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	11/14/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview, record review and review of other facility documentation, it was determined that for one (R1) out of three residents sampled for accidents, the facility failed to ensure that R1received adequate supervision to prevent accidents. R1, a completely dependent resident, fell on her face from the bed to the floor while receiving care from a staff member and sustained multiple rib fractures, clavicle fracture and splenic laceration. The facility's failure to provide adequate supervision caused harm to R1. Findings include: 1/20/09 - A facility document entitled, Fall Assessment, Prevention, and Management, revised 1/20/23 and 1/3/25 included, It is the policy of [name of facility] to assess for all risks and implement measure to prevent and manage the identified risks. The document also included, Factors that may result in resident falls include, but are not limited to. environmental hazards. functional impairments.R1's clinical record revealed:3/17/21 - R1 was admitted to the facility with diagnoses including but not limited to dementia, muscle weakness, contractures of left knee and both ankles, hemiplegia and hemiparesis.3/18/21 - R1's admission fall care plan [revised 5/28/24] documented, At risk for falls related to weakness, cognitive deficits, incontinence.3/29/21 - R1's activities of daily living [ADLs]care plan [revised 9/21/21] documented, .ADLs - self-care performance deficient r/t [related to] muscle weakness, decreased mobility. The interventions included, Assist with daily hygiene, eating toileting, dressing .The care plan lacked documentation of how many staff members were needed to assist with the ADLs.4/3/24 - R1's mobility/transfer form documented, Potential for impaired mobility. The interventions included, Resident requires Hoyer lift [mechanical lift] with transfers (assist of 2.) Resident requires assist of two [persons] with rolling side to side.5/29/25 - R1's clinical record documented, LAL [low air loss mattress].R1's clinical record lacked evidence of a care plan for safety/bed mobility for the use of the low air loss mattress.11/4/25 - R1's quarterly MDS assessment documented impairments on both upper and lower extremities, required set up/clean up assistance with eating, and complete dependence on staff for all other activities of daily living, including incontinence care and rolling from side to side in bed.11/5/25 - R1's quarterly fall assessment documented a fall risk score of 5 (high).11/7/25 10:51 AM - R1's clinical record documented, .Resident was receiving morning care by CNA. When turning onto her right side, resident was rolled onto the floor. When nurse responded, resident was seen lying face down leaning on her left side.11/7/25 2:08 PM - A facility reported document submitted to the Division documented, Fall from bed to floor, resident c/o [complained of] pain to her head, and left flank. Physician present and made aware, orders obtained to transfer her to the ER [emergency room] for further evaluation.11/9/25 7:45 PM - A hospital reported document submitted to the Division documented, Immobile pt. [patient] fell out of bed while being changed. Multiple rib fx [fractures], clavicular fx and splenic lac [laceration].11/13/25 1:15 PM - During an interview, E7 (UM) stated, The residents' transfer, and bed mobility status are in the closet. That is how the staff knows how to transfer and move them. [R1] required 2 persons for rolling from side to side, and 2 persons with the Hoyer lift for transfers.11/13/25 1:30 PM - During an interview, E4 (OT) stated, [R1] required 2 persons assistance to roll from side to side for the staff to wash and clean her. She was not able to help with her care.11/13/25 2:00 PM - During a telephone interview, E5 (CNA) stated, I have been an aide for four years, but I was new to this facility. I was told that this resident [R1] was on my assignment for the shift. I rolled her on her side to clean her bottom, and she rolled out of the bed on to her face. The Surveyor asked E5 if she knew where the transfer/bed mobility/rolling side to side information for the resident was located. E5 stated, I was told it was in the closet, but I was not actually shown where it was located. I saw other aides take care of her by themselves, so I thought I have to do her care by myself. No one ever told me I had to have another aide with me when I was taking care of her. The Surveyor asked E5 whether R1 was able to move, hold herself to the side in the bed or assist in her ADLs, E5 stated, No, she was not able to move herself or help with anything. The staff did everything for her. 11/13/24 2:20 PM - The facility 5 day follow up report submitted to the Division included, .Resident remains hospitalized at this time. Upon return she is to be evaluated by therapy and care plan will be updated to include concave LAL and bilateral fall mats while in bed.11/14/25 10:00 AM - During a combined interview with E1 (NHA) and E2 (DON), the Surveyor asked what the facility's investigation revealed to be the root cause of R1's fall. E1 stated, The aide did not position her properly in the bed and she rolled out. The Surveyor asked E1 whether the facility had identified that the R1's plan of care for two persons assistance with rolling side to side was not implemented during incontinent care. E1 stated, The resident did not have to be rolled side to side for incontinent care. The aide's statement said that she had positioned her [R1] on her