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	05/29/2026

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

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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 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. Based on record review and interview, it was determined that for one (R5) out of two (2) residents reviewed for abuse and injury of unknown origin, the facility failed to recognize and consequently report an injury of unknown origin. Findings include: Review of R5's clinical record revealed:5/1/26 - R5 was admitted to the facility. 5/1/26 11:45 PM - An admission assessment documented the following skin conditions for R5: right elbow skin tear closed; coccyx (tail bone) redness; left forearm skin tear with dressing in place (unable to assess); multiple discolorations to bilateral upper extremities and right chest; redness to sacrum (buttocks); right forearm closed skin tear with scabbed area; small discoloration to bilateral lower extremities; upper arm skin tear with transparent dressing in place. 5/14/26 1:22 PM - A weekly skin assessment documented the following skin conditions for R5: bruising to face, upper chest, and bilateral upper extremities; fading bruises bilateral lower extremities, abdomen, and bilateral tops of feet; skin tear left upper extremity; Multiple scabs to bilateral upper extremities; redness to sacrum; and scab left lower and upper lip. 5/28/26 2:22 PM - During an interview, E33 (LPN) stated she completed the skin check on R5 and recalled having faded bruises on the abdomen. E33 stated the expectation was when staff identifies a new skin area to document on the skin assessment, initiate risk management (internal incident report), initiate treatment and notify management. 5/29/26 11:24 AM - During an interview, E34 (LPN) stated that he completed the admission assessment for R5 and any skin areas noted on admission would have been documented in the assessment. E34 stated he recalled R5 having multiple areas noted to bilateral arms and bilateral legs. E34 stated he did not recall seeing any bruises noted on the abdomen when the assessment was completed and also stated he would have a CNA complete the skin assessment so all areas would be identified. 5/29/26 12:00 PM - During an interview, E3 (ADON) stated that an internal risk management report was not initiated for any skin areas for R5.Based on interview and review of clinical records it is unclear if R5 had abdominal bruising noted on admission or if the bruising occurred between 5/1/26 and 5/14/26 when it was identified. The facility lacked evidence that an injury of unknown origin was reported to the State Agency. 5/29/26 2:15 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, it was determined that for one (R1) out of four residents reviewed for dysphagia, the failed to develop a person - centered care plan to address R1's identified eating behaviors. Findings include: Cross refer F684 Review of R1's clinical record revealed:1/25/24 - R1 was admitted to the facility with diagnoses including stroke, GERD, dysphagia.1/26/24 - During an initial Speech Evaluation, R1 was observed to be at risk for aspiration during PO (by mouth) intake. Strategies and/or maneuvers for safe oral intake were identified by the speech therapist including alternation of liquid/solids, general swallow techniques/precautions, cyclic ingestion technique, rate modification and bolus size modifications upright posture during meals and upright posture for > (more) 30 mins (minutes) after meals.11/24/24 - A Speech Therapy Treatment Note documented R1 verbalized to both the speech therapist and his primary nurse that he has had some trouble tolerating his medications within the last 5 days. 12/3/24 - A Speech Therapy Note documented . [R1] reports to have occasional episodes of larger pills being struck, however, indicating towards proximal region of esophagus and states that with multiple intake of water is able to clear medications and reports when in seated in WC (wheelchair) is able to tolerate it better .educated patient to be seated upright in wheelchair for the medication if possible . Educated [R1] on the risk of aspiration/choking and reviewed on safe swallow strategies to be implemented with meals and medication mainly small sips/bites, slow rate, upright seating, and alternate solids/liquids, additionally, medication may be taken with puree consistency as well.12/12/24 - A Speech Discharge Summary for R1 documented that it was recommended for R1 to use the following strategies and/or maneuvers during oral intake: general swallow techniques/precautions upright posture during meals and upright posture for > 30 minutes after meals. 