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

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Broadmeadow DATE SURVEY COMPLETED: November 10, 2021

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 November 1, 2021 through November 10, 2021. 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 115. The survey sample totaled 50 residents.	Cross refer to the CMS 2567-L survey completed November 10, 2021: F550, F558, F563, F568, F580, F584, F641, F655, F656, , F657, F677, F684, F689, F692, F761, F791, and F812.	
3201	**Regulations for Skilled and Intermediate Care Facilities**	3201.6.9.2.4 1. A. E23 was not adversely affected by this deficient practice. B. All staff have the potential to be affected by this deficient practice. Current and future staff will be protected from this practice by following the corrective action outlined below. C. Staff Educator / designee will screen all new employees for Tuberculosis history (past exposure / positive PPD or BCG vaccine or previous treatment for TB). All new employees will be tested for Tuberculosis by Mantoux test (PPD) prior to first day of employment. PPD will be read by Staff Educator / Designee 48-72 hours after administration. An employee may begin working with patients after a negative 1st step PPD. D. Staff Educator / Designee will randomly audit 3 new employees. Random audits will be completed once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 months. Once compliance is met the deficient practice will be considered resolved. Audits will be reviewed by the Quality Assurance Committee.	1/14/22
3201.1.0			
3201.1.2	**Scope** **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 here- by adopted and incorporated by reference.** This requirement is not met as evidenced by the following: Cross Refer to the CMS 2567-L survey completed November 10, 2021: F550, F558, F563, F568, F580, F584, F641, F655, F656, F657, F677, F684, F689, F692, F761, F791, and F812.		
3201.6.9.2			

Provider's Signature [signature] Title Administrator Date 12-3-21

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

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

NAME OF FACILITY: Cadia Rehabilitation Broadmeadow

DATE SURVEY COMPLETED: November 10, 2021

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201.6.9.2.4	**Specific Requirements for Tuberculosis** **Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.** Based on interview, review of personnel records, and review of facility policy and procedure, it was determined that the facility failed to ensure that four (E20, E21, E22, and E23) out of 20 sampled employees reviewed had their pre-employment TB screening completed. Findings include: Review of the facility's policy and procedure titled Employee Tuberculosis Prevention and Control, with a revision date of 6/2/21 stated, "Upon hire: New employees will be screened for TB history...Employee with no TB history will be tested for tuberculosis by ...An employee may begin working with patients after a negative 1st step PPD. The 2nd step PPD may be performed after the employee starts working...Employee with history of TB, positive PPD...will be testing for tuberculosis by chest x-ray...". 1. E23 (CNA) – E23's first day in the facility was 5/19/21 and due to a past history of a positive	3201.6.9.2.4 2. A. E20 was not adversely affected by this deficient practice. B. All staff have the potential to be affected by this deficient practice. Current and future staff will be protected from this practice by following the corrective action outlined below. C. Staff Educator / designee will screen all new employees for Tuberculosis history (past exposure / positive PPD or BCG vaccine or previous treatment for TB). All new employees will be tested for Tuberculosis by Mantoux test (PPD) prior to first day of employment. PPD will be read by Staff Educator / Designee 48-72 hours after administration. An employee may begin working with patients after a negative 1st step PPD. D. Staff Educator / Designee will randomly audit 3 new employees. Random audits will be completed once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 months. Once compliance is met the deficient practice will be considered resolved. Audits will be reviewed by the Quality Assurance Committee.	1/14/22

Provider's Signature [signature] Title Administrator Date 12-3-21

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

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

NAME OF FACILITY: Cadia Rehabilitation Broadmeadow

DATE SURVEY COMPLETED: November 10, 2021

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	PPD result, a chest x-ray was performed on 5/20/21, which indicated no evidence of TB. The facility failed to ensure pre-employment screening was performed on E23. 2. E20 (PT) – E20's first day in the facility was 7/5/21 and the first step PPD was initiated on 7/6/21 and the result was negative on 7/8/21. The facility failed to ensure pre-employment screening was performed on E20. 3. E21 (CNA) – E21's first day in the facility was 5/19/21 and the first step PPD was initiated on 5/20/21 and the result was negative on 5/22/21. The facility failed to ensure pre-employment screening was performed on E21. 4. E22 (CNA) – E22's first day in the facility was 5/19/21 and due to a past history of a positive PPD result, a chest x-ray was performed on 5/20/21, which indicated no evidence of TB. The facility failed to ensure pre-employment screening was performed on E22. 11/9/21 12:10 PM – An interview with E14 (HR Director) revealed that for all the above employees, their first day in the facility would be orientation to the facility and no contact with any resident. Beginning with the second day in the facility, they would likely have contact with the residents. 11/9/21 1:45 PM – An interview with E4 (ICN/SE) confirmed the above findings.	3201.6.9.2.4 3. A. E21 was not adversely affected by this deficient practice. B. All staff have the potential to be affected by this deficient practice. Current and future staff will be protected from this practice by following the corrective action outlined below. C. Staff Educator / designee will screen all new employees for Tuberculosis history (past exposure / positive PPD or BCG vaccine or previous treatment for TB). All new employees will be tested for Tuberculosis by Mantoux test (PPD) prior to first day of employment. PPD will be read by Staff Educator / Designee 48-72 hours after administration. An employee may begin working with patients after a negative 1st step PPD. D. Staff Educator / Designee will randomly audit 3 new employees. Random audits will be completed once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 months. Once compliance is met the deficient practice will be considered resolved. Audits will be reviewed by the Quality Assurance Committee.	1/14/22

Provider's Signature Carol J Lamunion Title Administrator Date 12-3-21

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

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

NAME OF FACILITY: Cadia Rehabilitation Broadmeadow

DATE SURVEY COMPLETED: November 10, 2021

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		3201.6.9.2.4 4. A. E22 was not adversely affected by this deficient practice. B. All staff have the potential to be affected by this deficient practice. Current and future staff will be protected from this practice by following the corrective action outlined below. C. Staff Educator / designee will screen all new employees for Tuberculosis history (past exposure / positive PPD or BCG vaccine or previous treatment for TB). All new employees will be tested for Tuberculosis by Mantoux test (PPD) prior to first day of employment. PPD will be read by Staff Educator / Designee 48-72 hours after administration. An employee may begin working with patients after a negative 1st step PPD. D. Staff Educator / Designee will randomly audit 3 new employees. Random audits will be completed once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 months. Once compliance is met the deficient practice will be considered resolved. Audits will be reviewed by the Quality Assurance Committee.	1/14/22

Provider's Signature [signature] Title Administrator Date 12-3-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility beginning November 1, 2021 through November 10, 2021, 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 115. 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 from November 1, 2021 through November 10, 2021. 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 115. The survey sample totaled 50 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; Bed Mobility - the ability to perform specific movements while in bed; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact 08-12: Moderately impaired 00-07: Severe impairment;	F 000		

