

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Cadia Rehabilitation Silverside		STREET ADDRESS, CITY, STATE, ZIP CODE 3322 Silverside Road Wilmington, DE 19810	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on observation and interview, it was determined that for one (R1) out of five residents reviewed for communication, the facility failed to provide R1 with a fully functional phone in her room or a location outside her room where calls can be made without being overheard. Findings include:3/26/18 - R1 was admitted to the facility with diagnoses including but not limited to stroke.5/24/21 - A diagnosis of hallucinations was added to R1 diagnoses list in the EMR.8/30/22 - R1 was diagnosed with paranoid personality disorder.5/26/23 - A PASARR Level II documented R1, As of 1/24/23, you having ongoing false beliefs and routinely call government agencies sharing your false beliefs. You have paranoia, choose not to take your medication, and sometimes choose not to have your labs. You are hyper-verbal regarding your false beliefs and unable to be redirected. The PASARR Level II documented, At this time you meet PASARR inclusion criteria for Serious mental illness with the diagnosis of Paranoid Delusional Disorder and Major Depressive disorder. You also have the diagnoses of Paranoid Personality disorder, Cognitive Disorder NOS (not otherwise specified) and Anxiety Disorder NOS. 6/17/25 - A quarterly MDS evaluation documented R1 as having a BIMS score of 15, which is reflective of normal cognition.11/24/25 10:20 AM - Surveyors observed [R1] sitting in her wheelchair at the open nurses' station on a telephone and R1 was discussing the FBI with whomever she was speaking with.11/24/25 10:40 AM - During an interview, R1stated, My phone. the number nine does not work. Surveyor asked permission to check the phone in her room with R1 present; the number 9 on that phone was non-functional.11/25/25 2:45 PM - A review of R1's Care Plan revealed documentation, .[R1] has a behavior problem: . 5. [R1] makes excessive phone calls to 911- May 2024 Police have stated this is an arrestable offense and resident will be arrested if the behavior continues. 6. [R1] excessively interrupts nursing staff to use the phone. Interventions- Ombudsman consulted and phone removed with continued behaviors. Resident given her phone back with #9 disabled, if resident needs to make a phone call requiring a 9, then resident may make two 15-minute phone calls a day at the nursing station, all phone calls to be dialed by staff due to repeated 911 calls- every shift. Date initiated 4/22/24It should be noted that R1's estranged husband's telephone number has the number 9 in it.12/1/25 9:16 AM - During an interview, E5 (SSA) stated when asked about R1's phone, I am not aware of that (that the #9 on R1's phone was non-functional). I can put a work order in for that. E5 also stated that R1 typically dials the phone numbers herself.12/1/25 10:25 AM - A review of R1's EMR September, October and November 2025 TAR (Treatment Administration Record) revealed an order, two 15-minute phone calls a day at the nursing staff (sic), all phone calls dial by staff due to repeated 911 calls every shift. This order was documented as being initiated on 4/22/24.12/1/25 11:45 AM - During an interview, E1 (NHA) stated that the Ombudsman was aware that the #9 on [R1]'s phone was disabled. E1 also stated that there was a private phone alcove on the first floor. E1 stated that typically [R1] makes her phone calls at the nurses' station and asked if the facility offered her [R1] access to the private phone alcove would that fulfill the regulation.The facility failed to provide R1 a place where calls can be made without being overheard since April of 2024.12/1/25 3:30 PM - The findings were reviewed at the exit conference with E1(NHA) and E2 (DON).		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 085056	Facility ID: 085056 If continuation sheet Page 1 of 7

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that for five (R1, R2, R3, R4, R5) out of five residents reviewed for care plans, the facility failed to have evidence that an attending physician participated in the IDT team care plan meeting. Findings include:1. Review of R1's clinical record revealed:3/26/18 - R1 was admitted to the facility.6/26/25 3:58 PM - R1's EMR documented in a Care Conference Note, . resident refused to be apart (sic) of it. Residents (sic) family was invited, but did not attend. IDT (Interdisciplinary team) members present include Nsg (nursing), UMs (unit managers), dietician, ST (speech therapy), OT (occupational therapy) and SSA (social services assistant). Activities director unable to attend but gave report to SSA. CNA (certified nursing assistant) also provided input for todays (sic) meeting.9/25/25 12:37 PM - R1's EMR documented in a Care Conference Note, . resident stated that she