5/19/26 11:35 AM - In an interview, E19 (LPN) stated, [R1] eats in the dining room or sometimes in his bed, based on his preference. I am not aware that he has any issues with eating or that he eats very fast. I did not know about his swallowing precaution instructions.5/19/26 11:50 AM - During an interview, E16 (RN, UM) stated, I never saw him having trouble with chewing or swallowing .Monitoring for signs of dysphagia did not necessarily mean it will be acted or documented in the task. Staff observations will be documented if necessary. I did not know about his swallowing precaution instructions. Nothing was reported to me by the staff so there was nothing to document - intervention stated, ?monitor as needed' only.5/19/26 10:19 AM - In an interview, E18 (CAN) stated There were no instructions in his task in our computer to tell me what to watch out or monitor or even say that he should eat in the dining room all the time so he can be observed. I did not know about his swallowing precaution instructions. 5/27/26 1:55 PM - During an interview, E20, stated that [R1] was always eating fast . I was with the impression that nurses and the other CNAs are aware that he eats so fast and puts a lot of food in his mouth at a fast rate that he could have trouble chewing that's why we keep him in the dining room so we can all watch and remind him to slowdown and eat smaller bites. I witnessed him cough before while in the middle of eating. I don't sign it off in our CNA task as it's not indicated for us to sign. There were no instructions for us to watch him closely for signs and symptoms of choking or that he has to take small bites and alternate his meal with water or anything liquid. I think it would have been helpful if the instructions were clearly added in our CNA task so we can all be aware specially those who are working part time or PRN who may not know a lot about the residents. It would have been better if those specific swallow precautions/ instructions and unsafe eating and feeding behaviors were documented as task for all of us to now. 5/29/26 2:00 PM - Findings were discussed with E1 (NHA) and E2 (DON).5/29/26 2:15 PM - Findings were reviewed with E1 and E2 during the Exit Conference.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interview, it was determined that for one (R5) out of six residents in the investigative sample, the facility failed to provide services that meet professional standards of quality by having Licensed Practical Nurses (LPN) complete admission assessments. Findings include: Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2024 . admission Assessments * - RN .* = Once a care plan is established, the LPN may do assessments .Review of R5's clinical record revealed:5/1/26 - R5 was admitted to the facility. 5/1/26 11:45 PM - An admission assessment documented the following skin conditions for R5: right elbow skin tear closed; coccyx (tail bone) redness; left forearm skin tear with dressing in place (unable to assess); multiple discolorations to bilateral upper extremities and right chest; redness to sacrum (buttocks); right forearm closed skin tear with scabbed area; small discoloration to bilateral lower extremities; upper arm skin tear with transparent dressing in place. 5/29/26 11:24 AM - During an interview, E34 (LPN) stated that he completed the admission assessment for R5 and any skin areas noted on admission would have been documented in the assessment. E34 stated he recalled R5 having multiple areas noted to bilateral arms and bilateral legs. E34 stated he did not recall seeing any bruises noted on the abdomen when the assessment was completed and also stated he would have a CNA complete the skin assessment so all areas would be identified. 5/29/26 10:47 AM - During an interview, E16 (RN) stated that the nurse assigned to the resident's room is responsible to complete the following assessments: fall risk, pain, skin, braden, oral and full admission assessment when the resident is admitted . E16 stated that an LPN can not complete an admission assessment without an RN oversight. 5/29/26 11:53 AM - During an interview, E36 (RN) stated that she was working on 5/1/26 when R5 was admitted and was responsible for inputting new physician orders into the system. E36 confirmed that she did not complete any assessments when R5 was admitted . 5/29/26 2:15 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interviews, clinical record review, and review of other pertinent records, it was determined that for one (R1) out of four residents reviewed for dysphagia, the facility failed to provide the necessary care and services to R1 when the facility failed to identify R1 as high risk for choking and aspiration. On 5/15/26, R1 was served breakfast in bed and left unsupervised. Approximately 20 minutes later, staff found R1 unresponsive. EMS (Emergency Medical Services) documents revealed severe airway obstruction with large quantities of food (ham and eggs) removed from the airway and difficulty ventilating/intubating due to obstruction. The death certificate listed the immediate cause of death as airway obstruction by food bolus while consuming food. The facility failed to implement known