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

Electronically Signed | 12/03/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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	Continued From page 1 CNA - Certified Nurse's Aide; CNO - Chief Nursing Officer; COVID-19/Coronavirus - a respiratory illness that can be spread person to person; DCS - Director of Clinical Services; DON - Director of Nursing; Hemodialysis - procedure that removes waste and extra fluid from the body through the blood; Hospice- a care provider for patients with a terminal illness or poor life expectancy; Locomotion - movement, walking or the ability to move from one space to another; LPN - Licensed Practical Nurse; LTC - Long Term Care; MD - Medical Doctor; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; ml (milliliters) - a measure of fluid volume; NHA - Nursing Home Administrator; NP - Nurse Practitioner; Outbreak - a single new COVID-19 infection in a facility staff member or any LTC facility onset COVID-19 infection in a resident; OT - Occupational Therapy; PT - Physical Therapy/Physical Therapist; RD - Registered Dietitian; RN - Registered Nurse; SSA - Social Worker Assistant; SW - Social Worker; UM - Unit Manager; - - negative, minus, loss; % - percentage.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and	F 550		1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 550	Continued From page 2 access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was	F 550	F550 Resident Rights/Exercise	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 550	Continued From page 3 determined that the facility failed to ensure care was provided in a way that promoted dignity during dining for one (R103) randomly observed residents. Findings include: 1. Random lunch meal observation revealed the following: 11/1/21 12:16 PM - Dietary cart arrived in the unit with the lunch meals for the residents. 11/1/21 12:27 PM - R59 was provided her meal. 11/1/21 12:42 PM - R103, R59's roommate received her meal, approximately 15 minutes after R59 was provided her meal. 11/1/21 12:51 PM - An interview with E24 (RN), upon completion of the last lunch tray to a resident revealed that she was uncertain how the trays were organized in the cart, thus, staff had to pull multiple trays to locate a tray for a specific resident. E24 stated that the trays are not organized in the cart in a manner to allow for orderly distribution of the meals.	F 550	A.No residents were adversely affected by the deficient practice. All residents received meal trays. B.All residents have the potential to be affected by this practice. The facility completed a random audit to ensure that residents in the same room received their trays at the same time. C. The root cause analysis determined that the facility failed to organize the meal cart in a manner to allow orderly and timely distribution of meals. All meal tray carts will be organized in order of rooms effective 11/1/21. Education will be provided to Dietary staff by the Dietitian and/or designee on Proper Meal Tray Cart Organization for each nursing unit. Education will be provided to all Nursing staff by the Dietitian on Timeliness of Meal Tray Distribution on each nursing unit. The dietitian and/or designee will monitor / audit meal tray distribution from carts to ensure compliance. D.The Dietitian and/or designee will conduct random audits of all meals to ensure meal trays are distributed from carts in a manner which prevents time variances between roommate tray deliveries. The audit will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 550	Continued From page 4	F 550	consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview it was determined that the facility failed to provide services for all residents' needs with reasonable accommodations and preferences, when upper bed rails were removed for three residents (R18, R35, and R64) out of 27 current residents sampled for a care area. R18, R35, and R64 complained that they needed both upper bed rails as enablers for bed mobility and without them they fear of falling out of bed. Findings include: 10/6/21 - E1 (NHA) wrote a letter to the facility residents and responsible parties that stated "Effective October 6, 2021, [the facility] will no longer allow bed rail[s] on resident beds. Studies have shown that bed rails can be a potential safety risk to residents. To best serve and protect all our residents our facility is now a Bed Rail Free Facility. Our maintenance staff have been instructed to remove all bed rails effective immediately. Please feel free to contact me at	F 558	F558 Reasonable Accommodations 1. A.R64 was not harmed by the deficient practice. The resident was picked up by therapy to address expressed concerns. B. All residents have the potential to be affected by the deficient practice. All residents who had side rails removed were re-assessed by therapy. C. A root cause analysis was completed and revealed that the facility failed to reassess residents when they expressed concern regarding side rail removal. A resident concern form will now be completed immediately when a resident expresses concern regarding side rail removal and the concern forms will be brought to the morning meeting for	1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 558	Continued From page 5 [phone number] if you have any questions." 11/2/21 7:30 AM - During an interview, E2 (DON) stated, "The facility is bed rail free. Newly admitted residents will not have bed rails or enablers placed on their beds until and only if Therapy evaluated the resident and approved them for bed rails / enablers. Some residents have had enablers on their beds for many years, so they are being evaluated by Therapy. If not approved, many residents are upset that their enablers / bed rails have been removed." 11/3/21 3:04 PM - During an interview, E41 (Corporate Therapy Director) said "A couple of months ago, corporate-wide, all of their facilities became side-rail and enabler free [upper ¼ bed length bed rails]. So, no newly admitted residents have side rails placed on their beds. The residents that have side rails are being evaluated by Therapy and the enablers are removed if the resident is not independent with bed mobility and getting out of bed. We try other alternatives, like a trapeze, but the bottom line is that the risk of entrapment or injury is not worth the benefit." When asked how resident rights are addressed if a resident wants to have siderails, E41 said "We do not allow side rails or enablers." When asked if a resident could sign a waiver to say they understand the risks and still want siderails or enablers, E41 said "The corporation will not allow a waiver." When asked how the residents are evaluated, E41 said "There is a screening form in the electronic medical record." When asked if the facility has a procedure or guideline related to bed rails and/or the evaluation, E41 responded "No. We are a bed rail free facility, so we do not need a policy."	F 558	therapy review. The following system was put into place to prevent recurrence. System Changes 1)Therapy completes hands-off screening for all residents using Enabler Rehab Recommendation tool in the EMR (document attached). 2)Therapist provides education to resident/responsible party on risk of side rails when side rails are not recommended as enablers. 3)Therapist completes Resident Concern Form when resident/responsible party expresses concern about side rail removal for those residents who already have side rails. 4)Physician order obtained for hands-on Therapy Evaluation for those residents who have objections to side rails not being indicated or those having objections to recommendation for removal of side rails. 5)Therapy goals for bed mobility/transfers without side rails established, if appropriate. 6)Therapy training provided to resident and/or caregivers, equipment trialed as alternatives to side rails specific to the expressed concern. 7)Therapist may request physician order for 7-day trial of positioning side rails in lowered position to initiate side rail removal transition, if and when appropriate. 8)If training, equipment and/or trial of lowered position of side rails is not successful, therapist documents Resident/Responsible Party request for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 558	Continued From page 6 1. Review of R64's clinical record revealed: 10/6/20 - R64 was admitted to the facility. 9/28/21 - A Quarterly MDS assessment documented that R64 was cognitively intact and needed only supervision of staff for bed mobility and transfers from bed to the wheelchair. 11/4/21 10:27 AM to 11:05 AM - During the Resident Council Meeting with the Surveyor and nine Residents, R64 complained that "[E12 Rehab Director] took away my right side handrail off my bed a couple weeks ago. I have spine degeneration and a lot of back pain, so I have to turn myself side to side frequently to relieve pain at night when I'm in bed. I still have the left rail, but I need the right rail back because I can't turn myself to the right side without the bedrail to hold onto. I'm afraid I will fall out of the bed too, without this siderail. [E1 NHA] sent out a letter and the next thing I know they took my bedrails off." R64 added that if she puts her call bell on it takes too long for staff to arrive to assist her at night. There was no evidence that the facility provided an accommodation to replace the right bed rail R64 used as an enabler. 11/8/21 8:30 AM - During an interview and observation with E3 (ADON), E2 (DON) told R64 he will have rehabilitation staff reevaluate her. 2. Review of R35's clinical record revealed: 8/1/20 - R35 was admitted to the facility. 8/21/21 - An Annual MDS assessment	F 558	Side Rail Accommodation in EMR. 9)Therapist contacts physician and requests an assessment be completed by therapist and education provided to the resident for Side Rail Accommodation and therapists documents consult in EMR. 10)Physician order obtained for Side Rail Accommodation in EMR. 11)Nursing updates Care Plan with Side Rail Accommodation in EMR. 12)Therapy completes hands-off screening using Enabler Rehab Recommendation tool in the EMR quarterly and/or with significant change for those residents with side rails. 13)Education- Regional Rehab Director / designee will provide in-service training to all nursing staff on the New Process for Side Rail Accommodation and the Enabler Rehab Recommendation Tool in the EMR. All therapists will attend an in-service provided by the Regional Rehab Director/ Designee which will review the new process for Side Rail Accommodation and the Enabler Rehab Recommendation Tool in the EMR. D.A side-rail accommodation audit will be completed weekly x 3 weeks on all residents with side rail accommodations to ensure each resident with side rails has been assessed and side rails remain appropriate, then all residents will be assessed monthly x 3, and then quarterly thereafter by the Director of Rehab / designee. The DON/ designee will conduct audits of concern form follow through daily until 100% compliant for 3 consecutive days, then weekly until 100%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 558	Continued From page 7 documented that R35 was cognitively intact and needed extensive assistance for bed mobility and transfers. 11/4/21 10:27 AM to 11:05 AM - During the Resident Council Meeting with the Surveyor, R35 complained that her upper bed rails were removed a couple of weeks ago and now she cannot turn herself in bed and is afraid of falling out of bed. There was no evidence that the facility provided an accommodation to replace the upper bed rails R35 used as an enabler and to address her fear of falling out of bed prior to removing her bed rails. 11/8/21 9:00 AM - During an interview, E3 (ADON) said that today R35 was being reevaluated by therapy for the need for upper bedrails. 3. Review of R18's clinical record revealed: 8/10/17 - R18 was admitted to the facility. 8/17/21 - A Quarterly MDS assessment documented that R18 had moderate cognitive impairment and needed extensive assistance of staff for bed mobility. 11/1/21 4:59 PM - During an interview and observation, R18 stated, "I am so upset because they removed the side rails that I hold onto to stay on my side while they change my dressings." R18 was lying flat in bed with no bed rails. The bed was in the highest position from the floor. 11/8/21 11:00 AM - During an interview and	F 558	compliant for 3 consecutive weeks, then monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed with the Quarterly QAPI Committee. 2. A.R35 was not harmed by the deficient practice. The resident was placed on therapy to address expressed concerns. B.All other residents have the potential to be affected by the deficient practice. All residents who had side rails removed were re-assessed by therapy. C.A root cause analysis was completed and revealed that the facility failed to reassess residents when they expressed concern regarding side rail removal. A resident concern form will now be completed immediately when a resident expresses concern regarding side rail removal and the concern forms will be brought to the morning meeting for therapy review. The following system was put into place to prevent recurrence. System Changes 1)Therapy completes hands-off screening for all residents using Enabler Rehab Recommendation tool in the EMR (document attached). 2)Therapist provides education to resident/responsible party on risk of side	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 558	Continued From page 8 observation with E3 (ADON), R18 complained that both of his upper bed rails were removed a couple of weeks ago and now he feels like he is going to fall out of bed. R18 stated, "This is crazy! Two nights ago, I caught myself falling halfway off the side of the bed." E3 told R18 that he would ask rehabilitation staff to reevaluate him. The facility failed to provide a reasonable accommodations and acknowledge R18's fear, when the bed rails were removed. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/9/21 during Exit Conference, beginning at 2:30 PM.	F 558	rails when side rails are not recommended as enablers. 3)Therapist completes Resident Concern Form when resident/responsible party expresses concern about side rail removal for those residents who already have side rails. 4)Physician order obtained for hands-on Therapy Evaluation for those residents who have objections to side rails not being indicated or those having objections to recommendation for removal of side rails. 5)Therapy goals for bed mobility/transfers without side rails established, if appropriate. 6)Therapy training provided to resident and/or caregivers, equipment trialed as alternatives to side rails specific to the expressed concern. 7)Therapist may request physician order for 7-day trial of positioning side rails in lowered position to initiate side rail removal transition, if and when appropriate. 8)If training, equipment and/or trial of lowered position of side rails is not successful, therapist documents Resident/Responsible Party request for Side Rail Accommodation in EMR. 9)Therapist contacts physician and requests an assessment be completed by therapist and education provided to the resident for Side Rail Accommodation and therapists documents consult in EMR. 10)Physician order obtained for Side Rail Accommodation in EMR. 11)Nursing updates Care Plan with Side Rail Accommodation in EMR. 12)Therapy completes hands-off	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 558	Continued From page 9	F 558	screening using Enabler Rehab Recommendation tool in the EMR quarterly and/or with significant change for those residents with side rails. 13)Education- Regional Rehab Director / designee will provide in-service training to all nursing staff on the New Process for Side Rail Accommodation and the Enabler Rehab Recommendation Tool in the EMR. All therapists will attend an in-service provided by the Regional Rehab Director/ Designee which will review the new process for Side Rail Accommodation and the Enabler Rehab Recommendation Tool in the EMR. D. The rehab director/ designee will conduct a side-rail accommodation audit will be completed weekly x 3 weeks on all residents with side rail accommodations to ensure each resident with side rails has been assessed and side rails remain appropriate, then all residents will be assessed monthly x 3, and then quarterly thereafter by the Director of Rehab / designee.The DON/ designee will conduct audits of concern form follow through daily until 100% compliant for 3 consecutive days, then weekly until 100% compliant for 3 consecutive weeks, then monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed with the Quarterly QAPI Committee. 