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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Capitol	1225 Walker Road Dover, DE 19904

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, it was determined that for one (R5) out of nine residents reviewed for medication administration, the facility failed to ensure that R5 received the correct dose of morphine sulfate for pain when R5 erroneously received 15 mL (milliliter) of the concentrated morphine sulfate oral solution instead of the physician prescribed dose of 0.25 mL on 12/7/25 at 10:58 AM. With this significant medication error, R5 was at risk of a severe, life-threatening respiratory depression or death. R5 was administered Naloxone 0.4 mg/mL intramuscularly two times to reverse R5's overdosage on 12/7/25 at 4:13 PM and 8:02 PM. An immediate Jeopardy (IJ) was identified starting 12/7/25. Due to the facility's corrective measures following the last incident, this is being cited as immediate jeopardy, past non - compliance with an abatement date of 12/11/25. Findings include: A facility policy titled Medication Administration, dated 1/13/26, documented, It is the policy of this facility to ensure that all medications are administered safely, accurately, timely, and in accordance with physician's orders, federal and state regulations . Medication administration shall comply with the Rights of Medication Administration . Definitions . Medication Administration Rights: Right resident, right medication, right dose, right route, right time, right documentation, right reason, right response. Review of R5's clinical record revealed:8/16/19 - R5 was admitted to the facility with diagnoses including but not limited to dementia.9/25/25 - R5's quarterly MDS (Minimum Data Set) assessment revealed that R5's cognition was moderately impaired with a BIMS score of 10 and was receiving opioids (a class of drugs used primarily to treat moderate - to - severe pain).11/21/25 - R5 had a physician's order for 0.25 mL = 5 mg (milligram) morphine sulfate (an opioid concentrate) oral solution every three hours as needed for pain.12/7/25 7:04 AM - R5 had a new physician's order for MS Contin (morphine sulfate) oral tablet extended release 15 mg by mouth two times a day for pain. 12/7/25 4:43 PM - A nurse progress note documented, At about 1530 (3:30 PM) during rounds on (unit), the outgoing nurse called me because 300 mg morphine sol (sic) was given to [R5]. [P1] (facility Medical Director) was called, family was made aware and Hospice was too (sic). [R5] monitor for any changes.12/7/25 7:11 PM - A nurse progress note documented, Late entry at 1520 (3:20 PM) order from [P1] for naloxone (medication used to reverse or reduce the effects of opioids). Naloxone was given at 1613 (4:13 PM). 12/7/25 7:44 PM - A nurse progress note documented, Naloxone HCL (hydrochloride) Injection Solution 0.4 MG/ML Inject 0.4 mg/ml intramuscularly STAT (at once/immediately) for overdose.12/7/25 8:02 PM - A nurse progress noted documented, gave 2nd dose of Naloxone 0.4 mg/ml per [P1].12/7/25 - A written statement by E30 (LPN) documented, On December 7, 2025 at about 0900 am (sic), I made a medication error during my morning medication pass. I administered 15 mL of morphine to a patient [R5] instead of the intended dose of 0.25 mL. The system displayed the ordered dose of morphine 15 mg, while the patient's bottle label stated 0.25 mL. I sought clarification from my supervisor, who confirmed that I should follow the dose listed in the patient's MAR (Medication Administration Record) in the system. Unfortunately, I incorrectly interpreted 15 mg as 15 mL. 12/7/25 - A written statement by E19 (3-11 shift RN Supervisor) documented, During my rounds on (unit) the off going (sic) nurse [E30] called me and she said 'I made a medication error on the narcotic' . I called [P1] and notified her of the error . 12/8/25 9:12 AM - A physician note by P1 documented, I was notified yesterday, 12/7/25 at 3:30 PM by (continued on next page)

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.