swallowing precautions and supervision interventions, resulting in cardiopulmonary arrest and death. Immediate Jeopardy was initiated on 5/27/26 and abated on 5/28/26 after the facility implemented corrective actions. Findings include: Cross refer F656Review of R1 's clinical record revealed:1/25/24 - R1 admitted with diagnoses including stroke, dysphagia, GERD, and aphasia.1/26/24 - A speech assessment completed by E4 (former Speech Language Pathologist [SLP]) identified swallowing impairment, oral residue, wet vocal quality, aspiration risk, and need for swallow precautions. E4 documented strategies that included: Slow rate of intake/rate modification, small bites/bolus size modification, Alternating liquids and solids and Upright positioning during and after meals.1/26/24 - A nutrition care plan intervention for R1 included monitoring for dysphagia symptoms, when necessary, but no individualized plan addressed impulsive eating behavior or supervision.1/31/24 - An admission MDS assessment revealed that R1's cognition was moderately impaired and required setup or clean - up assistance (helper sets up or cleans up) with eating. R1 had loss of liquids/solids from mouth when eating or drinking and was holding food in mouth/cheeks or had presence of residual food in mouth after meals. R1 had no natural teeth or tooth fragments and was on mechanically altered therapeutic diet. 1/31/24 - 3/18/24 - R1's speech therapy notes documented R1 as a very impulsive eater requiring cues to slow intake and reduce bolus size. Wet vocal quality and coughing noted during intake. 4/2/24 - A Speech Therapy Discharge Summary by E4 documented that staff education on safe swallow strategies (small bites, alternating liquids/solids, slow pace, upright seating) and caregiver follow-through was emphasized in discharge planning. R1's prognosis was good with consistent staff follow-through.5/2/24 - R1's quarterly MDS assessment revealed that R1 was independent with eating. 10/24/24 2:49 PM - A Care Conference note documented R1's diet as NAS (no added salt) regular texture and thin consistency. R1 was eating his lunch in the main dining room on Mondays - Fridays only. 11/24/24 - R1's was seen and evaluated again by Speech Therapy for dysphagia therapy and medication tolerance. A clinical bedside assessment was completed by E4 who noted that R1 was reported to have complaints of increased difficulty swallowing and R1 stating that he was feeling like his food was increasingly feeling stuck in his throat. E4 also noted that R1 was unable to swallow only one simulated pill stating inability to swallow resulting in expelling of larger pill.11/24/24 - A Speech Therapy note by E4 documented, .Nursing noted no complaints with medication on this date of eval however patient did verbalize during the eval to both this SLP and his primary nurse that (sic) has had some trouble with the last 5 days but it's not all the time .It was noted that from 2/2024 through 12/2024 that R1's speech notes repeatedly documented: fast eating/increased rate of eating, need for cuing and reminders, safe swallow strategies (small bites, alternating liquids/solids, slow pace, upright seating) and coughing/wet vocal quality at times. 12/3/24 - A Speech Therapy Note by E9 (part time former SLP) suggested possible GI consult for esophageal dysphagia and reinforced aspiration precautions. 12/12/24 - Speech Therapy Discharge Summary by E4 documented that R1 was at highest practical level but explicitly documented continued swallowing strategies and staff follow-through expectations.1/16/25 - An annual MDS assessment documented that R1 required setup or clean - up assistance with eating. 4/17/25 - A quarterly MDS assessment revealed that R1 required setup or (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	clean - up assistance with eating. 5/29/25 - R1 had a physician's order for NAS (No Added Salt) diet Regular texture, thin consistency and two handle cup with sippy lid for hot beverages at all meals.7/17/25 - A quarterly MDS assessment revealed that R1 required setup or clean - up assistance with eating. 8/8/25 - A Speech Therapy (ST) Evaluation and Plan of Treatment by E13 (SLP) documented that R1's evaluation was requested to establish skilled ST interventions for memory and word finding. E13 further documented that R1's previous ST services to address dysphagia from 11/24/24 - 12/12/24 was discharged due to highest practical level achieved by R1. E13 also documented that R1 had normal swallow score but a clinical bedside assessment was not performed. 8/19/25 10:50 AM - An MDS clarification note with ARD (Assessment Reference Date) of 7/17/2025 by E14 (RNAC) documented, . there is an error coding noted on eating, per interview with therapy, it was found out that [R1] is set up with eating.10/16/25 - A quarterly MDS assessment revealed that R1 required setup or clean - up assistance with eating. 1/13/26 - An annual MDS assessment revealed that R1 required setup or clean - up assistance with eating. 