Disorder with depressed mood -Delusional Disorder -Dementia -Mood Disorder NOS (not otherwise specified) -Anxiety Disorder NOS -Psychotic Disorder NOS -Insomnia	F0644	Continued from page 8 Resident Review (PASRR) was updated to reflect the updated diagnosis. The request for an updated PASRR was submitted to the PASRR team was completed on 1/23/26. All residents who require a PASRR assessment have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined in #3. A root cause analysis was conducted and it was determined that the facility social worker was not being informed when residents had a change in psychiatric diagnosis. A facility wide audit was conducted and no other issues were identified. The Psychiatric Nurse Practitioner will be educated to notify the social worker of any changes in diagnoses so that the social worker can refer the resident for a PASSR evaluation. The Director of Nursing/designee will conduct audits of all psychiatric notes for any changes and/or a new mental health diagnosis was added to the resident's chart to determine if a new PASSR is needed daily until 100% compliance is achieved for 3 consecutive audits, then weekly until 100% compliance is achieved for 3 consecutive audits, then monthly until 100% compliance is achieved and at that time the deficient practice will be considered resolved. Review of documentation will determine if a new diagnosis was added or a new medication was added in the resident's chart to determine if a new PASRR is needed. All audit findings will be brought through the facility's quarterly QA Meeting for review.	

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F0644 SS = D	Continued from page 9 -Major Depressive Disorder, recurrent, severe, with psychotic symptoms 2/14/25 - R5's quarterly MDS (Minimum Data Set) assessment revealed R5's new psychiatric/mood disorder diagnoses including bipolar disorder, adjustment disorder with mixed anxiety and depressed mood and unspecified mood affective disorder. 3/25/25 - R5's significant change MDS assessment revealed R5's psychiatric/mood disorder diagnoses including but not limited to: bipolar disorder, restlessness and agitation, unspecified mood affective disorder and adjustment disorder with mixed anxiety and depressed mood. 6/25/25 - R5's quarterly MDS (Minimum Data Set) assessment revealed R5's new psychiatric/mood disorder diagnoses including but not limited to: bipolar disorder, adjustment disorder with mixed anxiety and depressed mood and unspecified mood affective disorder. 9/25/25 - R5's quarterly MDS (Minimum Data Set) assessment revealed R5's new psychiatric/mood disorder diagnoses including but not limited to: bipolar disorder, adjustment disorder with mixed anxiety and depressed mood and unspecified mood affective disorder. 12/26/25 - R5's quarterly MDS (Minimum Data Set) assessment revealed R5's new psychiatric/mood disorder diagnoses including but not limited to: bipolar disorder, adjustment disorder with mixed anxiety and depressed mood and unspecified mood affective disorder. 1/22/26 2:00 PM - A review of R5's mental health diagnoses report revealed that R5's new diagnoses with onset dates included: -Adjustment Disorder with mixed anxiety and depressed mood (7/24/24) -Bipolar Disorder, unspecified (1/17/24) -Unspecified Dementia, unspecified severity with other behavioral disturbance (1/17/24) 1/22/26 4:00 PM - During an interview, E1 (NHA) confirmed that R5's PASRR evaluation was not updated and submitted to the PASRR state authority when R5 was diagnosed with Adjustment Disorder with mixed anxiety and depressed mood, Bipolar Disorder and Unspecified Dementia unspecified severity with other behavioral disturbance in 2024.	F0644		

