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: March 27, 2025

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. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare and Medicaid Services (CMS). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 03/10/25 - 3/27/25 Survey Census: 111 Sample Size: 41		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed March 27, 2025: F585, F600, F609, F610, F623, F625, F684, F689, F690, F759, F814 and F880.		

Provider's Signature Nichole Nolan Title ADHP Date 4/2/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A Recertification, Complaint, and Emergency Preparedness survey was conducted by Healthcare Management Solutions, LLC, on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality on 03/10/25 through 03/27/25. The facility was found to be in substantial compliance with 42 CFR 483 73.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare and Medicaid Services (CMS). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 03/10/25 - 3/27/25 Survey Census: 111 Sample Size: 41	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the	F 585		5/11/25

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

Electronically Signed | 04/10/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 1 facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 2 example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to inform seven of seven residents in the resident council about the facility's grievance policy, the grievance official responsible for overseeing the grievance process was with their contact information and resolve grievances for three (Residents (R)158, R34, and R59) of three residents reviewed for grievances. This failure could prevent residents from addressing concerns and seeking resolution, leading to frustration and potentially impacting their well-being. Findings include: Review of the facility policy titled, "Grievances," review date 01/03/25, provided by the facility revealed "All grievances reported by a resident, responsible party, resident representative or family member will be promptly investigated and resolved. Follow up will be reported to the resident and/or reporting party." "The facility will post guidance on how to file a grievance or complaint in prominent locations throughout the facility." "a. All grievance decisions shall be documented on the Resident Concern Form." 1. Review of the resident council minutes for March 2024 through February 2025 did not include any discussion of the facility's grievance process. On 03/12/25 at 01:48 PM, the grievance policy was observed posted in the glass case in the front hallway at the second-floor main entrance. The posting was high above the standard height, making it difficult to read.	F 585	1. Grievance policy/procedures reviewed in Resident Council on 3/27/25. Grievance policies posted throughout the facility were immediately moved to wheelchair height. Grievance policy/procedures included in the new admission hospitality welcome packet. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in Section C. 3. A review of all residents with current grievances was completed to ensure grievance policy and procedures were followed correctly and no other residents were affected by this deficient practice. A root cause analysis was conducted that determined staff failed to follow facility□s grievance policy/procedures. The Staff Developer/designee will educate all staff on Cadia□s grievance policy/procedures. The Social Services Director/designee will review the grievance policy/procedures with all alert and oriented residents. The facility will place grievance/concern boxes in common areas for residents to be able to file grievances anonymously. 4.The Social Services Director/designee will review all new concerns/grievances weekly to ensure proper documentation/completion of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 4 On 03/11/25 at 2:29 PM, seven of seven residents in the resident council stated they were unaware of any formal complaint process the facility had. They were also unaware of any posting that would inform them. None of them knew of anyone designated to report complaints to, except the social worker. During an interview on 03/11/25 at 5:03 PM, the Social Service Director (SSD) was asked who the facility's grievance officer was. SSD stated it was the Administrator. SSD stated most complaints come through her department. SSD stated she writes out the concern and gives it to that department to be investigated and resolved. The Administrator then reviews it and signs off on them. SSD was asked how residents learned how to make a complaint. SSD stated they asked during resident council if anyone has a concern, and the policy was also posted. SSD was asked how residents that don't attend resident council find out about the grievance process. SSD stated she wasn't sure but going forward they will find a way to better educate. During an interview on 03/14/25 at 2:11 PM, the Administrator was informed during the resident council interview, seven of seven residents stated they were unaware of the facility's grievance process, how to make an anonymous complaint or who the grievance officer was. The Administrator stated there was a complaint box in front of the building residents could use and she has received complaints from residents from the box. 2. Review of the undated "Admission Record" in the electronic medical record (EMR) under the	F 585	grievance/concern form and resolution within the allotted 5 days of receiving the form. The Social Services Director/designee will randomly interview 5 residents from each floor to ensure they have no grievances/concerns. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings. 1. R158 no longer resides in the facility. R158 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in Section C. 3. A review of all residents with current grievances was completed to ensure grievance policy and procedures were followed correctly and no other residents were affected by this deficient practice. A root cause analysis was conducted that determined staff failed to follow facility□s grievance policy/procedures.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 5 "Profile" tab revealed R158 was admitted to the facility on 08/30/24 and was discharged on 11/08/24. R158's closed record was reviewed. During an interview on 03/11/25 at 3:47 PM, Family Member (FM)1, the responsible party for R158, stated there were multiple concerns occurring during R158's stay at the facility. FM1 stated she had filed grievances and talked with numerous staff including the SSD, Director of Nursing (DON), and the Administrator. FM1 stated one of her concerns was poor housekeeping services. FM1 stated the housekeeper assigned to R158's room did not clean the room and bathroom adequately. FM1 stated R158's toilet went five days one time without getting cleaned. FM1 stated public areas were also not cleaned and there were dirty floors, furniture etc. R158 stated staff did not address her concerns adequately and filed housekeeping grievance more than once. Review of a "Resident Concern Form" dated 09/03/24 and provided by the facility revealed FM1's grievance was taken by the SSD and included two concerns. One concern related to nursing and call bells and the other concern was about housekeeping. The housekeeping concern indicated there was a lack of housekeeping over the weekend, the garbage was full, and there were flies. The "Resident Concern Form" investigation was completed by the DON and addressed the nursing concern; however, did not address the housekeeping concerns. There was no response to the "Resident Concern Form" addressing the housekeeping issues. Review of a "Resident Concern Form" dated 10/11/24 revealed FM1 filed a grievance on this	F 585	The Staff Developer/designee will educate all staff on Cadia□s grievance policy/procedures. The Social Services Director/designee will review the grievance policy/procedures with all alert and oriented residents. The facility will place grievance/concern boxes in common areas for residents to be able to file grievances anonymously. 4.The Social Services Director/designee will review all new concerns/grievances weekly to ensure proper documentation/completion of grievance/concern form and resolution within the allotted 5 days of receiving the form. The Social Services Director/designee will randomly interview 5 residents from each floor to ensure they have no grievances/concerns. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings. 1. R34 still resides in the facility. R34 was not negatively impacted by this deficient practice. 2. All residents have the potential to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 6 date with the SSD due to R158's room and bathroom not being cleaned for days at a time, feces on the bathroom floor and the dining room not getting cleaned from the previous day. The "Resident Concern Form" investigation was completed by the Housekeeping Director (HD) and FM1 was contacted on 10/18/24 with the results. Resolutions included inservicing housekeeping staff about the importance of cleaning rooms. During an interview on 03/12/25 at 3:10 PM, the SSD stated she did not remember FM1 expressing any concerns to her. The SSD stated when residents or family brought her concerns, she initiated the "Resident Concern Form" and then forwarded the form to the relevant department to do the investigation, document their response and contact the complainant once the investigation was completed. The SSD stated once the investigation was completed, the department head brought her the completed form, and she took it to the Administrator for signature. During an interview on 03/12/25 at 3:27 PM, the Housekeeping Director (HD) stated she remembered speaking to FM1 about housekeeping concerns and had responded to a "Resident Concern Form." The HD stated when she received a "Resident Concern Form" she investigated the concern, documented the information on the form, and then contacted the complainant to discuss the results. The HD reviewed two "Resident Concern Forms" one dated 09/03/24 and one dated 10/11/24. The HD stated she completed the investigation and responded to the "Resident Concern Form" dated 10/11/24. The HD stated she personally checked	F 585	impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in Section C. 3. A review of all residents with current grievances was completed to ensure grievance policy and procedures were followed correctly and no other residents were affected by this deficient practice. A root cause analysis was conducted that determined staff failed to follow facility□s grievance policy/procedures. Facility updated Food brought from home to include that personal refrigerators are not permitted in resident rooms and included in new admission hospitality welcome packet. The Staff Developer/designee will educate all staff on Cadia□s grievance policy/procedures. The Social Services Director/designee will review the grievance policy/procedures with all alert and oriented residents. The facility will place grievance/concern boxes in common areas for residents to be able to file grievances anonymously. 4. The Social Services Director/designee will review all new concerns/grievances weekly to ensure proper documentation/completion of grievance/concern form and resolution within the allotted 5 days of receiving the form. The Social Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 7 R158's room for cleanliness after the grievance filed on 10/11/24. The HD reviewed the "Resident Concern Form" dated 09/1024 and verified she had not responded to that grievance and there was no response on the form related to the housekeeping concerns. The HD stated she did not remember responding to more than one "Resident Concern Form" from FM1. During an interview on 03/14/25 at 11:30 AM, the DON stated she met with FM1 several times about her concerns. The DON verified she responded to the nursing concerns on the "Resident Concern Form" dated 09/03/24. The DON stated when a grievance had concerns that addressed two departments such as nursing and housekeeping, two copies of the form were made with each copy going to the appropriate department head. The DON stated she did not investigate or respond to the housekeeping concerns on the "Resident Concern Form" dated 09/03/24. During an interview on 03/14/25 at 1:46 PM, the Administrator stated she was not employed when the grievance in September 2024 was filed by FM1. The Administrator stated the Administrator oversaw the grievance process and signed off on the grievance once completed. The Administrator stated if there were allegations for two different departments, each department should get a copy of the grievance and each department should respond. The Administrator stated the two responses should get combined for the total response. During an interview on 03/14/25 at 4:05 PM, the Administrator stated she could not find where the housekeeping part of the grievance dated	F 585	Director/designee will randomly interview 5 residents from each floor to ensure they have no grievances/concerns. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings. 1. R59 still resides in the facility. R59 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in Section C. 3. A review of all residents with current grievances was completed to ensure grievance policy and procedures were followed correctly and no other residents were affected by this deficient practice. A root cause analysis was conducted that determined staff failed to follow facility□s grievance policy/procedures. The Staff Developer/designee will educate all staff on Cadia□s grievance policy/procedures. The Social Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 8 09/03/25 had been addressed. 3. Review of R34's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 12/10/24 and located in the EMR under the "MDS" tab, revealed R34 had an admission date of 02/13/17 and a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated R34's cognition was intact. The MDS assessment indicated R34 had diagnoses that included depression, anxiety, and cerebrovascular disease. Review of R34's "care plan," dated 03/20/20, located in the EMR under the "Care Plan" tab revealed an intervention "R34 states that it is important to her to take care of her personal belongings and things. R34 prefers to use personal products she has purchased (dollar store/trips) but will also use facility issued personal products. She performs her own oral care and for hygiene requests that the staff keep her well groomed and "nice". She prefers to have her personal items kept in order in her room." Review of R34's "orders," dated 07/01/20, located in the EMR under the "Order" tab revealed "Palliative Care..." Review of the facility's grievances, dated 03/2024 to 03/2025, revealed no grievance addressing R34's personal property. During the resident council interview on 03/11/25 at 2:29 PM, R34 stated she had a small refrigerator for two or three years in her room and staff recently took it out of her room with no explanation. R34 stated the small refrigerator was currently at the nurse's station for her family to	F 585	Director/designee will review the grievance policy/procedures with all alert and oriented residents. The facility will place grievance/concern boxes in common areas for residents to be able to file grievances anonymously. 4. The Social Services Director/designee will review all new concerns/grievances weekly to ensure proper documentation/completion of grievance/concern form and resolution within the allotted 5 days of receiving the form. The Social Services Director/designee will randomly interview 5 residents from each floor to ensure they have no grievances/concerns. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 9 pick up. R34 went on to say it was only big enough to hold two or three cans of soda. During an interview on 03/11/25 at 3:48 PM, Licensed Practical Nurse Supervisor (LPNS)2 confirmed R34's small refrigerator was removed from her room and stored in a drawer at the nurses' station. LPNS2 opened the drawer, and the refrigerator was observed to be a mini box cooler only big enough to hold a few canned drinks. LPNS2 was asked why R34's refrigerator was removed from her room. LPNS2 stated "because it's the facility's policy no personal refrigerators in resident rooms" as they have a designated refrigerator for residents behind the nurses' station. On 03/12/25 at 9:24 AM, R34 was awake in bed watching television. R34 was asked in what manner was her refrigerator removed and how long ago. R34 stated two nurses came into her room sometime after Christmas saying they were conducting "room checks." R34 stated the nurses walked around her bed and spotted her small refrigerator. They told her "You can't have this" and took it. They gave her no explanation. R34 stated she was so upset over the manner she called her granddaughter. Her granddaughter came in and the staff told her "It's unsafe" without further explanation. During an interview on 03/12/25 at 9:34 AM, the Social Service Director (SSD), was asked if she was aware R34's small refrigerator was removed earlier this year. SSD stated, "Yes, it was an administrative decision." SSD stated the reason was because the refrigerator was a fire safety risk, she but she wasn't sure how it was a safety risk. SSD was asked if it was a new policy and	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 10 SSD stated, "No." SSD was asked why R34 wasn't given an explanation. SSD stated she didn't know. During an interview on 03/12/25 at 9:41 AM, the Administrator was asked if she was aware of R34's mini box cooler was removed sometime after Christmas. The Administrator stated, "Yes" for safety, as R34 was unable to maintain its cleanliness, ensured it was at the correct temperature and food was dated. The Administrator stated, "the company doesn't allow it," and the reason was explained to R34's niece. The Administrator was asked for a personal property policy. The Administrator stated they didn't have a policy addressing personal property, just the grievance policy. The Administrator was asked if the admission packet included no small refrigerators allowed. The Administrator stated she wasn't sure. The Administrator was asked why the facility's outside food policy didn't mention the designated resident refrigerator at the nurses' station and only addressed "perishable foods" (time/temperature controlled foods). The Administrator was informed that R34's small refrigerator was a box cooler that only held soda cans which aren't perishable foods. The Administrator stated she would look at the policy and update it as indicated. The Administrator was asked if there was documentation of the staff's right to take R34's property. The Administrator stated, "No" after reviewing the EMR and finding no documentation. 4. Review of R59's quarterly "MDS," with an ARD of 12/04/24 and located in the EMR under the "MDS" tab, revealed R34 had an admission date of 06/03/22 and a "BIMS" score of 15 out of 15, which indicated R59s cognition was intact. The	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 11 MDS assessment indicated R59 had impairment on one side of this upper extremity, was dependent with transfers and had diagnoses that included other paralytic syndrome following nontraumatic intracerebral hemorrhage affecting left non-dominant side, epilepsy, and muscle weakness. Review of R59's "care plan," dated 06/13/22, located in the EMR under the "Care Plan" tab revealed an intervention "R59 states that it is important to him to: take care of his personal belongings and things ..." Review of R59's "social service" note, dated 01/07/25, located in the EMR under the "Progress Note" tab revealed "Met with resident about several issues today and called his [family member] to keep her in the loop. His electric razor is missing, but his [family member] doesn't want to buy another one and is just encouraging him to get used to disposable razors, which he used today. Also - per [family member], resident will need reminders about phone scams and to be more cautious. Nsg [nursing] already aware and SS [social services] discussed this with him today ..." On 03/14/25 at 11:10 AM, R59 was awake in bed holding his cell phone. R59 stated the facility does a good job with care, except his electric razor had been missing recently. R59 stated he ordered it off Amazon and it cost $60. R59 stated he asked Certified Nursing Aide (CNA)11 to plug it in to charge and that's when it was discovered gone. He reported it to the Unit Managers and maintenance looked around his bed for it and it was not found. R59 stated the electric razor kept him more independent as it's easier to do a good	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 12	F 585		