1/16/26 - A Speech Therapy Discharge Summary by E13 (SLP) documented that R1 had a normal swallow and R1's oral phase, bolus control and pharyngeal phase were within functional limits. 4/9/26 - A quarterly MDS assessment revealed that R1 required setup or clean - up assistance with eating. Despite the MDS increasingly coded R1's eating status from independent on 10/22/24 to requiring set-up or clean - up assistance starting 1/16/25 until 4/9/26, a recommendation for a GI consult after R1 reported occasional episodes of larger pills being stuck on 12/3/24 and R1 was put back on SLP caseload on 8/2025 until 1/2026 for cognitive and language (word finding) therapy, the facility:Lacked evidence that a follow up swallowing re-evaluation was completed for R1.Lacked evidence that an individualized care plan was developed to address R1's dysphagia and the interventions including swallowing strategies to prevent aspiration.Lacked evidence that staff monitored R1's swallowing strategies in the CNA or nursing documentation.5/15/26 (Day of Event) - A review of E18's written statement and the town and county EMS (Emergency Medical Services) response reports revealed:8:30 AM - E18 (CNA) delivered breakfast tray to R1 in bed. R1 was repositioned upright in bed and left alone eating. R1's meal included ham, eggs, cheese and English muffin.8:50 AM - 8:52 AM - E18 returned and found R1 unresponsive. Code Blue was initiated. 8:53 AM - The town and county EMS response reports documented:- unit was notified- severe airway obstruction by food- ham and egg pieces repeatedly removed from airway- difficulty ventilating/intubating due to obstruction- airway cleared only after repeated suctioning and forceps use- CPR (cardiopulmonary resuscitation) unsuccessful5/15/26 9:39 AM - A police report documented that R1 was pronounced deceased by P7 (Medical Examiner).5/15/26 - R1's death certificate documented obstruction of airway by food bolus (accidental choking while eating).5/18/26 2:33 PM - In a telephone interview, FM1 [R1's niece] stated, [R1] was left in bed eating breakfast, and he choked. They were supposed to get him up and had him eat in the dining room. He would go there for lunch.I was told that [R1] had a new CNA taking care of him that morning and she didn't get him out of bed to eat in the dining room. He usually eats in the dining room because he needs to be watched. He eats very fast - he was high risk for choking. the speech therapist and the dietitian knew that. That should be part of his care plan. I went to the facility and was met by the medical examiner or the forensic investigator . thought to be asphyxiation (suffocation).5/19/26 9:30 AM - In an interview, E32 (CNA) stated that for residents who are identified to have difficulty swallowing and other eating problems, We get them out of bed and take them to the dining room/activity room where we watch them eat their breakfasts, lunches and dinners. Some residents prefer to eat in their rooms while others want to eat in bed, so we let them eat their breakfast in the rooms. head of bed elevated upright to 90 degrees and checked on them from time to time. For residents needing feeding assistance, we bring them to the dining room, easier to assist them there and watch them how they eat. 5/19/26 9:35 AM - In an interview, E25 (RN) stated, At the start of shift and before they do their rounds, we tell the CNAs of those residents we need to watch out for aspiration risks during mealtimes. We identify these residents, and we get them (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	out of bed and bring them to the (unit) dining room where they can be watched and supervised while they are eating. Some residents prefer to eat in their room, so we remind the CNAs to check on them frequently that they are able to feed themselves and swallow their food with no problems or unusual behaviors.5/19/26 10:00 AM - During an interview, E20 (CNA) stated, .I get [R1] out of bed and put him in the (unit) dining room so he will not make a mess in bed when he eats. He eats fast and doesn't chew his food very well.[R1] should be supervised at least every couple of minutes while he is eating .5/19/26 10:19 AM - In an interview, E18 (CNA) stated . I delivered [R1's] food tray at 8:32 AM, he was eating regular food and used a Kennedy cup (an adaptive spill - proof drinking cup designed for individuals with limited mobility) for drinking his water or juice. He was pulled up 90 degrees, like he sat on his bed. I left him and went out to assist another resident with feeding. I did not know that he had to be watched for coughing and difficulty swallowing.I was not aware that he was high risk for choking. his food tray was on the overbed table across his chest .he had breakfast sandwiches -hamburger buns, eggs, cheese, ham, side of scrambled eggs, hot chocolate and apple juice. I went back to check [R1] at 8:51 am and found him not responding and his color looked so different I called his nurse [E19] . and she initiated CPR, and we called for Code Blue. No one told me.There were no instructions in his task in our computer to tell me what to watch out or monitor or even say that [R1] should eat in the dining room all the time so he can be observed. I was not aware that [R1] had swallowing precaution instructions. 