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

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

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Broadmeadow **DATE SURVEY COMPLETED: September 23, 2026**

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 complaint survey was conducted at this facility on September 23, 2026. The deficiencies contained in this report are based on observations, interviews, reviews of residents' clinical records, and reviews of other facility documentation as indicated. The facility census on the first day of the survey was 112 (one hundred-twelve). The investigative sample totaled 3 (three) residents		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS-2567-L survey completed September 23, 2026: F609 & F805.		

Provider's Signature Laurel Saunders Title NHA Date 10/13/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	500 SOUTH BROAD STREET , MIDDLETOWN, Delaware, 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
F0000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility on September 23, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The facility census on the first day of the survey was 112. The investigative sample totaled 3 residents. Abbreviations/definitions used in this report are as follows: ALS- Advanced Life Support EMS- Emergency Medical Service; Non- ST Elevation (NSTEMI) myocardial infarction- Heart Attack; Methicillin-Susceptible Staphylococcus Aureus Infection- Bacterial infection.	F0000		
F0805 SS = J	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and review of other pertinent records, it was determined that for one (R1) of three residents reviewed for therapeutic diet, the facility failed to provide food in a form designed to meet R1's individual needs. R1 was admitted to the facility on September 18, 2026, with an order for a regular diet with puréed texture and thin-liquid consistency. Despite the puréed-texture order, R1 was served a regular-texture meal tray on Sept 19, 2026. After consuming food from the tray,	F0805	"Past Noncompliance - no plan of correction required"	10/13/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0805 SS = J	Continued from page 1 R1 reported food lodged in his throat and vomited while attempting to clear his airway. EMS (Emergency Medical Services) was activated, and R1 was transported to the emergency department for evaluation. The facility's failure to ensure R1 received food in the ordered puréed texture resulted in R1's choking, which could likely result in airway obstruction, aspiration, respiratory compromise, hospitalization, and/or death. Immediate Jeopardy was initiated on September 19, 2026, and abated on September 22, 2026, after the facility implemented corrective actions that were verified by the survey team. Findings include: Review of R1's clinical record revealed: 9/18/26- R1 was admitted to the facility with diagnoses including, but not limited to, Non-ST elevation (NSTEMI) myocardial infarction (Heart Attack), retention of urine, Methicillin-Susceptible Staphylococcus Aureus Infection (bacterial infection), and muscle weakness. 9/18/26- A diet order for R1 was placed by E3 (Primary Physician), with an order summary stating: "Regular Diet, pureed texture, Thin consistency (liquids)." 9/19/26 12:06 PM- A progress note, written by E4 (RN), revealed that "report called to (hospital)...report included that resident is ordered a puree diet, but received a regular-texture tray. Resident subsequently expelled some food contents and continued to report a sensation of food being stuck in his throat. Reason for transfer was explained as evaluation of swallowing difficulty/possible retained food following the above episode...". 9/19/26 1:34 PM- Another progress note, written by E5 (NP), revealed that "I (NP) was asked by nursing to reassess patient due to choking episode. Nurse reports patient received regular diet breakfast tray instead of puréed diet as ordered. Nurse reports patient was able to cough up some of the food but is still complaining of something in his throat.... Patient stated he feels like he has something stuck on the left side of his throat and continues to try to cough up the contents. Patient now noted a gurgling sound and intermittent coughing. Discussed with patient and nursing staff on sending patient to the ED for further evaluation and treatment. Patient was agreeable." 9/23/26 9:30 AM- An interview with E6 (EMS) revealed that "The facility served [R1] the wrong meal, which appeared to cause a partial airway	F0805		10/13/2026

