

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  03/07/2024
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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 29015</p> <p>Based on interviews, medical record review, and policy review, the facility failed to ensure the responsible party (RP) for one of three residents (Resident(R)214) sampled for pressure ulcers, were made aware of the resident's change in condition.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Provider Notification of Resident Change in Medical Condition dated 01/03/24, documented staff will notify the provider and applicable POA (power of attorney)/responsible parties of accident with injury, abnormal and critical diagnostic testing results, significant change in condition in physical, mental, or psychosocial status in either life-threatening or clinical components.</p> <p>Review of R214's undated Admission Record located in the electronic medical record (EMR), under the Profile tab, indicated R214 was admitted on [DATE], and discharged on [DATE]. R214's diagnoses included Parkinson's disease without dyskinesia, without mention of fluctuations, dementia, abnormal posture, muscle weakness, and acute embolism and thrombosis of left iliac vein.</p> <p>Review of R214's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 09/14/23, revealed the Brief Interview for Mental Status (BIMS), revealed a score of five out of 15, indicating R214 was severely cognitively impaired.</p> <p>Review of R214's Skin Alteration incident report, dated 10/13/23, provided by the facility, documented ulceration to left shoulder blade noted during care. Further review of the report revealed no documentation pertaining to the notification of R214's responsible party.</p> <p>Review of the Skin/Wound Note dated 10/16/23, located in the EMR under the Progress Notes tab, documented abrasion to left posterior shoulder, partial thickness. A physical therapy consult is recommended for the patient to evaluate for wheelchair evaluation-concern about round screws securing high back chair to frame being source of abrasion. Further review of R214's Progress Notes revealed there is no documentation related to notification of R214's responsible party.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview conducted with the Wound Care Nurse on 03/07/24 at 12:05 PM, the wound care nurse revealed after a new pressure ulcer was identified, an incident report would have been completed, and the family would be notified by the person completing the incident report. The wound was identified as resulting from a screw on the wheelchair and therapy was consulted for cover/pad for wheelchair. On 03/07/24 at 12:12 PM, the Wound Care Nurse confirmed the family was not notified of abrasion on shoulder.</p> <p>During an interview conducted with the Administrator on 03/07/24 at 3:37 PM, the Administrator confirmed the incident report was incomplete and that it was expected for the staff to complete the form and notify the responsible party.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 11599</p> <p>Based on observation, interview, review of housekeeping procedures, and record review, the facility failed to ensure one (Resident (R)1) room out of 33 rooms observed was properly cleaned to ensure a homelike environment.</p> <p>Findings include:</p> <p>Review of R1's Profile in the electronic medical record (EMR) under the Clinical tab revealed R1 was admitted on [DATE] and had diagnoses that included acute and chronic respiratory failure with hypoxia, acute and chronic respiratory failure with hypercapnia, chronic obstructive pulmonary disease (COPD), and chronic diastolic heart failure.</p> <p>Review of R1's Quarterly Minimum Data Set (MDS) in the EMR under the MDS tab with an Assessment Reference Date (ARD) dated 02/19/24 revealed a Brief Interview for Mental Status (BIMS) with a score of 15 out of 15 indicating R1 was cognitively intact.</p> <p>During an observation and interview with R1 on 03/04/23 at 1:18 PM in the resident's room revealed the floor around R1's bed was observed with dirt and debris, the bed frame had a heavy buildup of dust on the headboard and footboard, and the frame holding the air mattress pump located at the end of the bed had a heavy buildup of dirt and debris. The bedside table was observed to have a buildup of dust on the top. In an interview, at the time of the observation, R1 stated, look at the wardrobe, look at the dust there, they never clean that, they never been taught how to clean. R1 stated, Why don't they clean my side of the room, just because I'm in bed?</p> <p>During an observation on 03/04/24 at 3:28 PM, R1's room remained in the same condition.