5/19/26 10:51 AM - In an interview, E21 (CNA) stated, He could choke because he eats very fast.5/19/26 11:00 AM - In an interview, E22 (CNA) stated, He sometimes eats in bed with the head of bed elevated at 90 degrees.5/19/26 11:14 AM - During an interview, E17 (LPN) stated, When I used to work as his charge nurse on the floor, I was never informed that R1 had dysphagia and was being monitored for choking and difficulty swallowing. I did not know about his swallowing precaution instructions.5/19/26 11:35 AM - In an interview, E19 (LPN) stated, [R1] eats in the dining room or sometimes in his bed, based on his preference. I am not aware that he has had any issues with eating or that he eats very fast. I did not know about his swallowing precaution instructions.5/19/26 11:50 AM - During an interview, E16 (RN, UM) stated, I observed him at lunch during dining room duty, and I never saw him having trouble with chewing or swallowing. He liked to eat a lot. Monitoring for signs of dysphagia did not necessarily mean it will be acted or documented in the task. Staff observations will be documented if necessary. I did not know about his swallowing precaution instructions. [R1] was independent with eating and had no eating issues. Nothing was reported to me by the staff so there was nothing to document - intervention stated, ?monitor as needed' only.5/19/26 2:46 PM - In an interview, E23 (LPN) stated, For residents with dysphagia, we get them up and out of bed for meals, watch them in the dining room while eating and monitor them if they start coughing. We also instruct the CNAs, especially the new ones to check on the residents with eating issues from time to time every 10-15 minutes - after delivering the food tray.5/19/26 12:53 PM - In an interview, E24 (RN) stated, If a resident is identified to have dysphagia, it should be care planned for risk for aspiration and interventions be put in place to increase monitoring, to make sure to let the CNAs know . indicate in their tasks and talk to them prior to start of care . give them a heads up about residents' special instructions.5/19/26 1:34 PM - In an interview, P3 (NP) stated, .Unfortunately [R1] had a coronary event. He was not acutely ill. I am not aware that they (nursing staff who performed CPR on R1) suctioned some amount of food in [R1's] mouth.5/19/26 1:50 PM - During an interview, E13 stated, I was his therapist starting August 2025 until recently. I saw him for cognition, speech and language. I did not evaluate him for his swallowing; no clinical bedside assessment was done. There were times when I had sessions with him at lunch and I observed him eating at a fast rate when he got excited with the food that he ate. He eats fast. He loved to eat. No, I did not see that as an issue. I did not receive any requests or referral from the nursing staff regarding R1's swallowing and chewing issues.5/19/26 2:15 PM - In an interview, E6 (RD) stated, He was a good eater and really likes to eat a lot. During my nutrition assessments, I never observed him having difficulties with eating, chewing or swallowing.5/20/26 1:05 PM - When asked about R1's person - (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	centered care plan to address R1's risk for aspiration and his impulsive behavior of eating fast and how the facility ensured that R1 was monitored for safe swallowing strategies and signs and symptoms of dysphagia, E1 (NHA) stated, [R1] was independent with eating and never had any issues with his eating, chewing, coughing and swallowing. The nutrition care plan interventions [Monitor/document/report PRN any s/sx of dysphagia: Pocketing, Choking, Coughing, Drooling, holding food in mouth, several attempts at swallowing, refusing to eat, Appears concerned during meals] .are the general interventions applied to all residents in the facility even to those without dysphagia issues. [R1] was cleared by the speech therapists for regular consistency, thin liquid diet. We tell the staff that if they see something, they say something. If nothing is reported, nothing is documented, then it was not observed.5/26/26 - A review of R1's MAR (Medication Administration Record) from January 2026 - May 2026 lacked evidence that R1 was monitored by licensed nurses for safe swallowing strategies.5/26/6 - A review of R1's CNA flowsheets from January 2026 - May 2026 lacked evidence that R1 was monitored by CNAs for safe swallowing strategies.5/26/26 - A review of R1's CNA Behavior flowsheets from August 2024 through October 2025 lacked evidence that R1 was monitored by CNAs for