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F0644 SS = D	Continued from page 10 1/27/26 5:45 PM - Findings were reviewed at the exit conference with E1 (NHA) and E2 (DON).	F0644		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review it was determined for one (R6) out three residents sampled for respiratory care the facility failed to provide professional standards of practice by ensuring R6's BiPap equipment was stored in a protective plastic bag when not in use. Findings include: A review of R6's clinical record revealed: 1/10/24 – R6 was admitted to the facility with diagnoses of acute respiratory failure and interstitial pulmonary disease. 12/28/25 – A quarterly MDS documented that R6 was cognitively intact. 1/20/26 – A physician's order documented BIPAP application at bedtime (HS) and PRN. The order specified: "BIPAP setting: 10 cm H ,O with O , bleed-in at 2 liters." 1/26/26 – A review of the treatment administration record lacked evidence of an order directing that the BIPAP mask and tubing be stored in a protective plastic bag when not in use. 1/20/26 at 10:11 AM – R6's BIPAP mask was observed lying on the bedside table, with the tubing on the floor. 1/21/26 at 8:40 AM – R6's BIPAP mask was again observed lying on the bedside table, with the tubing on the floor. 1/21/26 at 8:50 AM – During an interview, E5 (LPN)	F0695	R6 was not negatively impacted by this deficient practice. R6's BiPap mask was placed in a protective bag upon discovery. All residents who have orders for a BiPap mask have the potential to be affected by this deficient practice. The facility will put a process in place to prevent this deficient practice from occurring in the future. Future residents will be protected from this deficient practice by taking the corrective action outlined in #3. A root cause analysis was conducted and it was determined that the facility failed to assure that the BiPap mask was placed in a plastic storage bag when not in use. A facility wide sweep was conducted and no other residents were identified as being affected by this deficient practice. The facility unit managers/supervisors will conduct unit rounding twice a shift to audit if resident's BiPap masks are properly stored in plastic bags when not in use. The DON/designee will educate nursing staff on proper storage of BiPap masks when not in use. The DON/designee will conduct audits on all residents with BiPap masks for proper storage daily until 100% compliance is achieved for 3 consecutive audits, then weekly until 100% compliance is achieved for 3 consecutive audits, then monthly until 100% compliance is achieved and at that time the deficient practice will be considered resolved if BiPap masks are found to be stored properly when not in use during internal audits. All audit findings will be brought through the facility's quarterly QA Meeting for review.	03/13/2026

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F0695 SS = D	Continued from page 11 stated that BIPAP masks and tubing are required to be stored in a protective plastic bag when not in use. Following the interview, E5 entered R6's room and confirmed that the BIPAP mask and tubing were not stored in a protective plastic bag. E5 immediately placed the BIPAP mask and tubing into a protective plastic bag. 1/21/26 8:50 AM - During an interview, E5 (LPN) stated that BIPAP masks and tubing are required to be stored in a protective plastic bag when not in use. Following the interview, E5 entered R6's room and confirmed that the BIPAP mask and tubing were not stored in a plastic bag. E5 immediately placed the BIPAP mask and tubing in a protective plastic bag. 1/27/2026 5:45 PM – Findings were reviewed at the exit conference with E1 (NHA) and E2 (DON).	F0695		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no	F0756	R81 was not negatively affected by this deficient practice. A PRN Epi Pen order was added and currently available. The diagnosis for R81's Risperdal was updated to major depression disorder. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined in #3. A root cause analysis was conducted and it was determined that the facility did not have a process in place to assure that all Monthly Regimen Reviews (MRR's) were reviewed and recommendations were addressed with the provider. The DON will be made aware by the Pharmacy via email when an MRR has been completed. A facility-wide sweep was conducted and no further issues were found. The DON/designee will track all future MRR's to ensure completion and recommendations implemented. The DON/designee will educate the Nursing Admin team on the process for MRR follow up. The Director of Nursing/Designee will conduct audits on all MRRs monthly until 100% compliance is achieved for 3 consecutive audits and at that time the deficient practice will be considered resolved. The DON will compare the MRR'S that are returned from the Unit Managers with what the pharmacy has sent to assure all MRR's were addressed timely. All audit findings will be brought through the facility's quarterly QA Meeting for review.	03/13/2026

