DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

N. .E OF FACILITY: Cadia Rehabilitation Silverside **DATE SURVEY COMPLETED: March 27, 2023**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Complaint Survey was conducted at this facility from March 20, 2023 through March 27, 2023. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 112. The survey sample size was 28 residents.	1. No resident was affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected by the action plan outlined below. 3. Daily staffing will be reviewed by NHA/designee, both projected for current day and actual PPD for previous day, to ensure adequate staffing and compliance with Delaware Nursing Home Staffing Laws. On Fridays, projected staffing and PPD will be reviewed for the upcoming weekend and on Mondays the actual PPD for Friday, Saturday, and Sunday will be reviewed. Additionally, we will continue to attempt to acquire new agency contracts, offer incentives to all staff, including PRN staff to pick up open shifts and ensure competitive rates to help recruitment for vacant positions. 4. Daily staffing will be reviewed by NHA/designee daily to ensure 100% compliance at all times.	4/12/2023
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** Cross refer to CMS 2567-L survey completed March 27, 2023: F582, F791.		
16 Del., Chapter 11, Sub-[illegible]ter [illegible] 1162 Nursing staffing	**(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds**		

Provider's Signature Laura L. Dittmer Title NHA Date 4/12/23

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	have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement. **Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:** **RN/LPN CNA*** **Day - 1 nurse per 15 res. 1 aide per 8 res.** **Evening 1:23 1:10** **Night 1:40 1:20** *** or RN, LPN, or NAIT serving as a CNA.** **(g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week.** **This requirement is not met as evidenced by:** A desk review staffing audit was conducted by the State of Delaware, Division of Health Care Quality, Office of Long Term Care Residents Protection. The facility was found to be noncompliant with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities. Based on review of facility documentation it was determined that on the seven days reviewed, the facility failed to provide a staffing level of at least 3.28 hours of direct care per resident per day (PPD). Findings include: Review of the Facility Staffing Worksheets, completed and signed by E1 (Nursing Home Administrator) revealed the following: 2/9/2023 – PPD = 3.17 2/10/2023 – PPD = 3.12 3/12/2023 – PPD = 2.82 3/13/2023 – PPD = 3.20 3/14/2023 – PPD = 2.91 3/17/2023 – PPD = 3.21		

Provider's Signature _____ Title _____ Date _____

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	3/18/2023 – PPD = 3.11 The facility failed to maintain the minimum PPD staffing requirement of 3.28. 3/27/23 10:40 AM - Findings were confirmed by E1 (CNO) and E2 (NHA). 3/27/2023 2:00 PM – Findings were reviewed during the Exit Conference with E1, E2 and E3 (DON).		

Provider's Signature _____ Title _____ Date _____

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 _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION SILVERSIDE	3322 SILVERSIDE ROAD WILMINGTON, DE 19810

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E 000	Initial Comments An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility beginning 3/20/2023 and ending 3/27/2023, by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census on the first day of the survey was 112. For the Emergency Preparedness Survey, all contracts, operation plans, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility beginning 3/20/2023 and ending 3/27/2023. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 112 residents. The investigative sample totaled twenty-eight (28) residents. Findings include: Abbreviations/definitions used in this report are as follows: ADON- Assistant Director of Nursing; CMS- Centers for Medicare and Medicaid Services; CNA- Certified Nursing Assistant; CNO- Chief Nursing Officer; DON- Director of Nursing; LPN- Licensed Practical Nurse; MDS (Minimum Data Set)- standardized	F 000		

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

Electronically Signed | 04/12/2023

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.

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F 000	Continued From page 1 assessment forms used in nursing homes; NHA- Nursing Home Administrator; NOMNC- Notice of Medicare Non-Coverage; RN- Registered Nurse; SNFABN- Skilled Nursing Facility Advance Beneficiary Notice.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		5/12/23

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F 582	Continued From page 2 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that for two (R74 and R255) out of three Medicare Part A discharges reviewed for the required notice for changes of coverage and services under Medicare, the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) to R74 who remained in the facility after the discontinuation of her Part A services. Additionally, the facility failed to provide the Notice of Medicare Non-Coverage (NOMNC) to R255 who was discharged from Part A services and left the facility the day after his last covered day. Findings include: 1. R74's clinical record revealed:	F 582	F582 A. R74 still resides in the facility and was not negatively impacted by this deficient practice. B. All residents under a Medicare stay have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by taking the corrective actions in section C. C. A root cause analysis was conducted, and it was determined that the facility Social Worker failed to identify that R74 was provided with the Skilled Nursing	

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F 582	Continued From page 3 10/20/22 - R74 started Medicare Part A skilled services. 2/24/23 - R74 was discharged from Medicare Part A skilled care services and remained living in the facility as a long-term care resident with 10 benefit days remaining. 3/23/23 9:50 AM - R74's SNF Beneficiary review revealed that a NOMNC form was provided, however, a SNFABN form was not given to the resident. Centers for Medicare and Medicaid Services, (CMS) form 20052, last revised 10/2022, documented the following: "Resident has skilled benefit days remaining and is being discharged from Part A services and will continue living in the facility" should receive both NOMNC and SNFABN forms. 3/23/23 10:38 AM - During an interview, E4 (Social Service Director), verified that R74 was still living in the facility and that a SNFABN form was not given to the resident. 2. R255's clinical record revealed: 11/8/22 - R255 started Medicare Part A skilled services. 11/20/22 - R255 was discharged from Medicare Part A skilled care services with 26 benefit days remaining. 11/21/22 - R255's discharge summary revealed that he was discharged to his home from the facility.	F 582	Facility Advanced Beneficiary Notice (SNFABN) after the discontinuation of her Medicare Part A services. A facility wide audit was conducted, and no other residents were identified as not receiving their SNFABN notice when Part A services had ended. The Corporate RNAC will educate the facility Social Worker as to the process of administering the SNFABN after the discontinuation of Part A services. D. The Corporate RNAC/designee will audit all residents who are determined to be ending their Medicare Part A services and assuring that a SNFABN is given to the resident. The audit process will be conducted three times a week until compliance is consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, reassessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the facility QAPI meetings. A. R255 no longer resides in the facility. R255 was not negatively impacted by this deficient practice.	