3. A.R18 was not harmed by the deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 558	Continued From page 10	F 558	practice. The resident was picked up by therapy to address expressed concerns. B.All other residents have the potential to be affected by the deficient practice. All residents who had side rails removed were re-assessed by therapy. C.A root cause analysis was completed and revealed that the facility failed to reassess residents when they expressed concern regarding side rail removal. A resident concern form will now be completed immediately when a resident expresses concern regarding side rail removal and the forms will be brought to the morning meeting for therapy review. The following system was put into place to prevent recurrence. System Changes 1)Therapy completes hands-off screening for all residents using Enabler Rehab Recommendation tool in the EMR (document attached). 2)Therapist provides education to resident/responsible party on risk of side rails when side rails are not recommended as enablers. 3)Therapist completes Resident Concern Form when resident/responsible party expresses concern about side rail removal for those residents who already have side rails. 4)Physician order obtained for hands-on Therapy Evaluation for those residents who have objections to side rails not being indicated or those having objections to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 558	Continued From page 11	F 558	recommendation for removal of side rails. 5)Therapy goals for bed mobility/transfers without side rails established, if appropriate. 6)Therapy training provided to resident and/or caregivers, equipment trialed as alternatives to side rails specific to the expressed concern. 7)Therapist may request physician order for 7-day trial of positioning side rails in lowered position to initiate side rail removal transition, if and when appropriate. 8)If training, equipment and/or trial of lowered position of side rails is not successful, therapist documents Resident/Responsible Party request for Side Rail Accommodation in EMR. 9)Therapist contacts physician and requests an assessment be completed by therapist and education provided to the resident for Side Rail Accommodation and therapists documents consult in EMR. 10)Physician order obtained for Side Rail Accommodation in EMR. 11)Nursing updates Care Plan with Side Rail Accommodation in EMR. 12)Therapy completes hands-off screening using Enabler Rehab Recommendation tool in the EMR quarterly and/or with significant change for those residents with side rails. 13)Education- Regional Rehab Director / designee will provide in-service training to all nursing staff on the New Process for Side Rail Accommodation and the Enabler Rehab Recommendation Tool in the EMR. All therapists will attend an in-service provided by the Regional Rehab Director/	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 558	Continued From page 12	F 558	Designee which will review the new process for Side Rail Accommodation and the Enabler Rehab Recommendation Tool in the EMR. D.A side-rail accommodation audit will be completed weekly x 3 weeks on all residents with side rail accommodations to ensure each resident with side rails has been assessed and side rails remain appropriate, then all residents will be assessed monthly x 3, and then quarterly thereafter by the Director of Rehab / designee. The DON/ designee will conduct audits of concern form follow through daily until 100% compliant for 3 consecutive days, then weekly until 100% compliant for 3 consecutive weeks, then monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed with the Quarterly QAPI Committee.	
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable	F 563		1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 563	Continued From page 13 clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure the residents right to receive visitors by placing signs at entrances denying all visitor entry. Additionally, after being cleared post COVID-19 outbreak, the facility failed to reopen for indoor visitation for 10 days. Findings include: CMS QSO 9/17/20 Memo regarding nursing home visitation indicated, "Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission (note: compassionate care visits should be permitted at all times). The facility policy, last revised on 5/18/21, indicated, "Purpose: To promote safety of our residents during the COVID-19 pandemic by decreasing the risk of exposure to illness by	F 563	F563 Right to Receive/Deny Visitors 1. A.The signs observed by the Surveyor were immediately removed when brought to the attention of facility staff. Some residents and families were affected by the multiply communications released during our outbreak investigation and the re-opening of indoor and outdoor visitations evidenced by weekly letters to residents and weekly Robo-Calls sent to responsible parties. All residents and responsible parties have been made aware that visitation is allowed for all residents, at all times. B.All residents have the potential to be adversely affected by this practice. A facility wide sweep has been completed to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 563	Continued From page 14 limiting visitation to the facility...The facility will accommodate and support indoor visitation...When a single COVID-19 infection in a facility is identified, a facility should immediately begin outbreak testing and suspend indoor visitation until at least one round of facility wide testing can be completed. Visitation can resume based on the following criteria: If the first round of outbreak testing reveals no additional COVID-19 cases in other areas of the facility, then visitation can resume for residents in areas/units with no COVID -19 cases...If no additional cases are identified within the initial round of outbreak testing, unaffected areas of the facility may resume indoor visitation." 10/25/21 - A COVID-19 facility activity notification letter addressed to (facility) residents, dated and signed by E1 (NHA) on 10/25/21, stated, "Effective today (10/25/21), our facility will re-open for scheduled Outdoor and Indoor visitations." 1. 11/1/21 through 11/4/21- Upon entry into the facility the Surveyor observed signs, one on each of the four entrance doors, printed in capital letters with bold red and black ink, "NO ENTRY. ATTENTION ALL VISITORS. WE ARE NOT ACCEPTING ANY VISITORS [any visitors was underlined] AT THIS TIME. WE ARE TRYING TO PROTECT OUR RESIDENTS FROM ANY POSSIBLE COVID-19 OUTBREAKS IN OUR AREA. PLEASE BE PATIENT WITH US, AND FEEL FREE TO CONTACT ANY OF OUR STAFF FOR UPDATES ON YOUR LOVED ONES." During an interview on 11/5/21 at 12:37 PM, E2 (DON) confirmed the presence of the "NO ENTRY..." signs located on two sets of entry	F 563	remove any signage not in compliance with the State and Federal Regulations. Current and future residents will be protected from this practice by following the corrective action outlined below in section C. C. A root cause analysis determined the posted sign observed by the surveyor was not updated from the previous regulatory requirement. The facility has developed policies and procedures that follow the new CMS revised (11/12/21) Nursing Home Regulation related to Nursing Home Visitations for COVID-19. Visitation is now allowed for all residents, at all times. The staff educator will educate all staff on facility visitation process/ policy. D.Signage accuracy and compliance will be audited by the Nursing Home Administrator and/or designee once weekly for 3 consecutive weeks until 100% compliance is achieved, and then once Monthly until 100% compliance is achieved. Once 100% compliance is met, the deficient practice will be considered resolved. 2. A.R24 is able to receive visitation as per Federal regulations and facility policy. The new CMS visitation regulation allows visitations for all residents at all times. Resident R-24□s family is aware that visitation is permitted, and appointments are not necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 563	Continued From page 15 doors to the facility were placed "At the beginning of the pandemic" and removed on 1/5/21; the intent of the signs was "From when we [the facility] were closed." 11/4/21 10:27 AM to 11:05 AM - During the Resident Council Meeting with the Surveyor and nine Residents, in response to the question "Have you been informed of the rules at the facility (such as are there restrictions on visiting hours)?" One Resident stated a concern that there is no indoor visitation allowed and it is getting colder outside. The Residents were informed that E2 (DON) told the Surveyor team that indoor visitation is allowed. Residents expressed they were sure indoor visits are not allowed and that there is also a rule if visitors have not been vaccinated. The Surveyor informed the group that there is no government recommendation that unvaccinated visitors cannot visit indoors and the Surveyor will ask facility staff to communicate with Residents and families that indoor visitation is allowed. During an interview on 11/4/21 at 11:52 AM, E4 (ICP) confirmed the facility's last outbreak was due to a COVID-19 positive employee tested on 10/14/21 with no further COVID positive employees or residents and that since 10/14/21 all visitation was shut down except for compassionate visits. When asked when will indoor visits resume, E4 stated, "After our NHA returns." E1 (NHA) returned to the facility on 11/8/21. During an interview on 11/4/21 at 1:40 PM with E9 (Activities Director) it was reported that the facility closed all visitation "Mid October."	F 563	B.All residents had the potential to be affected by this deficient practice. Future residents will be protected by the corrective action outlined in section C. C. A root cause analysis suggests during that time period all visitors were required to make an appointment prior to their visitation. Based on the core principles of COVID-19 prevention certain meeting times were not available due to reserved meeting space by visitors. CMS has released a revised regulation related to visitations on 11/12/21. Visitations are now allowed for all residents at all times. All staff, residents, and families have been notified of the regulation change. The facilities policy will reflect the regulatory change. D.The Nursing Home Administrator and/or designee will continue to communicate with residents, employees, and families weekly on visitation protocols / updates set by the Centers of Medicare and Medicaid Services. Visitation regulations/updates will be reviewed quarterly by the Quality Assurance Committee. 3. A.R17 and her family are aware that visitation is permitted without appointment. B.All residents had the potential to be impacted by this deficient practice. Future	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 563	Continued From page 16 During an interview on 11/5/21 at 9:33 AM, E2 (DON) was asked the facility's current visitation status and replied, "We are doing indoor and outdoor visits, if they want indoor, they have to request and that is as long as there are no COVID-19 positive residents in the building, except there are some on compassionate and nursing schedules. Sometimes we have to have breaks due to active COVID. Our administrator [E1 NHA] will send out a robocall and it will let everyone know what our status is at that time. We have been open for indoor visits since November first, outdoor maybe a week prior to that." There was no evidence that residents were allowed indoor visitors from 10/25/21 - 11/8/21. 2. Interviews and R24's record review revealed the following: : 10/1/21 - 10/31/21 - Review of the facility visitation appointments revealed no scheduled visitation appointments for R24. During a telephone interview on 11/3/21 at 10:49 AM, FM2, an immediate family member of R24, reported, "We were having issues scheduling visits on patio... one Saturday on an afternoon, sometime last month [October] at 3:00 PM they wouldn't let us in. We then spoke to the Visitation Coordinator [E9 (AD)] and she said they shouldn't have done that. Later on that week he got a call from the Visitation Coordinator stating you can now come in as a compassion visit. Just come in, let them know and there shouldn't be a problem. Then we got the announcement that a staff member was COVID-19 positive and they shut the facility again. I was then told she [E9] was instructed to remove the compassion visits, R24	F 563	residents will be protected by the corrective action outlined in section C. C. A root cause analysis suggests indoor and outdoor visitations were available by scheduled appointment times. Based on the core principles of COVID-19 prevention not all visitors preferred times were available, and during that time period outdoor visitations were recommended /preferred per DHCQ. CMS has released a revised regulation related to visitations on 11/12/21. Visitations are now allowed for all residents at all times. All staff, residents, and families have been notified of the regulation change. The facility policy will reflect the regulatory change. D.The Nursing Home Administrator and/or designee will continue to communicate with residents, employees, and families weekly on visitation protocols / updates set by the Centers of Medicare and Medicaid Services. Visitation regulations/updates will be reviewed quarterly by the Quality Assurance Committee. 4. A.R78 and his family are aware that visitations are permitted without appointment. B. All residents had the potential to be impacted by this deficient practice. Future residents will be protected by the corrective action outlined in section C.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 563	Continued From page 17 no longer qualified. I called and spoke to E1 (NHA) and he said once the facility re-opened that we would be fine to come back in. But my brother came and they wouldn't let him, they said it was late, but we were never told visiting hours and they didn't let us get an appointment." During an interview on 11/4/21 at 11:52 AM, E4 (ICP) confirmed the facility's last outbreak was due to a COVID-19 positive employee tested on 10/14/21 with no further COVID positive employees or residents and that since 10/14/21, all visitation was shut down except compassionate visits. When asked when will indoor visits resume, E4 stated, "After our NHA returns." E1 (NHA) returned to the facility on 11/8/21. During an interview on 11/4/21 at 12:00 PM, E2 (DON) confirmed that "After one week of outbreak testing, we resumed outdoor visitation. We are fully open, we established that on 11/1/21, we started with outside first then we resumed indoor visits." During an interview on 11/4/21 at 1:40 PM with E9 (AD), it was reported that the facility closed all visitation "Mid October." During the same interview, E9 confirmed that R24's family expressed concerns regarding visitation. E9 stated, "We have documentation in the progress note that FM2 wanted to come in a couple times. FM2 said he was granted compassionate care visit(s), but I don't know who did [approved] that. So, I waited to talk to the Director, but FM2 still tried to come in. One time three weeks ago he came in at 9:00 PM or 10:00 PM and he told them he wanted to come in due to a compassionate visit and he hadn't called me. The Nurse said R24	F 563	C. A root cause analysis suggests indoor and outdoor visitations were available by scheduled appointment times. Based on the core principles of COVID-19 prevention not all visitors preferred times were available, and during that time period outdoor visitations were recommended /preferred per DHCQ. CMS has released a revised regulation related to visitations on 11/12/21. Visitations are now allowed for all residents at all times. All staff, residents, and families have been notified of the regulation change. The facilities policy will reflect the regulatory change. D.The Nursing Home Administrator and/or designee will continue to communicate with residents, employees, and families weekly on visitation protocols / updates set by the Centers of Medicare and Medicaid Services. Visitation regulations/updates will be reviewed quarterly by the Quality Assurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 563	Continued From page 18	F 563		

