

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/04/2012
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NAME OF PROVIDER OR SUPPLIER  BRANDYWINE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 GREENBANK ROAD WILMINGTON, DE 19808
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from December 27, 2011 through January 4, 2012. The deficiencies contained in this report are based on observations, interviews, review of residents' records and review of other documentation as indicated. The facility census the first day of the survey was 160. The Stage II sample totaled forty-five (45) residents.</p> <p>F 205 SS=D 483.12(b)(1)&amp;(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR</p> <p>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility documentation, record review and staff interviews, it was determined that the facility failed to provide verbal and written notice</p>	F 000	<p><u>Disclaimer Statement:</u> Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of both Federal and State Laws.</p> <p>F 205 483.12(b)(1)&amp;(2) NOTICE OF BEDHOLD POLICY BEFORE/UPON TRANSFER</p> <ol style="list-style-type: none"> <li>1. R3 returned from her hospital stay to an appropriate bed. R3's financial POA was notified at the time of transfer as R3 was not conscious at the time of transfer.</li> <li>2. All residents transferred or discharged from the facility could be affected.</li> <li>3. The facility's bed hold policy was reviewed and revised. Staff will be inserviced regarding changes</li> <li>4. Bed hold policy adherence will be monitored by the Social Service Director/designee for compliance and reported through the QA process.</li> </ol>	1-30-12 1-30-12 1-30-12 1-30-12
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Fred A. Bartolo</i>	TITLE <i>Administrator</i>	(X6) DATE
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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.

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F 205	<p>Continued From page 1</p> <p>which specified the duration of the bed hold policy to R3 and/or the family member or legal representative. Finding includes:</p> <p>Review of the admissions package, provided to residents and/or family members upon admission and R3's signed admission agreement were reviewed. R3 received Medicaid benefits and had a bed hold of seven days upon transfer to the hospital. R3 was re-admitted to the facility on 7/15/11 post hospitalization.</p> <p>Record review revealed R3 was responsible for her own decisions (own self-guardian) while at the facility and the facility had a family emergency contact number which was incorrect.</p> <p>In an interview with R3 on 12/27/11, R3 stated she was angry that she was moved out of her room after returning from the hospital on 7/15/11.</p> <p>In an interview with R3 on 1/4/12, she revealed that she was in the hospital for at least 14 days in July 2011.</p> <p>In an interview with E11 (Admissions Director) on 1/4/12 with E7 (Social Services Director), E11 revealed that R3's letter (to the resident or responsible party) regarding bed hold prior to the transfer to the hospital was missing. Review of R3's record lacked evidence that a letter was sent or provided to the family or resident.</p> <p>In an interview with the facility discharge nurse E4 (Unit Manager for Greenbank Unit) with E7 on 1/4/11, resident was sent to the hospital in an emergency situation and the resident was not conscious. She stated she called the family</p>	F 205	See Following Page	
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F 205 Continued From page 2  
member but did not reach anyone as the phone was not working and they did not have the most current phone number.

Procedure entitled "Bed Hold and Readmission Policy" under section titled "Procedure, 3" revealed that: "at the time of transfer of a resident for 24 hour emergency hospitalization, scheduled hospitalization ..., the admission director will provide the resident and responsible party (if possible) with written notice which specifies the duration of the bed hold. A copy of the Bed Hold letter must be sent with the interagency transfer form". Section 4 of the procedure indicated that "should a Medicaid resident's leave exceed the bed-hold period, the Medicaid resident must be given the first available bed in a semi-private room .....

The facility failed to provide verbal and written notice to R3, or a family member, about the bed hold when R3 was discharged to the hospital in an emergency situation in July 2011.

F 246 SS=E 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:  
Based on observations, it was determined that

F 205 See Following Page

F 246 483.15(e)(1) REASONABLE ACCOMODATION OF NEEDS/PREFERENCES

1. R35, R62, R63, R121, and R189 suffered no untoward effect. R121 is able to move throughout her room and is able to access her call bell at will as was stated by E2 (DON) to the survey team during the survey.

