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	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Broadmeadow	500 South Broad Street Middletown, DE 19709

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that for one (R1) out of three residents reviewed for Neglect, the facility failed to identify and report an allegation of neglect when on [DATE], R1 had a choking episode and the present staff failed to provide essential services (airway clearance, assess lung air movement and initiate CPR) required to intervene on behalf of R1. Findings include: Cross refer F678 and F726Facility's Abuse, Neglect. policy stated, Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress and includes: lack of attention to physical needs of the resident; . Identification- Abuse may be identified through assessment of residents with unexplained changes in behavior and/or suspicious injuries and review of grievances and events for patterns and trends. Reviewed [DATE]. [DATE] - R1 was admitted to the facility with diagnoses including, but were not limited to, stroke with right-sided paralysis, chronic respiratory failure with hypoxia (low oxygen concentration), and dysphagia (trouble swallowing)XXX[DATE] approximately 3:41 PM - From the paramedic records, E9 (paramedic) arrived at the facility and found R1 pulseless with agonal (irregular, gasping breaths that occur when the body is not receiving enough oxygen) respirations. The report documented that staff provided no life-saving interventions for the patient and failed to recognize the patient was in cardiac arrest. [DATE] 1:30 PM - During a telephone interview, E8 (LPN) stated that F1 (R1's wife) approached him around 4:30 PM (sic) stating, [R1] is choking. Come here, hurry up. E8 stated that he obtained vital signs and R1's pulse oximetry was 64% with a heart rate of 149 or 150. E8 stated that he checked R1's supplemental oxygen flow and increased it. When asked about lung sounds, E8 stated, I did not listen to her lungs. E8 stated that the paramedics took over once they were on the scene and the paramedics were the people who initiated CPR (cardio-pulmonary resuscitation) on R1. The facility failed to identify and report of an allegation of neglect when staff failed to provide lifesaving servicesXXX[DATE] 9:30 AM - During an interview, E2 (DON) stated that the facility did not report the incident to the State as he was unaware that of any allegations of inappropriate care.The facility failed to identify and report that nursing staff failed to perform an essential assessment of R1's airway after a choking incident. [DATE] - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (CNO).

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, interview, record review and review of other documentation as indicated, it was determined for one (R1) out of three residents reviewed for change of condition, the facility failed to initiate CPR for R1, who was choking and became hypoxic and unresponsive. The RN supervisor did not assess R1's airway or respiratory status after choking and only delegated applying a non-rebreather mask and preparing for transfer without initiating CPR or further emergency intervention. The facility's failure resulted in R1 death. Due to this failure an Immediate Jeopardy (IJ) was called at 1:58 PM on 7/3/25. Findings include: Cross Refer F726A facility policy last reviewed 1/3/25 for Code Status Policy documented. Staff will initiate CPR when cardiac or respiratory arrest occurs for residents who have requested CPR on their Code Status Form. Review of R1's clinical record revealed:6/6/25 - R1 was admitted to the facility with diagnoses including, but were not limited to, stroke with right-sided paralysis, chronic respiratory failure with hypoxia (low oxygen concentration), and dysphagia (trouble swallowing).6/12/25 - R1's admission MDS revealed R1 was cognitively intact. 6/20/25 - R1's facility resuscitation form for CPR revealed. Full code means use CPR to attempt resuscitation. The form was signed and dated by R1 on 6/20/25. 6/29/25 3:35 PM - E8 (LPN) was notified by R1's F1(wife) the resident was choking. 