was sleeping and that he can come tomorrow and that was that, we just don't let people come in and he didn't call he just showed up."

During an interview on 11/5/21 at 9:33 AM, E2 (DON) was asked the facility's current visitation status and replied, "We are doing indoor and outdoor visits, if they want indoor, they have to request and that is as long as there are no COVID-19 positive residents in the building, except there are some on compassionate and nursing schedules. Sometimes we have to have breaks due to active COVID. Our Administrator [E1 NHA] will send out a robocall and it will let everyone know what our status is at that time. We have been open for indoor since November first, outdoor maybe a week prior to that."

The facility failed to ensure R24's right to receive indoor visitation was accommodated when the facility was not in an outbreak status on 11/1/21.

3. Interviews and R17's record review revealed the following:

R17's care plan for potential for psychosocial isolation secondary to COVID-19 restrictions, updated 6/16/20, included the intervention that the resident will use alternative means of communication (e.g., telephone) to reach their loved ones when it is deemed necessary for no visit/limited visitation.

10/1/21 - 10/31/21 - Review of the facility visitation appointments revealed one outdoor/patio visit scheduled for R17 on 10/27/21 and no indoor visitation.

10/25/21 - A COVID-19 facility activity notification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 563	Continued From page 19 letter addressed to (facility) residents, dated and signed by E1 (NHA) on 10/25/21 stated, "Effective today (10/25/21), our facility will re-open for scheduled Outdoor and Indoor visitations." During an interview on 11/1/21 at 11:04 AM, R17 was asked if there were any concerns and R17 stated, "They keep closing the building. He [E1 NHA] claims he's protecting us. I have a supportive family they can't come inside. Or they get here and get turned away. I need my family to come inside because she can do things the Aides don't have time to do like switch out my summer and winter clothes." During an interview on 11/4/21 at 1:40 PM, E9 (AD) was asked whether R17 expressed concerns regarding visitation. E9 stated, "Yes, before we'd opened for visits indoors, she wanted family to come inside and visit." The facility failed to ensure R17's right to receive indoor visitation was accommodated when the facility was not in an outbreak status on 11/1/21. 4. Interviews and R78's's record review revealed the following: 11/2/21 at 9:07 AM - During a telephone interview, FM1 (R78's family member) revealed concerns about facility visitations that were limited to outdoor visits only. FM1 stated that she spoke to the Nurse in (unit) on 11/1/21 in the morning and asked if she could visit R78 indoors on 11/1/21 at 1:00 PM. FM1 further stated that she was told by the Nurse that she could only do an outdoor visit.	F 563		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 563	Continued From page 20 11/4/21 at 1:36 PM - In an interview, E25 (RN UM) stated that FM1 was here for an outdoor visit with R78 on 11/1/21 in the early afternoon. E25 further stated, "Only E9 (Activities Director) can tell what type of visits are available based on the appointments with family members that are already being set up. I know for right now we are still doing outdoor visitations." 11/4/21 at 2:46 PM - Review of the facility's Visitation Appointments for 11/1/21 prepared by E9 revealed that R78 was scheduled to receive a patio (outdoor)/Private Dining (indoor) visit by FM1 on 11/1/21 at 4:00 PM. The facility failed to ensure R78's right to receive indoor visitation was accommodated when the facility was not in an outbreak status on 11/1/21. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/9/21 during Exit Conference, beginning at 2:30 PM.	F 563		
F 568 SS=E	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request.	F 568		1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 568	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on record review, interview, and observation, it was determined that the facility failed to provide quarterly statements of personal funds accounts for two (R48 and R104) out of two residents reviewed for personal funds. Findings include: August 2021 - The facility's Admission packet stated, "On a quarterly basis the Business Office provides each Resident with a statement which included: balance at the beginning of the statement period, total deposits and withdrawals, interest earned, if any, and ending balance. The statement is mailed to the Resident's Patient Representative or Legal Representative or delivered to the Resident if s/he has no Patient Representative or Legal Representative." 1. Review of R48's clinical record revealed the following: 10/11/19 - R48 was admitted to the facility. 9/14/21 - The Annual MDS Assessment documented that R48 was cognitively intact for decision making. 11/1/21 5:40 PM - During an interview, R48 stated, "I don't get a statement. I don't know how much money I have, but I go to the office and take out 15 or 20 dollars pretty often." 11/9/21 11:00 AM - During an interview, R48 stated that she did not remember agreeing to have her brother receive her personal funds statements.	F 568	F568 Accounting and Records of Personal Funds 1. A.R48 has been provided with her financial statement. B.All residents with FMS accounts have the potential to be impacted by this deficient practice. Future residents will be protected by process change below. C. The root cause analysis determined that the statements were being sent to RP's unless the resident was their own RP. All qualified residents were interviewed and ask to sign regarding their preference to receive a copy of their quarterly statement. Quarterly statements will be hand delivered to facility during weekly visits by facility Biller. Statements will then be delivered to all residents who prefer to receive their statements. The remainder of the statements will be mailed to the residents responsible party. The Billing Coordinator and /or designee will monitor all delivered and mailed copies by maintaining records of all quarterly statements distributed for future reference. D.Social Services Director / designee will audit during weekly care conferences for a complete quarter that quarterly statements are provided to resident /	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 568	Continued From page 22 2. Review of R104's clinical record revealed the following: 8/8/14 - R104 was admitted to the facility. 10/19/21 - The Annual MDS Assessment documented that R104 was cognitively intact for decision making. 11/1/21 4:59 PM - During an interview, R104 stated, "I do have an account here, but I don't ever get a statement. I have to ask the people who give me the cash how much money I have available." 11/9/21 10:27 AM - During a phone interview, E33 (Billing Manager) stated, "None of the residents at the facility receive personal funds statements. Even when they are alert and oriented, we mail the quarterly personal funds statements attached to the monthly billing statements to the residents' Representative." When asked, E33 stated, "We do not keep copies of these or send them certified mail, so there is no record that they were sent." 11/9/21 11:00 AM - During an interview, R104 stated that she did not remember agreeing to have her brother receive her personal funds statements. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/9/21 during Exit Conference, beginning at 2:30 PM.	F 568	responsible party as appropriate and per preference. If 100% compliance is achieved for 2 consecutive quarters, problem will be considered resolved. Audit results will be reviewed during the facility Quarterly Quality Assurance Committee. 2. A.R104 has been provided with her financial statement. B.All residents with FMS accounts have the potential to be impacted by this deficient practice. Future residents will be protected by process change below. C. The root cause analysis determined that the statements were being sent to RP's unless the resident was their own RP. All qualified residents were interviewed and ask to sign regarding their preference to receive a copy of their quarterly statement. Quarterly statements will be hand delivered to facility during weekly visits by facility Biller. Statements will then be delivered to all residents who prefer to receive their statements. The remainder of the statements will be mailed to the residents responsible party. The Billing Coordinator and /or designee will monitor all delivered and mailed copies by maintaining records of all quarterly statements distributed for future reference. D.Social Services Director / designee will audit during weekly care conferences for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 568	Continued From page 23	F 568	a complete quarter that quarterly statements are provided to resident / responsible party as appropriate and per preference. If 100% compliance is achieved for 2 consecutive quarters, problem will be considered resolved. Audit results will be reviewed during the facility Quarterly Quality Assurance Committee.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 580	Continued From page 24 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R72) out of three (3) residents reviewed for pressure ulcer investigation, the facility failed to immediately consult the resident's Physician when R72 had a significant change in condition as evidenced by a new wound in the sacral region (large triangular bone at base of spine). In addition, the facility failed to promptly notify R72's representative of the new wound. Findings include: The facility's manual titled Skin Integrity Program (undated), stated the following: "... Initial Wound Assessment ...Clarify individualized treatment plan with Attending Provider ...".	F 580	F580 Notify of Changes A.R72□s physician and responsible party were made aware of the wound. B.All residents with new pressure ulcers have the potential to be impacted by this deficient practice. All residents with pressure ulcers were reviewed to ensure that the physician and resident/responsible party were notified as appropriate. No issues identified. C.Licensed nurses will receive additional education provided by the Staff Educator to notify physician and resident representatives for all significant changes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 580	Continued From page 25 Review of R72's clinical record revealed the following: 10/11/21 9:20 PM - A Nursing Progress Note documented an open wound in the sacral region. There was lack of evidence that R72's Attending Physician was consulted immediately of the new wound of the sacral region. 11/5/21 9:43 AM - An interview with E18 (RN UM) revealed that after the identification of a new wound, the Resident's Attending Physician must be notified and treatment orders obtained. In addition, if applicable, the resident's responsible party should be notified of the new wound. E18 confirmed that the facility was unable to provide evidence that the Attending Physician or R72's responsible party were notified. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/9/21 during the Exit Conference, beginning at 2:30 PM.	F 580	in clinical condition for residents. A root cause analysis was conducted, and it was determined that a system was needed to assure that Providers and Resident representatives were notified for all changes in clinical conditions for residents. Physician and responsible party notification for all incidents, significant changes in treatment and resident status will now be reviewed in the morning meeting by the DON/Designee. D.The DON or designee will utilize PCC risk management to audit that all necessary notifications were completed as appropriate for any resident with significant changes. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance achieved for 3 consecutive months. Problem will then be considered resolved. All audit results will be reviewed by the quarterly Quality Assurance Committee.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 584	Continued From page 26 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to maintain a clean, comfortable and homelike environment for seven (R32, R43, R45, R58, R61, R79, and R98) randomly observed residents. Findings include:	F 584	F584 Safe/ Clean / Comfortable / Homelike Environment 1. A.R58 was not affected by the deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 584	Continued From page 27 1. Review of R58's clinical record revealed: 8/9/17 - R58 was admitted to the facility. During random observations on the Warner Unit, R58 was observed: 11/1/21 10:22 AM - R58 was observed in the hall sitting in a wheelchair with food like stains on the seat. 11/3/21 12:10 PM - R58's wheelchair continues to have the same dried food like stains and dirty wheel spokes. 11/4/21 3:00 PM - During an interview and observation of R58 sitting in her wheelchair, E31 (RN UM) confirmed there were multiple crusty, dried, hard food-like stains on the wheelchair seat and dirt and hairs imbedded in the wheel spokes of the wheelchair. E31 stated she will have environmental services clean the wheelchair this evening. 