1-30-12

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F 246	<p>Continued From page 3</p> <p>the facility failed to ensure five (R35, R62, R63, R121, and R189,) out of 45 sampled residents had reasonable accommodation of their needs. The facility failed to ensure that these residents' call bells were within reach. Findings include:</p> <p>1. Observation on 12/27/11 at 12:35PM revealed R63 seated in her wheelchair with her lunch tray in front of her on the over bed table and the call bell was not within her reach. R63 stated "they must have forgotten to put it on the bed this morning".</p> <p>The quarterly MDS (Minimum Data Set) assessment, dated 12/2/11 stated that R63 required extensive assistance of 2 persons for transfers.</p> <p>2. Observations made during the environmental tour on 1/3/2012 at 3:30 PM with E10 (Maintenance Director) revealed that R121's emergency call bell was not within reach and was inaccessible to the resident. R121 was observed sitting by the window away from the bed, and the call bell cord was on the bed not within reach. E10 was observed moving the resident in her wheelchair near the bed so the call bell could be reached. In an interview with E2 (DON) on 1/4/12, he acknowledged this finding and stated that R121's call bell should had been within reach.</p> <p>3a. Observation on 12/27/11 at 12:40 of R35's room revealed her call bell was attached to the pillow on the left side of the bed not within reach. In an interview with R35 on 12/27/11 to determine if she could reach and use the call bell, R35 was seen placing her arm between the side rail bars</p>	F 246	<p>483.15(e)(1) REASONABLE ACCOMODATION OF NEEDS/PREFERENCES (Con't)</p> <p>2. All residents have the potential to be affected.</p> <p>3. All staff will be inserviced regarding proper placement and accessibility of the call bell</p> <p>4. Random call bell audits will be conducted by the Unit Managers weekly X 4, monthly X 2 and reported through the QA process.</p>	<p>1-30-12</p> <p>1-30-12</p> <p>1-30-12</p>
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F 246	<p>Continued From page 4 and was unable to reach it.</p> <p>b. On 12/28/11 at 8:25 AM while R35 was sitting in her wheelchair in front of the TV with her back to the privacy curtain, the call bell was observed attached to the privacy curtains out of reach and out of her view. In an interview with E12 (Nurse) on 12/28/11, she confirmed the finding.</p> <p>4. Observation on 12/28/11 at 11: 44 AM revealed R189 sitting in her room in front of the TV away from her bed. R189's emergency call bell was not within reach and was inaccessible to the resident. The call bell was observed laying on the bed.</p> <p>In an interview with E13 (Restorative Aide) on 12/28/11, she stated that the resident was dropped off from physical therapy and placed in her room. E13 stated that R189 needed assistance to move her wheelchair from one point to another in the room and the facility. E13 on 12/18/11 confirmed the call bell should have been within reach.</p> <p>E2 on 1/4/12 acknowledged this finding and stated that R189's call bell should had been within reach.</p> <p>5. Observation made during the environmental tour on 1/3/2012 at 3:00 PM with E10 (Maintenance Director) revealed that R62's call bell was not within reach and was inaccessible to the resident. R62 was observed sitting in her w/c in her room away from her bed and the call bell was not within reach. When surveyor asked E14 (nursing aide) on 1/3/12 if the call bell should be within reach, E14 was observed placing the call bell on the right handle of R62's wheelchair, and</p>	F 246	See Previous Page	
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F 246	Continued From page 5 stated the call bell should had been within reach.	F 246	See Previous Page	
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to review and revise the care plan for one (R103) out of 45 sampled residents. Findings include:</p> <p>Cross refer to F309</p>	F 280	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <ol style="list-style-type: none"> <li>1. R103 suffered no untoward outcome. R103 has a built in clamp attached to his dialysis access site. Therefore, as per his dialysis center, no other clamp is required.</li> <li>2. Any dialysis resident could potentially be affected.</li> <li>3. Care plans for dialysis residents will be reviewed for accuracy and revised as needed</li> <li>4. RNAC/designee will audit care plans for dialysis residents and report accuracy through the QA process.</li> </ol>	<p>1-30-12</p> <p>1-30-12</p> <p>1-30-12</p> <p>1-30-12</p>