</p> <p>During an observation and interview on 03/05/24 at 11:06 AM, R1 stated they swept the room, but didn't dust anything, the guy is new, he doesn't know anything.</p> <p>During an observation and interview on 03/06/24 at 10:21 AM, the Housekeeping Director (HKD) was observed dry mopping the hallway outside R1's room. The HKD was asked to describe the expectations of housekeeping staff when cleaning a resident room. HKD stated, we have a five step process, high dust, wipe high touch areas, empty trash, dry mop the floor, and then damp mop the floor. The HKD confirmed the heavy buildup of dust and dirt on R1's bed, dresser, wardrobe, and frame holding the air mattress pump. The HKD said he did have a new employee and would provide training today, (03/06/24), and would also clean R1's room appropriately.</p> <p>Review of the undated Procedure provided by the HKD, revealed step two of the five step cleaning process as Horizontal Surfaces - disinfected using a solution of properly diluted germicide, sanitize all horizontal surfaces. As you enter the room, work clockwise around the room hitting all surfaces. Use your high duster to dust hard to reach areas, such as the tops of closets, high lights, and ceilings areas as needed. Tabletops, headboards, windowsills, chairs, over bed lights, wall ledges, over bed tables, and the bases of over bed tables should all be done.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18947</p> <p>Based on facility policy review, record review, resident and staff interviews, the facility failed to ensure two Residents of six residents (Resident (R) 62 and R86) reviewed for abuse remained free from physical abuse. A total of 33 residents were reviewed in the sample.</p> <p>Findings include:</p> <p>Review of the facility's Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime Policy most recently reviewed 01/03/24 read, in pertinent part, It is the policy of Cadia Healthcare to protect residents and prevent occurrences of abuse, neglect, mistreatment, misappropriation of resident property, exploitation, and crime.</p> <p>1. Review of R86's Admission Record, found in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted on [DATE] with diagnoses including dementia with mood and behavior disturbance.</p> <p>Review of R86's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/09/24, revealed a Brief Interview for Mental Status (BIMS) assessment could not be done due to the resident's poor cognition. The assessment indicated the resident had both short and long-term memory deficits. The assessment indicated R86 required substantial assistance from staff to complete his Activities of Daily Living (ADLs), including bed mobility and transfers. The resident did not exhibit any behaviors during the assessment reference period according to the assessment.</p> <p>Review of R86's Care Plan, dated 05/2023 and found in the EMR under the Care Plan Tab, indicated the resident was resistive to care at times, including refusing to take his medication, refusing to have his blood sugar checked, and refusing to get out of bed. Interventions included leaving the resident if he refused cares and reapproaching in 10 to 15 minutes and allowing the resident to make decisions about his own treatment to give him a sense of control.</p> <p>Review of an Incident Report related to R86, dated 06/21/23 and provided to the survey team, read, in pertinent part, at 1515 (3:15 PM) today, resident stated that he was picked up and swung into bed last night. Assigned CNA (Certified Nursing Assistant) suspended (during) investigation. Further review of the report revealed a staff member who was interviewed during the investigation stated she witnessed another staff member (CNA2) handling R86 roughly while helping him to sit down in his wheelchair. In addition, the report indicated a resident who was interviewed during the investigation of the incident reported she witnessed two staff members (CNA1 and CNA2) being rough with R86. Both CNA1 and CNA2 were suspended during the investigation and were terminated for rough handling of R86. The document indicated the allegation of CNA1 and CNA2 rough handling R86 was substantiated.</p> <p>During an interview with the Administrator and the Director of Nursing (DON) on 03/06/24 at 12:15 PM, both indicated they were not employed at the facility at the time of the investigation into R86's allegation of abuse. Both confirmed the investigation report revealed substantiated staff to resident abuse. Both stated their expectation was residents residing in the facility were to be free from all types of abuse.