6/29/25 3:43:20 PM - Review of a prehospital paramedic report revealed upon arrival to the facility on patient contact BLS (Basic Life Support) advised staff member was holding the head of R1 in a neutral sniffing position and R1 was gasping for air. CPR was started R1 was placed on monitor and found to be in asystole. A tube was attempted to be placed in R1's throat and was met with resistance then chewed up food was observed coming up the tube.7/2/25 10:03 AM - During a phone interview E9 (Paramedic) revealed and confirmed. EMT's arrived a minute, before the Paramedics. R1 was sitting up in the wheelchair in the chin to chest position, very pale and did not appear to be breathing. A nurse standing behind R1 and no CPR was being performed. R1 was transferred to the stretcher took a gasping breath and was pulseless and in cardiac arrest (heart stops beating) Paramedics started CPR. 7/2/25 1:03 PM - During a phone interview, F1 revealed. The family brought food in from a restaurant and R1 had cheesesteak. R1 was eating the meat out of the bread so she could have more meat and less bread, R1 choked and inhaled after coughing and somehow inhaled part of the cheesesteak. F1 stated, I told [E8] [R1] was choking. The RN supervisor came and looked at her and talked to her, and then [E7 (RN Supervisor)] called 911. F1 confirmed, [R1] was not able to speak words. 7/2/25 1:14 PM - During a phone interview, E7 stated, I was notified that [R1] had choked while eating and was hypoxic, [R1] exhibited signs of respiratory distress and was not verbally responsive I instructed [E8] to put a non-rebreather mask on [R1], I went to call 911. E7 confirmed and stated, No I did not listen to [R1's] lungs.7/2/25 1:30 PM - During a phone interview, E8 reported that the nurse was notified R1 was choking on food. R1 was unable to speak in full sentences and was slow to respond. At the time, R1 was receiving continuous oxygen at 3/lpm via nasal cannula, with an oxygen saturation of 64% and a heart rate ranging from 149 - 150 bpm. R1 was brought back to the room and switched to an oxygen concentrator; however, the non-rebreather mask was not inflating. R1 was then placed back on the oxygen tank at a flow rate of 15/lpm. R1's oxygen saturation improved slightly to around 77%, with respirations noted at 10 per minute. E8 stated, Typically [R1'] s oxygen saturation is 92% or higher. E8 also confirmed, I did not listen to [R1's] lungs during this time.The RN supervisor and other staff did not assess R1's airway or respiratory status, nor did they take appropriate emergency measures such as listening to lung sounds or abdominal thrusts. The facility also failed to initiate CPR for R1 who was hypoxic and unresponsive, despite R1's documented full code status. 7/3/25 1:58 PM - The facility's response to abatement for R1's incident was reviewed. All staff in the facility and staff reporting for scheduled shifts were provided with In-service education on responding appropriately to clinical emergencies inclusive of conducting thorough assessments and initiating appropriate interventions, for airway management, complete physical assessments and the initiation of life-saving interventions presented by the staff educator. A clinical tool was created Rapid Response Team/Code Blue. The RN Supervisor will utilize this form to document the residents' clinical situation, background, assessment, intervention (staff member to stay with resident until condition resolves or transfer to hospital, code and outcome.) Facility staff interviews were conducted starting 7/3/25 to verify in-service education, staff interviews concluded on 7/7/25 at 2:30 PM. Staff training records were reviewed; the facility's date of abatement is 7/5/25 at 4:00 PM. 7/7/25 2:45 PM - Findings were reviewed with E1(NHA), E2 (DON), E3 (ADON) and E4 (CNO) at the exit conference.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, interview, and record review it was determined that for one (R1) out of three residents reviewed for change in condition the facility failed to ensure that licensed nursing staff had the skill set to recognize an emergent situation. R1 had a choking episode that progressed to respiratory distress which compromised R1's breathing. Nursing staff failed to provide competent nursing care for R1 that included assessments and interventions for a resident that had a change in respiratory status. Additionally, R1 was a full code and staff failed to initiate CPR on R1's behalf. The facility's failure resulted in R1's in death. Due to this failure an Immediate Jeopardy (IJ) was called at 2:20 PM on 7/3/25. Findings include:Cross Refer F678A facility policy last reviewed 1/23/25 for Provider Notification of Resident Change in Medical Condition documented. That a resident experiencing a significant change in condition is monitored continuously until the resident is stable or transferred to another level of care. A review of R1's clinical record revealed:6/6/25 - R1 was admitted to the facility with a diagnosis including, but were not limited to, stroke with right sided paralysis, chronic respiratory failure with hypoxia (low oxygen concentration) trouble swallowing. 6/20/25 - R1's facility resuscitation form for CPR revealed. Full code means use CPR to attempt resuscitation. The form was signed and dated by R1 on 6/20/25. 6/29/25 1:22 PM - A review of R1's vital signs documented. Oxygen saturation of 95% via nasal cannula. 