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	nursing staff that pt (patient) was given 15 ml of liquid morphine by floor nurse at 930 AM 12/7/25. Liquid morphine has concentration of 20 mg/ml so pt was given 300 mg of morphine instead of 5 mg. I was told that the nurse made a mistake. I was told that pt's sleepy but vitals are stable. I requested 0.4 mg Narcan to be administered. I called back at 5 PM and was told that pt's heart rate is dropping, so I ordered another dose of Narcan 0.4 mg. I also advised staff to hold all PO meds until further orders. I called back at 9 PM, and I was told that pt is stable and is resting. I have emailed DON and Administrator today to set up a call to investigate this grave med error and so that we can do a root cause analysis.12/10/25 - A facility follow up report documented that approximately 9:00 AM E30 administered 15 mL of morphine sulfate concentrate to R5 after reading morphine 15 mg 1 tablet on the MAR. During the shift exchange (between 7-3 and 3-11) E30 recognized the error in administration of mL versus mg. The follow up report further documented, [R5] had order for Morphine Sulfate Solution 100 mg/5mL give 0.25 mL every 3 hours as needed. On 12/7 [R5] had new order for MS Contin oral tablet give 15 mg two times a day for pain which was pending delivery from the pharmacy . Upon identification of medication error, [R5] was assessed and monitored. [P1] was notified and order was given for Narcan (Naloxone), which was administered twice. [R5] was placed on alert charting and vital signs, respiratory status and mentation monitored. [P1] gave order to hold medications . 1/22/26 2:20 PM - In an interview, E12 (RN) stated that she was the supervisor on 12/7/25 during the 7-3 shift. E12 stated that on that morning she was doing her rounds and was walking to E30's unit on her way to see another resident. E12 stated she saw E30 who was passing meds. E30 stopped her to ask what to do when a resident's narcotic medication ran low, and whether to administer the last dose of the medication or to hold it. E12 stated that she told E30 to administer the medication as ordered by the physician and to call the doctor and pharmacy for refill. E12 further stated, I did not know what specific narcotic medication she was talking about. I thought it was just a general procedure question that she asked me as I walked past her on my way to another resident's room. At the end of our day shift, I was notified by the incoming nurse that [E30] gave the wrong dose of medication to [R5]. 1/22/26 3:34 PM - During an interview, E16 (LPN) stated that she worked on 12/7/25 and was the incoming and reliving nurse on the 3 - 11 shift. E16 stated that she saw E30 looking at the narcotic book and told her that R5 ran out of the concentrated morphine sulfate. E16 stated that she worked a double shift (7-3 and 3-11) the day before on the same unit with R5 on her assignment and was familiar with R5's morphine sulfate dosage order. E12 further stated, I know [R5] gets 0.25 mL morphine sulfate every three hours when needed for pain. I left my shift at 11:00 PM on 12/6/25, with [R5's] 17.25 mL remaining morphine sulfate concentrate in the bottle. [E30] informed me that she gave 15 mL morphine sulfate concentrate to [R5]. The facility failed to ensure that R5 was free from significant medication administration error when R5 received 15 ml of the concentrated morphine sulfate oral solution instead of the ordered dose of 0.25 ml on 12/7/25 at 10:58 AM. This resulted in a significant medication error for R5 who received 59 more doses of the morphine sulfate solution than the prescribed physician order.1/27/26 10:45 AM - An Immediate Jeopardy (IJ) was called and reviewed with the facility leadership including E1 (NHA). During this conference, E1 confirmed that there had been no other incidents of significant medication error after the 12/7/25 incident. 1/22/26 - E1 (NHA) presented to surveyor an acceptable documentation of corrective action plan that was fully abated on 12/11/25. The facility's corrective actions at the time of the incident included:1. Upon discovery of the medication error, R5 was immediately assessed, and physician was notified. New order for Narcan (Naloxone) obtained and administered out of an abundance of caution. R5's responsible party and Hospice were also notified. R5 was placed on alert charting to monitor vital signs and respiratory status. R5 remains in the facility and had no adverse outcomes related to the medication error.2. All residents with orders for liquid morphine have the potential to be affected by this deficient practice. An audit was completed on like residents receiving morphine and no other errors were identified. An audit of like residents receiving controlled substances was completed to determine if any other residents had orders for the same medication in (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	two different forms and no other residents were identified. 3. The facility conducted a root cause analysis, and it was determined that the assigned nurse failed to perform the five rights of medication administration when the nurse misinterpreted 15 mg as 15 ml. Education with licensed nurses was completed on five rights of medication administration. Education was completed on 12/11/25. Medication error was reviewed with medical director at an ad hoc QAPI meeting on 12/10/25. The facility was back in substantial compliance on 12/11/25.4. Director of Nursing will conduct audits of liquid morphine medication administration. The audits will be performed weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Performance Improvement Committee.No immediate action required related to past non-compliance. This was verified by review of facility documents and interview with facility staff and residents.1/27/25 5:45 PM - Findings were reviewed at the exit conference with E1 (NHA) and E2 (DON).

