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	12/12/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure one of 29 residents (Resident (R) 39 reviewed had their call light accessible for use creating the potential for needs not to be met. Findings include: Review of the admission Record located under the Profile tab in the electronic medical record (EMR) revealed R39 was initially admitted on [DATE] with diagnoses that included adjustment disorder with depressed mood, congestive heart disease, chronic kidney disease stage three, and gout. Review of the annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 10/29/24 revealed R39 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R39 was moderately cognitively impaired. On 12/09/24 at 12:44 PM, R39 was in bed and the call light was underneath his bed. On 12/09/24 at 1:09 PM, R39 was observed in bed and the call light was underneath the bed. During an interview at the time of the observation. R39 said he did not know where the call light was. During an observation on 12/11/24 at 8:35 AM, R39 was in bed and the call light was underneath his bed. During an interview on 12/11/24 at 9:41 AM, Licensed Practical Nurse (LPN1) was asked was R39's call light. LPN1 located the call light under the bed and confirmed that R39 was able to use the call light if it was in reach of his right hand. LPN1 stated, He can't use his call light if it's under the bed, the staff know better than this. During an interview on 12/11/24 at 10:39 AM, Certified Nurse Aide (CNA3) stated, Yes, I took care of [R39] this morning. I didn't realize the call light was under the bed. Interview on 12/11/24 at 4:30 PM, R39 demonstrated how he was able to push the call bell with his right hand and stated, I can push it, just my left hand doesn't work. Interview on 12/12/24 at 9:16 AM, the Director of Nurses (DON) confirmed that the CNAs were to ensure that each resident had their call light accessible to them during and after cares. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/12/24 at 4:00 PM, the Nurse Consultant (NC2) stated, We don't have a policy on call lights.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure two (Residents (R) R71 and R37) of six residents reviewed for abuse, were free from resident-to resident abuse for two separate incidents. This had the potential to affect resident safety at the facility. Findings include: Review of the facility's abuse policy titled, Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime, revised January 12, 2023, indicated, . It is the policy of Cadia Healthcare to protect residents and prevent occurrences of abuse . 1. Review of R52's electronic medical record (EMR) revealed a Face Sheet located under the Profile tab indicated the resident was admitted to the facility on [DATE] with diagnosis of depression, dementia, anxiety disorder and Alzheimer's. Review of the quarterly Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 11/09/24 indicated a Brief Interview for Mental Status (BIMS) score of 0 out of 15 indicating the resident was severely cognitively impaired. The assessment indicated the resident exhibits physical and verbal behavior toward others. Review of the Care plan located in the EMR under the Care Plan tab indicated R52 had a tendency to be verbally and physically aggressive to others. Review of the Progress Note located in the EMR under the Progress Note tab revealed that on 11/25/23, R71 was ambulating in the hallway and began urinating in the floor. R52 walked up to R71 and struck him in the back. The residents were immediately separated. Review of R71's Face Sheet located in the EMR under the Profile tab in the EMR indicated the resident was admitted to the facility on [DATE] with diagnosis of alcohol abuse, schizophrenia, anxiety, and depression. Review of the quarterly MDS located in the EMR under the MDS tab with an ARD of 09/05/24, indicated the resident had a BIMS score of four out of 15 indicating the resident was severely cognitively impaired. Review of R71 Care Plan located in the EMR under the Care Plan tab indicated the resident with a behavior of being verbally aggressive. Review of a facility incident reported 11/25/23 revealed R71 was ambulating in the hall outside of his room and started to urinate on the floor. The nurse attempted to redirect the resident to his room without success. R52 was ambulating in the hall and yelled at R71. R52 walked up to R 71 striking him in the back. During an interview on 12/12/24 at 10:01 AM, Registered Nurse 2 (RN) stated that both residents can get agitated, but both can be redirected easily. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/12/24 at 12:59 PM, the Director of Nursing (DON) stated the incident was resident to resident abuse. 2. R63 was admitted to the facility on [DATE] with diagnosis of toxic encephalopathy, alcohol abuse, anxiety disorder, depression, and dementia. Review of the quarterly MDS located under the MDS tab with an ARD of 10/25/24 indicated a BIMS score of nine out of 15 indicating the resident was moderately cognitively impaired. The assessment indicated the resident exhibits verbal behaviors directed at others. Review of the resident's care plan located under Care Plan tab in the EMR revealed R63 was identified with behaviors of resisting care with use of his walker and wheelchair. R37 was admitted to the facility on [DATE] with diagnosis of subarachnoid hemorrhage, dementia, depression, and traumatic brain injury. Review of R37's Annual MDS located under the MDS tab in the EMR indicated a BIMS of four out of 15 indicating the resident was severely cognitively impaired. Review of the resident's Care Plan located in the EMR under the Care Plan tab indicated the resident exhibited verbal behavior toward others. Review of the facility's investigation of the incident revealed that on 05/07/24 at 17:00, R63 and R37 were reported to have gone for the same chair at dinner. R63 stated that R37 got smart with him, and he smacked her on the left side of the face. No redness, swelling or any other injury noted. R37 denied having said or done anything to R63. During an interview on 12/12/24 at 08:59 AM, the DON stated that the incident with R63 slapping R37 was resident to resident abuse.