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	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Silverside	3322 Silverside Road Wilmington, DE 19810

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, it was determined that for one (R43) out of three residents reviewed for accident hazards, the facility failed to notify the provider when a new skin alteration was identified after an earlier incident where R43 spilled coffee. Findings include: R43's record revealed: 3/5/26 - R43 was admitted to the facility. 3/11/26 - The admission MDS documented that R43 required set-up assistance for eating. 3/30/26 8:30 AM - A nurse's note by E21 (RN/SD) documented, Resident placed his coffee on the bed railing after letting go of the cup it fell back onto his lap spilling onto his bilateral upper thighs. Resident was not wearing pants (sic) this nurse and CNA were about to assist resident with morning care. B/L [Bilateral] upper thighs nonblanchable redness all skin intact at this time. After morning care resident denied pain to the area . 3/30/26 1:47 PM - A nurse's note by E20 (Wound Care RN) documented, Evaluated skin to abdomen, thighs . No scalded skin present. PT [Patient] denies pain. 3/30/26 2:47 PM - A progress note by E19 (NP) documented under Physical Exam . Skin: refer to skin assessment . 3/31/26 12:00 AM - A late entry nurse's note by E22 (RN) was documented on 4/1/26 at 8:57 AM. The note stated, during incontinence care by assigned CNA a right upper thigh broken blister . was noticed . Right upper thigh broken blister cleaned with saline pat dry and applied kin (sic) prep. Review of the facility's incident documentation revealed that E23 (MD) was notified of R43's blister on 4/1/26 at 8:38 AM, over 24 hours after the blister was identified. 4/23/26 2:17 PM - During an interview, E19 (NP) stated that she was notified of R43's coffee spill on 3/30/26. However, E19 reviewed the physician binder and confirmed that there was no evidence of R43's change of skin condition was communicated to a Provider as noted on 3/31/26. The facility failed to notify the on-call Provider when R43 had a change in skin condition after an incident where R43 spilled coffee on his skin. 4/27/26 1:35 PM - Finding was reviewed with E1 (NHA), E2 (DON), E3 (COO), E16 (Corp. Nurse) and E17 (Corp. Nurse).

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview, record review and other facility documentation it was determined for one (R12) out of four residents sampled for falls the facility failed to ensure that an RN performed the initial post fall assessment and documentation after R12 slid off of the bed and was lowered to the floor on the 11 PM-7 AM shift. An RN post fall assessment was not performed until the 7 AM - 3PM shift. Findings include: Cross Refer F689R12's clinical record revealed:1/2/19 - R12 was admitted to the facility with the following diagnoses including but not limited to anoxic brain injury, abnormal posture, multiple contractures of the upper and lower limbs and idiopathic progressive neuropathy.12/3/25 1:00 AM - A facility reported incident to the division documented [R12] sustained fall 12/3/25 complaint of ankle pain later in day. Xray obtained, results unclear. Repeat film obtained on 12/5/25.12/3/25 8:34 AM - A review of R12's initial post fall assessment was performed by E15 (ADON) on the 7 AM - 3 PM shift. [R12's] clinical record lacked evidence of an initial RN assessment until the next shift.04/22/2026 2:30 PM - A review of a facility form titled, Investigative Protocol Witness Summary Witness Written Summary by E14 (LPN) documented. [R12] was in a seated position s/p (sic) fall denied any pain. Assessed completed range of motion denied pain vss (sic) assisted CNA with care returned to bed.4/23/26 1:38 PM - During an interview E2 (DON) stated, the fall was not reported by the E24 (CNA) and E14 because they felt like it was not a fall because [R12] was assisted down to the floor.4/27/26 1:11 PM During a phone interview E14 stated and confirmed I was called by E24 saying [R14] fell we went in and provided care and assessed [R12]. I believe we called down to the RN, but I don't remember that was so long ago. I wrote what E24 said on the incident report. I wasn't there when [R12] fell.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, and review of other documentation as indicated, it was determined that for three (R12, R63, and R76) out of three residents sampled for accidents, the facility failed to ensure that the residents received adequate assistance and supervision to prevent accidents to the extent possible. R12, a completely dependent resident, sustained a fall from the bed to the floor while a staff member was providing care and sustained a right ankle fracture. R63, a resident who required extensive assistance for transfers, sustained L2 and L3 fractures during a transfer from the shower bed to the bed and was sent emergently to the hospital. R76, a resident who was completely dependent on staff for transfers, sustained an injury to the top of his head during a transfer from a mechanical lift to his motorized wheelchair. R76 was sent emergently to the hospital and received three staples to his scalp. Findings include: Cross Refer F658 1. R12's clinical record revealed: 1/2/19 – R12 was admitted to the facility with the following diagnoses, including, but not limited to, anoxic brain injury, abnormal posture, multiple contractures of the upper and lower limbs and idiopathic progressive neuropathy. 