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, it was determined that for two (R30 and R108) out of nine residents sampled for abuse, the facility failed to report an allegation of abuse to the state agency within two hours. Findings include:2. Review of R108's clinical record revealed: 10/26/25 - E7 (CNA) documented in a written statement, On October 25, 2025 .around 11:15 PM I went to check on all my patients. When I got to [R108] she stated that 'the CNA that had her torn her clothes and was rough with her . 10/26/25 11:08 AM - The facility submitted an allegation of staff to resident abuse incident involving R108 to the state agency, greater than two hours after R108's initial report to the facility. 1/23/26 10:19 AM - During an interview E7 (CNA) confirmed the aforementioned written statement and that R108's allegation of abuse was reported to a nurse on 10/25/25. 1/23/26 1:57 PM - During an interview E3 (ADON) confirmed the finding. E3 stated, I found out through reading notes and things that it happened on the 25th but no one made leadership aware. 1/27/26 5:45 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON). The facility policy on abuse last updated 1/9/26 indicated, Allegations of abuse shall be reported to the appropriate state regulatory authority within two hours. 1. A review of R30's clinical record revealed: 1/6/19 – R30 was admitted to the facility. 10/25/25 7:15 PM – R30 reported E4 (CNA) was rough with care. 10/27/25 11:09 AM – The facility reported an allegation of abuse to the State agency. 1/22/25 11:07 AM – During an interview with E3 (DON), it was confirmed that the allegations of abuse must be reported within two hours. 1/22/25 12:00 PM – During an interview with E1 (NHA), it was confirmed that the alleged abuse was not reported within two hours. The facility failed to report the allegation of abuse to the State Agency within the designated timeframe of two hours. 1/27/26 5:45 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, it was determined that for one (R5) out of three residents reviewed for PASRR (Preadmission Screening and Resident Review), the facility failed to refer R5 for a PASRR evaluation as required when a resident experiences a significant change in mental health status. Findings include: Review of R5's clinical record revealed:2/6/23 - R5 was re-admitted to the facility. 11/13/23 - R5's Notice of PASRR Level II Outcome indicated that R5 had the following mental health diagnoses: -Adjustment Disorder with depressed mood-Delusional Disorder-Dementia-Mood Disorder NOS (not otherwise specified) -Anxiety Disorder NOS-Psychotic Disorder NOS-Insomnia-Major Depressive Disorder, recurrent, severe, with psychotic symptoms2/14/25 - R5's quarterly MDS (Minimum Data Set) assessment revealed R5's new psychiatric/mood disorder diagnoses including bipolar disorder, adjustment disorder with mixed anxiety and depressed mood and unspecified mood affective disorder. 3/25/25 - R5's significant change MDS assessment revealed R5's psychiatric/mood disorder diagnoses including but not limited to: bipolar disorder, restlessness and agitation, unspecified mood affective disorder and adjustment disorder with mixed anxiety and depressed mood. 6/25/25 - R5's quarterly MDS (Minimum Data Set) assessment revealed R5's new psychiatric/mood disorder diagnoses including but not limited to: bipolar disorder, adjustment disorder with mixed anxiety and depressed mood and unspecified mood affective disorder. 9/25/25 - R5's quarterly MDS (Minimum Data Set) assessment revealed R5's new psychiatric/mood disorder diagnoses including but not limited to: bipolar disorder, adjustment disorder with mixed anxiety and depressed mood and unspecified mood affective disorder. 12/26/25 - R5's quarterly MDS (Minimum Data Set) assessment revealed R5's new psychiatric/mood disorder diagnoses including but not limited to: bipolar disorder, adjustment disorder with mixed anxiety and depressed mood and unspecified mood affective disorder. 1/22/26 2:00 PM - A review of R5's mental health diagnoses report revealed that R5's new diagnoses with onset dates included:-Adjustment Disorder with mixed anxiety and depressed mood (7/24/24)-Bipolar Disorder, unspecified (1/17/24)-Unspecified Dementia, unspecified severity with other behavioral disturbance (1/17/24) 1/22/26 4:00 PM - During an interview, E1 (NHA) confirmed that R5's PASRR evaluation was not updated and submitted to the PASRR state authority when R5 was diagnosed with Adjustment Disorder with mixed anxiety and depressed mood, Bipolar Disorder and Unspecified Dementia unspecified severity with other behavioral disturbance in 2024.1/27/26 5:45 PM - Findings were reviewed at the exit conference with E1 (NHA) and E2 (DON).