11/4/21 3:30 PM - During an interview, E37 (Regional Housekeeping Director) stated she noticed that R58's wheelchair was dirty yesterday, and it is on the schedule to be cleaned this week. When asked when was the last time R58's wheelchair was cleaned by housekeeping, E37 referred to a log and said October 1, 2021. 2. Random lunch observations in the Warner Unit's dining/activity room revealed the following: 11/1/21 11: 45 AM to 12:30 PM - Six (R32, R43, R45, R61, R79, and R98) residents, sitting at tables, were served their lunch on trays and ate their lunch off of the trays.	F 584	practice. R58 wheelchair was cleaned and sanitized when identified by the surveyor. B.All residents with wheelchairs have the potential to be adversely affected by the deficient practice. A facility wide audit was completed to ensure all wheelchairs were clean. No other issues identified. C. Root cause analysis suggests wheelchair cleaning schedule was not being followed properly. All staff will be in-serviced by the Staff Educator and/or designee on the importance of timely reporting of any environmental issues i.e., unclean wheelchairs to maintain a safe clean homelike environment. Environmental Service Director and/or designee will conduct weekly environmental rounds of center to ensure that resident□s wheelchairs are kept clean. The plan will be that all wheelchairs are power washed monthly and as needed by Environmental Services Staff. Wheelchairs will also be routinely wiped down by nursing staff as needed to maintain cleanliness / infection control. D.The Environmental Services Director and/or designee will randomly audit for DME requiring immediate attention to maintain a safe and clean environment. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 584	Continued From page 28 11/3/21 12:00 PM to 12:25 PM - Five (R32, R43, R45, R61, and R79) residents, sitting at tables, were served their lunch on trays and ate their lunch off of the trays. 11/9/21 2:00 PM - During an interview, E25 (RN UM) and E31 (RN UM) confirmed the above findings and stated that most residents are served meals on trays when they eat in the Warner Unit's dining/activity room. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/9/21 during Exit Conference, beginning at 2:30 PM.	F 584	consecutive months. Once 100% compliance is achieved, the deficient practice will be considered resolved. Audit results will be reviewed by the Quality Assurance Committee. 2. A.R32, R43, R45, R61, R79, R98 were not affected by the deficient practice of being served their meals on trays. B. All residents have the potential to be adversely affected by this deficient practice. A random audit was completed to ensure that all residents in dining rooms had meals removed from trays. Future residents will be protected from this practice by the following actions outlined in section C. C. Root cause analysis suggests nursing staff were non-compliant with the proper procedure of removing foods from trays during dining room service. The plan is for the Dietitian and/or designee to educate all nursing staff on the proper procedure for removing food off trays and positioning properly in front of resident while in dining rooms to promote a home like experience. D.Dietitian and/or designee will audit communal meal service daily until 100% compliance is achieved with meals being removed from trays for 3 consecutive days. Random audits will continue once	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 584	Continued From page 29	F 584	weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once compliance is met, the deficient practice will be considered resolved. Audit results will be reviewed by the Quality Assurance Committee.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and clinical record review, it was determined that for one (R104) out of 36 Residents sampled for care plan review, the facility failed to ensure that the MDS assessment accurately reflected the residents status. Findings include: Cross-refer F692. Review of R104's clinical record revealed the following: 8/8/14 - R104 was admitted to the facility. January - November 2021 - In a review of R104's orders there was no order for a prescribed weight-loss regimen or diet. 10/19/21 - The Annual MDS Assessment documented that R104 had a significant weight loss, but was on a physician-prescribed weight-loss regimen.	F 641	F641 Accuracy of Assessment A.R104 was not adversely impacted by the deficient practice. The residents MDS was corrected. B.All residents who lose weight in the facility have the potential be miscoded on MDS. An audit was completed of all MDS□s completed in the previous month to identify potential coding errors. No errors identified. C. Root cause analysis determined no orders were prescribed for weight loss regimen or diet. The plan is to assure orders are prescribed and the facility RNAC and Dietician will now review and discuss MDS coding completed by the Dietician to ensure accuracy in coding. D.Corporate RNAC or designee will	1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 641	Continued From page 30 11/5/21 11:06 AM - During an interview, E19 (NP) confirmed that R104 does not have a prescribed weight-loss program, does not need to lose weight and "She has never expressed to me that she wants to lose weight." Findings were reviewed with E1 (NHA) and E2 (DON) on 11/9/21 during Exit Conference, beginning at 2:30 PM.	F 641	conduct random selection audits of 3 MDS assessments to ensure they capture accurate weight loss assessments. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for three consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. The audit results will be reviewed by the Quality Assurance Committee.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 655	Continued From page 31 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R106 and R409) out of three (3) newly admitted residents reviewed, the facility failed to ensure that the baseline care plan was developed within 48 hours of the resident's admission and failed to have evidence that the resident was provided the baseline care plan summary. Findings include: 1. Review of R106's record review revealed: 10/14/21 - R106 was admitted to the facility. 10/14/21 12:57 AM - The Baseline Care Plan document included names of E11 (Dietician), E12	F 655	F655 Baseline Care Plan 1. A.R106 was not negatively impacted by deficient practice. The family and resident received a copy of the plan of care. B.All newly admitted residents have the potential to be impacted by this deficient practice. A baseline care plan compliance audit was completed on all residents admitted within the last 30 days to ensure compliance. All residents baseline care plans will be initiated timely, dated, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 655	Continued From page 32 (Rehabilitation Director), and E18 (RN UM), however, there was lack of evidence of the date when the baseline care plan was completed by these staff members. In addition, the document indicated that the baseline care plan was provided to R106's spouse, however, there was lack of evidence when the summary was provided to the spouse. 11/3/21 2:45 PM - An interview with R106 revealed that she has not received a baseline care plan summary. 11/3/21 3:30 PM - An interview with E18 (RN UM) revealed that the facility's expectation was to complete the baseline care plan within 48 hours after the resident's admission to the facility. In addition, to provide the summary to the resident and if applicable, to the resident's designated representative. E18 confirmed that the above baseline care plan document did not include when the baseline care plan was completed. In addition, E18 was unable to provide a reason for R106 not being provided the summary. 2. Review of R409's record review revealed: 10/30/21 - R409 was admitted to the facility. 10/30/21 6:32 PM - The Baseline Care Plan document included names of E11 (Dietician), E12 (Rehabilitation Director), and E18 (RN UM), however, there was lack of evidence of the date when the baseline care plan was completed by these staff members. In addition, the document indicated that R409 received the baseline care plan summary, however, there was lack of evidence of the date in which R409 was provided these documents.	F 655	signed by the resident. All residents will receive a copy of the baseline care plan. C. Root cause analysis determined that the facility failed to provide the resident with a copy of the baseline care plan. The DON or designee will educate the IDT team on the importance of thorough documentation of the Baseline care plan to include the date it was completed. A copy of the baseline care plan will be given to the resident and a signed copy will be scanned into the resident□s medical record. In cases where resident is not able to comprehend, a copy will be provided to the Responsible party. A signed copy will be maintained in the resident record. D.The DON or designee will randomly audit new admissions baseline care plans. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance achieved for three consecutive months. Then, the deficient practice will be considered resolved. All audit results will be reviewed by the Quality Assurance Committee. 2. A.F409 was not negatively impacted by deficient practice. F409 has since been discharged from the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 655	Continued From page 33 11/3/21 9:30 AM - An interview with R409 revealed that he has not received a baseline care plan summary since admission. 11/3/21 10 AM - During an interview with E18 (RN UM), E18 revealed that R409 was provided the baseline care plan summary on 11/2/21. During this interview, the Surveyor verbalized to E18 that R409 stated that he has not received the baseline care plan summary. E18 stated that she will follow-up with R409. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/9/21 during the Exit Conference, beginning at 2:30 PM.	F 655	B.All newly admitted residents have the potential to be impacted by this deficient practice. A baseline care plan compliance audit was completed on all residents admitted within the last 30 days to ensure compliance. All residents baseline care plans will be initiated timely, dated, and signed by the resident. The residents will receive a copy of the baseline care plan. C. Based on the root cause analysis it was determined that the facility failed to provide the resident with a copy of the baseline care plan. The DON or designee will educate the IDT on the importance of thorough documentation of the Baseline care plan to include the date it was complete and provided to the resident. A copy of the baseline care plan will be given to the resident and a signed copy will be scanned into the resident□s medical record. In cases where resident is not able to comprehend, a copy will be provided to the Responsible party. A signed copy will be maintained in the resident record. D.The DON or designee will randomly audit new admissions baseline care plans. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance achieved for 3 consecutive months. Then, the deficient practice will be considered resolved. All	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 655	Continued From page 34	F 655	audits will be reviewed by the Quality Assurance Committee.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 656	Continued From page 35 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that, for two (R72 and R160) out of 36 residents sampled for care plan review, the facility failed to develop and implement a comprehensive person-centered care plan. Findings include: Cross refer F684, Example #1. 1. Review of R160's clinical record revealed the following: 4/21/21 - R160 was admitted to the facility with multiple diagnoses including anemia. 4/29/21 - A Physician's Order was written for blood work for an indication for anemia. 11/8/21 4 PM - An interview with E18 (RN UM) confirmed that she was unable to locate a care plan for anemia. Cross-refer F677. 2. Review of R72's clinical record revealed: 9/22/21 - R72 was admitted to the facility. 9/29/21 - The Admission MDS Assessment documented that R72 was moderately impaired	F 656	F656 Develop/Implement Comprehensive Care Plan 1. A.R160 was not negative impacted by deficient practice. R160 has been discharged from the facility, therefore care plan was not updated. B.All residents who have a diagnosis of Anemia have the potential to be affected by this deficient practice. A facility wide audit was completed to ensure that all residents with an anemia have a corresponding care plan. C. The root cause analysis determined that the facility failed to complete a comprehensive care plan that included Anemia. MDS Coordinator received additional education by Corporate RNAC on the importance of ensuring comprehensive care plans are in place for all active conditions. D.The DON or designee will randomly audit 3 care plans for residents with anemia. The audits will be performed daily or until 100% compliance is achieved for 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 656	Continued From page 36 for daily decision making, was independent with eating, however, relied on staff to set-up her meals. 