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F0756 SS = D	Continued from page 12 change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for one (R81) out of five residents reviewed for unnecessary medication review the facility failed to implement the MRR policies when recommendations made by the pharmacist and agreed by the provider were not completed by the facility. Findings include: The facilities Pharmacist monthly drug review policy last updated 1/23/26 indicated, "Facility will encourage physician/prescriber or other responsible parties and the DON to act upon the recommendations contained in the monthly drug review." Review of R81's clinical record revealed: 5/15/25 - R81 was admitted to the facility with multiple diagnoses including dementia with behavioral disturbance, anxiety, depression and an allergy to bee venom. 5/30/25 - An MRR recommended an EpiPen be considered related to R81's bee venom allergy, and that R81's Risperdal prescribed for major depressive disorder was an inappropriate use for an antipsychotic. The recommendations were marked as agreed by R81's physician. 6/29/25 - An MRR recommended an EpiPen be considered related to R81's bee venom allergy. The recommendation was marked as agreed by R81's physician. 7/27/25 - An MRR recommended an EpiPen be considered related to R81's bee venom allergy, and that R81's Risperdal prescribed for mood was an inappropriate use for an antipsychotic. The recommendations were marked as agreed by R81's physician. 1/22/26 10:00 AM - Review of R81's physicians orders revealed the order for Risperdal continued as indicated	F0756		

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F0756 SS = D	Continued from page 13 for 'mood'. There was no order written for an EpiPen, 1/22/26 10:38 AM - During an interview E9 (LPN) unlocked and opened the medication cart where R81's medications were stored and confirmed that there was no EpiPen prescribed to R81 in the medication cart. 1/22/26 10:40 AM - During an interview E8 (LPN, UM) confirmed that the correct diagnosis for R81's order for Risperdal not listed and that there was no epi-pen ordered for the resident. 1/27/26 5:45 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0756		
F0760 SS = SQC-J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R5) out of nine residents reviewed for medication administration, the facility failed to ensure that R5 received the correct dose of morphine sulfate for pain when R5 erroneously received 15 mL (milliliter) of the concentrated morphine sulfate oral solution instead of the physician prescribed dose of 0.25 mL on 12/7/25 at 10:58 AM. With this significant medication error, R5 was at risk of a severe, life-threatening respiratory depression or death. R5 was administered Naloxone 0.4 mg/mL intramuscularly two times to reverse R5's overdosage on 12/7/25 at 4:13 PM and 8:02 PM. An immediate Jeopardy (IJ) was identified starting 12/7/25. Due to the facility's corrective measures following the last incident, this is being cited as immediate jeopardy, past non - compliance with an abatement date of 12/11/25. Findings include: A facility policy titled "Medication Administration", dated 1/13/26, documented, "It is the policy of this facility to ensure that all medications are administered safely, accurately, timely, and in accordance with physician's orders, federal and state regulations ... Medication administration shall comply with the "Rights of Medication Administration" ... Definitions ... Medication Administration Rights: Right resident, right medication, right dose, right route, right time, right documentation, right reason, right	F0760	"Past Noncompliance - no plan of correction required"	03/13/2026

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F0760 SS = SQC-J	Continued from page 14 response." Review of R5's clinical record revealed: 8/16/19 - R5 was admitted to the facility with diagnoses including but not limited to dementia. 9/25/25 - R5's quarterly MDS (Minimum Data Set) assessment revealed that R5's cognition was moderately impaired with a BIMS score of 10 and was receiving opioids (a class of drugs used primarily to treat moderate - to - severe pain). 11/21/25 - R5 had a physician's order for 0.25 mL = 5 mg (milligram) morphine sulfate (an opioid concentrate) oral solution every three hours as needed for pain. 12/7/25 7:04 AM - R5 had a new physician's order for MS Contin (morphine sulfate) oral tablet extended release 15 mg by mouth two times a day for pain. 12/7/25 4:43 PM - A nurse progress note documented, "At about 1530 (3:30 PM) during rounds on (unit), the outgoing nurse called me because 300 mg morphine sol (sic) was given to [R5]. [P1] (facility Medical Director) was called, family was made aware and Hospice was too (sic). [R5] monitor for any changes." 12/7/25 7:11 PM - A nurse progress note documented, "Late entry at 1520 (3:20 PM) order from [P1] for naloxone (medication used to reverse or reduce the effects of opioids). Naloxone was given at 1613 (4:13 PM)." 12/7/25 7:44 PM - A nurse progress note documented, "Naloxone HCL (hydrochloride) Injection Solution 0.4 MG/ML Inject 0.4 mg/ml intramuscularly STAT (at once/immediately) for overdose." 12/7/25 8:02 PM - A nurse progress noted documented, "gave 2nd dose of Naloxone 0.4 mg/ml per [P1]." 12/7/25 - A written statement by E30 (LPN) documented, "On December 7, 2025 at about 0900 am (sic), I made a medication error during my morning medication pass. I administered 15 mL of morphine to a patient [R5] instead of the intended dose of 0.25 mL. The system displayed the ordered dose of morphine 15 mg, while the patient's bottle label stated 0.25 mL. I sought clarification from my supervisor, who confirmed that I should follow the dose listed in the patient's MAR (Medication Administration Record) in the system. Unfortunately, I incorrectly interpreted 15 mg as 15 mL."	F0760		