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of R62's undated Admissions Record located in the EMR under the Profile tab, indicated R62 was admitted to the facility initially on 08/06/20, with a readmission of 02/21/24, with diagnoses including functional quadriplegia, adjustment disorder with depressed mood, and cognitive communication deficit.</p> <p>Review of R62's quarterly MDS located in the EMR under the MDS tab, with an ARD of 12/06/23 revealed a BIMS score of 13 out of 15, indicating R62's cognition was intact. R62 was assessed as not displaying any behavioral indicators.</p> <p>Review of R62's Care Plan located in the EMR under Care Plan tab, revision date of 03/05/24, revealed R62 had an activities of daily living (ADLs) self-care performance due to deconditioning and impaired mobility-has history of decline from fractures, and most recently PNA (pneumonia). Interventions included R62 states that it is important to her to choose what type of bath she receives, she is scheduled for hair care/nail care and shower/bed bath weekly on Tuesday and Friday, 7-3 shift, avoid scrubbing &amp; pat dry sensitive skin, provide a sponge bath when a full bath or shower cannot be tolerated.</p> <p>During an interview with R62 on 03/04/24 at 1:15 PM, R62 stated that she had been abused, and mistreated in the past. R62 stated that in the past year there was a CNA that had been rough with her while providing her care and turning her in the bed. R62 stated she had reported it to the Administration.</p> <p>Review of the Facility Reported Incident (FRI) provided by the facility, documented R62 was admitted to facility with rheumatoid arthritis, resident is an assist with all ADLs. On 11/08/23, R62 stated to social services that her assigned CNA (CNA7) for 7-3 [first shift] was rough with her during care. Resident has a BIMs of 11 .while speaking to the resident, the resident informed us (administration) that another CNA(CNA3) had overheard the accused CNA's interaction with the resident. Second CNA3 was interviewed, and resident's statements, and accusations were confirmed. CNA7 was terminated.</p> <p>Review of a Witness statement provided by the facility dated 11/13/23, documented by CNA3, revealed that on 11/08/23, around lunch time, (CNA3) witnessed (CNA7) storm out of (R62's) room. CNA3 went into R62's room to check on the resident. CNA3 observed that R62's bed was raised to about waist level, and the resident's lower body was exposed, R62 told CNA3 that CNA7 had been rough with her, pushing her around, and roughly turning her. R62 told CNA3 that she (R62) had told CNA7, can you be nice to me like you were this morning. CNA3 documented that she went to speak with CNA7, and CNA7 told CNA3 the same things as R62.</p> <p>Review of CNA7's written statement dated 11/13/23, CNA7 documented incident never occurred because the resident does not eat and only drinks coffee so she would not have to choose between the two. CNA7 refused to give further statements to Director of Nursing (DON) when requested by the DON on 11/14/23.</p> <p>During an interview on 03/05/24 at 1:57 PM with CNA3, CNA3 confirmed the witness statement she had written about the incident between CNA7 and R62. CNA3 reiterated that she had witnessed CNA7 storm out of R62's room, and she appeared mad. CNA3 stated she did not recall the verbal exchange between CNA7 and R62. However, R62 was visibly upset and crying when she went into the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Unit Manager (UM)2 on 03/05/24 at 1:59 PM, the UM stated that CNA7 had told her she was not taking care of R62 anymore. UM2 went and spoke with R62, who informed her that CNA7 had been rough with her.</p> <p>During an interview with the DON on 03/05/24 at 2:04 PM, the DON stated she had spoken with R62, and both the CNAs (3 and 7) that were involved as part of her investigation. After interviewing both CNAs and the resident the DON substantiated the incident and terminated CNA7.</p> <p>During an interview with the Administrator on 03/05/24 at 2:12 PM, the Administrator was questioned about what she recalled about the incident. The Administrator stated she had spoken to R62 while doing rounds, resident reported to her she was very upset, that CNA7 had exposed her. The Administrator spoke with CNA3, who wrote her witness statement. After speaking with CNA7, CNA7 was terminated.</p> <p>29015</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>29015</p> <p>Based on interview, record review, document review, and facility policy review, the facility failed to ensure that an allegation of staff to resident abuse was reported timely to the State Agency for one of six residents (Resident(R)62) sampled for allegations of abuse. This had the potential to place the resident at risk for further abuse.