job shaving. R59 stated that other razors have been broken when the CNAs pushed his overbed table away during care very fast and his razor flies off, breaking it.

During an interview on 03/14/25 on 11:15 AM, CNA11 was asked about R59's missing electric razor. CNA11 confirmed R59 had an electric razor, and he asked her a while ago to plug the razor in to charge and it wasn't there. CNA11 stated the razor was there the shift before her's.

During an interview on 03/14/25 at 12:22 PM, the Director of Nurses (DON) asked about R59's missing razor on or around January 2025. The DON stated she thought she remembered something about this, and the social worker made a note. The DON asked if the missing razor should have been written as a grievance. The DON stated she thought so.

During an interview on 03/14/25 at 1:41 PM, Licensed Practical Nurse Supervisor (LPNS)2 was asked if she was aware R59's electric razor was missing. LPNS2 stated, "Yes," she was aware, but it was already reported to social services. LPNS2 stated his [family member] said she wasn't going to buy him any more razors as he keeps breaking them. LPNS2 was asked if R59 was his own representative and LPNS2 stated, "Yes" but it was the [family member's] Amazon account that he ordered the razors from. LPNS2 informed R59 stated the CNAs push his overbed table away during care very fast and his razor flies off it and they break. LPNS2 stated she was unaware of that.

During a telephone interview on 03/14/25 at 6:38 PM, the Activity Assistant (AA) stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 13 assisted SSD and was asked if she was aware R59's electric razor was missing. AA stated, "Yes" she knew about it in January 2025 and R59's [family member] wanted R59 to use disposable razors because he's broken too many electric razors. AA was asked if R59 was his own representative and AA stated, "Yes but R59 wants his [family member] in on his financial business." AA was asked if a written report was made about the missing razor. AA stated, "No because R59's [family member] was not overly concerned about it." AA was asked could R59 had lost his electric razor since he was confined to the bed and required total assistance to get out of bed. AA stated, "No." AA was asked if anyone looked for his razor beyond his room such as laundry in case it got caught in his bedding or if it fell in the trash or if it was stolen. AA stated she wasn't sure and would have to check with SSD. During an interview on 03/14/25 at 7:16 PM, the Administrator was asked why R59's missing electric razor wasn't written as a grievance per their policy. The Administrator stated R59 broke it and his [family member] said she wasn't going to get him anymore. The Administrator was informed the R59 reported it as missing and not broken. However, R59 reported the other electric razors had been broken when the CNAs pushed his overbed table aside quickly to give care. The Administrator stated she visits R59 regularly and he has never told her that.	F 585		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F 600		5/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 14 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, staff interview, and resident interview, the facility failed to protect the resident's right to be free from abuse for three of three (Resident (R) 80, 359, 78) reviewed for abuse of 41 sampled residents. This failure to protect the residents increased the risk of further exposure to abuse. Findings include: Review of the facility's policy titled, "Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime," dated 01/03/25, revealed, "Policy It is the policy of Cadia Healthcare to protect residents and prevent occurrences of abuse, neglect, mistreatment, misappropriation of resident property, exploitation, and crime. Cadia Healthcare adopts this policy to standardize procedures for employee screening, employee training, prevention, identification, investigation, protection, and reporting of abuse, neglect, mistreatment, misappropriation of resident property, exploitation, and reasonable suspicions of crime. Purpose: To ensure that all residents	F 600	1.R80 still resides at the facility. R80 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A review of all residents with current allegations of abuse was completed and no other residents were affected by this deficient practice. A route cause analysis was conducted, and it was determined that the nursing staff failed to report the abuse allegation in the regulatory allotted time frame. The Staff Developer/designee will educate the nursing staff on the time requirements of reporting abuse and on who to report to. 4. The DON/designee will review all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 15 are protected from abuse, neglect, mistreatment, misappropriation of resident property, exploitation, and crime ... Guidelines ... Prevention: The facility will; Provide residents and staff information on how to report concerns and incidents without fear of retribution. Provide training to ensure resident rights and safety are met. Monitor staffing patterns in relation to reported allegations or suspicions of abuse, neglect, mistreatment, misappropriation of resident property, exploitation, and crime ... Protection: The facility will respond immediately to protect the alleged victim, the integrity of the investigation and provide protection from retaliation. Assessment of the alleged victim will be conducted for signs and symptoms of injury (physical and/ or psychosocial). Increased supervision, room changes, and staffing changes may be provided to the alleged victim and other residents. Psychological support will be offered during and after the investigation. The named person accused of the act will be immediately suspended pending outcome of the investigation. Reporting and Response: Witnessed or suspected incidents of abuse or reasonable suspicions of crime are to be reported immediately ... The DON (Director of Nursing) or designee is responsible to conduct the abuse investigation. The NHA (Nursing Home Administrator) serves as the abuse coordinator. Allegations of resident abuse shall be reported to the appropriate state regulatory authority within 2 hours. Incidents involving reasonable suspicions of criminal conduct are reported to the applicable state agency and law enforcement within 8 hours or within 2 hours if the conduct causes serious bodily harm ..." 1. Review of R80's undated "Admission Record,"	F 600	allegations of abuse to ensure that they have been reported within the regulatory timeframe. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings. 1. R17 still resides at the facility. R17 was not negatively impacted by this deficient practice. R78 still resides at the facility. R78 was not negatively impacted by this deficient practice. The facility identified the abuse and took the appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A review of all residents with current allegations of abuse was completed and no other residents were affected by this deficient practice. All residents with aggressive behaviors will be reviewed by ADON to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 16 located in R80's electronic medical record (EMR) under the "Profile" tab, revealed R80 was admitted to the facility on 05/26/23 with diagnoses that include cerebral infarction, unspecified dementia with agitation, major depressive disorder. Review of the annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/29/24, located under the "MDS" tab revealed a "Brief Interview for Mental Status (BIMS)" score of five out of 15 which indicated R80' was cognitively severely impaired. Review of the facility investigation, started 07/11/24, revealed the incident occurred on 07/07/24 when Certified Nursing Assistant (CNA) 1 stuck her tongue out and threw three wipes toward R80's head while in the process of changing the resident. R80 then attempted to throw spit at CNA1. CNA2 witnessed the incident and she and CNA1 left the room. CNA2 reported the incident to Licensed Practical Nurse (LPN)1 on 07/07/24. The incident was not reported to the Abuse Coordinator until 07/11/24. Failing to report the allegation of abuse allowed CNA1 to remain on schedule and she worked 07/08/24, 07/10/24, 07/11/24. Phone interview on 03/13/25 at 12:26 PM CNA2 stated, "R80 was aggressive like normal when we went to change her. Then CNA1 threw three individual wipes at R80's face, R80 then spit in her hand and threw it at CNA1. After that we both walked out of the room, and I went to tell the nurse (LPN1) what happened. I went back to check on R80 and she was fine, she didn't say anything about it."	F 600	appropriate interventions are in place including behavior monitoring and psych evaluation. All residents with roommate issues will be reviewed by IDT to determine if room change is necessary. The Staff Developer/designee will educate all staff on Cadia□s abuse policy. 4. The ADON/designee will review all residents with new aggressive behaviors to determine if a room change is needed. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings. 1. R78 no longer resides at the facility. R78 was not negatively impacted by this deficient practice. The facility identified the abuse and took the appropriate steps to remediate the noncompliance and protect R78 from additional abuse immediately. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17 During a phone interview on 03/13/25 at 1:20 PM, the former Administrator stated, "The CNA was suspended during the investigation and later terminated. By terminating her we would have confirmed the abuse. The DON performed the investigation." 2. Record review of facility provided documentation and resident record review revealed one incident of resident-to-resident aggression with R17 as the assailant. On 06/12/24, R78 was revealed to have informed the facility that they had been struck by R17 on 06/11/24, the previous day. Review of R17's electronic medical record (EMR) "Profile" tab, revealed admission to the facility on 01/26/23 with diagnoses of syncope and collapse, undifferentiated schizophrenia, epilepsy, and major depressive disorder recurrent/moderate. Review of R17's quarterly " MDS" under the "MDS" tab of the EMR, with an ARD of 05/01/24, revealed a " BIMS" score of nine out of 15 which indicated moderate cognitive impairment. Further review revealed that R17 had no behaviors including physical and/or behavioral symptoms directed toward others. The incident of resident-to-resident behavior occurred 06/11/24. Review of R17's annual MDS under the "MDS" tab of the EMR, with an ARD of 01/29/25, revealed a BIMS score of twelve out of 15 which indicated moderate cognitive impairment. Further review revealed that R17 had no behaviors including physical and/or behavioral symptoms directed toward others. No recording of any	F 600	3. A review of all residents with current allegations of abuse was completed and no other residents were affected by this deficient practice. The Staff developer/designee will educate all staff on Cadia□s abuse and customer service policy. 4. The ADON/designee will randomly interview 5 residents on each floor to ensure they have not experienced abuse. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 18 physical and/or behavioral symptoms directed towards others since the 06/11/24 incident. Review of R17's "Care Plan" in the EMR under the "Care Plan" tab, initiated 02/17/23 and last revised 08/02/23, revealed R17 had the potential to have socially inappropriate behavior with the potential for physical resistiveness towards others as evidenced by scratching, swinging, kicking, pushing, and/or slapping. Interventions identified prior to the incidents below, to allow ten to 15 minutes for the resident to calm down then reapproach, approach calmly and unhurriedly, to avoid overstimulation, and to explain all care tasks prior to providing care. Review of R78's EMR "Profile" tab, revealed admission to the facility on 04/28/23 with diagnoses of Parkinson's disease, dementia, neurocognitive disorder with Lewy bodies, and anxiety disorder. Review of R78's annual "MDS" under the "MDS" tab of the EMR, with an ARD of 05/03/24, revealed a "BIMS" score of twelve out of 15 which indicated moderate cognitive impairment. Further review revealed R78 had no behaviors nor rejected care. The incident of resident-to-resident behavior occurred 06/11/24. Review of R78's quarterly MDS under the "MDS" tab of the EMR, with an ARD of 01/31/25, revealed a BIMS score of ten out of 15 which indicated moderate cognitive impairment. Further review revealed that R78 had no behaviors nor rejection of care. No recording of any physical and/or behavioral symptoms directed towards others since the 06/11/24 incident.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 19	F 600		