6/29/25 3:35 PM - E8 (LPN) was notified by R1's F1 (wife) the resident was choking. E8 reported R1 was in respiratory distress. R1's oxygen saturation was 64% on 3 Liters of oxygen and heart rate was 149 - 150 beats a minute. 6/29/25 3:40 PM - Facility video surveillance revealed R1 was taken back to the room in the wheelchair with her head down and chin to chest. 6/29/25 3:48 PM - A review of R1's vital signs documented. Oxygen saturation of 77% via oxygen mask. 6/29/25 3:50:14 PM - Facility video surveillance revealed EMT's arrived to R1's room.PM Paramedics entered [R1's] room at 3:51:12 PM. 7/2/25 10:03 AM - A phone interview, with E9 (Paramedic) revealed upon entering the room R1 was in the wheelchair chin to chest, very pale and did not appear to be breathing. E9 confirmed R1 was pulseless and in asystole in (cardiac arrest) and no CPR had been performed. 7/2/25 1:30 PM - During a phone interview E8 reported that the nurse was notified R1 was choking on food. R1 was unable to speak in full sentences and was slow to respond. At the time, R1 was receiving continuous oxygen 2 liters per minute via nasal cannula, with an oxygen saturation of 64% and a heart rate ranging from 149 to 150 beats per minute. R1 was brought back to the room and switched to an oxygen concentrator; however, the non-rebreather mask was not inflating. R1 was then placed back on the oxygen tank at a flow rate of 15 liters per minute. R1's oxygen saturation improved slightly to 77%, with respirations noted at 10 per minute. E8 stated, Typically R1's oxygen saturation is 92% or higher. E8 also confirmed, I did not listen to [R1's] lung's during this time.7/2/25 9:22 AM - During an interview, E2 (DON) stated, Staff stated R1 was responsive, and she was not choking.7/3/25 1:58 PM - The facility's response to abatement for R1's incident was reviewed. All staff in the facility and staff reporting for scheduled shifts were provided with In-service education on responding appropriately to clinical emergencies inclusive of conducting thorough assessments and initiating appropriate interventions, for airway management, complete physical assessments and the initiation of life - saving interventions presented by the staff educator. A clinical tool was created Rapid Response Team/Code Blue the RN Supervisor will utilize this form to document the residents' clinical situation, background, assessment, intervention (staff member to stay with resident until condition resolves or transfer to hospital, code and outcome.) 7/3/25 4:55 PM - An interview with E8 confirmed, In-service training and education had been provided prior to the start of the 3PM - 11PM shift. 7/5/25 - Review of the facility's attendance in-service training record for Recognizing and Responding to Medical Emergencies confirmed, E7 had been provided in-service training and education prior to the start of the shift.Facility staff interviews were conducted starting 7/3/25 to verify in-service education, staff interviews concluded on 7/7/25 at 2:30 PM. Staff training records was reviewed; the facility's date of abatement is 7/5/25 at 4:00 PM. 7/7/25 2:45 PM -Findings were reviewed with E1 (NHA), E2 (DON), E3 (NHA) and E4 (CNO) at the exit conference.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and interview, it was determined that for one (R1) out three residents reviewed for emergency care, the facility failed to ensure that the facility's assessment included nursing staff competencies, and the skill sets necessary to provide the level and types of care that are needed for the resident population. Findings include: Cross Refer to F678 and F726. A review of R1's records revealed:6/29/25 4:30 PM - E7 (RN) documented in R1's clinical records, Upon entering the (sic) unit at approximately 3:35 PM, E8 (LPM) stated he needed assistance and motioned towards dining room. Resident was in wheelchair with her wife at her side. Resident 66% on 2L of O2, instructed nurse to put on non-rebreather (NRB) and this writer called 911 at approximately 3:40 PM. Nurse took resident by wheelchair to her room. I entered behind them and adjusted the NRB. oxygen between 77% - 79% .EMT's arrived at approximately 3:50 PM.transported patient to ED (emergency department via stretcher at 4:21 PM. The facility's staff failed to identify and intervene when they were informed that R1 was experiencing respiratory distress after she had choked on her food, had decreased oxygen levels and became unresponsive.7/7/25 12:00 PM - A review of a facility document entitled, Facility Assessment Broadmeadow 2024-2025 lacked evidence of staff training and interventions for residents in a medical emergency including but not limited to choking with respiratory distress.7/7/25 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (CNO) at the exit conference.