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime review date 01/03/24, documented Reporting and Response: Witnessed or suspected incidents of abuse or reasonable suspicions of crime are to be reported immediately. A witness who fails to report abuse, neglect, mistreatment, misappropriation of resident property, exploitation, or suspicions of crime is considered to be as culpable as the accused. Their name will also be reported to the appropriate regulatory agency and/or law enforcement for further investigation. The Director of Nursing (DON) or designee is responsible for conducting the abuse investigation. The Nursing Home Administrator (NHA) serves as the abuse coordinator. Allegations of resident abuse shall be reported to the appropriate state regulatory within 2 hours.</p> <p>Review of R62's undated Admissions Record located in the electronic medical record (EMR) under the Profile tab, indicated R62 was admitted to the facility initially on 08/06/20, with a readmission of 02/21/24, with diagnoses including functional quadriplegia, adjustment disorder with depressed mood, and cognitive communication deficit.</p> <p>Review of R62's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab, with an assessment reference date (ARD) of 12/06/23, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R62's cognition was intact. R62 was assessed as not displaying any behavioral indicators.</p> <p>During an interview conducted with R62 on 03/04/24 at 1:15 PM, R62 stated that she had been abused, and mistreated in the past. R62 stated that she couldn't remember the exact date, but in the past year there was a Certified Nursing Assistant (CNA) that had been rough with her while providing her care and turning her in the bed. R62 stated she had reported it to the Administration the same day it occurred.</p> <p>Review of the Facility Reported Incident (FRI) provided by the facility, revealed the FRI was submitted on 11/13/23 at 3:21 PM. The incident description was documented as resident stated CNA was ruff (sic) with her during care. Investigation on-going. Incident date/time: 11/13/23 at 12:00 PM. Upon further review of the FRI it was documented the incident occurred on 11/08/23, five days prior to the incident being reported.</p> <p>During an interview with the Administrator on 03/04/24 at 3:58 PM, the Administrator confirmed the incident was on 11/08/23, and the facility was aware of the allegations on 11/08/23. When questioned why the incident was not reported until 11/13/23, the Administrator stated the Director of Nursing (DON) thought it was more of a customer service issue at first.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947</b></p> <p>Based on facility policy review, record review, and resident and staff interviews, the facility failed to ensure a thorough investigation was completed related to allegations of potential abuse for two Residents of six residents (Resident (R)59 and R62) reviewed for abuse. A total of 33 residents were reviewed in the sample.</p> <p>Findings include:</p> <p>Review of the Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime Policy most recently reviewed 01/03/24 read, in pertinent part, It is the policy of Cadia Healthcare to protect residents and prevent occurrences of abuse, neglect, mistreatment, misappropriation of resident property, exploitation, and crime; and Investigation: The NHA (Nursing Home Administrator) or designee shall investigate allegations and report to appropriate regulatory agencies and/or law enforcement. All persons identified as involved in or with knowledge of the occurrence will be interviewed.</p> <p>1. Review of R59's Admission Record, found in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted on [DATE] with diagnoses including rheumatoid arthritis and unsteadiness on her feet.</p> <p>Review of R59's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/16/24, revealed a Brief Interview for Mental Status (BIMS) assessment score of 10 out of 15, indicating the resident was moderately cognitively impaired. The assessment indicated R59 used a wheelchair for mobility. The resident did not exhibit any behaviors during the assessment reference period according to the assessment.</p> <p>Review of the Progress Notes located in the EMR under the Notes Tab, read, Resident (R59) reported that she had a wheelchair leg rest thrown on her right foot after resident (R51) was shouting at her. Right foot assessed, blanching erythema to 4th digit noted. Resident states it hurts just a little. Resident offered an ice pack and PRN (as needed) Tylenol (a medication used to control pain), resident refused both stating, it's not that bad it will be fine. This nurse told resident (R59) to let me know if she changed her mind and wanted any of those interventions offered or if the pain had gotten any worse at all, resident agreed. Resident (R59) asked this nurse what she should have done, resident educated that if she encounters an aggressive/angry resident to back away from them or the situation for her safety and to come find a staff member immediately and to never try to intervene herself. Resident shook her head in agreement. Resident returned to her room. This nurse will continue to monitor. Supervisor and Assistant Director of Nursing (ADON) aware.