10/1/25 – A review of R12's quarterly MDS documented R12 required substantial maximum assistance to roll left and right in the bed. 12/30/25 – A review of R12's quarterly MDS documented R12 required substantial maximum assistance to roll left and right in the bed. 12/3/25 1:00 AM – A facility reported incident to the division documented [R12] sustained fall 12/3/25 complaint of ankle pain later in day. Xray obtained, results unclear. Repeat film obtained on 12/5/25. 12/3/25 8:24 AM – A review of R12's post fall assessment documented by E29 (ADON) What was resident doing just prior to fall. Care being provided. Additional comments on R12's post fall assessment documented Proper positioning of resident. 12/3/25 8:33 AM – A progress note authored by E18 (LPN UM) documented Therapy reported to nursing R12 reported sliding out of bed when care was being provided. E18 also documented [R12] stated, Slid out of bed and was in a seated position on R12's bottom. 12/4/25 11:15 AM – A review of R12's initial right ankle Xray report addendum documented This is a limited study. There is a question of a fracture at the tip of medial malleolus seen on the AP view. Recommend follow up films including oblique views to see if a fracture is present or not. 12/5/25 12:48 PM – A review of R12's right ankle Xray findings documented Compared to study performed on 12/4/25 concluded stable fracture. 12/5/25 2:37 PM – A progress note documented Xray to right ankle completed and noted with stable fracture. Reviewed with E19 (NP) new order received to send [R12] to hospital for evaluation. FM2 made aware and in agreement. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	12/5/25 11:07 PM – A progress not documented [R12] received back for the hospital at 10:48 PM as per hospital report, resident has a fracture to ankle, rest, ice, elevate ankle to help it heal. Ibuprofen or Tylenol to be taken as needed for pain. 12/12/25 – A facility five day follow up report to the division documented Through interviews with staff members it was determined that at approximately 1:00 AM, while resident was receiving care, R12 was sliding off the side of the bed and was lowered onto the floor in a seated position. 4/21/26 2:13 PM – A care plan for R12 initiated 4/1/20 documented [R12] is at high risk for falls related to cognitive impairment, contractures urinary and bowel incontinence, psychotropic and opioid medications and history of actual falls. 4/22/26 11:47 AM – During an interview E13 (LPN) reported [R12] required two person assistance total care and has always been a two person assist with care and transfers. 4/23/26 12:39 PM – During an interview with E25 (OT) reported [R12] reported rolling out of the bed to E25 during care. E25 stated, [R12] is dependent for bed mobility. E25 also stated, [R12] would not have been able to roll or slide off the bed and does not have the ability to do that [R12] is dependent for bed mobility. 4/23/26 12:45 PM – During an interview E19 (NP) reported [R12] was complaining of pain and when they did a further investigation it was founded [R12] had fallen out of bed during care. 4/23/26 3:11 PM – During a phone interview E24 (CNA) reported [R12's] call light was on I went in the room [R12] had thrown up, I was looking around to see if towels were in the room, I wasn't really paying attention, but I was standing on the right side of the bed and then [R12] started sliding off the bed to the left. I ran to try to catch [R12] but it was too late, so I lowered [R12] on the floor in a seated position. I ran to the door and called E14 (LPN). We put [R12] back in bed with the Hoyer lift. 4/23/26 3:30 PM – During an interview E29 (CNA) reported I have to physically assist [R12] to turn in bed [R12] is not able to move in the bed without help [R12's] legs don't move they just are there laying on top of the bed [R12] is total care. 4/24/26 9:40 AM – During an interview E15 (ADON) reported [E24] went into [R12's] room and [R12] had thrown up. [E24] was trying to clean up [R12] and had a towel under the resident's neck [R12] started sliding off the bed [E24] was on the other side of the bed and ran over to try to catch [R12] but ending up placing [R12] on the floor. E15 then stated, I'm thinking [R12] was too far over on the left side of the bed. 4/27/26 1:11 PM – During a phone interview E14 (LPN) reported I was called by E24 and told [R12] had fell I assessed [R12] and then assisted E24 with transferring the resident back to bed and with care. I wasn't there when the fall happened, I just wrote on the witness statement what E24 said happened. The facility failed to ensure R12 received adequate hands on assistance and supervision for a resident that required substantial maximum assistance with bed mobility when R12 slid out of the bed and had to be lowered to the floor and sent to the hospital for treatment and evaluation for a right ankle fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. R76's clinical records revealed: 6/2/22 – R76 was admitted to the facility with diagnoses, including but not limited to, brain bleed, seizure disorder and craniotomy which resulted in left sided paralysis. 