Review of R78's "Care Plan" in the EMR under the "Care Plan" tab, initiated 09/29/23 and last revised 11/08/23, revealed R78 had the potential to be verbally aggressive (yelling and cursing) to staff and make false accusations of staff not providing care when all needs were met. Interventions identified prior to the incident below were to provide paired care for the resident, assess the resident's understanding of the situation and allow time for the resident to express self and feelings towards the situation, to assess and anticipate the resident's needs, and when the resident becomes agitated, to intervene before agitation escalates and guide away from source of distress.

Review of the facility provided the Incident Report that documented on 06/12/24 at 1:30 PM, that there was a resident-to-resident abuse situation between R17 and R78. The incident was unwitnessed, and the resident representatives and the physician were notified timely. R78 stated that on 06/11/24, the day prior, R17 had stood over her and hit her in the face. She reported that the incident occurred during the night of 06/11/24 and that R17 had used her open hand and struck her in the forehead. She also stated that this was the first physical altercation with R17.

The investigation of the 06/11/24 incident revealed no injuries to R17. R78 was sent to the hospital for a psychological evaluation on 06/12/24 and was readmitted on 06/13/24 with no new physician orders. R17 was readmitted to a different room. R78 was followed by psych services, with no deviation from baseline. Other facility residents were interviewed to determine if they had experienced any abuse, and there were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 20 no identified concerns. Staff were also interviewed with no identified concerns. The investigation revealed the interventions after the resident-to-resident included sending R17 to the hospital for psychiatric evaluation upon notification of the incident, a room change, and in-house psychiatric follow-up. No additional observations or reported incidents of resident-to-resident abuse have been documented between R17 and R78 since the event on 06/11/24. During an interview on 03/10/25 at 4:13 PM, R17 stated that she was not fearful of any residents or staff in the facility, including R78. She stated she was satisfied with her private room. She was unable to recall the resident-to-resident incident. During an interview on 03/11/25 at 11:18 AM, R78 stated she had a previous concern with a former roommate. She was unable to recall the resident's name, but stated she was not afraid of the other resident or anyone else. R78 said she was not bothered by the incident from 06/11/24 and had no concerns that she wished to discuss. During an interview on 03/14/25 at 11:25 AM, the Assistant Director of Nursing (ADON) said that she had completed the initial report for the resident-to-resident incident, but the former Director of Nursing had completed the investigation. She stated that staff would have told her what happened, reported the incident, and she would have informed the former Director of Nursing. She said she had two hours to report it and the investigation would have had to be done in five days. She stated that she would	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 21	F 600		

expect to see interviews with the residents involved, any witnesses, and staff. She said the facility would have gotten statements with other residents to see if they had any problems with the residents in the incident. She stated that there were no problems at all. She said the residents lived on separate hallways. The ADON said that R17 had her own room since the incident, and there had been no further issues. She said that R17 was able to be moved into a new room right away because there was open and available at the time of the incident.

During an interview on 03/14/25 at 2:23 PM, the Director of Nursing (DON) stated she had not been in her current position during the time of the incident. She stated R17 did have behaviors, but the facility staff had been able to redirect her. The facility provides emotional support. Whenever they see the resident "cycling" or "ramping" up with behaviors, they have psych services see her again, to which she is usually agreeable. The resident was provided with her own room because she has had some roommate problems in the past, due to personality conflicts. She said R17 liked and did best in her own room. She does come out of her room, is social, circles around the nurse station, and sometimes goes to activities. The DON stated that staff have been trained to redirect her and provide her support because they want staff to deescalate the situation and makes sure all residents are safe. She stated dementia training was provided upon new hire and annually so they can handle difficult behaviors. She said that R78 has no ongoing behavioral issues and has done well with her new roommate. She said that if staff see abuse, she wants them to report it immediately so she can report it immediately and do the investigative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 22	F 600		

process. The DON said she wants residents to be safe, and to separate them if there is a resident-to-resident behavior. She stated that if there is any incident they will begin behavior monitoring until psych services can see them. She said an investigation includes interviewing staff to complete the whole investigation process. She said psych services typically get involved with resident-to-resident incidents, and that they come in regularly so the residents can be assessed.

During an interview on 03/14/25 at 3:44 PM, the Social Service Director (SSD) stated that R17 did have some paranoid behaviors and could get agitated. She said R17 had some history of agitation with other residents and staff, just yelling out. SSD said R17 was redirectable. SSD stated R17 was given her own room because she had believed that her former roommate had talked about her. SSD confirmed the resident did best in her own room. She stated that abuse training was completed by all staff upon hire and annually.

During an interview on 03/14/25 at 6:45 PM, CNA13 stated that abuse training was completely on an ongoing basis. CNA13 said R17 moved rooms, to a different unit, and had not seen any behaviors since the original incident. She stated R78 had not been observed interacting with R17 since the room change.

During an interview on 03/14/25 at 6:55 PM, Licensed Practical Nurse (LPN) 5 stated that the facility did abuse training a few times each year. He stated that he started last summer and had multiple abuse training since he had been at the facility, because the facility did not tolerate any types of abuse. LPN5 stated that if anyone saw

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 23	F 600		

anything that could be considered as potential abuse, anything on the body or that you notice is new, you had to report it immediately so it could be investigated. LPN5 said that there had been no identified concerns with R17 or R78 since working at the facility.

3. Review of R359's annual " MDS," with an ARD of 10/08/24 and located in the EMR under the "MDS" tab, revealed R359 had an admission date of 10/01/24 and a " BIMS" score of 15 out of 15, which indicated R359's cognition was intact. The MDS assessment indicated R359 had diagnoses that included glaucoma, acquired absence of right leg above knee, and cerebrovascular disease.

Review of R359's "care plan," revised 10/29/24 located in the EMR under the "Care Plan" tab revealed "The resident has an ADL [activities of daily living] self-care performance deficit r/t [related to] Activity Intolerance, RAKA [right above the knee amputation], Impaired balance, Limited Mobility, Musculoskeletal impairment/Acquired absence of right leg below the knee." An intervention included "Assist with hygiene, grooming, toileting, dressing, oral care, and eating as needed."