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review it was determined for one (R6) out three residents sampled for respiratory care the facility failed to provide professional standards of practice by ensuring R6's BiPap equipment was stored in a protective plastic bag when not in use. Findings include:A review of R6's clinical record revealed:1/10/24 - R6 was admitted to the facility with diagnoses of acute respiratory failure and interstitial pulmonary disease.12/28/25 - A quarterly MDS documented that R6 was cognitively intact.1/20/26 - A physician's order documented BIPAP application at bedtime (HS) and PRN. The order specified: BIPAP setting: 10 cm HˆO with Oˆ bleed-in at 2 liters.1/26/26 - A review of the treatment administration record lacked evidence of an order directing that the BIPAP mask and tubing be stored in a protective plastic bag when not in use.1/20/26 at 10:11 AM - R6's BIPAP mask was observed lying on the bedside table, with the tubing on the floor.1/21/26 at 8:40 AM - R6's BIPAP mask was again observed lying on the bedside table, with the tubing on the floor.1/21/26 at 8:50 AM - During an interview, E5 (LPN) stated that BIPAP masks and tubing are required to be stored in a protective plastic bag when not in use. Following the interview, E5 entered R6's room and confirmed that the BIPAP mask and tubing were not stored in a protective plastic bag. E5 immediately placed the BIPAP mask and tubing into a protective plastic bag.1/21/26 8:50 AM - During an interview, E5 (LPN) stated that BIPAP masks and tubing are required to be stored in a protective plastic bag when not in use. Following the interview, E5 entered R6's room and confirmed that the BIPAP mask and tubing were not stored in a plastic bag. E5 immediately placed the BIPAP mask and tubing in a protective plastic bag.1/27/2026 5:45 PM - Findings were reviewed at the exit conference with E1 (NHA) and E2 (DON).

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview it was determined that for one (R81) out of five residents reviewed for unnecessary medication review the facility failed to implement the MRR policies when recommendations made by the pharmacist and agreed by the provider were not completed by the facility. Findings include: The facilities Pharmacist monthly drug review policy last updated 1/23/26 indicated, Facility will encourage physician/prescriber or other responsible parties and the DON to act upon the recommendations contained in the monthly drug review.Review of R81's clinical record revealed:5/15/25 - R81 was admitted to the facility with multiple diagnoses including dementia with behavioral disturbance, anxiety, depression and an allergy to bee venom. 5/30/25 - An MRR recommended an EpiPen be considered related to R81's bee venom allergy, and that R81's Risperdal prescribed for major depressive disorder was an inappropriate use for an antipsychotic. The recommendations were marked as agreed by R81's physician. 6/29/25 - An MRR recommended an EpiPen be considered related to R81's bee venom allergy. The recommendation was marked as agreed by R81's physician.7/27/25 - An MRR recommended an EpiPen be considered related to R81's bee venom allergy, and that R81's Risperdal prescribed for mood was an inappropriate use for an antipsychotic. The recommendations were marked as agreed by R81's physician. 1/22/26 10:00 AM - Review of R81's physicians orders revealed the order for Risperdal continued as indicated for 'mood'. There was no order written for an EpiPen, 1/22/26 10:38 AM - During an interview E9 (LPN) unlocked and opened the medication cart where R81's medications were stored and confirmed that there was no EpiPen prescribed to R81 in the medication cart. 1/22/26 10:40 AM - During an interview E8 (LPN, UM) confirmed that the correct diagnosis for R81's order for Risperdal not listed and that there was no epi-pen ordered for the resident. 1/27/26 5:45 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview it was determined that the facility failed to maintain accurate and complete records for one (R119) out of three residents reviewed for beneficiary notification. Findings include:Review of R119's medical record revealed:7/25/25 - The facility provided a Notice of Medicare Non-Coverage (NOMNC) to R119 to relay that services would end on that date.1/23/26 - During the beneficiary notification review, a review of R119's worksheet and relevant documents lacked evidence of the second page, the signature page to validate the resident or their responsible party received and understood the notice.1/23/26 1:15 PM - During an interview, E6 (SW) confirmed the finding and relayed that the facility was unable to locate R119's signature page to their NOMNC.1/27/26 5:45 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).