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to ensure an incident of resident-to-resident abuse was reported to the State Agency (SA) within two hours of the incident as required for one residents (R)71) from six residents reviewed for abuse. Findings include: Review of the facility's policy titled, Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime, revised January 12, 2023, indicated, . It is the policy of Cadia Healthcare to protect residents and prevent occurrences of abuse .Guidelines .Reporting and Response .Allegations of resident abuse shall be reported to the appropriate state regulatory authority within 2 hours . 1 Review of R52's electronic medical record (EMR) revealed a Face Sheet located under the Profile tab indicated the resident was admitted to the facility on [DATE] with diagnosis of depression, dementia, anxiety disorder and Alzheimer's. Review of the quarterly Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 11/09/24 indicated a Brief Interview for Mental Status (BIMS) of 0 out of 15 indicating the resident was severely cognitively impaired. Review of R71's EMR revealed a Face Sheet located under the Profile tab indicated the resident was admitted to the facility on [DATE] with diagnosis of alcohol abuse, schizophrenia, anxiety, and depression. Review of the quarterly MDS located under the MDS tab with an ARD of 09/05/24 indicated a BIMS score of four out of 15 indicating the resident was severely cognitively impaired. Review of the facility incident report dated 11/25/23 revealed R71 was ambulating in the hallway outside of his room and started to urinate on the floor. R52 yelled at R71 then walked up to him, striking him in the back. During an interview on 12/12/24 at 12:59 PM, the Director of Nursing (DON) stated she became aware of the incident when she was reading notes from her home and called to find out what happened. The nurse that was on duty when the incident occurred failed to follow the reporting requirement to notify her of the incident. She stated that she reported the incident to the SA as soon as she was aware, but it should have been reported within two hours of the incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review, interview and policy review, the facility failed to complete a through investigation of an allegation of abuse for one of six residents (Resident (R) 11) reviewed for abuse and neglect out of a total sample of 29. This failed practice had the potential to affect resident safety at the facility. Findings include: Review of R11's electronic medical records (EMR) revealed the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/23/24 found under the MDS with an admission date of 03/26/23 and a Brief Interview for Mental Status (BIMS) score of 15 out 15 which indicated R11 was cognitively intact. Interview on 12/10/24 at 8:43AM, R11 stated that he has never had any problems with staff at the facility. R11 also stated that no one has ever been rough with him during care, and no one has ever pulled on his testicles. During an interview on 12/12/24 at 9:30AM, the Director of Nurses (DON) stated that R11 reported on 01/11/24 that while receiving care on 12/25/24, Certified Nurse Aide (CNA)9 was rough with him during care; forcefully pulling on his genitals. The DON stated that CNA9 was suspended pending an investigation. The DON stated that the investigation revealed that the facility could not substantiate R11's allegation due to lack of evidence. The DON stated that the facility interviewed a female resident and no other residents, whether there were any issues with CNA9 being rough during care. The DON was asked if the facility should have interviewed other male residents that CNA9 had provided care to on 12/25/24. The DON stated that other male residents should have been interviewed. Review of the facility's investigative document revealed that the facility had only interviewed one female resident about how CNA9 had provided care. There was no documentation of interview with other residents especially male residents regarding the care CNA9 provided. Review of the facility's policy titled Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime dated 01/03/24 indicated, .all alleged incidents involving abuse . shall be reported to the NHA [Nursing Home Administrator] or designee immediately. The NHA or designee shall investigate allegations . All persons identified as involved in or with knowledge of the occurrence will be interviewed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure one of 29 residents (Resident (R) 29 reviewed had a mattress that fit the bed frame. The failure created the potential for an injury if R29 's feet became tangled in the gap between the mattress and the footboard of the bed. Findings include: Review of the admission Record located under the Profile tab in the electronic medical record revealed R29 was admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis following a cerebral infarction, and disorders of bone density and structure. Review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 10/19/24 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R29 was cognitively intact. On 12/10/24 at 11:56 AM, R29 was observed in bed with the head of the bed in an upright position. A large gap, which measured 11 inches from the mattress to the footboard was observed. The footboard was noted to be angled away from the mattress. R29 was asked if she ever slides down, toward the footboard, when in bed and stated, Yes, I have many times when I am put in the bed. When asked if her feet had ever become entangled in the gap, R29 said, Yes. On 12/11/24 at 10:37 AM, R29 was observed in bed with the head of the bed in an upright position and a six inch gap was noted between the mattress and the footboard. On 12/11/24 at 11:02 AM, the Administrator, Director of Nurses (DON), and Nurse Consultants (NC1 and NC2) observed the gap between the mattress and the footboard of R29's bed. The DON was asked to measure the gap which was noted to be six inches. R29 stated, My feet have gotten down in the hole before, when I move the bed up. The DON stated, Yes, six inches. We need a bolster. The Administrator and DON were asked to provide a policy on ensuring resident's mattress fits bed frames. No policy was provided as of the exit, on 12/12/24 at 5:45 PM.