impulsive oral intake, and increased rate of food consumption.5/27/26 1:50 PM - In an interview, E7 stated, . In April, last month, [R1] has been eating meals in his room. depends on what he wants; he usually eats in his room or in the main dining room when it's open for lunch on Mondays through Fridays only. The main dining room is closed for breakfast and dinner, so he eats wherever he wants to eat. The (unit) dining room is always open - [R1] often goes there to eat as well. 5/27/26 1:55 PM - During a follow up interview, E20, stated that [R1] was always eating fast, and they said he eats like that because it stemmed from him being in the military. They (staff) all knew him - he was the former HR lady's uncle.I was with the impression that nurses and the other CNAs were aware that he eats so fast and puts a lot of food in his mouth that he could have trouble chewing. that's why we keep him in the dining room so we can all watch and remind him to slowdown and eat smaller bites. I witnessed him cough before while in the middle of eating. I know I have to keep a close eye on him because I've known him for a long time. The swallowing strategies were not specifically indicated in our task to sign off so a lot of the staff wouldn't know. There're no instructions for us to watch him closely for signs and symptoms of choking or that he has to take small bites and alternate his meal with water or anything liquid. I think it would have been helpful if the instructions were clearly added in our CNA task so we can all be aware specially those who are working part time or PRN who may not know a lot about the residents.It would have been better if those specific swallow precautions/ instructions and unsafe eating and feeding behaviors by the resident were documented as task for all of us to now. [R1] did not wear a denture, he ate with regular teeth, but he did have some few missing top and bottom teeth . I get him out of bed, sit him upright in the wheelchair, have him eat in the dining room for his meals and I cut the food on his tray for him to get small bites. He liked to drink his beverages and food at one at a time. So, he likes to drink all his hot chocolate first and when it's all done, he will eat his sandwich until it's finished, then proceed with his cake or whatever else is on his tray. We all watched him in the dining room because we had to coach him to slow down and watch him that he will not choke.5/27/26 2:16 PM - In a follow up interview, E13 stated, . I'm not aware of the recommendation for GI consult in December 2024, I was not here yet. He had natural teeth, no dentures. some missing upper and bottom teeth but was able to chew on food with no issues. I know of [R1's] safe intake strategies including alternating intake between liquid and solid food to clear his mouth and also to give verbal cues for him to slow down or slow his rate of intake. I don't know how the instructions were communicated to nursing. When I started working here as speech therapist, I was only told by nursing staff that eating at a fast rate was his baseline. I observed him eating in the dining room and E8 (former LPN) was there cueing him to slow down, repositioning him on his wheelchair upright and reminded him to alternate his drink with solid food. Nobody came to me for referrals if there were any concerns. It would have been better if the 12/12/24 discharge instructions swallow strategies for [R1] were communicated to the nursing (continued on next page)

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	05/29/2026

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	staff. The former nurse knew about [R1's] safety precautions but she left. The new staff will never know that [R1] had swallowing strategies to observe to prevent aspiration.5/27/26 2:54 PM - In an interview, E12 (OT) stated, [R1] was able to cut his food; assessed to be capable to hold two handle adult sippy cup for hot beverages. I am aware he had dysphagia and he was a high risk for aspiration.5/27/26 3:30 PM - In a joint interview with E2, E1 re-stated that R1 was independent with eating and was cleared by speech therapists on multiple assessments that he had no problem with swallowing. The swallowing strategies identified were general swallowing precautions that all residents should be observed for. E1 further stated that R1's nutrition care plan did not require documentation as basis for monitoring. Furthermore, E2 stated, [R1] eats like that even from before - so fast, with no issues.it stemmed from him being in the military. When asked if R1's recommendation for GI consult on 12/3/24 was followed up, E2 stated, No the doctor did not make a recommendation. 