Review of the facility investigation dated 10/28/24, provided by the facility, revealed "on October 28, 2024, at approximately 2pm, the resident and [family member] reported to his assigned nurse that they were upset about events that occurred over the weekend. The nurse then reported immediately to the social worker [name] and [name] ADON The social worker then met with the resident to perform a psychosocial visit. The resident stated that his 11-7 CNA (identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 24 as CNA10) on Friday, October 25, 2024 "treated him rudely and told him he needed to clean up his room because it was a mess". He also stated later on this past weekend (resident unsure of date/time) another CNA who he could not identify "yanked up his brief causing him pain". Resident stated to the social worker to talk to his [family member] [name] as she knows everything that happened "now it's not fresh in his mind". [name] ADON spoke to resident's [family member] [name] who stated that the resident called her on October 26, 2024, around 12:37pm and stated his new CNA on 11-7 told him "Rudely to clean up his room, but he cannot see well so he couldn't do it". [Family member] also stated that she received a call from her husband on Sunday October 27, 2024, around 21:16 pm that he had put his call light on and an aide who he did not know came in and he asked for a diaper and the aide "told him to put it on himself'. When he said he couldn't, she was very rough with him and pulled the tabs tight causing him "pain to his penis and scrotum". A skin assessment was completed by nursing and no injury or skin abnormality was found on the resident. DON [Director of Nurses] and ADON were able to identify the 11-7 CNA who was involved in the October 25, 2024, incident as [CNA10] who was suspended immediately pending further investigation. Further investigation revealed [name] CNA10 did tell the resident to clean up his room because it was a mess. [CNA] was subsequently terminated on October 30, 2024, related to poor customer service. DON and ADON were unable to identify who the suspected CNA was involved in the alleged October 27, 2024, incident. All cognitively appropriate residents along the hallway where R359 resides were interviewed to determine if they experienced any care concerns. Full body	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 25 skin checks were also completed on other residents who could not be interviewed, and no new skin abnormalities were identified. Staff members were also interviewed and denied having any knowledge of the- in question or any other incident involving the resident or any other residents, nor did they recall any concerns, issues, or complaints from R359 when providing care." Review of the facility's all staff training, conducted on 10/28/24, provided by the facility, revealed an abuse in-service was conducted by the staff developer in response to the abuse investigation that was substantiated for R359. The in-service included all types of abuse, reporting all suspected and alleged abuse immediately following the chain of command, writing statements, and monitoring residents involved in abuse. Review of CNA10's statement, dated 10/28/24, provided by the facility revealed "I did a double 10/25 into 10/26 11-7 ... On west [hall] I enter room [number] spoke with [bed number] R359 [resident's name]. Approx. [approximately] 12:25 when doing rounds I noticed his room had been cleaned w/ [with] things in it proper place. I mentioned that his room looked cleaned and that would be nice because he might receive a visitor. That comment came from a conversation [room and bed number] bed had with [room and bed number] bed to which they included me in saying that they were roommates at one point and that [room and bed number] would be visiting him [R359 room and bed number]. Later that morning [room and bed number] became bothered by the comment and reported some what of the truth to the RN [registered nurse] at the desk. I was	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 26 informed not to enter that room." Review of the ADON's statement, dated 10/28/24, provided by the facility revealed "I sat down with CNA10 to discuss the complaints from R359 and his [family member] [name]. I explained to her that they were very upset about way she talked to him, on October 26 at 12:37 in the morning. She [CNA10] stated to me that his room was a mess. that there were papers and trash on the floor and she did tell him that the room was disgusting and he needed to clean this mess up in case he had visitors." Review of CNA10's personnel file provided by the facility, revealed CNA10 was suspended pending the investigation on 10/28/24 and terminated on 10/30/24 due to poor customer service. During an interview on 03/12/25 at 2:13 PM, the ADON stated she became aware of the allegation by another staff member. The DON asked her to conduct skin assessments and interviews. The ADON stated she didn't remember specifics as it's been too long ago but she obtained a statement from CNA10. The ADON stated CNA10 admitted to her she told R359 his room was a mess; his room was disgusting and he needed to clean this mess up in case he had visitors. The ADON stated after further investigation they determined there was only one perpetrator. During an interview on 03/12/25 at 6:11 PM, the Administrator and DON stated "safe surveys" were completed on residents that had contact with CNA10 with questions about abuse and safety. The DON stated staff were also interviewed and statements were obtained from	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 27 those who had worked with CNA10. During an interview on 03/13/25 at 6:26 PM, the SSD was asked about R359's investigation. SSD stated staff alerted her to R359's room as he had a complaint and was upset. SSD stated R359 told her his CNA pulled on his brief, and it was hurting him. SSD stated R359 didn't remember the details, but he had told his [family member] earlier. SSD stated she reported it immediately and the ADON called the [family member]. SSD stated she understood there was only one perpetrator identified and that it was CNA10. SSD stated R359 had no lasting pain from the brief. During a follow up interview on 03/13/25 at 6:30 PM, the ADON stated the timeframes helped substantiate that there was only one perpetrator, CNA10. ADON stated they compared the nursing schedule using a 72-hour timeframe and statements were taken from all nursing staff. R359 had no roommate, and there was not a second staff member present to witness care. During an interview on 03/13/25 at 7:00 PM, DON stated the ADON told her about R359's complaint and they "started putting the pieces together by comparing schedules and assignment sheets." DON stated, "just one person was identified, and a second person could not be substantiated." DON stated R359 wasn't certain CNAs by name and by process of elimination they figured it out. DON stated she didn't get the impression CNA10 meant any harm in her interactions with R359, and they couldn't prove his brief was pulled off abruptly as R359 had no injury or redness.	F 600		
F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 28 §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 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 interviews, record review, and policy review, the facility failed to ensure allegations of abuse were reported for one of three residents (Resident (R) 80) reviewed for abuse. The facility did not report to the State Agency alleged staff-to-resident abuse within the required time frame. Facility staff did not report R80's allegation of employee-to-resident abuse to the	F 609	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 29	F 609		

Administrator. This failure to report the allegation in a timely manner allowed the accused staff member to continue working in the facility with other residents.

The Immediate Jeopardy began on 07/07/24, undetermined time between 12:00 PM and 3:00 PM.
On 03/13/25 at 7:42 PM, the Administrator was notified of Immediate Jeopardy (IJ) Past Non-Compliance (PNC) in the area of Resident Abuse at F609. Prior to this survey, the facility identified the seriousness and immediacy of the deficient practice and implemented a Removal Plan on 07/11/24. A review of the facility ' s investigation revealed that the episode of failing to report abuse in a timely manner was brought to QAPI on 07/15/24, and a Performance Improvement Plan (PIP) was developed in response. The PIP was in place and reviewed from 07/15/24 through the end of September. Residents were selected randomly for review regarding abuse. All staff received re-education for abuse and the proper reporting of abuse.

The survey team validated implementation of the Removal Plan on 03/13/25 at 7:56 PM. Based on the facility's implementation of corrective actions, the IJ and Substandard Quality of Care (SQC) were determined to be PNC and the IJ was removed, with substantial compliance achieved on 07/17/24

Findings include:

Review of the facility's policy titled, "Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime," dated 01/03/25, revealed, "Policy-It is the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 30	F 609		

policy of Cadia Healthcare to protect residents and prevent occurrences of abuse, neglect, mistreatment, misappropriation of resident property, exploitation, and crime. Cadia Healthcare adopts this policy to standardize procedures for employee screening, employee training, prevention, identification, investigation, protection, and reporting of abuse, neglect, mistreatment, misappropriation of resident property, exploitation, and reasonable suspicions of crime. Purpose: To ensure that all residents are protected from abuse, neglect, mistreatment, misappropriation of resident property, exploitation, and crime ... Guidelines ... Protection: The facility will respond immediately to protect the alleged victim, the integrity of the investigation and provide protection from retaliation. Assessment of the alleged victim will be conducted for signs and symptoms of injury (physical and/ or psychosocial). Increased supervision, room changes, and staffing changes may be provided to the alleged victim and other residents. Psychological support will be offered during and after the investigation. The named person accused of the act will be immediately suspended pending outcome of the investigation. Reporting and Response: Witnessed or suspected incidents of abuse or reasonable suspicions of crime are to be reported immediately ... The DON (Director of Nursing) or designee is responsible to conduct the abuse investigation. The NHA (Nursing Home Administrator) serves as the abuse coordinator. Allegations of resident abuse shall be reported to the appropriate state regulatory authority within 2 hours. Incidents involving reasonable suspicions of criminal conduct are reported to the applicable state agency and law enforcement within 8 hours or within 2 hours if the conduct causes serious

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 31 bodily harm ..." Review of R80's undated "Admission Record," located in R80's electronic medical record (EMR) under the "Profile" tab, revealed R80 was admitted to the facility on 05/26/23 with diagnoses that include cerebral infarction, unspecified dementia with agitation, major depressive disorder. Review of the annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/29/24, located under the "MDS" tab revealed a "Brief Interview for Mental Status (BIMS)" score of five out of 15 which indicated R80' was severely cognitively impaired. Review of the facility investigation revealed the incident occurred on 07/07/24 when Certified Nursing Assistant (CNA) 1 stuck her tongue out at R80 and threw three wipes toward R80's head while in the process of changing the resident. R80 then attempted to throw spit at CNA1. CNA2 witnessed the incident and she and CNA1 left the room. CNA2's undated witness statement revealed that after CNA1 threw the wipes at R80, R80 spit into her hand and threw it at CNA1. CNA2 reported the incident to Licensed Practical Nurse (LPN)1 on 07/07/24. The incident was not reported to the Abuse Coordinator until 07/11/24. Failing to report the allegation of abuse allowed CNA1 to remain on schedule and she worked 07/08/24, 07/10/24, 07/11/24. Further review of the Facility Reported Incident revealed a written statement from CNA1, dated 07/11/24, indicating "I stuck my tongue out at R80 in response to a comment from her. R80 then	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 32 called me a B**** and that's when I threw three wipes at her playing around." Phone interview on 03/13/25 at 12:26 PM CNA2 stated, "R80 was aggressive like normal when we went to change her. Then CNA1 threw three individual wipes at R80's face, R80 then spit in her hand and threw it at CNA1. After that we both walked out of the room, and I went to tell the nurse (LPN1) what happened. I went back to check on R80 and she was fine, she didn't say anything about it." During an interview on 03/13/25 at 12:52 PM, Unit Clerk (UC) 1 revealed that she initially thought to report the incident but forgot after taking care of another resident. She learned about the incident on 07/08/24, did not report it at that time, and instead reported it on 07/11/24 after recalling it when the resident returned from the hospital. During an interview on 03/13/25 at 12:52 PM, Unit Clerk (UC) 1 revealed that she initially thought to report the incident but forgot after taking care of another resident. She learned about the incident on 07/08/24, did not report it at that time, and instead reported it on 07/11/24 after recalling it when the resident returned from the hospital. During a phone interview on 03/13/25 at 1:20 PM, the former Administrator stated, "The CNA was suspended during the investigation and later terminated. By terminating her we would have confirmed the abuse. The DON performed the investigation." During an interview on 03/13/24 at 2:24 PM LPN1 revealed, "I could not get a clear story as to what happened, I was not able to ask R80 due to	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 33 cognitive status. I finished toileting R80 and made sure she was ok. Made sure that the aide did not return to the resident's room. I did not report anything. I thought at the time that keeping CNA1 away from R80 and keeping R80 safe was enough. Since then, I was retrained on the proper reporting of abuse allegations. I received training upon hire and in services after. The incident was at the end of the shift. I have no knowledge of any other concerns with CNA1.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure an injury of unknown origin was investigated for one out of 11 residents reviewed for abuse (Resident (R)2). R2's thumb was noted with a 1.5	F 610	1. R2 still resides at the facility. R2 is alert and oriented with a BIMS of 15. Facility conducted full investigation based on R2□s statement that CNA2 hurt his thumb during an altercation with CNA2. Review	5/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 34 centimeter (cm) by 1.5 cm purple area with swelling; once staff to resident abuse was ruled out as a potential cause, the facility failed to investigate further to determine how R2 sustained the injury. Findings include: Review of the facility's "Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime" policy dated 01/03/25 revealed, "It is the policy of [facility name] to protect residents and prevent occurrences of abuse, neglect, mistreatment, misappropriation of resident property, exploitation, and crime ... Injuries of unknown source are injuries where the source of the injury was not observed by any person; the source of the injury could not be explained by the resident; the injury is suspicious because of the extent of the injury or the location of the injury ... All alleged incidents ... including injuries of unknown source, shall be reported to the NHA [Nursing Home Administrator] or designee immediately. The NHA or designee shall investigate allegations ..." Review of the undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed R2 was admitted to the facility on 05/24/17 with diagnoses including cerebral palsy, major depressive disorder, and anxiety disorder. Review of the quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 02/19/25 in the EMR under the "MDS" tab revealed R2 was intact in cognition with a Brief Interview for Mental Status (BIMS) score of	F 610	of video evidence revealed CNA2 did not injure R2□s thumb. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A review of all residents with injuries of unknown origin was completed and no other residents were affected by this deficient practice. A full investigation will be conducted for all injuries of unknown origin. Staff Developer/designee will educate all nursing staff on the definition of an injury of unknown origin including the process of documenting and reporting. 4. Wound care nurse/designee will audit risk management reports to ensure all injuries of an unknown origin are investigated properly. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 35 15 out of 15. Review of the "Incident Report for Web Intake #84519" (Initial Report) dated 03/18/24 and provided by the facility revealed R2 reported on 03/18/24 that on 03/17/24 at 1:30 PM Certified Nursing Assistant (CNA)2 pinched his thumb after he threw a soda can at her, causing an injury to his thumb. Review of the facility's "Incident Report for Web Intake #84519 - Follow Up" (Five Day Follow up Investigation file) provided by the facility dated 03/21/24 indicated on 03/17/24 at 2:00 PM, CNA2 was sitting at the computer on wheels in the long hallway and R2 approached and requested that she make his bed. CNA2 asked him to give her a minute as she was charting. R2 responded by pushing the computer on wheels into her knees and moving the computer screen side to side. CNA2 stated she was logging off the computer to leave when R2 threw a soda can at her. CNA7 came out of another resident's room and observed CNA2 charting and R2 sitting next to her. CNA7 witnessed R2 throw a can of soda at CNA2. CNA2 alerted 911 to file a police report against R2. R2 was transported to the emergency room [ER] for a psych evaluation on 3/17/24 at 3:00 PM and returned at 9:30 PM. The report indicated that review of the ER records revealed R2 stated he felt like staff was not cleaning him up after an accident or providing him with food so became frustrated and threw food. The investigation revealed on 03/18/24 R2 showed the Speech Therapist his right thumb and stated CNA2 hurt him on 03/17/24. R2's thumb was assessed and a 1.5 cm x 1.5 cm area of purple tone was noted. An X-ray was obtained on 03/18/24 and showed no acute fracture or	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 36	F 610		