11/1/21 12:51 PM - The Surveyor notified E18 (RN UM) that R72 requested assistance of staff to cut her meat and E18 confirmed that R72 required set-up for her meals, which would include cutting the meat. 11/2/21 4 PM - An interview with E18 (RN UM) confirmed that she was unable to locate a care plan for activities of daily living which included that R72 required set-up of her meal. E18 stated she will check with E3 (ADON). 11/3/21 10:46 AM - An interview with E2 (DON) revealed that his understanding was that R72 was independent with eating and was currently receiving therapy services. At the conclusion of this interview, the Surveyor requested the facility's evidence of a comprehensive care plan for activities of daily living, which included that R72 required set-up of her meal to eat. No further information was provided during the survey. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/9/21 during Exit Conference, beginning at 2:30 PM.	F 656	consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance achieved for 3 consecutive months. At that point, the deficient practice will be considered resolved. All audit results will be reviewed by the Quality Assurance Committee. 2. A.R72 was not negatively impacted by deficient practice. R72□s care plan was updated to include a care plan for activities of daily living which included that R72 requires set-up for meals. B.All residents who require assistance with feeding have the potential to be affected by this deficient practice. All residents who require assistance with feeding were reviewed to ensure that the assistance required with meals was listed on the care plan. C. The root cause analysis determined that the facility failed to update the residents care plan to include ADL's. MDS coordinator received additional education from the Corporate RNAC on the importance of ensuring a comprehensive care plan is in place for meal set up when assistance is needed. The facility will now add meal assistance to the ADL care plan. D.The DON or designee will randomly audit 3 care plans for residents that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 656	Continued From page 37	F 656	require assistance with feeding. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance achieved for 3 consecutive months. At that time, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 657	Continued From page 38 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to review and revise the care plan for two (R99 and R104) out of 36 residents sampled for care plan review. For R99, the facility failed to revise the fluid restriction amount of 1,200 ml per day, as ordered on 10/8/21. The facility failed to revise R104's nutrition care plan for prescribed weight loss program and failed to ensure the required interdisciplinary team members (Attending Physician or designee and the CNA with responsibility for the Resident) provided input for the comprehensive care plan. Findings include: Cross refer F684, Example #2. 1. Review of R99's clinical record revealed the following: 10/7/21- R99 was readmitted to the facility and was on hemodialysis (procedure that removes waste and extra fluid from the body through the blood) due to kidney disease. 10/8/21 - A Physician's Order was written for a 1,200 ml per day fluid restriction with 720 ml from dietary and 480 ml from nursing. 10/13/21 (Last revision date) - The care plan for fluid restriction included interventions to encourage food intake and fluid intake up to the fluid restriction of 1,500 ml per day.	F 657	F657 Care Plan Timing and Revision 1. A.R99 was not adversely impacted by the deficient practice. The care plan was immediately corrected. B.All residents with fluid restrictions have potential to be impacted by deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in section C. C. The root cause analysis revealed that the facility failed to update the fluid restriction care plan. All residents who require fluid restrictions were reviewed to ensure that a care plan was present and updated per the Physician prescribed fluid restriction. The MDS coordinator was educated by the cooperate RNAC on the importance of ensuring an updated care plan is in place for all active conditions. D.Facility RNAC or designee will conduct random select 3 care plans for residents with fluid restriction orders. The audits will be performed daily or until 100% compliance is achieved for 3 days. Random audits will continue once weekly or until 100% compliance is achieved for 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 657	Continued From page 39 There was lack of evidence that the facility reviewed and revised the above care plan, thus, they failed to revise the fluid restriction amount to 1,200 ml per day, as ordered on 10/8/21. 11/9/21 10:45 AM - An interview with E18 (RN UM) confirmed that the above care plan failed to include the 1,200 ml fluid restriction. 2. Cross-refer F692. Review of R104's clinical record revealed the following: 8/8/14 - R104 was admitted to the facility. a. Lack of Care Plan Revision: 4/1/21 (last revised) - A care plan was initiated on 2/26/20 that R104 "Maintains nutrition and hydration on a therapeutic diet d/t [due to] elevated blood sugar and hx [history] of CHF [congestive heart failure] with the goal of weight loss." "An intervention was initiated on 3/3/20 for "Resident is on a planned weight change program (safe weight loss of 1-2# per week to resident goal of 150#)", but it has not been revised. 10/19/21 - The Annual MDS Assessment documented that R104 had a significant weight loss, but was on a physician-prescribed weight loss regimen. R104 was cognitively intact for decision making. 11/5/21 11:06 AM - During an interview, E19 (NP) confirmed that R104 does not have a prescribed weight-loss program, does not need to lose weight and "She has never expressed to me that she wants to lose weight."	F 657	consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once practice will be considered resolved, all audits will be reviewed by the Quality Assurance Committee. 2a A.R104 was not adversely impacted by the deficient practice. B.All residents with weight loss goals have the potential to be impacted by deficient practice. C. The root cause analysis revealed that the facility failed to update the residents care plan to reflect the residents current nutritional status. All residents with a goal of weight loss will be reviewed to ensure care plans are revised, and physician□s order is present as appropriate. MDS Coordinator was educated by Corporate RNAC to validate physician orders are present and supportive of care plan revisions. D.Cooperate RNAC or designee will conduct random selection audits of 3 MDS assessments to ensure they capture accurate weight loss assessments. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 657	Continued From page 40 b. Input into the Care Plan by the required interdisciplinary team members: 11/5/21 8:55 AM - During an interview when reviewing R104's Care Conference notes, E29 (SSA) confirmed that E11 (RD) has not attended the meetings and she obtains the nutrition information for the notes from E11's notes, not direct verbal communication. When asked if input was obtained from the Physician or CNA, E29 stated the Unit Manager was responsible for obtaining their input for the care plan. 11/5/21 9:30 AM - During an interview, E32 (CNA) stated that she was aware of the care plan meetings and has never been asked for input about her residents. E32 added that she thinks they use the information she documents in the chart about residents for the care plans. 11/5/21 9:50 AM - During an interview, E34 (CNA) said she has never attended any care plan meetings or been asked for input. 11/5/21 10:20 AM - During an interview, E31 (RN UM) stated that she obtains input for the care plan meetings by reviewing the physician notes and orders, reviewing the CNA documentation, and asking the CNAs and Nurses for any updates, but confirmed that this input was not specifically documented. 11/5/21 11:06 AM - E19 stated that she had not attended any of R104 care plan meetings since she began working at the facility in January of 2021, but she does attend some residents' meetings who are having concerns or a family requests.	F 657	consecutive months. Once 100% compliance is met, the deficient practice will be reviewed by the Quality Assurance Committee. 2b A.R104 was not adversely impacted by deficient practice. B.All residents that have a care plan meeting have the potential to be impacted by deficient practice. C. The root cause analysis revealed that the appropriate disciplines were not attending care plan meetings as required. Facility dietitian is now required to attend all care plan meetings and to ensure that Nurse Practitioner (NP) or Physician inputs related to nutrition is congruent with resident goals and related to resident, and or POA during care plan meetings. The dietitian has been educated as to her role related to nutrition updates and nurse practitioner or physician inputs. D.DON or designee to audits attendance sheets from care plan meetings to assure dietitian presence, physician/ Nurse practitioner and assigned certified nursing assistance. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Random audits will continue monthly or until 100% compliance is achieved for 3 consecutive months. Once	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 657	Continued From page 41 The facility failed to update R104's nutrition care plan and include input from R104, E19 (NP), and E28 (MD) in the plan of care and goals. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/9/21 during Exit Conference, beginning at 2:30 PM.	F 657	100% is met, the deficient practice will be reviewed by the Quality Assurance Committee.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and clinical record review, it was determined that the facility failed to provide the necessary services for one (R72) out of five (5) sampled residents dependent with activities of daily living. Findings include: Cross-refer F656, Example #2. Review of R72's clinical record revealed: 9/22/21 - R72 was admitted to the facility. 9/29/21 - The Admission MDS assessment documented that R72 was moderately impaired for daily decision making, was independent with eating, however, she relied on staff to set-up her meals. 11/1/21 12:50 PM - During a random lunch meal observation, R72 was in her room and verbalized that she was not able to cut her mushroom swiss steak.	F 677	F677 ADL Care Provided for Dependent residents A.R72 was not adversely impacted by this deficient practice. R72 was immediately assisted with her meal. B.All residents that require set-up assistance with meals have the potential to be impacted by this deficient practice. A facility wide audit was completed to assure that all resident meal preparation needs are accurately documented and entered onto the resident Kardex in the electronic medical record. C. The root cause analysis revealed that the facility failed to communicate residents needs to CNA's. CNA□s will be in-serviced by the staff educator on reviewing the Kardex for all residents on their assignment to understand ADL	1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 677	Continued From page 42 11/1/21 12:51 PM - The Surveyor notified E18 (RN UM) that R72 requested assistance of staff to cut her meat and E18 confirmed that R72 required set-up for her meals, which would include cutting meat. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/9/21 during the Exit Conference, beginning at 2:30 PM.	F 677	assistance required for meal set up prior to providing care. Unit Managers will be in-serviced by the staff educator to enter orders related to meal prep on the resident Kardex so that CNA□s are aware of assistance required. D.DON or designee to audit residents that require assistance with eating to ensure care plan and Kardex are updated and that residents are receiving the assistance with meals that they require. 5 audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Random audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. The audit results will be reviewed by the Quality Assurance Committee.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 684	Continued From page 43 Based on record review, interview, and review of the facility's policy and procedure, it was determined that the facility failed to ensure that three (R99, R104, and R160) out of 27 residents reviewed for care areas. R160 had a history of anemia and the facility failed to ensure that the laboratory tests ordered were performed. For R99 and R104, the facility failed to monitor fluid restrictions. Findings include: Cross refer F656, Example #1. LABORATORY TEST: 1. Review of R160's clinical record revealed the following: 4/21/21 - R160 was admitted to the facility with multiple diagnoses including anemia. 