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F 280	<p>Continued From page 6</p> <p>The facility policy entitled, "Care of the Resident Receiving Dialysis" stated, "...6. The residents care plan will include...care of the access site..."</p> <p>R103 was admitted to the facility on 3/25/11 with a diagnosis of end stage renal disease (ESRD) on hemodialysis. Upon admission to the facility R103 had an AV (arterio-venous) fistula in his arm which provided access for hemodialysis. A care plan was developed on 3/25/11 for the problem "Potential for...complications of access area including bleeding or infection..."</p> <p>Interventions included "Notify MD of any changes related to but not limited to...bleeding... Assess access site for (signs &amp; symptoms) of infection...No blood draws or (blood pressure) in access arm, check for bruit/thrill every shift..."</p> <p>R103 was admitted to the hospital on 3/30/11 and returned to the facility on 4/28/11. Review of the hospital discharge summary, dated 4/28/11 revealed that R103's AV fistula was no longer in use and instead a right internal jugular (IJ) triple lumen catheter had been inserted for dialysis.</p> <p>Although the facility was documenting that R103's care plan was reviewed periodically, it was never revised to reflect that the resident now had a right IJ catheter, that there was no longer a need to check for bruit/thrill of an AV fistula, that blood pressures were no longer prohibited in the arm and that a clamp needed to be kept at the bedside.</p>	F 280	See Previous Page	
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain</p>	F 309	See Following Page	

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F 309	<p>Continued From page 7</p> <p>or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for one (R103) out of 45 sampled residents, the facility failed to follow the plan of care and facility policy for providing care and services and monitoring of a catheter used for hemodialysis. Findings include:</p> <p>The facility policy entitled, "Care of the Resident Receiving Dialysis" stated, "...3. All AV (arterio-venous) fistulas/shunts and or catheter sites will be assessed by nursing every shift for signs of bleeding, infection...6. The residents care plan will include...care of the access site..."</p> <p>R103 was admitted to the facility on 3/25/11 with a diagnosis of end stage renal disease (ESRD) on hemodialysis. Upon admission to the facility R103 had an AV fistula in his arm which provided access for hemodialysis. A care plan was developed on 3/25/11 for the problem "Potential for...complications of access area including bleeding or infection..." Interventions included "Notify MD of any changes related to but not limited to...bleeding... Assess access site for (signs &amp; symptoms) of infection...No blood draws or (blood pressure) in access arm, check for bruit/thrill every shift..."</p> <p>R103 was admitted to the hospital on 3/30/11 and</p>	F 309	<p><b>483.25 PROVIDE CARE/ SERVICES FOR HIGHEST WELL BEING</b></p> <ol style="list-style-type: none"> <li>1. R103 suffered no untoward outcome. R103 has a built in clamp attached to his dialysis access site. Therefore, as per his dialysis center, no other clamp is required.</li> <li>2. Any dialysis resident could potentially be affected.</li> <li>3. Care plans for dialysis residents will be reviewed for accuracy and revised as needed by</li> <li>4. RNAC/designee will audit care plans for dialysis residents and report accuracy through the QA process.</li> </ol>	<p>1-30-12</p> <p>1-30-12</p> <p>1-30-12</p> <p>1-30-12</p>
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F 309	<p>Continued From page 8</p> <p>returned to the facility on 4/28/11. Review of the hospital discharge summary, dated 4/28/11 revealed that R103's AV fistula was no longer in use and instead a right internal jugular (IJ) triple lumen catheter had been inserted for dialysis.</p> <p>Although the facility was documenting that R103's care plan was reviewed periodically, it was never revised to reflect that the resident now had a right IJ catheter.</p> <p>Review of nurse's notes and medication and treatment records for December 2011 lacked evidence that nursing staff were checking the access site for bleeding and/or infection or other complications every shift as per the plan of care.</p> <p>R103 was observed on 1/4/12 with right chest IJ triple lumen catheter. Observation of R103's environment lacked evidence that a clamp was taped to the wall in case of breakage/bleeding from the IJ catheter.</p> <p>During an interview with E6 (nurse) on 1/4/12, she acknowledged that there was no evidence that nursing staff was checking the catheter site every shift for bleeding and for signs of infection. E6 also acknowledged that there was no clamp taped near R103's bedside in the event of catheter breakage or bleeding.</p>	F 309	See Previous Page	
F 325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels,</p>	F 325	See Following Page	