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F0805 SS = J	Continued from page 2 obstruction requiring transport to the hospital. When the BLS crew arrived, there were multiple chunks of a meat-like substance, possibly sausage, in a napkin next to the patient. The patient stated that he felt like food was lodged in his throat. While BLS was moving the patient to the stretcher, the patient stopped breathing and changed color. Once the patient was placed in a seated position, he was able to cough and began breathing again. Due to that episode, BLS requested Advanced Life Support (ALS). During transport, the patient coughed up an additional piece of the substance, approximately one-half inch in diameter. The patient was transported to the [hospital]." 9/23/26 1:30 PM- An interview with E7 (Food Service Director) revealed that "nursing is responsible for meal diet slips to be correct when they reach the resident." 9/23/26 2:30 PM- An interview with E8 (CNA) revealed that "breakfast came around 7:45-8:00 AM. [E9 (RN)] realized that R1 did not have a breakfast tray. [E9] asked me [E8] to get [R1] a breakfast tray from the kitchen. I admit that I did not check the order in the computer and assumed that he was on a regular diet. I put the breakfast tray in front of the resident, but he refused to eat. I left the tray in his room on his table in case he changed his mind. [E9] later realized that the tray was supposed to be a pureed diet, so I ordered him a pureed diet from the kitchen, but it never came. [R1] was then seen by therapy around 10:00 AM, and therapy staff brought the resident back into his room and set up the regular diet tray in front of him, which is when he began eating it. R1's roommate called for help via callbell and requested that I check on his roommate [R1], who was coughing and choking on food." 9/23/25 3:15 PM- An interview with E9 revealed that "I saw that [E8] brought [R1] a regular diet tray, but I knew he was a pureed diet. I moved the tray away from the resident, but never removed it from the room. I did not see [R1] again until after [E8] told me he was choking on food." The facility failed to ensure that R1 received food prepared in the ordered puréed texture to meet R1's individual swallowing needs. R1 was served a regular-texture meal tray, after which R1 experienced a partial airway obstruction, stopped breathing and changed color, required emergency medical services transport to the hospital, and was hospitalized for further evaluation. The facility's action plan included:	F0805		10/13/2026

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F0805 SS = J	Continued from page 3 The facility conducted a review of residents receiving mechanically altered diets to identify residents who could potentially be affected by the same deficient practice. E1 (DON) conducted a verification of current residents receiving mechanically altered diets to verify that the texture diet is accurate. System Changes that were initiated to prevent recurrence include: A diet list will be printed daily and kept by the phone in the kitchen. Manual diet slips sent to the kitchen will be kept on the tray line until the resident's tray ticket is active in the Nutrition Management system. Tray tickets will be printed before each meal DON/Staff educator will educate licensed nurses for new admission and readmission to verify the diet order and provide the diet slip to the kitchen. DON/Staff educator will educate all nursing staff on ensuring all meal trays have a tray ticket that matches the food on the tray and to remove the tray immediately if there is a discrepancy. Food Service Director/ Staff Educator will educate dietary staff on verifying a resident's diet order when they receive a call before preparing a tray, and not send a meal tray without a tray ticket/diet slip. Food Service Director will educate identified dietary staff on printing tray tickets before each meal. The DON/ Nurse Manager will conduct meal observations on new admissions/readmissions and 25% of current residents with mechanically altered diets to verify residents receive a tray with the tray ticket/diet slip and correct diet order. NHA/Food Service Director will audit the kitchen to ensure an updated diet list is printed and available in the kitchen and new admission/readmission diet slips are on the tray line until their tray ticket is available. Audits will be performed daily until 100% compliance is achieved for three consecutive days. Audits will then be conducted weekly until 100% compliance is achieved for three consecutive weeks. Audits will subsequently continue monthly until 100% compliance is maintained for one month.	F0805		10/13/2026