6/13/22 – R76's transfer care plan documented, The resident requires Mechanical Lift (Hoyer) with 2 staff assistance for transfers. 9/3/24 – R76's care plan (revised 9/4/24) documented, [R76] is on anticoagulant therapy.monitor for bleeding. 9/28/24 – R76's medications included Xarelto 10 mg (anticoagulant) daily for deep vein thrombosis. 3/3/26 – R76's quarterly MDS assessment documented a BIMS score of 15, indicating a completely intact cognitive status, and a complete dependance on staff for all bathing and transfer needs. 3/31/26 5:00 PM – R76's clinical record included, Notified by the CNA that during two persons transfer with Hoyer lift in the shower room, the top of the lift made contact with his head. He has a small laceration to the top of his head, and c/o [complained of] neck pain 9/10. Resident stated, Hoyer lift came down on top of his head during transfer. 4/1/26 1:00 AM – R76's physician's record documentation included, . Sustained a head strike from a Hoyer lift. Patient states that he was being lifted out of the shower back into his wheelchair when the Hoyer lift collapsed onto his head. It struck him on the top of his head. He did not lose consciousness. He did not sustain any other injuries. Since the injury he has had pain on the top of his head . He endorses pain here along with neck pain.Given concern for intracranial hemorrhage [brain bleed] and particular because of his Xarelto use, CT head and C-spine was completed. R76's medication administration record from 4/1/26 to 4/19/26 revealed the use of pain medications for 17 out 39 opportunities for complaints of head and neck pain at a level between 7 and 9. 4/21/26 9:00 AM – During an interview, R76 stated, After my shower, the two aides used the lift to move me from the shower bed (in the shower room) to my chair. The hooks of the lift were not properly hooked to the bars, and this caused the front of the lift to become unbalanced and tilt backwards and I was dropped onto the chair. I was glad that the chair was there, or I would have fallen to the floor. This movement caused the bars of the lift to fall on top of my head. This is where I had the craniotomy. He indicated the top of his head and stated, My head and neck hurt now, and I have been taking pain medicine. The Surveyor asked the resident about other times when he was showered and how he got back into the chair. R76 stated, They usually bring me back into the room in the shower bed and transfer me to the bed and get me dressed in the bed. This has never happened to me before. I don't think the lift was operated correctly because the lift was not moving when they tried to put me in the chair and the bars fell on my head. 4/22/26 1:30 PM – During a telephone interview, E5 (CNA) stated, I helped [E6] (CNA) get [name of resident] from the wheelchair onto the shower bed. We used the purple lift. I left to do my work and then went back to check on the resident and [E6] a little later and saw that the resident had received his shower, was dressed and ready to get into the wheelchair. The sling was hooked up (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	to the lift and [E6] was using the control to guide the lift. I was holding the sling to help guide him to the wheelchair. [E6] started to move the lift, it came above the wheelchair, and it looked like it was stuck because it wouldn't move. The way the lift was positioned, it looked like it was going sideways to the wheelchair. I told [6] that this does not look right and tried to pull him [R76] back to correct it, but the lift came upwards, and the bar hit him on his head. We got him into the chair and got the nurse. 4/22/26 3:30 PM – During an interview, E6 stated, I have worked at the facility for about 3 months now. I showered and dressed [R76] and hooked the sling up to the Hoyer lift. [E5] came in to help me get him into the chair. [E5] was guiding the resident in the sling, and I was using the control and moving the lift. I lifted him up and was putting him in the chair and his weight shifted causing the lift to tip back and the bar hit him on top of his head. I put him in the chair and told the nurse. 4/23/26 10:00 AM – The facility provided the Surveyor with a facility report dated, 4/1/26, and entitled Inspection Report – ARJO HOYER LIFT. A review of the document revealed that the lift was rated to use safely with patients up to 500 lbs. The lift was inspected and was found to be in proper working condition and met all operational and safety requirements, no repairs were required at that time. 4/23/26 11:00 AM – During an interview, the Surveyor asked E30 (PT) who makes the determination for the residents' transfer statuses. E30 stated, Therapy evaluates residents and writes the order for their transfer status based on what equipment and how much help they need to move from the bed to the wheelchair or the wheelchair to the bed and other surfaces. [R76] was not able to bear weight on his feet, and the Hoyer lift was determined to be safe to use for his transfers. The Surveyor asked E30 if it was likely that R76's head injury could have been caused during the transfer because his weight shifted. E30 stated, Not if the lift was used properly. R76's weight was 167.8 lbs. on 3/28/26. 