did not want to have a care plan meeting and she refused to participate. Residents family was invited but did not attend. IDT members present include Nsg, UMs, PT (physical therapy), dietician, SSA (social services assistant) and case manager. CNA (certified nursing assistant) also provided input for todays (sic) meeting.The facility failed to provide evidence of the attending physician's participation in both the 6/26/25 and 9/25/25 care plan meetings for R1.2. Review of R2's clinical record revealed:9/26/25 - R2 was admitted to the facility.9/30/25 - R2's EMR documented in a Care Conference Note, .IDT team; SSD (social services director), dietician, PT, OT, ST met with son over phone to review current goals. CNA also provided input to care plan.The facility failed to provide evidence of the attending physician's participation in the 9/30/25 care plan meeting for R2.3. Review of R3' Clinical record revealed:10/30/23 -R3 was admitted to the facility.7/31/25 4:08 PM - E5 (SSA) documented in R3's EMR in a Care Conference Note, .resident family was invited but did not attend. IDT team members present for this meeting include Nsg, UM, dietician, OT, Activities director and SSA. PT was unable to attend meeting but gave report to SSA. CNA also provided input for todays (sic) meeting.10/30/25 12:03 PM - E5 (SSA) documented in R3's EMR in a Care Conference Note, .resident family was invited but did not attend. IDT team members present for this meeting include PT, OT, SSA, Activities director and case manager. Nsg UM and dietician were unable to attend meeting but gave report to SSA. CNA also provided input for todays (sic) meeting.The facility failed to provide evidence of the attending physician's participation in the 7/31/25 and 10/30/25 care plan meetings for R3.4. Review of R4's clinical record revealed:3/8/22 - R4 was admitted to the facility.7/24/25 2:42 PM - E5 (SSA) documented in R4's EMR in a Care Conference Note, .resident's family was invited but did not attend. IDT team members present include Nsg UM, dietician, and SSA. CNA also provided input for today's care plan meeting.10/16/25 2:59 PM - E5 (SSA) documented in R4's EMR in a Care Conference Note, .resident's family was invited but did not attend. IDT team members present include Nsg UM, dietician, and SSA. PT was unable to attend meeting, but gave report to SSA. CAN also provided input for today's care plan meeting.The facility failed to provide evidence of the attending physician's participation in the 7/24/25 and 10/16/25 care plan meetings for R4.5. Review of R5's clinical record revealed:10/14/24 - R5 was admitted to the facility.6/26/25 12:56 PM - E5 documented in R5's EMR in a Care Conference Note, Care plan meeting was held today in resident's room, with resident's daughter, [name], present via speakerphone. IDT team members present include NSG UM, dietician and SSA. Activities director was unable to attend but gave report to SSA. CNA also provided input for todays (sic) care plan meeting. 9/25/25 12:30 PM - E5 documented in R5's EMR in a Care conference Note, .Resident informed SSA that she did not want her son-in-law to participate in this meeting. IDT team members present include Nsg UM, dietician and SSA. CAN also provided input for todays (sic) care plan meeting.The facility failed to provide evidence of the attending physician's participation in the 6/26/25 and 9/25/25 care plan meetings for R5.12/1/25 3:30 PM - The findings were reviewed at the exit conference with E1(NHA) and E2 (DON).		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that for one (R1) out of five residents reviewed for social services, the facility failed to provide medically-related social services to R1, a resident diagnosed with a paranoid personality disorder. Findings include: Cross refer F576, F657 example 1 According to the CMS's RAI Version 3.0 Manual, Section C - Brief Interview for Mental Status (BIMS) revealed the following: . A resident's performance on cognitive tests can be compared over time.-An abrupt change in cognitive status may indicate delirium and may be the only indication of a potentially life-threatening illness.-If performance worsens, then an assessment for delirium and/or depression should be considered, as a decline in mental status may also be associated with a mood disorder. When cognitive impairment is incorrectly diagnosed or missed, appropriate communication, activities, and therapies may not be offered. Section E: Behavior. Hallucinations and delusions may be distressing to residents and families, cause disability, interfere with delivery of medical, nursing, rehabilitative and personal care, and lead to dangerous behavior or possible harm. Planning for Care. When the cause is not reversible, the focus of management strategies should be to minimize the amount of disability and distress. Review of R1's clinical record revealed: 5/13/25 4:14 PM - A psychiatry consultation by C1 (NP) documented, . (checked) Other Dx (diagnoses). F22 [Delusional Disorder] F60.0 [Paranoid Personality Disorder] F44.2 [Other Hallucinations] Psych consult for evaluation and treatment. Psychotropic Medications none. Psychiatric History. 