</p> <p>Review of R51's Admission Record, found in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted on [DATE] with diagnoses including congestive heart failure and dementia.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R51's Quarterly MDS with an ARD of 01/30/24, revealed a BIMS score of three out of 15, indicating the resident was severely cognitively impaired. The resident exhibited verbal behaviors toward others on one to three days during the assessment reference period according to the assessment. R51 did not exhibit any physical behaviors toward others during the assessment reference period.</p> <p>Review of an Incident Report related to R51 and R59, dated 01/08/24 and provided by the facility to the survey team, read, in pertinent part, Resident (R51) was in the hallway shouting at (R59) holding wheelchair leg. This nurse intervened. (R59) reports that (R51) hurt her foot with the wheelchair leg.</p> <p>Review of the facility's Investigation File related to the above incident report, dated 01/08/24 through 01/10/24 and provided by the facility to the survey team, revealed no interviews were conducted with statements by staff or residents, other than R51 and R59 related to the incident during the investigation. The allegation of potential abuse was not substantiated by the facility based solely on interviews with R51 and R59 and a physical assessment of R59 immediately after the incident (which was negative for any physical signs or symptoms of abuse).</p> <p>During an interview with the Administrator and the Director of Nursing (DON) on 03/06/24 at 11:33 AM, both confirmed no additional resident interviews were conducted and no staff interviews were conducted during the investigation into the above incident between R51 and R59. The DON indicated she had been responsible for conducting the investigation and stated, I spoke with the UM (Unit Manager) and she saw the episode. If there isn't a statement in the record I didn't get one. I did not talk to any other staff members or get any statements. I did not speak to any residents or get statements from them. The DON stated, In this situation I spoke to the UM who told me what happened, so I just went with that. The Administrator stated her expectation was staff and residents were to be interviewed during an investigation of potential abuse.</p> <p>2. Review of R62's undated Admissions Record located in the EMR under the Profile tab, indicated R62 was admitted to the facility initially on 08/06/20, with a readmission of 02/21/24, with diagnoses including functional quadriplegia, adjustment disorder with depressed mood, and cognitive communication deficit.</p> <p>Review of R62's quarterly MDS located in the EMR under the MDS tab, with an ARD of 12/06/23, revealed a BIMS score of 13 out of 15, indicating R62's cognition was intact.</p> <p>Review of the Facility Reported Incident (FRI) provided by the facility, documented R62 was admitted to facility with rheumatoid arthritis, resident is an assist with all Activities of Daily Living (ADLs). On 11/08/23, R62 stated to social services that her assigned Certified Nursing Assistant (CNA)7 for was rough with her during care. Further review of the FRI indicated that additional residents and staff were not interviewed concerning the incident between CNA7 and R62.</p> <p>During an interview conducted with the Administrator on 03/05/24 at 4:14 PM, the Administrator revealed since the resident was alert and oriented, she didn't feel it was necessary to conduct official resident interviews. Upon further review of the FRI the Administrator confirmed the incident was incomplete.</p> <p>29015</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 11599</p> <p>Based on observation, interview, record review, and review of facility policy, the facility failed to complete a smoking assessment and secure smoking materials for one (Resident (R)61) out of one resident who the facility identified as a smokier out of a sample of 33 residents. This had the potential for an accident/hazard related to smoking.