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F 582	Continued From page 4 3/23/23 9:50 AM - R74's SNF Beneficiary review revealed that a NOMNC form was not provided to the resident. CMS form 20052 documented the following: "Resident has skilled benefit days remaining and is being discharged from Part A services and is leaving the facility immediately following the last covered skilled day" should receive a NOMNC form. 3/23/23 10:38 AM - During an interview, E4 confirmed that R255 was discharged from his Part A services on 11/20/22 and was discharged to his home from the facility on 11/21/22. 3/27/23 2:00 PM - Findings were reviewed with E1 (CNO), E2 (NHA), and E3 (DON) during the Exit Conference.	F 582	B. All residents under a Medicare stay have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by taking the corrective actions in section C. C. A root cause analysis was conducted, and it was determined that the facility Social Worker failed to identify that R255, who discharged from the facility, was given a Notice of Medicare Non-Coverage (NOMNC) when the resident was discharged from Medicare Part A services. A facility wide audit was conducted, and no other residents were identified as not receiving their NOMNC notice when discharged from the facility. The Corporate RNAC will educate the facility Social Worker on the process for administering a NOMNC when a resident is discharged from the facility under Medicare Part A services. D. The Corporate RNAC/designee will audit all Notices of Medicare Non-coverage (NOMNC) for compliance for residents who are discharged under a Medicare Part A stay. The audit process will be conducted three times a week until compliance is consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, reassessment of on-going issues and corrective actions will be taken. If	

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F 582	Continued From page 5	F 582	compliance is achieved, corrective measures will be noted as successful. All results will be brought through the facility QAPI meetings.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those	F 791		5/12/23

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F 791	Continued From page 6 circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R49) out of two residents reviewed for dental services, the facility failed to promptly assist a resident with follow up dental services after a consultation. Findings include: The facility policy for dental services available to residents, last updated 1/20/23, indicated, "Lost /Damaged dentures. Residents with lost or damaged dentures are referred for dental services after consultation with resident and/or the next of kin. The resident is referred for dental services within three days." Review of R49's clinical record revealed: 4/1/22- An annual MDS assessment listed that R49 had no natural teeth or tooth fragment(s). 12/6/22 - During a dental exam for cleaning, E5 (Dentist) documented that R49 was in need of dentures, and that the resident stated, "I lost my dentures that were made for me." Review of R49's clinical record lacked evidence of a facility response regarding the 12/6/22 dental	F 791	F79 A. F49 was not negatively impacted by this deficient practice. B. All residents have the potential to be affected by this deficient practice. Further residents will be protected from this deficient practice by taking the corrective actions in section C. C. A root cause analysis was conducted, and it was determined that the facility failed to initiate a dental consult for F49 after it was determined that a dental consult was needed related to missing dentures. It was also determined that the facility did not have a formal process in place to identify when a resident needs a dental consult and the steps to be taken to assure the consult is completed. The facility will review all residents in the facility morning meeting who are in need of a dental consult and the steps needed to assure a consult has been completed. A facility wide audit was conducted and no other residents were identified as needing	

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F 791	Continued From page 7 visit that identified R49 lost his dentures. 1/6/23 - R49 was discharged home from the facility. Review of R49's discharge paperwork lacked evidence of any dental related consults, referrals, appointments or follow up care regarding R49's lost dentures. 3/9/23- An entry tracking MDS assessment showed that R49 was readmitted to the facility. The dental section was blank. 3/10/23 - R49 was readmitted to the facility with no dentures. During an interview on 3/20/23 at 1:15 PM, R49 reported to the Surveyor that he was in "Need of a new set (dentures) and the loss was reported to the facility with no response." During an interview on 3/23/23 at 12:02 PM, R49 stated that since readmission he reported the missing dentures to E6 (RN). During an interview on 3/23/23 at 12:33 PM, E4 (SW) reported being unaware that R49 was in need of dentures. During an interview on 3/23/23 at 12:52 PM, E6 (RN) confirmed that she was aware R49 did not have dentures, but she did not report the loss to Social Work or other staff for a dental referral. During an interview on 3/24/23 at 10:18 AM, E4 (SW) confirmed the facility was unable to find any documentation of a response to R49's lost dentures, that was first reported in December	F 791	a dental follow up. The Chief Nursing Officer will educate the Social Worker on the steps to be taken when a resident needs a dental consult. D. The Director of Social Services will audit all residents who have been identified as needing a dental consult. The audit process will be conducted three times a week until compliance is consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, reassessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the facility QAPI meetings.	

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F 791	Continued From page 8 2022. E4 stated that she would be initiating a dental referral that day. During an interview on 3/24/23 at 10:58 AM, E1 (CNO) confirmed the facility had no evidence of response to R49's lost dentures. 3/27/2023 at 2:00 PM - Findings were reviewed during the Exit Conference with E1 (CNO), E2 (NHA) and E3 (DON).	F 791		