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F 325	<p>Continued From page 9</p> <p>unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, it was determined that the facility failed to maintain acceptable parameters of nutritional status, such as body weight for one (R186) out of 45 sampled residents. R186 lost a total of 19 pounds (lbs) or 8.75% over a nine and a half week time period, and although the weight loss was beneficial, it was unplanned. Findings include:</p> <p>R186 was admitted to the facility on 10/21/11 with diagnoses that included hypertension, elevated cholesterol, osteoarthritis, anxiety and dementia. The admission Minimum Data Set (MDS) assessment, dated 10/31/11 stated R186's cognitive skills were moderately impaired and that she was able to feed herself independently. The MDS stated R186 was experiencing "little interest or pleasure in doing things; feeling down, depressed or hopeless; feeling tired or having little energy" on 2 to 6 days of the 7 day observation period. Additionally, this same MDS stated R186 was exhibiting rejection of care behaviors that occurred daily during the 7 day observation period.</p> <p>Admission orders, dated 10/21/11 included an order for R186 to receive HCTZ</p>	F 325	<p><b>483.25(i) MAINTAIN NUTRITIONAL STATUS UNLESS UNAVOIDABLE</b></p> <ol style="list-style-type: none"> <li>R186 was care planned at the time of admission for beneficial weight loss. The RD discussed the nutritional plan with R186 and the resident is pleased with her weight loss.</li> <li>Any resident desiring weight loss may be affected.</li> <li>The RD will discuss, review, and document planned weight loss with those residents identified as requesting or requiring weight loss.</li> <li>The RD/designee will audit care plans and supporting documentation of those requesting or requiring planned weight loss and will report findings through the QA process.</li> </ol>	<p>1-30-12</p> <p><del>3-30-12</del></p> <p>1/30/12 R45</p> <p>1-30-12</p> <p>1-30-12</p>

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NAME OF PROVIDER OR SUPPLIER  BRANDYWINE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 GREENBANK ROAD WILMINGTON, DE 19808
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(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
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F 325	<p>Continued From page 10</p> <p>(Hydrochlorothiazide - antihypertensive/diuretic) 25 mg daily. The HCTZ was subsequently discontinued on 11/2/11. R186 was ordered to receive a Regular diet with no added salt, cholesterol controlled, and low fat.</p> <p>The facility developed a care plan on 10/21/11 for the problem, "Resident at Nutritional Risk (as evidenced by): Therapeutic Diet and Resident would benefit from weight loss (secondary to increased BMI) at the request of Dr. or RD (Registered Dietitian) recommendation. The stated goal for this care plan was "Resident will tolerate diet as evidenced by no significant changes in weight by the next review period x 92 days."</p> <p>A Nutritional Assessment completed by E5 (RD), dated 10/24/11 stated R186's height was 66 inches and she weighed 217 lbs. The assessment stated the resident had a BMI (Body Mass Index - a measure of body fat based on height and weight) of 35 (BMI of 30 and over indicates obesity). The nutritional assessment stated "Post admission re-weigh pending. Estimated nutritional needs calculated based on adjusted body weight of (approximately) 72 kg + appetite (approx. 75% meal completion x 3 days). Will monitor resident's weekly weight. Will continue to monitor resident's nutritional status."</p> <p>On 11/9/11 a nutrition note stated "Current weight 209.9 reflects 7.1 lbs (loss) in 3 weeks (since admission). (Increased) BMI, (positive) appetite meal completion (up/down) 50-100%. May benefit from gradual, safe weight (loss) secondary (increased) BMI. (Medical Doctor) aware of the weight (loss) no new order given." Although, the</p>	F 325	See Previous Page	
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F 325	<p>Continued From page 11</p> <p>RD stated that the resident may benefit from a "safe, gradual weight loss" there was no evidence that a weight reduction plan was developed and put in place. Review of physician's progress notes from 11/10/11 through 12/12/11 lacked any documentation of R186's weight loss and that she was on a weight reduction program.</p> <p>A nutrition note, dated 11/30/11 stated, "Current weight 205.3. Weight on slight (decreasing) trend, (positive) appetite, meal completion 75-100% (some 25% noted). (Increased) BMI. May benefit from gradual weight (loss). Will make no changes at this time. Will continue to monitor resident's nutritional status." Again there was no evidence that a change was made to R186's plan of care for a planned weight reduction or that this was discussed with the resident and/or her responsible party.</p> <p>R186's weekly weights were as follows: 10/21/11 - 217 10/24/11 - 214.7 11/2/11 - 213.1 11/9/11 - 209.9 11/16/11 - 210.9 11/23/11 - 208.1 11/30/11 - 205.3 12/7/11 - 204.9 12/14/11 - 201.8 12/21/11 - 200.3 12/28/11 - 198</p> <p>Review of the weekly weights revealed that from 10/21/11 through 11/23/11 R186 experienced a weight loss of 8.9 lbs. or 4.14% in 1 month (not significant). However, from 10/21/11 through 12/21/11 R186 had a total weight loss of 16.7 lbs or 7.69% in 2 months (7.5% loss in 3 months is a significant weight loss). Additionally from 12/21/11</p>	F 325	See Previous Page	