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F0760 SS = SQC-J	Continued from page 15 12/7/25 - A written statement by E19 (3-11 shift RN Supervisor) documented," During my rounds on (unit) the off going (sic) nurse [E30] called me and she said 'I made a medication error on the narcotic' ... I called [P1] and notified her of the error ...". 12/8/25 9:12 AM - A physician note by P1 documented, " I was notified yesterday, 12/7/25 at 3:30 PM by nursing staff that pt (patient) was given 15 ml of liquid morphine by floor nurse at 930 AM 12/7/25. Liquid morphine has concentration of 20 mg/ml so pt was given 300 mg of morphine instead of 5 mg. I was told that the nurse made a mistake. I was told that pt's sleepy but vitals are stable. I requested 0.4 mg Narcan to be administered. I called back at 5 PM and was told that pt's heart rate is dropping, so I ordered another dose of Narcan 0.4 mg. I also advised staff to hold all PO meds until further orders. I called back at 9 PM, and I was told that pt is stable and is resting. I have emailed DON and Administrator today to set up a call to investigate this grave med error and so that we can do a root cause analysis." 12/10/25 - A facility follow up report documented that approximately 9:00 AM E30 administered 15 mL of morphine sulfate concentrate to R5 after reading morphine 15 mg 1 tablet on the MAR. During the shift exchange (between 7-3 and 3-11) E30 recognized the error in administration of mL versus mg. The follow up report further documented, "[R5] had order for Morphine Sulfate Solution 100 mg/5mL give 0.25 mL every 3 hours as needed. On 12/7 [R5] had new order for MS Contin oral tablet give 15 mg two times a day for pain which was pending delivery from the pharmacy ... Upon identification of medication error, [R5] was assessed and monitored. [P1] was notified and order was given for Narcan (Naloxone), which was administered twice. [R5] was placed on alert charting and vital signs, respiratory status and mentation monitored. [P1] gave order to hold medications...". 1/22/26 2:20 PM - In an interview, E12 (RN) stated that she was the supervisor on 12/7/25 during the 7-3 shift. E12 stated that on that morning she was doing her rounds and was walking to E30's unit on her way to see another resident. E12 stated she saw E30 who was passing meds. E30 stopped her to ask what to do when a resident's narcotic medication ran low, and whether to administer the last dose of the medication or to hold it. E12 stated that she told E30 to administer the medication as ordered by the physician and to call the doctor and pharmacy for refill. E12 further stated, "I did not know what specific narcotic medication she was	F0760		