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure that beard guards were worn during food production in accordance with professional standards for food service safety and failed to store food in accordance with professional standards for service safety with the potential to affect 109 of 109 residents who consumed food from the kitchen. This failure had the potential for physical contamination of the food in the facility. Findings include: 1. Review of the facility's policy titled, Dress Code dated August 30, 2017, revealed sanitary food preparation staff must wear: hair net or a disposable hat while on duty. Any employee with facial hair must wear a beard guard. During observation of the lunch meal preparation on 12/09/24 at 11:45 AM, two male Dietary Aide (DA)2 and DA 3 with beards did not have beard nets covering their beard at the food preparation station. During observation of the dinner meal preparation on 12/09/24 at 4:45 PM, DA2 and DA3,with beards did not have beard nets covering their beard at the food preparation station. During observation of the breakfast meal preparation on 12/10/24 at 8:10 AM, DA2 and DA3 with beards did not have beard nets covering their beard at the food preparation station. During observation of the noon meal preparation on 12/10/24 at 11:30 AM, while accompanied by the Dietary Manager (DM), DA2 and DA3 with beards did not have beard nets covering their beard at the food preparation station. During an interview on 12/10/2024 at 11:40 AM, the Food Service Director (FSD) stated that staff with beards must wear a beard net to cover their beard. I did not observe the two male kitchen staff members not wearing beard nets until I observed them today. During an interview on 12/10/24 at 1:25 PM, the Dietary Aide (DA) 2 stated, Yes, I know that I must wear a beard guard when I'm in the kitchen. I just forgot. During an interview on 12/10/24 at 1:30 PM, the Dietary Aide (DA) 3 stated, Yes, I know that I must wear a beard guard when I'm in the kitchen. I just forgot. 2. During the observation of the main refrigerator on 12/09/24 at 09:30 AM, while accompanied by the FSD the following food items were expired or had no current dates after being used: Cardboard box with black substance on the right side of the outside of the cardboard box. Inside the cardboard were two 64 oz containers of potato salad that were split open. Outside the cardboard box was a dated 08/28/24. One gallon size plastic container of Thousand Island salad dressing was dated 08/28/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Twenty peeled, hard-boiled eggs were wrapped individually in plastic wrap without a date. One 64-ounce grape jelly glass jar with half a jar remaining contained no date. Chicken salad in a 64-ounce metal container was half full and undated. 3. During the observation of the main freezer on 12/09/24 at 10:30 AM, while accompanied by the FSD the following food items that were expired or had no current dates after being used: An open cardboard box revealed an open plastic bag of 32 frozen chicken cutlets with no date. Open cardboard box revealed an open plastic bag of 40 frozen hamburger patties with no date. During an interview on 12/09/2024 at 10:55 AM, the FSD stated that the weekend kitchen staff are supposed to check and throw out food items that are out of date.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 29 sample residents (Resident (R) 50 had an alternative call light device available when the call light system malfunctioned. The failure created the potential for the resident's care needs to be unmet. Findings include: Review of the admission Record located under the Profile tab in the electronic medical record (EMR) revealed R50 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease, congestive heart failure with hypoxia, and interstitial pulmonary disease. Review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 10/03/24 revealed a Brief Interview for Mental Status (BIMS) score of six out of 15 which indicated R50 was severely cognitively impaired. Observation on 12/11/24 at 10:46 AM, R50 had no call light plugged into the wall unit, or a substitute call device available. R50 stated, I haven't had one, the other one broke. When asked how she would call staff for assistance, R50 stated, I don't have anything, just my voice. During an interview on 12/11/24 at 11:10 AM, the Administrator, Director of Nurses (DON), and nurse consultants (NC1 and NC2) were notified of R50 not having a call bell device. R50 stated to the administrative staff, I guess I could try to yell. The DON looked for the doorbell device in the resident's room, however none was located. During an interview on 12/11/24 at 11:59 AM, the Administrator identified that the call light system had failed in May 2024. All but two rooms returned to normal functioning. R50 resided in one of the two rooms that did not have a functioning call light system. The Administrator stated, Due to the wiring. [R50's] room could not be fixed. The DON stated, we gave them all a doorbell. Observation of the two rooms identified not having a functioning electronic call light system, on 12/11/24 at 12:13 PM, revealed three of the four residents (R4, R12, and R14) had doorbell like devices which rang into the hall. R50 had no such device. On 12/11/24 at 4:30 PM, the Administrator stated, The Certified Nurse Aides (CNAs) know to check on the residents. We will make sure they check for the bell too. Interview on 12/12/24 at 8:47 AM, CNA3 stated, Yes, we check for the bell. I don't know what happened to it.