5/27/26 3:22 PM - During a meeting with facility management, the Survey Team notified E1 (NHA) and E2 (DON) of an Immediate Jeopardy when the facility failed to identify R1 as high risk for choking and aspiration. Additionally, the facility failed to implement identified swallowing precautions and meal supervision interventions during breakfast service on 5/15/26 that resulted in R1 experiencing an airway obstruction while eating that led to R1's cardiopulmonary arrest and death.5/27/26 6:29 PM - E1 submitted a signed and dated abatement plan to the State Agency.The facility's abatement included:Facility reviewed all residents to determine which residents had a diagnosis of dysphagia.All residents with a diagnosis of dysphagia were reviewed by speech therapists to determine what, if any, interventions needed to be communicated to staff.Any noted interventions were added to the residents' CNA tasks.Speech therapists were educated on documentation of necessary speech interventions and communicating them to nursing staff. Education was completed on 5/27/26.Education with nursing staff on where to locate any resident - specific speech therapy interventions was initiated on 5/27/26. All nursing staff currently in-house were educated with 100% compliance on 5/27/26. An OnShift message was sent to all nursing staff. All oncoming staff will be educated before starting their shifts until 100% compliance is achieved. Education will be completed by 5/28/26.5/29/26 9:58 AM - In a telephone interview, E4 (former SLP) stated, . I saw [R1] in 2024 .[R1] had a stroke, with impulsive behavior of putting too much food in his mouth, he responded to cues for him to slow down and not to put too much food. sometimes I noticed him coughing in between bites. FEES swallow study was not done. but I watched him for chemical obstruction (tissue damage resulting from the ingestion of corrosive chemicals like when medications getting lodged or long term acid reflux). [R1] had wet vocal quality . not necessarily in the airway but close to the airway .When I discharged [R1] to long term care, written instructions in the discharge summary were provided for staff to follow through. I notified the nursing staff verbally - and they were aware. I expected that staff passed on [R1's] swallowing strategies to the other nursing staff as well during change of shift and that the regular staff nurses and CNA who were familiar with [R1] were able to communicate to the new employees those swallowing strategies as well. I communicated to nursing verbally, not necessarily in writing. I can't confirm nor deny if the other SLP [E9's] recommendation for GI consult was followed through. She probably made that recommendation because [R1] also had GERD.5/29/26 1:03 PM - In a follow up telephone interview, P3 (NP) stated, I am not aware of the referral for [R1's] GI consult for esophageal dysphagia on 12/3/24. I started seeing residents in the facility on 5/21/25.5/29/26 12:30 PM - 1:05 PM - Collective interviews with staff, resident observations and record reviews confirmed facility's completion of the abatement plan. Staff was able to articulate location of resident specific speech therapy interventions listed on the residents' task in the EHR (electronic health record). 5/29/26 1:05 PM - In an interview, E26 (LPN) stated We received education that speech therapy instructions for each resident can be located in the EHR (electronic health record) under Task which can be accessed by both nurses and CNAs. Usually, the speech therapist tells the nurse any updates, changes or orders for the resident who was seen and evaluated. It's important that specific instructions are noted in the EHR so everyone will know what (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	they need to monitor and watch out for, especially the new nursing staff who are not familiar with the residents. 5/29/26 - In a telephone interview, E9 (former part time SLP) stated that it's been a long time since she last saw R1. Surveyor read to E9 the notes E9 wrote when she saw R1 for speech therapy session on 12/3/24. E9 stated that what she wrote on her notes where shared to the nursing staff. E9 further stated, When we find somethings, we notify the nurses and the Rehab Director verbally or in writing.the expectation was for the nurses to share the information such as swallowing strategies to the nursing staff including the CNAs. E9 stated, . At that the time of my visit, [R1] had no issues with oropharyngeal but .when he complained of occasional larger pills being stuck in his throat. it was near the esophagus and that was the reason why I recommended for a GI consult for esophageal dysphagia evaluation - and R1 also had GERD. The GI specialists are the ones looking into this. With [R1] saying that with multiple intakes of water he was able to clear medications and when seated in wheelchair he was able to tolerate it better . he had to be cued and reminded of the safe swallow strategies with meals and medications [small sips/bites, slow rate, upright seating, and alternate solids/liquids]. 5/29/26 2:00 PM - Findings were discussed with E1 (NHA) and E2 (DON).5/29/26 2:15 PM - Findings were reviewed with E1 NHA and E2 DON during the Exit Conference.