4/24/26 2:00 PM – During an interview E3 (COO) stated, It is the facility's position that the incident occurred when the resident's weight shifted during the transfer. We reviewed the incident and the staff involved received education and training on safe transfers. It was an unavoidable accident. 4/27/26 2:15 PM: The facility provided the Surveyor with a document entitled, April 2026, entitled, Facility Position on Mr. [initial of R76's last name.] The document included, .The facility met all four key elements to minimize accident hazards, and the accident was UNAVOIDABLE. [Name of resident] weight shifted during at the last moment while transitioning from a supine to a sitting position in the sling of the mechanical lift. The facility utilized the proper equipment and personnel. A root cause analysis concluded, after gathering witness statements, return demonstrations by staff on proper Hoyer use, and satisfactory inspection of the equipment, that this last-minute weight shift caused him to bump his head, therefore was UNAVOIDABLE. The facility failed to ensure R76 received adequate assistance and supervision for a transfer from the Hoyer lift to the wheelchair resulting in an injury to the top of his head. 3. Review of R63's clinical record revealed: 9/23/24 – R63 was admitted to the facility with diagnoses including cerebral infarction and rheumatoid arthritis. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3/4/25 2:31 PM – An order entered in R63's clinical record documented, .Bed Mobility: extensive assist of one [staff person]. 4/24/25 – A quarterly MDS assessment documented R63 had a BIMS score of 11, indicating moderately impaired cognition. The assessment also documented that R63 required maximal assistance to roll from lying on her back to the left side or right side and for upper and lower body dressing. 4/29/25 12:10 PM – A facility incident report documented, .[R63] had been given a shower and was brought back to her room.[E7, CNA] lowered the side rail and pushed the shower bed against [R63]'s bed.[E7] prepped [R63] by turning her on her side and pulling the bath sheet out from under [R63] and started pushing the Hoyer pad underneath it.[R63] rolled over and fell between the 2 beds to the floor.[R63] was crying and very anxious. 4/29/25 12:47 PM – A Nurse's Note was entered in R63's clinical record documented, [R63] fell from shower bed to floor.[R63] transported to hospital. 4/29/25 – A facility document entitled, Education Note documented, .Employee Name: [E7] Education Provided: When using the shower bed, do not disengage the side railing until you are ready to transfer the resident and that all locks are engaged. 4/29/25 – A facility document entitled, Point of Inspection Review documented, .Equipment to be Inspected: Shower Beds.No repairs or maintenance issues were identified during the inspection.shower beds are in proper working order with secure locking and braking mechanisms. 4/29/25 9:25 PM – A hospital radiology report documented that R63 underwent a CT scan that revealed acute L2 and L3 vertebra compression fractures. 4/22/26 2:03 PM – During an interview, (E7) stated, I was getting [R63] ready to transfer back to her bed from the shower bed. I must have forgotten to lock the wheels on the shower bed. I rolled [R63] to put the Hoyer lift pad under her. The shower bed separated from [R63]'s bed and [R63] fell in between the two beds. [R63] won't take a shower anymore since the accident. [R63] will only take bed baths now. 4/23/26 9:39 AM – During an interview, (E2, DON) stated, Staff is trained on shower bed transfers during onboarding. The Surveyor asked if it was re-education for shower bed transfers that was provided to E7 on 4/29/25? E2 stated, Yes. 4/23/26 12:58 PM – Facility provided documentation of a QAPI meeting held on 4/29/25 to address R63's fall from shower bed, Nursing and CNA staff in-service shower bed transfer safety education completed on 4/29/25 and 5/6/25, and weekly audits of shower bed safety and CNA safe resident transfers conducted from 5/5/25 to 7/7/25. E2 confirmed that a Safe Patient Handling Competency training is completed by new staff upon hire and by existing staff during annual in-service training. 4/23/26 1:28 PM – Interviews were conducted with E8 (CNA), E9 (CNA), E10 (CNA), E11 (CNA) and E12 (CNA) to confirm that shower bed transfer safety education and Safe Patient Handling Competency training had been completed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	4/23/26 3:13 PM – Finding was reviewed with E1 (NHA) and E2. 4/27/26 1:35 PM - Finding was reviewed during the exit conference with E1, E2, E3 (COO), E16 (CN) and E17 (CN).