dislocation but showed soft tissue swelling to the R2's thumb. CNA2 was suspended related to the allegation of abuse made on 03/18/24. CNA2 stated she did not touch R2. CNA7, who was a witness stated she did not see CNA2 touch R2. Video footage showed R2 pushed the computer into CNA2, shook the computer screen, and threw a soda at the CNA which hit her. The video footage in the hallway did not show CNA2 making contact with R2. The investigation revealed there was no documentation about the thumb injury in the Emergency Room documentation on 03/17/24. The allegation of CNA2 abusing R2 was unsubstantiated. There was no additional documentation showing further investigation into the injury of R2's thumb, which became an injury of unknown origin after the allegation of abuse by CNA2 towards R2 was ruled out as the cause.

During an interview on 03/10/25 at 12:03 PM, R2 stated he remembered the incident with a CNA a year ago in which he was pinched. R2 stated a CNA wanted a soda from him and he stated "no" and threw the soda at her.

During an interview on 03/13/25 at 02:37 PM, the Assistant Director of Nursing (ADON) stated the abuse incident dated 03/17/24 included an allegation of CNA2 grabbing R2 which was not substantiated. The ADON stated she did not remember an injury to R2's hand when the original investigation was completed; however, the next day he had a scratch on his hand and it would be considered an injury of unknown origin. The ADON stated any bruising or injury that was new and the staff did not know how it happened, was considered an injury of unknown origin.