</p> <p>Findings include:</p> <p>Review of the facility's Smoking Policy, located in the Admission Packet, dated 08/21, revealed Smoking and/or the use of tobacco, tobacco products or electronic cigarettes by</p> <p>residents or visitors is not permitted anywhere on facility property at any time. The definition of facility property for the purpose of this policy includes all land, buildings, structures, parking lots, sidewalks, and any vehicles owned or leased to the facility. Failure to maintain a smoke-free campus by residents and/or visitors could result in outcomes up to and including discharge.</p> <p>During the entrance conference on 03/04/24 the Administrator identified that the facility was a non-smoking facility and that there was only one resident (R61) who smoked. The expectation was that R61 was to smoke off the facility premises and all smoking materials were kept locked at the nurses' station. R61 was identified as a smoker and that numerous vapes had been repeatedly removed from R61's room.</p> <p>Review of R61's Profile located in the Clinical tab in the electronic medical record (EMR) revealed R61 was admitted on [DATE] and had diagnoses that included paralytic syndrome following nontraumatic intracerebral hemorrhage affecting left nondominant side, seizures, unspecified lack of coordination, and muscle spasm.</p> <p>Review of R61's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 12/08/23 revealed R61 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R61 was cognitively intact. There was no evidence of a smoking assessment in R61's EMR.</p> <p>During an interview on 03/05/24 at 2:30 PM, R61 said I smoke some. I buy them from my friend two doors down. We have to go to the church parking lot, smoke, and throw the butts in the dumpster. I have no idea if I'm supposed to tell anyone that I'm going outside to smoke or that they have to lock up my lighters. During the interview, R61 placed his cell phone over a lighter he had on top of his electric wheelchair.</p> <p>During an interview with the Administrator and the Director of Nursing (DON) on 03/06/24 at 9:40 AM, the Administrator and the DON each confirmed that they were unaware of R61 smoking or having smoking materials in his room. The DON stated, the expectation is that smoking materials are kept locked at the nurses' station.</p> <p>(continued on next page)</p>		

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  03/07/2024
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Nurses Progress Notes located in the EMR, dated 03/06/24 at 10:35 AM, revealed a notation by the DON that read, Met with resident who acknowledge that he understood the facility is smoke free. Discussed with resident the expectation is that we hold onto any smoking material such as cigarettes and lighters. Resident denied smoking daily and stated he only occasionally smoked and does not currently have any cigarette or lighters however 2 lighters were taken from resident's room. Also discussed with resident and offered smoking apron to which he refused. Offered smoking cessation program to resident who refused and stated he only smokes every once in a while, and has no cravings for cigarettes. This writer asked resident to inform me if/when he does obtain cigarettes so that a smoking assessment can be completed at that time.</p> <p>During an interview on 03/06/24 at 10:20 AM, Certified Nursing Assistant (CNA)4 stated, yes, I'm aware R61 smokes, at least since last summer, I thought everyone knew.</p> <p>During an interview with the Unit Manager (UM)1 on 03/07/24 at 9:51 AM, the UM1 stated, I know the social service staff have taken vapes out of R61's room before. The night shift gave me a lighter from his room this morning and I gave it to the social service staff.</p> <p>During an interview with the Social Service Director (SSD)1 and the SSD2on 03/07/24 at 12:19 PM, both the SSD1 and SSD2 confirmed they had been given lighters confiscated from R61.</p>		

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  03/07/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>21382</p> <p>Based on interview and record review the facility failed to allow 30 days for a resident or their responsible party to rescind the voluntary Attachment #3: Binding Arbitration Agreement after it was signed. This failure would take the right to rescind the agreement away.</p> <p>Findings include:</p> <p>Review of the facility Attachment #3: Binding Arbitration Agreement revealed it stated . (3) this Agreement may be rescinded by written notice sent to the other party via Certified Mail, return receipt requested, within twenty-one (21) days of the date upon which it is signed.</p> <p>Interview with the Admission Coordinator on 03/07/24 at 10:33 AM confirmed the form allowed for only 21 days to rescind the Arbitration Agreement. She stated no one has pursued arbitration.</p>