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F0805 SS = J	Continued from page 4 All audit results will be reviewed by the Quality Assurance Committee for continued monitoring and follow-up. 9/23/26 4:30 PM: Based on the surveyor's review of the facility's investigation, documented response, completion of education, staff interviews and observation, and no further incidents involving food, the IJ was considered past non-compliance with a compliance date of 9/22/26. 9/23/26 5:00 PM- Findings were reviewed with E1 and E2 (NHA) during exit conference.	F0805		10/13/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that, for one (R1) of three residents reviewed for reporting of alleged violations, the facility failed to identify and report an allegation of	F0609	F609 R1 no longer resides at the facility. Unable to correct. All residents have the potential to be affected by this deficient practice. A facility-wide review was conducted of all incidents in the past 30 days to determine whether any event required additional investigation or reporting to the Division of Healthcare Quality. No issues identified. A root cause analysis was completed and determined that the facility did not believe the incident met the criteria for reporting as "choking episode" was not listed on the list of reportable incidents sent to facilities by DHCQ. The facility will now complete a root cause analysis of all incidents to determine if the root cause of the incident meets the reportable criteria. Staff Educator will educate all nursing staff on reportable incidents. Education will emphasize that when there is uncertainty regarding whether an event constitutes abuse, neglect, mistreatment, or another reportable occurrence, the event must be escalated to the Administrator/ DON for evaluation. Staff will no longer determine if an event is "not reportable". The Administrator/ DON will make the appropriate determination and ensure required State notifications are completed. This process will also be added to new hire orientation. Audits of all incidents will be conducted by the DON/ RN Designee to ensure all incidents are appropriately reported with an expectation of 100% compliance. Monitoring frequency will be daily until 100% compliance is achieved for three consecutive days, then weekly until 100% compliance is achieved	10/26/2026

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F0609 SS = D	Continued from page 5 neglect. Findings include: Cross-refer to F805. R1's clinical record revealed: 9/18/26- R1 was admitted to the facility. 9/18/26- E3 (Primary Physician) entered a diet order stating, "Regular Diet, pureed texture, Thin consistency." 9/19/26 12:06 PM- A progress note authored by E4 (RN) documented, "Report called to (hospital)…report included that resident is ordered a puree diet, but received a regular-texture tray. Resident subsequently expelled some food contents and continued to report a sensation of food being stuck in his throat. Reason for transfer was explained as evaluation of swallowing difficulty/possible retained food following the above episode…" 9/19/26 1:34 PM- A progress note authored by E5 (NP) documented, "I [NP] was asked by nursing to reassess patient due to choking episode. Nurse reports patient received regular diet breakfast tray instead of puréed diet as ordered. Nurse reports patient was able to cough up some of the food but is still complaining of something in his throat…. Patient stated he feels like he has something stuck on the left side of his throat and continues to try to cough up the contents. Patient now noted [with] a gurgling sound and intermittent coughing. Discussed with patient and nursing staff [the need] to send patient to the ED for further evaluation and treatment. Patient was agreeable." 9/19/26- Review of the State reporting system and facility incident-reporting records revealed no report submitted to the Division related to R1 receiving a regular-texture meal inconsistent with the prescribed puréed texture, the resulting choking/swallowing concern, or the emergency department transfer. 9/23/26 2:30 PM- During an interview, E8 (CNA) stated, "Breakfast came around 7:45 to 8:00 AM. [E9 (RN)] realized that R1 did not have a breakfast tray. [E9] asked me [E8] to get [R1] a breakfast tray from the kitchen. I admit that I did not check the order in the computer and assumed that he was on a regular diet. I put the breakfast tray in front of the resident, but he refused to eat. I left the tray in his room on his table in case he changed his mind. [E9] later realized that the tray was supposed to be a puréed diet, so I ordered him a puréed diet from the kitchen, but it never came. [R1] was then seen by	F0609	Continued from page 5 for three consecutive reviews, then monthly until 100% compliance is achieved for three consecutive months. The results will be reviewed through QAPI for sustained compliance.	10/26/2026

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F0609 SS = D	Continued from page 6 therapy around 10:00 AM, and therapy staff brought the resident back into his room and set up the regular diet tray in front of him, which is when he began eating it. R1's roommate called for help via call bell and requested that I check on his roommate [R1], who was coughing and choking on food." 9/23/26 3:15 PM- During an interview, E9 stated, "I saw that [E8] brought [R1] a regular diet tray, but I knew he was a puréed diet. I moved the tray away from the resident, but never removed it from the room. I did not see [R1] again until after [E8] told me he was choking on food." Although facility staff knew that R1 had an order for puréed texture, knew R1 received a regular-texture tray, and knew R1 subsequently experienced a choking/swallowing episode requiring emergency transfer to the hospital, the facility failed to identify the event as an allegation of neglect and failed to report the allegation to the Division/State Survey Agency.	F0609		10/26/2026