1. Cognitive Loss (checked) none. 5. Depression (checked) isolated. 6. Psychotic Features/Hallucinations/Delusions (checked) Paranoid. Compliant with Care (checked) No. Staff support/Directions (checked) Does not accept. Additional history. She has chronic paranoid delusions and hallucinations including smells from other rooms. She was calm and cooperative today she made eye contact. She is paranoid. She can make her needs known and accepts some care. she sleeps OK. Mood ok, affect in range. She denies suicide attempt. denies si hi [suicide ideation homicidal ideation]. Mental Status Examination. Speech. spontaneous, coherent. Thought process. (checked) Tangential and Disorganized. Mood (nothing checked). remains paranoid and refuses meds. Recommendation and Plan. cont (continue) supportive care. Not open to medications. Reviewed chart and discussed with staff. It should be noted that this was the last documented psych note in R1's clinical record. 5/27/25 - A progress note by E3 (Physician) documented, . Patient seen and examined today. Patient endorses she is very upset because of her usual paranoid ideation issues, very hard to re-direct her and I could not do it today. 5/30/25 at 12:03 AM - A nurse's note documented, Resident requested to make phone call. This nurse asked resident if she was aware of the time of night, and resident verbalized that she was aware of the time. Resident wrote down 2 phone numbers for this nurse to dial. This nurse dialed both calls this night. Resident could be heard speaking about things such as '?career criminals from Pennsylvania state prison.', '?prison gang here in the nursing home.' and '?the criminals are stalking and harassing the pastors from the local church.'. Resident also heard verbally attacking the other overnight care nurse. Resident completed phone calls by 1215 [12:15 AM] and returned to room. 6/17/25 - The quarterly MDS assessment for R1 was coded as: -BIMS was a 15/15 [cognitively intact] by E13 (RN). -Inattention and disorganized thinking were continuously present and did not fluctuate. -No hallucinations or delusions were checked as potential indicators of psychosis. -No verbal or physical behaviors directed towards others. -No rejection of care. 6/17/25 2:44 PM - A social services note by E5 (SSA) documented, Resident remains on LTC with no plans to discharge at this time. Resident is alert and oriented x3. She allowed SSA to enter room to converse and provide support. Resident continues to have behaviors and delusions. Resident is not on any psychotropic medications at this time. SSA will continue to monitor resident. 6/18/25 12:34 PM - A nurse's note documented, . Resident educated on importance of having follow up dental visit. Resident (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	began shouting at both charge nurses swinging her back scratcher, stating 'I am a grown woman I do not need you to tell me what's important!' It's important for you to get the murderers and criminals out of here from Pennsylvania jail and turn off the industrial fans with chemicals.' Both nurses exited the room at request of resident.6/26/25 3:58 PM - A care conference note by E5 (SSA) documented, Residents care plan meeting was held today, resident refused to be apart of it. SS; [Social Services] Resident is not on any psychotropic medication at this time. SSA will continue to monitor resident for any LTC concerns.7/29/25 - A progress note by E3 (Physician) documented, . I went to patient's room, did not examined (sic), but she let out a [NAME] about her usual paranoid ideation, criminals from Pennsylvania jail are harming her in many ways, all illogical and unbelievable (sic). Unable to re-direct her today. Plan: Paranoid personality disorder. Staff endorses that patient increasingly agitated at times especially with new staff. Refuses formal therapy and medications. Often refuses meals/medications when given by new staff members. Declines labs/imaging in the ED.8/7/25 - A progress note by E6 (NP) documented, . Patient seen and examined today. continues with ongoing paranoia. Unable to redirect.8/11/25 5:14 PM - A nurse's note documented, Resident very agitated this evening. She told me the chemicals were coming into her room and three criminals from the state prison were in the hallway. Resident has a history of hallucinations and paranoid personality disorder.9/11/25 - The quarterly MDS assessment for R1 was coded as:-BIMS was a 00/15 (severe cognitive impairment) by E12 (ST).-Inattention and disorganized thinking were continuously present and did not fluctuate;-No hallucinations or delusions were checked as potential indicators of psychosis.