4/29/21 - A Physician's Order was written for blood work, a Complete Blood Count (CBC) for an indication for anemia. 5/3/21 - A review of the Treatment Administration Record lacked evidence that the CBC was completed as ordered. 11/08/21 1:54 PM - An interview with E3 (ADON) confirmed that the facility had no evidence that the CBC was completed as ordered on 5/3/21. FLUID RESTRICTIONS: The facility policy titled Fluid Restriction, with a revision date of 1/11/21, stated that the Dietary and Nursing departments would work together to ensure compliance with the Practitioner's order for fluid restrictions.	F 684	F684 Quality of Care 1. A.R160 was not adversely impacted by this deficient practice. R160 no longer resides in the facility. B.All residents who receive orders for labs have the potential to be adversely affected by this deficient practice. A facility wide audit was completed to ensure that all labs ordered in the previous week had been obtained with results available. C.Staff Educator will provide education to all Unit Managers and Shift Supervisors on completion of recurrent labs to ensure all ordered labs are to be checked during the shift. A facility wide was conducted and it was determined that the facility did not have a system in place to assure that all ordered labs were drawn with results reported. Going forward, all supervisors/unit managers will run the daily lab report in point click care for ordered labs and match the orders with the lab results obtained to assure each lab ordered has an associated lab result. D.DON or designee to audit 24 hour chart checks to ensure ordered labs are completed and results received. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Random audits will continue once	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 684	Continued From page 44 Cross refer F657, Example # 1. 2. Review of R99's clinical record revealed the following: 10/7/21- R99 was readmitted to the facility and was on hemodialysis due to kidney disease. 10/8/21 - A Physician's Order was written for a 1,200 ml per day fluid restriction with 720 ml from dietary and 480 ml from nursing. 10/13/21 (Last revision date) - The care plan for fluid restriction included interventions to encourage food intake and fluid intake up to fluid restriction of 1,500 ml per day (this was an inaccurate amount as the 10/8/21 order indicated 1,200 ml per day). 10/9/21 through 11/3/21 - Review of the Treatment Administration Record by Licensed Nursing Staff consistently documented that R99 was administered the ordered fluids per shift for a total of 480 ml per day. Review of the CNA documents titled Nutrition-Fluids documented varied amounts per shift. The Surveyor totaled the two amounts documented on the above records which revealed that for eight out of 26 days, R99 exceeded the 1,200 ml restriction. The amounts exceeding the restriction were as follows in ml; 1,660, 1,260, 1,500, 1,660, 1,400, 1,560, 1,360, and 1,320. There was lack of evidence that the facility was monitoring R99's fluid restriction on an ongoing daily basis. 11/4/21 1:35 PM - An interview with E11 (RD)	F 684	monthly or until 100% compliance is achieved for 3 consecutive months. Once 100% is met, the deficient practice will be considered resolved. The results will be reviewed by the Quality Assurance Committee. 2. A.R99 was not adversely impacted by this deficient practice. R99 no longer residents in the facility. B.All residents who have a fluid restriction order have the potential to be affected by this practice. All residents on fluid restriction were audited to ensure accurate documentation. Future residents will be protected from this deficient practice by taking the corrective action outlined below in Section C. C. A facility wide audit was conducted, and it was determined that the facility did not have a system in place to accurately monitor a resident□s intake while on a physician ordered fluid restriction. Going forward, the assigned nurse will be responsible for monitoring and measuring fluid intake while on a fluid restriction and documenting on the medication administration record each shift. The monitoring will include all fluids given on the meal tray and any fluid given during the medication pass. All licensed nurses will be educated by the staff educator on the new process for monitoring fluid restrictions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 684	Continued From page 45 revealed that she was not monitoring R99's fluid restriction and it was her understanding the Nursing Department was responsible for monitoring the compliance with fluid restrictions. 11/4/21 3 PM - An interview with E18 (RN UM) revealed it was her understanding that the Dietary Department would monitor the fluid restriction compliance. The Surveyor and E18 totaled the 24 hours fluids taken by R99 from 11/1/21 through 11/3/21 and E18 confirmed that R99 exceeded his restrictions on 11/3/21 by 120 ml and E18 was not aware until the Surveyor totaled the intake. E18 revealed that she was uncertain who was responsible to monitor R99's fluid restriction compliance. Cross refer F692. 3. Review of R104's clinical record revealed the following. 8/8/14 - R104 was admitted to the facility. 1/5/21 - A Physician's Order was written for a 2,000 ml per day fluid restriction with 1,320 ml from dietary (divided by meal as 360 ml breakfast, 480 ml lunch, 480 ml dinner) and 680 ml from nursing (divided by shift as 7-3: 270 ml, 3-11: 270 ml, 11-7: 140 ml). 1/6/21 - A Physician's Order was written for CHF (congested heart failure) Protocol. 10/19/21 - The Annual MDS Assessment documented that R104 had a BIMS score of 14 indicating she was cognitively intact. 11/1/21 4:59 PM - During an interview, R104	F 684	D.DON or designee will audit all residents on a physician ordered fluid restriction to assure that each resident is not exceeding the amount of allowed fluid. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Random audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% is met, the deficient practice will be considered resolved. Results will be reviewed by the Quality Assurance Committee. 3. A.R104 was not adversely impacted by this deficient practice. R104□s fluid restriction documentation was reviewed. B.All residents who have a fluid restriction order have the potential to be affected by this practice. All residents on fluid restriction were audited to ensure accurate documentation. Future residents will be protected from this deficient practice by taking the corrective action outlined below in Section C. C.A facility wide audit was conducted, and it was determined that the facility did not have a system in place to accurately monitor a resident□s intake while on a physician ordered fluid restriction. Going forward, the assigned nurse will be responsible for monitoring and measuring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 684	Continued From page 46 stated, "I stated my heart doctor put me on a fluid restriction, and they [the staff] split it up for me for each shift. I'm always so thirsty, I beg for drinks and the nurses give me extra sometimes." 11/5/21 9:25 AM - During an interview with R104's regular CNA, E30 stated that when R104 goes into the bathroom to brush her teeth she takes a cup and drinks as much water out of the facet as possible. 11/5/21 9:45 AM - During an interview with R104's regular day shift nurse, E35 (LPN) stated that she signs off on the TAR (Treatment Administration Record) that R104 got only the amount of fluids ordered for each shift and if she wants more, she can have ice chips (that are not accounted for on the intake amounts). When asked if R104 was compliant with her fluid restriction, E23 said no, and we try to educate her on how important it is because of her CHF and edema (swelling), but we do not account for the fluid intake from ice chips or the amount she drinks when noncompliant. 11/5/21 10:20 AM - During an interview, E31 (RN UM) was asked where the total intake was documented for each day/24 hours so staff can monitor if R104 was following her fluid restriction (2,000 ml a day). E31 stated there was not a daily total documented, but the CNAs document the fluids R104 drinks at each meal and her meals are served with only the allowed amounts. E31 added that the nurses document that E104 received the allowed amount of fluids each shift on the TAR. When reviewing the Treatment Administration Record (TAR) with E31, she confirmed that the nurses are only signing that R104 received the exact amount of fluids ordered	F 684	fluid intake while on a fluid restriction and documenting on the medication administration record each shift. The monitoring will include all fluids given on the meal tray and any fluid given during the medication pass. All licensed nurses will be educated by the staff educator on the new process for monitoring fluid restrictions. D.DON or designee will audit all residents on a physician ordered fluid restriction to assure that each resident is not exceeding the amount of allowed fluid. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Random audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% is met, the deficient practice will be considered resolved. The audit results will be reviewed by the Quality Assurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 684	Continued From page 47 per shift assigned to nursing (7-3: 270 ml, 3-11: 270 ml, 11-7: 140 ml), but does not account for R104 drinking more or less than this amount and there is no place to keep a running tally of intake throughout the shift. In addition, E31 explained that R104 frequently sneaks and hoards fluids, but these are not accounted for as intake, but the CNA's document on a behavioral form "Drinking water from the bathroom sink or requesting water from staff on other units." E31 said that the staff on other units call her when R104 asks for water and E31 will offer her ice chips or candy. There was lack of evidence that the facility was monitoring R104's fluid restriction on an ongoing basis. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/9/21 during Exit Conference, beginning at 2:30 PM.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to ensure that the resident environment remained free of accident hazards for one (R64) resident out of six residents	F 689	F689 Free of Accident hazards/Supervision/Devices A.R64 was not adversely impacted by this deficient practice. Immediately upon being	1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 689	Continued From page 48 sampled for accidents. Findings include: Review of R64's clinical record revealed: 10/6/20 - R64 was admitted to the facility. 9/28/21 - A Quarterly MDS assessment documented that R64 had a BIMS (Brief Interview for Mental Status) score of 14 indicating she was cognitively intact and needed only supervision of staff for bed mobility, transfers from bed to wheelchair, and locomotion on and off the unit. 11/5/21 9:40 AM - During a random observation, R64 was heard telling E40 (Maintenance) that since her right upper bed rail was removed, her mattress slides to the right and she must frequently ask staff to readjust it. E40 was then observed notifying E35 (LPN) of this information, but the slipping mattress was not addressed by staff. 11/8/21 8:30 AM - During an interview and observation with E3 (ADON), R64 showed us how her mattress has been sliding to the right side, she has had to stuff a pillow between the left side rail and mattress to fill in a five-inch gap created by the mattress sliding, and how when she transfers from bed to her wheelchair, her legs rub on the exposed left bed frame. R64 stated she has told many staff because she asks staff to readjust her mattress frequently. E3 said he will have a Dycem Non-Slip grip (grips on both sides to prevent movement) put under mattress. The facility failed to address the sliding mattress until the Surveyor showed E3 three days after the rails were removed on 11/5/21.	F 689	notified by the surveyor,Dycem was applied under the mattress to prevent the mattress from movement. B.All residents have the potential to be impacted by this deficient practice. A random audit was completed to ensure there were no other issues with mattress slipping. Future residents will be protected by this deficient practice by taking the corrective actions outlined in section C. C. The root cause analysis revealed that beds were not being routinely assessed. Staff Educator will provide education to all staff on how to enter Maintenance work orders through the TELS system and the subsequent procedure to alert maintenance to a potential issue with a mattress. D.Director of Maintenance or designee will audit all beds and mattresses for potential hazards and work orders in the TELs system to ensure orders are entered as required. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Random audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% is met, the deficient practice will be considered resolved. The results will be reviewed by the Quality Assurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 689	Continued From page 49 Findings were reviewed with E1 (NHA) and E2 (DON) on 11/9/21 during Exit Conference, beginning at 2:30 PM.