During an interview on 03/13/25 at 7:03 PM, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 37 Administrator confirmed the investigation occurred prior to her employment at the facility; however, she would look to see if there was any further information about the injury to R2's hand. During an interview on 03/14/25 at 12:03 PM, the Director of Nursing (DON) stated the investigation into R2's injury to his hand should be part of the original investigation. The DON stated she would review the file to determine if there was any additional information to show how R2's hand was injured. During an interview on 03/14/25 at 2:19 PM, the DON stated the facility did not investigate the injury to R2's thumb after it had been ruled out that CNA2 did not abuse R2.	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §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.	F 623		5/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 38 (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 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	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 39 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 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(k). This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to provide written	F 623	1. R30 no longer resides at the facility. R30 was not negatively impacted by this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 40 notification of a facility-initiated transfer to the resident/responsible party (RP) for three (Resident (R)41, R30, and R258) of four residents reviewed for hospitalization. The failure had the potential to affect the residents and/or their representative concerning the resident's appeal rights. Findings include: Review of the facility's policy titled "Resident and Ombudsman Notification of Transfer or Discharge," revised 11/28/27, provided by the facility, revealed "It is the policy of [facility name] to provide residents/resident representatives and the ombudsman with a notice of transfer/discharge as required by Center for Medicare & Medicaid Services (CMS)." "CMS requires advance written notification of a resident transfer/ discharge and the reasons for the discharge." This policy did not address emergency transfers to the hospital. Review of the facility's "Notice of Transfer/Discharge," undated, provided by the facility, revealed the notice included all the required elements for a facility-initiated transfer. This form was not utilized. 1. Review of R30's undated "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab, revealed R30 was admitted to the facility on 12/13/24 and was re-admitted on 01/08/25. Review of the EMR "Progress Notes" located under the "Progress Notes" tab, revealed a progress note, dated 12/19/24, "R30 sustained unwitnessed fall in his room at approx. 1600 (4:00	F 623	deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A root cause analysis determined that the facility staff failed to provide residents with a written notice of transfer upon leaving. Each resident will have a written transfer notice upon leaving the facility. Staff Developer/designee will educate all nursing supervisors on the Cadia□s transfer policy. 4. All transfers will be audited by the Unit Manager for completion upon transfer and uploaded into the residents EMR. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings. 1. R258 no longer resides at the facility. R258 was not negatively impacted by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 41 PM), found face down next to bathroom door with wheelchair on top of his legs ... R30 sustained lacerations to bridge of his nose and above left eyebrow and skin tear to LFA (left forearm)... Resident currently on Eliquis. Emergent transport initiated to Hospital for evaluation..." Further review of the record revealed no documentation that written notification containing information as to the reason for the hospital transfer was provided to the resident, or the resident's representative. During an interview on 03/13/25 at 6:00 PM, the Administrator revealed, "We did not provide any written transfer notice to the resident or the resident representative regarding the transfer to the hospital." 2. Review of "Admission Record," located under the "Profile" tab in the EMR," documented that R258 was re-admitted to the facility on 03/14/24 with a diagnosis of diabetes. Review of "Nurses Note," located under the "Notes" tab in the "EMR," indicated, "R258 noted with decreased blood sugars after receiving Lantus insulin at bedtime. Blood sugar (BS) 94 ...no signs or symptoms of hypoglycemia observed ...R258 transferred to hospital." No documented evidence of a written transfer notice given to R258 upon transfer to the hospital. Review of the "EMR" under the tab "Misc" indicated no documented evidence of a transfer notice back in February 2024. Interview on 03/14/25 at 3:00 PM, the Administrator confirmed that there was no	F 623	2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A root cause analysis determined that the facility staff failed to provide residents with a written notice of transfer upon leaving. Each resident will have a written transfer notice upon leaving the facility. Staff Developer/designee will educate all nursing supervisors on the Cadia□s transfer policy. 4. All transfers will be audited by the Unit Manager for completion upon transfer and uploaded into the residents EMR. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings. 1. R41 still resides in the facility. R41 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 42 transfer notice for R258 when he went to the hospital on 02/22/24. The Administrator confirmed that there should have been one. 3. Review of R41's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 11/18/24 and located in the EMR under the "MDS" tab, revealed R359 had an admission date of 09/22/22 and a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated R41's cognition was intact. The MDS assessment indicated R41 had diagnoses that included stroke, hemiplegia and hemiparesis, and chronic obstructive pulmonary disease. Review of R41's "care plan," revised 07/06/24 located in the EMR under the "Progress Note" tab revealed "R41 has altered cardiovascular status r/t [related to] CAD [coronary artery disease], HTN [hypertension], HDL[hyperlipidemia]." Review of R41's "nurse note," 07/02/24, located in the EMR under the "Progress Note" tab revealed "Resident returned from outside the building smoking. Upong [sic] entering the building resident c/o [complaint of] not being able to move right arm, right arm cold to touch upon assessment and resident unable to move fingers and states he couldn't feel this nurse touching his skin. Dr. [doctor] [name] arrived to resident's room to assess and ordered to send resident out to ER [emergency room] for eval [evaluation]. [family member] [name] made aware." Review of R41's "nurse note," 07/05/24, located in the EMR under the "Progress Note" tab revealed "Resident returned from the hospital at approximately 1640 via stretcher. Received alert and stable with no c/o pain or discomfort. VSS	F 623	Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A root cause analysis determined that the facility staff failed to provide residents with a written notice of transfer upon leaving. Each resident will have a written transfer notice upon leaving the facility. Staff Developer/designee will educate all nursing supervisors on the Cadia□s transfer policy. 4. All transfers will be audited by the Unit Manager for completion upon transfer and uploaded into the residents EMR. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 43 [vital signs stable], Resident skin warm intact. Encouraged to use call light when need assistance. Safety in place." On 03/11/25 at 10:26 AM, R41 was awake in bed. R41 stated he had a stroke one day after smoking and went to the hospital. R41 was asked if he received any paperwork when going to the hospital. R41 stated he doesn't remember receiving any papers for a hospital transfer during that time. During an interview on 03/12/25 at 2:26 PM, the Chief Nursing Officer (CNO) was asked about transfer notices. The CNO stated a transfer form wasn't completed for R41 for 07/02/24. The CNO stated the nurse sending R41 out would have given the emergency medical service (EMS) a packet with the transfer form but there was no record of it. During an interview on 03/13/25 at 11:52 AM, the Director of Nursing (DON) was asked about the process when sending a resident to the hospital. The DON stated they sent an interagency transfer form that was filled out manually, the face sheet and a list of medications were sent in a packet that is given to the EMS. The DON asked if a transfer form that includes the regulation details such as date/location/reason/appeals rights. DON stated the unit manager give the bed hold to the resident. The transfer form was requested for R41's 07/02/24 transfer notice when he was sent to the hospital. None was provided as of exit, 03/14/25. During an interview on 03/13/25 at 1:43 PM, Licensed Practical Nurse Supervisor (LPNS)1 and LPNS2 were asked if they use the titled	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 44 "Notice of Transfer/Discharge Form," provided by the DON, when a resident was sent to the hospital. LPNS1 and LPNS2 reviewed the form and stated, "No," they use another form and doesn't include appeal rights. LPNS1 and LPNS2 went on to say they gather the list of medications and face sheet and another hand-written transfer form that are given to EMS, but nothing was given to the resident. LPNS1 and LPNS2 were asked if R41 went to the hospital in July 2024 and they both stated, "Yes."	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §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	F 625		5/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 45 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. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure one of three residents (Resident (R) 30) reviewed for hospital transfers was given a written copy of a bed hold notice prior to or within 24-hours of emergency transfer to the hospital. This failure created the potential for residents and/or responsible parties not to have the information needed to safeguard their return to the facility. Findings include: Review of the facility's policy titled, "Bed Holds," dated 01/03/25, revealed "Policy: Bed Hod Policy. Purpose: It is the policy of Cadia to implement bed holds in accordance with federal and state law, which require two written notices of a facility's Bed Hold Policy be provided to a resident and his/her family member or legal representative as outlined below. Procedure: ... 2. Second Written Notice: (a) If the resident leaves the facility for emergency treatment at a hospital, a copy of the facility's Bed Hold Policy will be included in the documentation accompanying the resident to the hospital. In addition to the written notice included in the resident's paperwork, the Admission Director/Designee will call the resident's family member or legal representative, explain the Bed Hold Policy, and advise the family member or legal representative that the written notice will be mailed to them for review. The Admission Director/Designee will document this conversation, including the family member or	F 625	1. R30 no longer resides at the facility. R30 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A root cause analysis determined that the facility staff failed to provide residents with a written bed hold notice upon leaving. Each resident will have a written bed hold notice upon leaving the facility and 24 hours after the resident is out of the facility. NHA/designee will educate the admissions staff on Bed Hold Policy. 4. All transfers will be audited by the Admissions Director for completion upon transfer and uploaded into the residents EMR. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 46 legal representative's decision regarding the bed hold, in the resident's medical record ..." Review of R30's undated "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab, revealed R30 was admitted to the facility on 12/13/24 and was re-admitted on 01/08/25. Review of the EMR "Progress Notes" located under the "Progress Notes" tab, revealed a progress note, dated 12/19/24, "R30 sustained unwitnessed fall in his room at approx. 1600 (4:00 PM), found face down next to bathroom door with wheelchair on top of his legs ... R30 sustained lacerations to bridge of his nose and above left eyebrow and skin tear to LFA (left forearm)... Resident currently on Eliquis. Emergent transport initiated to Wilmington Hospital for evaluation..." Further review of the resident EMR failed to reveal documentation of the resident and/or the resident's representative was given written notice that specified the duration of the facility's bed hold policy. During an interview on 03/13/25 at 6:00 PM, the Administrator revealed, "We did not provide any written bed hold notice to the resident or the resident representative regarding the transfer to the hospital."	F 625	compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		5/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 47 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to ensure that physician's orders were followed for one resident (Resident (R) 208) from a sample of 41 residents reviewed. This failure has the potential to negatively impact R208 and others that have similar orders that currently reside at the facility. Findings include: Review of R208's "Admission Record," located under the "Profile" in the "Electronic medical record (EMR)," indicated, that R208 was re-admitted to the facility on 03/13/24 for hypertension. Review of R208's "Order Summary Report," dated 03/22/24, located under the "Orders" in the "EMR," indicated "Propranolol HCl Oral Tablet 40 milligrams (mg), give one tablet by mouth (PO) two times (BID) a day for hypertension, hold for heart rate (HR) less than 50." Review of "Medication Administration Record (MAR)," dated 03/01/24-03/30/24, under the tab "Orders" located in the "EMR," indicated, "...Propranolol HCL oral tablet 40 mg, give one tablet PO BID...hold for HR less than 50, starting 03/22/24." There is no documented HR taken on the following dates for the morning dose: 03/24/24 and there is no documented HR taken on the following dates for the bedtime dose:	F 684	1. R208 no longer resides at the facility. R208 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A root cause analysis determined that the facility nursing staff failed to follow physician orders by not obtaining/documenting R208□s heart rate per cardiac medication hold parameters. Nursing will ensure all residents on cardiac medications with orders for hold parameters are being followed correctly and documented in EMR. Staff Developer/designee will educate all nurses on following physician orders in regard to cardiac medication hold parameters and how to document correctly in EMR. 4. DON/designee will select 5 random residents on cardiac medications with hold parameter orders and verify hold parameters are being followed and documented correctly in EMR. The audit process will be conducted three times	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 48 03/22/24, 03/23/24, 03/25/24, and 03/26/24. Interview on 03/14/25 at 7:45 PM, the Director of Nursing (DON) confirmed that the HR was not taken on the dates listed above and should have been taken as ordered.	F 684	weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings.	
