**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:** October 1, 2026

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLE-TION DATE |
|---|---|---|---|---|
| | **The State Report incorporates by reference and also cites the findings specified in the Federal Report.**<br><br>An unannounced follow-up to the complaint and extended survey ending August 11, 2026, was completed on October 1, 2026. The survey process included observations, interviews, and review of residents' clinical records and other documentation. The facility census on the day of the survey was one hundred and sixteen (116). The survey sample size was three (3) 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.**<br><br>**This requirement is met as evidenced by:**<br><br>The facility was found to be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities as of September 25, 2026. | | | |

Provider's Signature Michele Nolan Title LNHA Date 10/15/26

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085056 | A. BUILDING<br>B. WING | 10/01/2026 |

| 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 |
|---|---|---|---|---|
| F0000 | INITIAL COMMENTS<br><br>An unannounced follow-up to the complaint and extended survey ending August 11, 2026 was completed on October 1, 2026. The survey process included observations, interviews, review of residents' clinical records and other documentation. The facility census on the day of the survey was one hundred and sixteen (116). The survey sample size was three (3) residents. The facility was found to be in substantial compliance as of September 25,2026. | F0000 | | |

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 |
|---|---|---|
| | | |