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F0760 SS = SQC-J	Continued from page 16 talking about. I thought it was just a general procedure question that she asked me as I walked past her on my way to another resident's room. At the end of our day shift, I was notified by the incoming nurse that [E30] gave the wrong dose of medication to [R5]. 1/22/26 3:34 PM - During an interview, E16 (LPN) stated that she worked on 12/7/25 and was the incoming and reliving nurse on the 3 - 11 shift. E16 stated that she saw E30 looking at the narcotic book and told her that R5 ran out of the concentrated morphine sulfate. E16 stated that she worked a double shift (7-3 and 3-11) the day before on the same unit with R5 on her assignment and was familiar with R5's morphine sulfate dosage order. E12 further stated, "I know [R5] gets 0.25 mL morphine sulfate every three hours when needed for pain. I left my shift at 11:00 PM on 12/6/25, with [R5's] 17.25 mL remaining morphine sulfate concentrate in the bottle. [E30] informed me that she gave 15 mL morphine sulfate concentrate to [R5]". The facility failed to ensure that R5 was free from significant medication administration error when R5 received 15 ml of the concentrated morphine sulfate oral solution instead of the ordered dose of 0.25 ml on 12/7/25 at 10:58 AM. This resulted in a significant medication error for R5 who received 59 more doses of the morphine sulfate solution than the prescribed physician order. 1/27/26 10:45 AM - An Immediate Jeopardy (IJ) was called and reviewed with the facility leadership including E1 (NHA). During this conference, E1 confirmed that there had been no other incidents of significant medication error after the 12/7/25 incident. 1/22/26 - E1 (NHA) presented to surveyor an acceptable documentation of corrective action plan that was fully abated on 12/11/25. The facility's corrective actions at the time of the incident included: 1. Upon discovery of the medication error, R5 was immediately assessed, and physician was notified. New order for Narcan (Naloxone) obtained and administered out of an abundance of caution. R5's responsible party and Hospice were also notified. R5 was placed on alert charting to monitor vital signs and respiratory status. R5 remains in the facility and had no adverse outcomes related to the medication error. 2. All residents with orders for liquid morphine have the potential to be affected by this deficient practice. An audit was completed on like residents	F0760		

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F0760 SS = SQC-J	Continued from page 17 receiving morphine and no other errors were identified. An audit of like residents receiving controlled substances was completed to determine if any other residents had orders for the same medication in two different forms and no other residents were identified. 3. The facility conducted a root cause analysis, and it was determined that the assigned nurse failed to perform the five rights of medication administration when the nurse misinterpreted 15 mg as 15 ml. Education with licensed nurses was completed on five rights of medication administration. Education was completed on 12/11/25. Medication error was reviewed with medical director at an ad hoc QAPI meeting on 12/10/25. The facility was back in substantial compliance on 12/11/25. 4. Director of Nursing will conduct audits of liquid morphine medication administration. 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. No immediate action required related to past non-compliance. This was verified by review of facility documents and interview with facility staff and residents. 1/27/25 5:45 PM - Findings were reviewed at the exit conference with E1 (NHA) and E2 (DON).	F0760		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional	F0842	R119 no longer resides in the facility. R119 was not negatively impacted by this deficient practice. The facility was unable to correct. All residents who are issued a Notice of Medicare Non-Coverage (NOMNC) have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined in #3. A root cause analysis was conducted and it was determined that the facility was not able to locate the signature page of the NOMNC. It was determined that the facility did not have a process in place to audit NOMNCs for completion and signature. A new process will be put into place that the MDS Director will audit all future NOMNC's to verify completion of the form and the signature page is in place before the form is uploaded into the medical record. A facility wide sweep was	03/13/2026

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F0842 SS = D	Continued from page 18 standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain-	F0842	Continued from page 18 conducted and no other issues were identified. The Corporate Registered Nurse Assessment Coordinator will educate the Social Worker on ensuring the NOMNCs are completed accurately. The MDS Director/Designee will audit NOMNCs for accurate completion daily until 100% compliance is achieved for 3 consecutive audits, then weekly until 100% compliance is achieved for 3 consecutive audits, then monthly until 100% compliance is achieved and at that time the deficient practice will be considered resolved. All audit findings will be brought through the facility's quarterly QA Meeting for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085048	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION CAPITOL	1225 WALKER ROAD , DOVER, Delaware, 19904

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F0842 SS = D	Continued from page 19 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that the facility failed to maintain accurate and complete records for one (R119) out of three residents reviewed for beneficiary notification. Findings include: Review of R119's medical record revealed: 7/25/25 - The facility provided a Notice of Medicare Non-Coverage (NOMNC) to R119 to relay that services would end on that date. 1/23/26 - During the beneficiary notification review, a review of R119's worksheet and relevant documents lacked evidence of the second page, the signature page to validate the resident or their responsible party received and understood the notice. 1/23/26 1:15 PM - During an interview, E6 (SW) confirmed the finding and relayed that the facility was unable to locate R119's signature page to their NOMNC. 1/27/26 5:45 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0842		