F 689 SS=D	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 §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 observations, interviews, and record review, the facility failed to ensure that fall interventions were followed for one resident (Resident (R) 82) out of five residents reviewed for falls, out of a sample of 41 residents. This failure had the potential to negatively impact R82 and other residents residing in the facility by not ensuring that staff consistently implemented fall interventions. Findings include: Review of R82's "Admission Record," located	F 689	1. R82 still resides at the facility. R82 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A root cause analysis determined that the facility nursing staff failed to follow fall interventions by placing bilateral fall mats	5/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 49 under the "Profile" tab in the "Electronic Medical Record (EMR)," indicated, that R82 was re-admitted to the facility on 09/23/24 was a diagnosis of fracture of the right pelvis and the right shoulder. Review of a significant change in status "Minimum Data Set (MDS)" assessment with an "Assessment Reference Date (ARD)," of 01/27/25, located under the "MDS" tab in the "EMR," indicated, R82 had a "Brief Interview for Mental Status (BIMS)" of nine out 15, making R82 moderately impaired cognitively. Review of facility provided "[name of state] Health and Social Services Division of Health Care Quality Incident Report," dated 09/20/24, "...resident status post (s/p) fall complaint (c/o) pain ...Sent to the hospital for further evaluation." Review of R82's "Order Summary Report," under the "Orders," tab dated 03/05/25, located in the "EMR," indicated, "Fall precautions: low bed, nonskid footwear every shift, no longer needs bolsters." Review of R82's "Care Plan," revised on 10/16/24, located under the "Care Plan" tab in the "EMR," indicated, "R82 is at high risk for falls related to impaired cognition/confusion, deconditioning, gait/balance problems ...history of community falls ...actual facility fall." Interventions: ...Bilateral fall mats (initiated: 07/10/24). There was no documented evidence that the care plan was revised to include a low bed as ordered by the physician on 03/05/25. During observation on 03/10/25 at 11:29 AM, R82 was sitting up in her bed with the television on.	F 689	down while R82 was in bed. Nursing will ensure all residents with orders for fall mats are placed correctly when the resident is in bed. Staff Developer/Designee will educate all nursing staff on the importance of following fall interventions and having fall mats placed correctly. 4. ADON/designee will select 5 random residents with fall mats as a fall intervention and audit that the mats are correctly placed. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 50 R82 was observed to be alert and confused. R82's bed was in a standard height with no bilateral floor mats. During this observation, R82 was attempted to be interviewed, but was confused. During observation on 03/11/25 at 11:00 AM and 6:00 PM, R82 was observed lying in bed. The bed was observed to be in standard height with no bilateral floor mats. During observations on 03/12/25 at 9:00 AM, 12:55 PM, and 5:13 PM, R82 was observed lying in bed. The bed was observed to be standard height with no bilateral floor mats. Interview on 03/13/25 at 3:25 PM, the ADON confirmed that R82 did not have bilateral floor mats, and that bed was in standard height.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 690		5/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 51 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and policy review, the facility failed to ensure that a resident with a urinary catheter bag was properly positioned in a manner to prevent potential urinary tract infections due to contamination for one of six residents (Resident (R)99) reviewed for urinary catheters and urinary tract infections out of a total sample of 41 residents. Findings include: Review of the facility's policy titled, "Indwelling Urinary Catheter Management," revised 01/03/25, revealed "It is the policy of [facility name] that residents with indwelling catheters are assessed for appropriate catheter use and that the resident's medical record reflects the supporting diagnosis ...The medical record of residents	F 690	1. R99 still resides in the facility. R99 was not negatively impacted by the deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A root cause analysis determined that the facility nursing staff failed to update R99□s care plan for non-compliance and following Cadia□s Indwelling Urinary Catheter Management policy. Nursing will ensure all residents with orders for foley catheters will have an updated care plan and follow Cadia□s policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 52 admitted with an indwelling catheter is reviewed to determine the diagnosis and necessity of continued catheter use ...The care plan is updated to reflect the resident's toileting needs ...Residents with an indwelling catheter will receive daily/prn [as needed] catheter care. Catheters and drainage bags will be changed every 60 days or s needed." Review of R99's "Admission Record," found in the "Profile" tab of the electronic medical record (EMR), revealed he was originally admitted on 02/25/25, with diagnoses including retroperitoneal hematoma, urinary tract infection, and hydronephrosis. Review of R99's five day "Minimum Data Set (MDS)" assessment located in the "MDS" tab in the EMR, with an Assessment Reference Date (ARD) of 02/08/25, revealed a "Brief Interview for Mental Status (BIMS)" assessment with a recorded score of six out of 15 which indicated severe cognitive impairment. R99 was documented to require a catheter and was administered antibiotic. R99 did not reject care. Review of the "Physician Orders" located in the EMR under the "Orders" tab revealed a 03/06/25 order for "Urinary Catheter Type: indwelling" Size 18 French balloon ...10 ml (milliliters) one time a day every 28 day(s) ... Interventions included to check tubing for kinks, to position the catheter bag and tubing below the level of the bladder, and to provide catheter are as ordered. Record review for R99 revealed there was no care plan initiated or revised for non-compliance with catheter care management.	F 690	Staff Developer/Designee will educate nursing supervisors to have proper care plans. Staff Developer/Designee will educate the nursing staff on Cadia□s Indwelling Urinary Catheter Management policy. 4. MDS will audit all residents with Foley catheters and ensure care plans are updated to reflect any non-compliance. Unit Managers will audit to ensure no foley catheters are placed touching the ground. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 53 During an observation on 03/10/25 at 2:05 PM, R99 was observed sleeping in bed. The catheter bag was observed hanging from the right side of the bed, visible form the hallway. The bag was observed uncovered, skimming in contact along the floor. During an observation on 03/11/25 at 9:50 AM, R99 was again observed sleeping in bed. The catheter bag was hung from the right side of the bed, visible from the hallway. The uncovered bag was in contact with the floor. During an additional observation on 03/12/25 from 8:45 AM through 9:20 AM, R99 was observed in bed. The uncovered catheter bag, and tubing, was observed resting completely on the floor. During an interview on 03/12/25 at 8:47 AM, Certified Nursing Assistant (CNA) 5 said that the CNAs empty catheter bags once or twice in a shift. She said the bags should be hung below the resident's waist, off the ground when in a wheelchair or in bed. During an interview on 03/12/25 at 8:54 AM, CNA6 said that catheter bags were managed and handled by the nurses. She stated that the catheter bags were hung on the side of the bed, above the floor. During an interview on 03/12/25 at 9:05 AM, Licensed Practical Nurse (LPN)2 observed R99 sleeping in bed and confirmed the catheter bag as on the floor. LPN2 confirmed the catheter bag should be hanging from the side of the bed, off the floor. LPN2 stated that the resident constantly pulled the bag off the hook. CNA5 entered the	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 54 resident's room and also confirmed the catheter bag was on the floor and should have been hanging on the side of the bed off the floor. CNA5 said the resident took the bag off the hook "all the time". CNA5 rehung the catheter bag. During an interview on 03/13/25 at 11:56 AM, the Director of Nursing stated that catheter bags should be placed below the bladder and should be covered in a privacy bag. She stated that catheter bags should be monitored for no kinks and no backflow. She said that catheter bags should not be on the floor, and that there was a place for staff to hang them when the resident was in bed. The Director of Nursing stated that both CNAs and nurses should be aware of where to place the catheter bag. She said her expectation was that nurses and CNAs monitored R99's catheter when they went into his room. She stated that if the resident was doing something to keep putting the catheter bag on the floor, the facility would want to know so they could care plan for it. She said the staff should be telling her. She stated that she was not sure R99 was able to be reasoned with regarding catheter care management, so the facility would want to mitigate any issues.	F 690		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and	F 759	1. R93 no longer resides at the facility.	5/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 55 interviews, the facility failed to ensure a medication error rate of less than five percent. During observation of medication pass, there were three errors observed out of 30 opportunities, resulting in a 10% error rate. This had the potential to place two residents (Residents (R) 36 and R93) at risk of not receiving the full benefit of their medication therapy. Findings include: 1.Review of R93's facility provided "Order Summary Report" revealed "ritalin oral tablet 20 milligrams (mg) (Methylphenidate HCL), give one tablet by mouth (PO) two times (BID) a day for attention deficit disorder (ADD), starting 01/15/25." Review of R93's facility provided "Order Summary Report" revealed "omeprazole oral capsule delayed release 40 mg, give one capsule PO one time a day for gastroesophageal reflux disease (GERD), starting 02/04/25." Review of facility provided "Blister Package" indicated "omeprazole 40 mg capsule, one time a day for GERD...Take on empty stomach, before eating." Review of facility provided "Blister Package" indicated "Methylphenidate 20 mg tablet twice daily for ADD. Preferably take 30-45 minutes before meals." Observation on 03/12/25 at 9:00 AM, Registered Nurse (RN) 1 prepared medications for R93, which included ritalin (hyperactivity medication) 20 mg one tablet, and omeprazole 40 mg one	F 759	R93 was not negatively impacted by the deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A root cause analysis was conducted, and it was determined that licensed nursing staff failed to follow physician orders and blister package labeling recommendations when administering medication. Licensed nursing staff will ensure that medications are administered according to physician orders and pharmacy recommendations. Staff Developer/designee will educate nurses on proper medication administration. 4. Staff Developer/designee will perform three random medication pass observations weekly. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 56 capsule, which she popped into a clear cup. After RN1 obtained all the medications needed for R93, she administered the medications. Interview on 03/12/25 at 9:05 AM, R93 said that she already had eaten breakfast. R93 said that she ate cereal this morning. Interview on 03/13/25 at 10:41 AM, RN1 confirmed that she was aware that these medications were to be given before meals; however, RN1 stated that she does her best to give them to the resident before breakfast but has other things to do prior to giving these medications. 2. Review of R36's facility provided "Order Summary Report" revealed "glipizide 2.5 mg, give one tablet PO one time a day every Monday, Wednesday, Friday for diabetes. Give 30 minutes before meals, starting 12/03/24." Review of the facility provided "Blister Package" indicated, "glipizide 2.5 mg one tablet PO one time a day every Monday, Wednesday, Friday for diabetes. Give 30 minutes before meals." Observation on 03/10/25 at 10:00 AM, Licensed Practical Nurse (LPN) 2 prepared medications for R36, which included glipizide (diabetes medication) 2.5 mg one tablet, which she popped into a clear cup. After LPN2 obtained all the medications needed for R36, she administered the medications. Interview on 03/10/25 at 10:15 AM, LPN2 confirmed that R36 already had her breakfast tray.	F 759	1. R36 still resides at the facility. R36 was not negatively impacted by the deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A root cause analysis was conducted, and it was determined that licensed nursing staff failed to follow physician orders and blister package labeling recommendations when administering medication. Licensed nursing staff will ensure that medications are administered according to physician orders and pharmacy recommendations. Staff Developer/designee will educate nurses on proper medication administration. 4. 4. Staff Developer/designee will perform three random medication pass observations weekly. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 57 Follow up interview on 03/13/25 at 12:05 PM, LPN2 said that R36's medication was held due to her blood sugar being low (blood sugar documented at 112) and said that she gave R36's medication around 9:00 AM; however, when the correct time for administration was discussed, LPN2 had nothing to say. Interview on 03/13/25 at 11:30 AM, the Director of Nursing (DON) said that she expects medications to be given as ordered, and according to blister package instructions.	F 759		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the outdoor garbage/dumpster area was maintained in a manner to prevent pests from accessing garbage. A large dumpster contained garbage; there was no lid, and the bags were observed with holes and food. Findings include: During an observation on 03/10/25 at 9:45 AM with the Dietary Manager (DM), there was garbage on the ground around the garbage compactor including cigarette buts, paper, and pieces of cardboard. The DM verified the presence of the garbage on the ground and stated maintenance was responsible for keeping the area cleaned up. In addition, there was an extra-large dumpster that did not have a lid, and it could not be closed. This dumpster contained a	F 814	1. No residents were negatively affected by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A review of the facility process was conducted and deemed to be a deficient practice with an open top dumpster and food trash bags accessible for rodents. NHA will educate the maintenance staff on proper waste management material and procedures. 4. Maintenance will audit the waste	5/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 814	Continued From page 58 lot of garbage, including large plastic bags of waste from the kitchen. There were five bags visible that had rips or torn areas with garbage such as food scraps/containers visible. The DM stated the compactor was gone for a while due to being repaired and that was why the large dumpster was present. The compactor had been repaired and returned to the premises; however, the large dumpster had not been removed. During an observation on 03/11/25 at 10:13 AM, the large dumpster was observed with the same garbage from 03/10/25 including the ripped garbage bags with food scraps/containers visible. During an observation on 03/11/25 at 7:05 PM, a large dumpster was observed with the same garbage noted at 10:13 AM with holes in the bags and food scraps/containers visible. During an observation on 03/12/25 at 10:01 AM, the DM and surveyor checked the dumpster area. The large dumpster continued to have ripped bags of garbage visible which was verified by the DM. The DM stated it was important to have a lid to cover the garbage so animals could not get into it. The DM stated the dumpster would be removed today. The garbage on the ground around the garbage compactor observed on 03/10/25 continued to be present (cigarette buts, paper, cardboard). During an interview on 02/12/25 at 10:18 AM, the Maintenance Director (MD) stated the large dumpster had been present for a couple of weeks while the compactor was repaired. The MD stated he had reached out to waste management to come and remove the dumpster. The MD stated waste management did not provide dumpsters	F 814	management sites for debris three times a week and make sure that if an open top is needed that it is covered. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 814	Continued From page 59 that had lids. The MD stated the maintenance staff typically cleaned the garbage area twice a week on Mondays and Fridays. The MD stated the large dumpster was scheduled to be picked up on 02/13/25. During an interview on 03/13/25 at 10:29 AM, the Administrator stated there was no facility policy related to maintenance of the dumpster area. During an interview on 03/13/25 at 5:35 PM, the Registered Dietitian (RD) stated she completed sanitation inspections of the kitchen which included checking the dumpster area. The RD stated she looked to ensure the dumpster was not overfilled, that the lid was closed, and that there was no food/garbage on the ground. The RD stated the lid should be closed to ensure animals did not get into the garbage. During an interview on 03/13/25 at 6:59 PM, the Administrator stated the large dumpster was picked up today. She stated she was not sure how long the dumpster had been present at the facility. The Administrator stated the dumpster should have had a lid so the garbage would be enclosed.	F 814		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		5/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 60 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 61 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, the facility failed to follow Transmission Based Precautions, use proper hand hygiene, and change gloves during incontinent care. These breaches in infection control could cause a spread in disease and affect all the residents. Findings include: Review of the facility policy titled "Infection Prevention and Control Program Policy," revised 04/14/21, provided by the facility revealed individuals with suspected or diagnosed communicable disease are placed on the appropriate precaution for that disease, as recommended by the Centers for Disease Control and Prevention (CDC) ..." Employees will follow hand hygiene practices consistent with standards of care ..."	F 880	1. R68 still resides in the facility. R68 was not negatively impacted by the deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A root cause analysis was conducted and determined staff failed to adhere to the facility□s infection control policies. Staff developer/designee will educate nursing staff on Cadia□s infection control policies including hand hygiene, PPE, changing gloves, and proper incontinence care. 4. Staff developer/designee will perform	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 62 Review of facility provided poster titled, "Stop: Enhanced Barrier Precautions Everyone Must:" Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Wear gloves and a gown for the following high-contact resident care activities: ...changing linen ...changing briefs or assisting with toileting, device care or use:...feeding tube." Review of facility provided policy titled, "Standard and Transmission Based Precautions," revised 01/02/25, indicated, " ...Policy: [name of the facility] institutes the following precautionary measures to help prevent the spread of Multi-Drug-Resistant Organisms (MDRO) and highly contagious infections/outbreaks. Our goal is to use these infection prevention principles to protect our residents and staff from spread of infections related to MDRO. The types of precautions and when to implement are defined below. Type of Precautions: 1. Standard Precautions-Applies to all residents. No room restrictions. Clean, non-sterile gloves when touching or coming into contact with blood, body fluids, secretions, or excretions. Remove gloves after use. Discard before touching non-contaminated items or environmental surfaces and before providing care to another resident. Hand Hygiene/alcohol-based hand gel/hand washing 2. Enhanced Barrier Precautions-Applies to all residents with wounds and/or indwelling medical devices (central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization as well as for residents with MDRO infection or colonization, when contact precautions do not otherwise apply. No room restrictions.	