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R104) out of six residents for nutrition review, the facility failed to identify and reassess R104 who had a significant weight loss. Findings include: Cross-refer F641 and F657. Review of R104's clinical record revealed the	F 692	F692 Nutrition/Hydration Status Maintenance A.R104 was not adversely affected by this deficient practice. The RD completed a nutritional assessment on the resident to assess weights. B.All residents with weight loss have the	1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 692	Continued From page 50 following: 8/8/14 - R104 was admitted to the facility. January - November 2021 - In a review of R104's physician orders there was no order for a prescribed weight-loss regimen or diet. 1/5/21 (Last diet order) - Concentrated Carbohydrate Diet, No added salt diet, regular texture, thin consistency. 4/1/21 (last revised) - A care plan was initiated on 2/26/20 that R104 "Maintains nutrition and hydration on a therapeutic diet d/t [due to] elevated blood sugar and hx [history] of CHF [congestive heart failure] with the goal of weight loss." 10/19/21 - The Annual MDS (Minimum Data Set) Assessment documented that R104 was cognitively intact for decision making and had a significant weight loss, but incorrectly documented she was on a physician-prescribed weight-loss regimen. The significant weight loss of 10.8% in the last six months was from a weight of 205 lbs. on the 4/27/21 quarterly MDS to 185 lbs. on the 10/19/21 annual MDS. 11/1/21 4:59 PM - During an interview, R104 revealed "I stated last week they [facility staff] told me I lost 11 pounds. I'm not sure why I'm losing weight. I do have Therapy cause I'm trying to walk again. After I had COVID last year I lost my ability to walk." 11/3/21 1:00 PM - During an interview, E11 (RD) stated that she has not discussed a weight loss goal with R104 since she started working at the	F 692	potential to be impacted by this deficient practice. A random audit of resident weights was completed to ensure accurate follow up on weight changes. Future residents will be protected by this deficient practice by taking the corrective action outlined in Section C. C. The root cause analysis revealed that the facility failed to re assess the resident when significant weight loss was identified. Corporate dietician will educate facility Dietician on adequate follow up on weight loss. All residents with weight loss will now be reviewed in the weekly high risk meeting to ensure accurate follow up. D.DON/ Designee will audit a random selection of resident weights to ensure proper follow up on weight loss. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Random audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% is met, the deficient practice will be considered resolved. The audit results will be reviewed by the Quality Assurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 692	Continued From page 51 facility (about a year ago), and the goal of 150 lbs. was entered into the care plan by the previous Registered Dietician. In addition, E11 stated that she had not attended any of R104 care plan meetings. 11/5/21 11:06 AM - During an interview, E19 (NP) confirmed that R104 does not have a prescribed weight-loss program, does not need to lose weight and "She has never expressed to me that she wants to lose weight." E19 added that, in the beginning of 2021, R104 complained of fatigue, lab tests showed she needed a thyroid supplement, and that since this medication was added she has been losing weight. After reviewing documentation that R104 usually eats 100% of her meals, E19 stated that R104 has been taking in sufficient nutrients and calories to meet her needs. There was no evidence that R104 was on a prescribed weight-loss program. There was no evidence that the facility assessed R104's significant weight loss identified on 10/19/21. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/9/21 during Exit Conference, beginning at 2:30 PM.	F 692		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 761	Continued From page 52 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and observations, it was determined that the facility failed to discard expired medications from one out of three medication carts that were reviewed for medication storage. Findings include: 11/05/21 9:15 AM - 9:36 AM - Review of Medication Cart 3 with E17, (RN) revealed: - R34's Humalog injection (insulin) had the date: "10/5/2021" handwritten on the medication packaging. E17 confirmed that the medication should have been discarded based on instructions written on the packaging to "discard after 28 days." - R262's Humulin Injection (insulin) had no open date written on the medication, therefore the expiration of the insulin could not be confirmed.	F 761	F761 Label/Store Drugs and Biologicals A.R34 and R262 were not adversely affected by this deficient practice. Immediately upon being notified of this deficient practice, and expired medications were discarded. B.All residents have the potential to be adversely affected by this deficient practice. All medication carts and rooms were audited to ensure that no other items were expired. Future residents will be protected by this deficient practice by the actions outlined below in section C. C.The Staff Educator will provide education to nursing staff on proper drug storage and assuring expired medications	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 761	Continued From page 53 - Multiple packs of protein powder were stamped "use by April 7, 2021 and use by January 31, 2021." E17 confirmed the protein powder was expired and it will be discarded. Interview with E17 (RN) confirmed that the facility's practice is to discard and reorder new supplies from the pharmacy when expired items are located. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/9/21 during the Exit Conference, beginning at 2:30 PM.	F 761	are destroyed. A root cause analysis was conducted, and it was determined that the facility did not have an audit program in place to review all medication carts for expired medications. The Unit Manager for each unit will be responsible for assuring the medication carts are reviewed for expired medications. D.The Unit managers or designee will audit the medication room and medication carts to ensure all expired medications are removed timely and labelled properly. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Random audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% is met, the deficient practice will be considered resolved. The audit results will be reviewed by the Quality Assurance Committee	
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	F 791		1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 791	Continued From page 54 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 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 observation, interview, and record review, it was determined that for one (R91) out of four sampled residents reviewed for dental, the facility failed to assist R91 in obtaining dental services. Findings include:	F 791	F791 Routine/Emergency Dental Srvcs in NFs A:R91 was not adversely affected by this deficient practice. However, there was potential for an adverse effect due to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 791	Continued From page 55 Review of R91's clinical records revealed the following: The facility's policy entitled, "Dental Services Available to Residents", effective 6/2013 and last revised on 2/25/21, included, "Social Services/Nursing is responsible for making necessary dental appointments...all requests for routine and emergency dental services are initially directed to Social Services to ensure that appointments are made timely." 1/8/21 - R91 was admitted to the facility. 10/12/21 - A Quarterly MDS assessment revealed no dental concerns. 10/19/21 - R91 had a physician's order for a dental consult to evaluate and treat her bottom dentures. 11/121 at 1:27 PM - During an interview, R91 revealed that she was never seen by the dentist since her admission in January 2021. R91 also stated that she would like to have her bottom dentures made so she can eat and bite corn on a cob again. 11/8/21 at 9:05 AM - In an interview, E8 (SW) revealed referrals usually come from the nursing department for residents that need dental consults. E8 confirmed that R91 was not on her list to be seen by the dentist. 11/8/21 at 9:15 AM - During an interview, E25 (RN UM) revealed that she saw R91 for her quarterly dental assessment on 10/12/21. E25 further revealed that R91 was on the list for a dental consult referral and R91's need for bottom	F 791	R91s missing lower denture. Resident□s weights and intake did not decline. Dental appointment was made upon identification of this deficient practice. B: All residents have the potential to be adversely affected by this deficient practice. A facility wide audit was completed to ensure that all other residents with dental issues have been referred to the dentist. Future residents will be protected by this deficient practice by the actions outlined below in section C. C: The root cause analysis revealed that there was a breakdown in communication between the Unit Manager and Social Services Director regarding request for dental services. Staff educator/designee will educate nursing staff and Social Services on timely dental referral and appointment setup. All dental issues will now be reviewed in the weekly high risk meeting to ensure residents nutritional needs are met and timely referral to dentist. D: Unit Managers/designee to audit residents with Complaints about Dental and Oral Care Concerns. The audit will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 791	Continued From page 56 dentures. 11/8/21 at 9:25 AM - E25 confirmed that the facility lacked evidence that R91's dental consult referral for treatment and evaluation of her bottom dentures was forwarded to the Social Worker for an appointment set up after the need was identified by the Surveyor. 11/8/21 at 10:05 AM - Findings were discussed with E2 (DON). Findings were reviewed with E1 (NHA) and E2 on 11/9/21 during Exit Conference, beginning at 2:30 PM.	F 791	audits will be reviewed by the Quality Assurance Committee.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 812	Continued From page 57 by: Based on observations and interviews, it was determined that the facility failed to ensure that food was stored, prepared, and served in a sanitary manner. Findings include: The following were revealed during the initial kitchen tour on 11/1/21 from 8:45 AM to 9:20 AM: - The ice machine scoop holder was dirty; - The Microwave interior was dirty; - The red sani bucket had no sanitizer; - The walk-in refrigerator box had rotten tomatoes; - The walk-in refrigerator had mold/dirt on the cart cover and the laminate paper; - The walk-in refrigerator had no date marked on shredded cheese and lettuce; - The turkey had a date label over 8 days old. Findings were reviewed and confirmed with E27 (Food Service Director) on 11/1/21 at approximately 9:30 AM. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/9/21 during Exit Conference, beginning at 2:30 PM.	F 812	F812 Food Procurement, Store/Prepare/ Serve-Sanitary A.No residents were adversely affected by the deficient practice. The ice machine scoop holder and microwave were cleaned and sanitized immediately, the red sanitizer bucket was disposed of immediately, the rotten tomatoes were discarded, and the remaining tomatoes were placed in a plastic container and dated, the mold on the laminate paper in the refrigerator was discarded, shredded cheese and lettuce were dated, sliced turkey with no label/date was discarded. B.All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in section C. C. The root cause analysis revealed that staff failed to follow protocols for proper food storage, dating and labeling, sanitizing of equipment and proper use of red sanitizer buckets. All Dietary staff will be in-serviced by the Food Service Director and/or designee on Labeling and Dating of Refrigerated Foods. Green buckets were purchased to be used for cleaning solutions and red buckets are to be used for sanitizing solutions. The ice machine scoop / holder, refrigerators, and microwave are now on a weekly cleaning schedule. All fresh produce will be inspected upon delivery by the Food Service Director and monitored daily. Cart	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	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 812	Continued From page 58	F 812	covers and laminated paper will no longer be used in the refrigerators to eliminate mold. D.The Food Service Director and/or designee will audit the cleanliness of all kitchen equipment, refrigerators, labeling and dating of foods, and sanitation solutions. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is achieved, the deficient practice will be considered resolved. Audit results will be reviewed at the Quality Assurance Committee.	