-Yes, verbal behavioral symptoms directed towards others occurred 1 to 3 days during the look back period of seven days.-No rejection of care.9/15/25 1:38 PM - A social services note by E5 (SSA) documented, Resident remains in LTC [long term care] with no plans to discharge. Resident is alert and oriented x3. Resident is independent with activities of her choosing but primarily stays in her room watching television and enjoys watching spiritual/religious programming. Resident will occasionally sit near the nurses station to use the phone and to socialize with staff. SSA will continue to monitor resident.9/25/25 12:37 PM - A social services note by E5 (SSA) documented, A care plan meeting was held with IDT team this morning. resident. refused to participate. SS; (sic) No psychotropic medication at this time. SSA will continue to monitor resident.Despite a change in R1's BIMS and verbal aggression towards others on the 9/11/25 MDS assessment, there was no evidence of social services follow-up.10/1/25 - A progress note by E6 (NP) documented, . History of Present Illness. chronic paranoia (constantly thinks that the nursing home is abusing her, poisoning her, etc.), has been at her baseline. seen and examined today. continues with paranoid thoughts. Unable to redirect. Plan: Paranoid personality disorder. Staff endorses that patient increasingly agitated at times especially with new staff. Refuses formal therapy and medications. Often refuses meals/medications when given by new staff members. Declines labs/imaging in the ED [emergency department].10/8/25 - A progress note by E3 (Physician) documented, . History of Present Illness. chronic paranoia (constantly thinks that the nursing home is abusing her, poisoning her,etc.), has been at her baseline. seen and examined today. continues with paranoid thoughts. Unable to redirect. Plan: Paranoid personality disorder. Staff endorses that patient increasingly agitated at times especially with new staff. Refuses formal therapy and medications. Often refuses meals/medications when given by new staff members. Declines labs/imaging in the ED [emergency department].It should be noted that the progress notes by two different medical providers, dated 7/29/25, 10/1/25 and 10/8/25, are exactly the same with respect to the plan to manage R1's paranoid personality disorder. The medical provider notes documented no plan because R1 refused formal therapy and medications. There was no evidence in the provider notes that R1's chronic paranoia was discussed and/or referred to social services for follow-up. While the following nursing notes documented R1's paranoia episodes, there was no evidence that social services followed-up with R1.-10/30/25 6:17 AM - . resident was on the bathroom floor. When I asked what happened resident stated to many chemicals and criminals are too much (sic) me.-10/31/25 2:57 AM - . Resident yelling out about ?the chemicals (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the phone with her delusions. E15 stated that family sends flowers on Valentine's Day, Mother's Day and they brought her Christmas gifts. E15 stated that R1 doesn't come out of her room except to use the phone at the nurse's station. The facility failed to provide medically-related social services for R1 after multiple documented staff interactions where R1's paranoia was interfering with medical care in addition to the 9/11/25 quarterly MDS assessment where her BIMS score of 00 revealed a significant decline in the resident's mental status. 12/1/25 3:30 PM - The findings were reviewed at 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 for one (R3) out of five residents reviewed resident records, the facility failed to accurately document in the EMR that R3 had a responsible party who makes medical decisions. Findings include:10/30/23 - R3 was admitted to the facility with diagnoses, including but not limited to, schizophrenia.7/28/25 - A quarterly MDS (Minimum Data Set) evaluation documented R3 as having a BIMS (Brief Interview for Mental Status) score of 9, which was reflective of a moderate cognitive impairment.10/7/25 - F3 (R3's niece/emergency contact) signed consents for R3 to receive the COVID-19 and influenza vaccinations.11/25/25 1:15 PM - A review of R3's EMR revealed that R3 was listed as her own responsible party despite having a documented BIMS score of 9.12/1/25 11:45 AM - During an interview, E1 (NHA) stated that a BIMS score under 12 showed a questionable cognitive status and the facility then obtains a responsible person who is willing to be the decision maker who signs all consents. E1 stated that the resident continues to be included in the conversations about care and decisions but the responsible person is the one who signs the consents.12/1/25 3:30 PM - The findings were reviewed at the exit conference with E1(NHA) and E2 (DON).		