F 880	three infection control observations weekly to ensure staff are following standard/transmission-based precautions. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings. Staff developer/designee will perform perineal care observations weekly to ensure staff are following standard/transmission-based precautions. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings. 1. R53 still resides in the facility. R53 was not negatively impacted by the deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 63 Hand Hygiene/alcohol-based hand gel/hand washing Personal protective equipment (PPE)-gloves and gown and/or face protection during high- contact resident care activities: i.e. ...changing linens, changing briefs or assisting with toileting, device care or use. 3. Contact Precautions - Applies to all residents infected or colonized with a MDRO [multidrug-resistant bacteria] in the following situations: presence of acute diarrhea, draining wounds, or other sites of secretions or excretions that are unable to be covered or contained, ..."" 1. Observation on 03/10/25 at 12:09 PM, Licensed Practical Nurse (LPN) 2 entered R68's enhanced barrier precaution (EBP) room with any person protective equipment (PPE) on and hung R68's tube feeding, removed the cap from the tube. LPN2 primed the line, dropped the tubbing on the floor, and picked the tubbing up off the floor. At the time of picking the tubbing off the floor, there was no observed cap at the end of the tubbing, and LPN2 flung it over the tube feed (TF) pole. LPN2 sat the two cups of liquid medications on the overbed table, then gave the medications. After incontinent care was completed, LPN2 went over to the TF pole, obtained the tubbing that was hung over the pole, and placed the tip of the tube into the g-tube without wiping it off. Observation on 03/10/25 at 12:24 PM, Certified Nursing Assistant (CNA) 12, entered R68's EBP room with PPE on. CNA12 had a gown, gloves, and mask. CNA12 brought another gown which she placed on R68's bed toward LPN2. LPN2 was on the right side of the bed that was closest to the window. CNA12 removed R68's wedges, and pillows. With the same gloves, CNA12 went to the bathroom got a gray basin, filled it with	F 880	2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A root cause analysis was conducted and determined staff failed to adhere to the facility□s infection control policies. Staff developer/designee will educate all staff on Cadia□s infection control policies. 4. Staff developer/designee will perform three infection control observations weekly to ensure staff are following standard/transmission-based precautions. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings. 1. R74 still resides in the facility. R74 was not negatively impacted by the deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 64 water, came back out and placed it onto the overbed table, and got R68's soap out of the top drawer of the nightstand. CNA12 removed R68's soiled brief tucking it under R68's bottom, then washing R68's perineal area. With the same gloves, CNA12 rinses and dries R68. CNA12 assists R68 in turning over to LPN2, and then CNA12 changed her. CNA12 removed fitted sheet, and bunched up brief which was soiled with bowel movement (BM) and washed, rinsed, and dried R68 all with the same gloves. CNA12 then placed a new brief on R68, and turned R68 towards her, while LPN2 removed linen, without LPN2 wearing PPE. After LPN2 removed the linen, LPN2 did not change gloves, but finished fixing R68's brief. CNA12 placed new linen on R68's bed with the same gloves. Review of "Order Summary Report," dated 12/18/24, under the "Orders" tab, located in the "Electronic Medical Record (EMR)," indicated, "EBP related to peg tube and history of extended-spectrum beta-lactamase (ESBL) in urine." Interview on 03/13/25 at 12:05 PM, LPN2 was unaware of EBP for tube feeding residents, stating that she has never worn a gown before giving tube feed. Indicated that the tube had a cap on it and that cap was present prior to her inserting the tip into the g-tube. Interview on 03/13/25 at 1:00 PM, CNA12 confirmed that she did not change her gloves when going from a dirty area to a clean area and indicated that she should have. 2. During observation on 03/11/25 at 10:06 AM, the Assistant Director of Nursing (ADON) went	F 880	deficient practice by measures outlined in Section C. 3. A root cause analysis was conducted and determined staff failed to adhere to the facility□s infection control policies. Staff developer/designee will educate all staff on Cadia□s infection control policies. 4. Staff developer/designee will perform three infection control observations weekly to ensure staff are following standard/transmission-based precautions. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings. 1. R11 still resides in the facility. R11 was not negatively impacted by the deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 65 into R53's room without washing and/or sanitizing her hands prior to entering the room. R53 is on enhanced barrier precautions (EBP) and there was a sign on the door to let staff know what to do and a clear bin next to R53's door for personal protective equipment (PPE). Review of "Order Summary Report," dated 12/02/24, under the "Orders" tab, located in the "EMR," indicated, "EBP related to gastrojejunostomy (GJ) tube." 3. During the medication observation pass on 03/11/25 at 10:39 AM, Registered Nurse (RN) 3 observed popping R74's seven medications into his left hand from the medication blister package followed by placing them into a clear medication cup on top of the medication cart. RN3 then gave R74 his medication. Interview on 03/13/25 at 10:53 AM, RN3 confirmed that he popped the medication into his hand; however, RN3 said that he sanitized his hands first and it was better than dropping the medication. Interview on 03/13/25 at 11:30 AM, the Director of Nursing (DON), she said that she expects nurses to pop medications directly into the medication cup, not into their hands. 4. Observation on 03/12/25 at 9:40 AM, the ADON entered R11's EBP room without washing her hands and/or sanitizing her hands; however, placed a gown on. Along with the ADON, Licensed Practical Nurse Supervisor (LPNS)2, entered the room at the same time, without putting on a gown, and did not wash hands and/or sanitize hands before entering the room but put	F 880	3. A root cause analysis was conducted and determined staff failed to adhere to the facility□s infection control policies. Staff developer/designee will educate all staff on Cadia□s infection control policies. 4. Staff developer/designee will perform three infection control observations weekly to ensure staff are following standard/transmission-based precautions. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings. 1. R82 still resides in the facility. R82 was not negatively impacted by the deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A root cause analysis was conducted and determined staff failed to adhere to the facility□s infection control policies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 66 on gloves. LPNS2 picked up linen off the floor near bed B and ADON left the room at 9:43 AM, removing her gown without sanitizing her hands or washing her hands, going down the hallway to get a hamper, and returned to the room. At 9:46 AM, ADON went back inside the room without washing hands and/or sanitizing hands and delivered hamper to LPNS2. LPNS2 finished gathering linen up off the floor and gathered linen off bed B, placing all linen in the hamper. Interview on 03/12/25 at 9:52 AM, the LPNS2 confirmed that she did not wear any PPE and should have. Confirmed that linen should not have been on the floor. 5. Observation on 03/13/25 at 3:25 PM, the ADON entered and exited R82's EBP room without washing and/or sanitizing her hands. Review of R82's "Order Summary Report," dated 12/11/24, located under "Orders" tab in the "EMR," documented, "Enhanced Barrier Precautions related to history of Methicillin-resistant Staphylococcus aureus (MRSA)." Interview on 03/14/25 at 2:00 PM, the ADON confirmed that she did not sanitize hands and/or wash her hands prior to and/or exiting EBP rooms as she should. Interview on 03/13/25 at 10:01 AM, the Infection Preventionist (IP) confirmed that medications should be popped directly into a medication cup, not into a nurse's hand. Said that when providing peri-care, gloves are to be changed when going from a dirty area to a clean area. She said that when giving medications through a gastrotomy	F 880	Staff developer/designee will educate all staff on Cadia□s infection control policies. 4. Staff developer/designee will perform three infection control observations weekly to ensure staff are following standard/transmission-based precautions. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings. 1. R158 no longer resides in the facility. R158 was not negatively impacted by the deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Further residents will be protected by this deficient practice by measures outlined in Section C. 3. A root cause analysis was conducted and determined staff failed to adhere to the facility□s infection control policies. Staff developer/designee will educate all staff on Cadia□s infection control policies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 67 tube (g-tube), if the tubing falls on the floor, that tubing is not to be used. If a resident is on EBP donning (putting on) is to occur prior to entering the room along with washing and/or sanitizing hands, and doffing (taking off) PPE prior to exiting the room, placing PPE in the bins provided in the room. After staff exit an EBP room, staff are to wash their hands and/or sanitize their hands. 6. Review of R15's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 02/05/25 and located in the electronic medical record (EMR) under the "MDS" tab, revealed R15 had an admission date of 01/30/25 and a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated R15's cognition was intact. The MDS assessment indicated R15 had diagnoses of aftercare following joint replacement surgery, cancer, and disorder involving the immune mechanism, unspecified. Review of R15's "nurses notes," dated 03/08/25, located in the EMR under the "Progress Note" tab revealed "Received Urinalysis culture report. Urine positive for ESBL [extended-spectrum beta-lactamase (a bacteria resistant to many antibiotics)]. Notified on call nurse [name] and obtained order for 1gm [gram] of Ertapenem [antibiotic] daily x 7 days. Notified Infection Control Nurse. Awit [sic] further recommendations. Called Mr. [name] and informed of UA [urine analysis] Culture report and the start of the antibiotics." Review of R15's "orders," dated 03/08/25, located in the EMR under the "Order" tab revealed " Contact Precautions r/t [related to] ESBL in urine with ABT [antibiotic] tx [treatment] every shift for	F 880	4. Staff developer/designee will perform three infection control observations weekly to ensure staff are following standard/transmission-based precautions. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 68 ESBL UTI [urinary tract infection] for 10 Days." On 03/10/25 at 2:12 PM, R15's room was noted to have a sign that read "Stop, Contact Precautions everyone must: clean their hands, including before entering and when leaving the room. Providers and staff must also: put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit ... Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person." A supply of protective personnel equipment (PPE) that included gowns and gloves were hanging on the outside of the door. On 03/10/25 at 2:13 PM, Heavy Housekeeping (HH)1 was observed to knock on R15's closed door, enter the room without donning a gown and gloves and started sweeping the floor. R15 was sitting in the room dressed and groomed and talking on her phone as HH1 swept the floor around her. On 03/10/25 at 2:15 PM, HH1 came out of R15's room and briefly went across the hall to another room to sweep with the same broom and then back to his cart. HH1 was asked if he was supposed to wear a gown and gloves when cleaning R15's room. The contact precaution sign and the supply of PPE supplies were pointed to on the door. HH1 stated he wouldn't have known if he should use the gowns as no one told him. HH1 confirmed he didn't wear a gown and gloves into R15's room. On 03/12/25 at 12:22 PM, Licensed Practical Nurse (LPN)2 was observed entering R15's room without donning a gown to give R15's	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 69 medications and stayed in the room for a few minutes talking with R15. LPN2 came out of R15's room and back to the medication cart. LPN2 was asked if R15 was still under contact precautions and LPN2 stated, "No." LPN was asked if she should have used PPE to give medications and the supply of PPE and the contact precaution sign were pointed to on the door. LPN2 stated, "No," only if she came in contact with R15's urine. During an interview on 03/13/25 at 10:30 AM, the Infection Preventionist (IP) was asked about R15. The IP stated R15 was currently taking an antibiotic for a urinary tract infection with ESBL. The IP stated R15 was complaining of burning upon urination and that's when a urinary analysis was conducted. The laboratory results came back with ESBL. The IP went on to say R15 was receiving treatment and contact precautions were started. The IP was asked if housekeeping should use PPE when cleaning R15's room since she has ESBL. The IP stated, "Yes, housekeeping should use PPE. The IP was informed that HH1 didn't use PPE on 03/10/25. The DON was present and stated housekeeping were contract and they are responsible for their own training. The IP stated she will assist with additional training with housekeeping if she identifies a need. During an interview on 03/13/25 at 10:35 AM, the IP asked if LPN2 should wear PPE while passing medications to R15 while in her room. The IP stated, "Yes." The IP was informed that LPN2 entered R15's room without donning PPE to give medications on 03/12/25. The IP was informed that LPN2 stated R15 wasn't under contact precautions and that she should only wear PPE if	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 70 she encountered R15's urine. 7. Review of the "COVID-19" policy dated 01/03/25 and provided by the facility revealed it was the policy of the facility, "to prevent the spread of COVID-19 (Coronavirus) ... When a resident meets the criteria to be a Person Under investigation (PUI) for symptoms identified or confirmed COVID, staff must contact the Provider and the Director of Nursing (DON). The resident will immediately be placed in isolation with contact/droplet precautions using Personal Protective Equipment (PPE) as described below ... Personnel entering the room should use PPE, including gown, gloves, N95 respirator (or equivalent or higher level respirator), and eye protection. Facemasks can be used if N95 respirator (or equivalent or higher level respirator) is not available. For residents with suspected or confirmed COVID-19, an N95 (or equivalent or higher level respirator) mask, eye protection, gloves, and gown must be worn while performing any of the above procedures." Review of the undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed R158 was admitted to the facility on 08/30/24 and was discharged on 11/08/24. R158's closed record was reviewed. Review of a "Physician's Order" dated 10/13/24 and provided by the facility revealed the Physician ordered droplet and contact precautions for R158 from 10/13/24 through 10/21/24. During an interview on 03/11/25 at 3:47 PM, Family Member (FM)1 stated R158 was quarantined during her stay due to being exposed to someone in the facility with COVID in October	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	C 03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 71 2024. During an interview on 03/13/25 at 10:12 AM with the IP and the DON, they stated if a resident was exposed to COVID, they were placed on quarantine with both contact and droplet precautions in place for eight days. All staff were required to don a gown, wear gloves, an N95 mask, eye protection, and a face shield to go into a COVID quarantine room. The IP and DON stated that the door to the room should remain closed. During an interview on 03/13/25 at 10:49 AM, LPN4 stated she remembered R158 being quarantined due to exposure to staff that tested positive for COVID. LPN4 stated R158 was under quarantine for seven days and there should have been a sign regarding isolation and PPE requirements posted outside the door. LPN4 stated contact isolation would have been in effect and nursing staff would have been required to wear full PPE if providing resident care: however, she did not think other staff such as housekeepers would have been required to wear PPE. LPN4 did not indicate that droplet precautions should also be in effect.	F 880		