

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/03/2015
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION BROADMEADOW			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH BROAD STREET MIDDLETOWN, DE 19709	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from March 29, 2015 through April 3, 2015. The census the first day of the survey was 115. The sample size included four (4) active and one (1) closed records. There were no deficiencies at the time of the survey.	F 000		

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

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.



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Broadmeadow

DATE SURVEY COMPLETED: April 03, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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The State Report incorporates by reference and also cites the findings specified in the Federal Report.

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Provider's Signature _____ Title _____ Date _____