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F 325	<p>Continued From page 12</p> <p>through 12/28/11, R186 lost another 2.3 lbs. The total percentage of weight loss from 10/21/11 through 12/28/11 was equal to 8.75% (over a nine and a half week time period) which was a significant weight loss and contrary to the stated goal of R186's nutrition care plan.</p> <p>Percentages of meal consumption records from 10/21/11 through 12/31/11 revealed that there were no consistently low intakes recorded.</p> <p>Review of R186's laboratory values revealed that an albumin level and total protein were drawn on 11/3/11. Results were: albumin was 3.3 (limits: 3.3-5.2 G/DL) and total protein was 5.1 (limits: 6.0-8.5 G/DL). On 11/10/11 an albumin level was 3.5 (within normal limits). Laboratory blood tests drawn on 1/3/12 revealed the albumin was 3.2 G/DL and the total protein was 5.6 G/DL. On 1/4/11 the physician ordered that R186 receive 30 ml (milliliters) Promod (liquid protein supplement) twice a day.</p> <p>On 12/30/11, R186 was observed at the midday meal. Calculations of the amount consumed by the resident after the tray was removed from the room was 25%. Review of the CNA Data sheet for meal consumption for that meal also documented 25% consumed.</p> <p>R186 was again observed on 1/3/12 during breakfast and lunch. The surveyor calculated that R186 ate only 25% at each of these two meals. The CNA Data sheet for meal consumption at breakfast and lunch on 1/3/12 documented that she had consumed 100%. This raised the question of the accuracy of the meal consumption records.</p>	F 325	See Previous Page	
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F 325	<p>Continued From page 13</p> <p>During an interview on 1/3/12 with E5, she stated that a "safe, gradual weight loss" would be 3-4 pounds per week and that it depended on the resident's weight, if their weight is lower then 1-2 lbs per week. E5 stated that R186 is still being monitored and followed weekly with weights and that the weight loss was beneficial.</p> <p>A physician's progress note, dated 1/4/12 stated "asked to evaluate (patient) weight change...I would like to see her (approximately) 180..." Review of earlier physician progress notes revealed no mention of R186's weight loss.</p> <p>On 1/4/11 at 11:30 AM at a second interview with E5 the concern of the accuracy of the meal consumption documentation from 1/3/11 was reviewed. E5 continued to state that R186's weight loss was beneficial. Although R186's weight loss was beneficial, the facility failed to develop a plan of care for a planned weight loss and failed to discuss this with the resident and family prior to the weight loss. The goal of the care plan of 10/21/11 and the comment of the RD on the 11/9/11 nutrition note are in conflict.</p>	F 325	See Previous Page	
F 364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 364	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>1. The two examples cited were test trays and were not intended for resident consumption. No resident was affected.</p>	1-30-12

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F 364	Continued From page 14 Based on test tray evaluations it was determined that the facility failed to ensure that food was palatable and served at proper temperature. Findings include:  1. On 1/3/12 at 12:20 PM, a test tray was sampled in the Greenbank Dining Room for temperature and palatability. The test tray was delivered on the second meal cart and after all residents received and began eating, the test tray was sampled for temperatures and taste. The food temperatures were as follows: ham=119.8 degrees Fahrenheit (F), sweet potatoes=118.5 F; brussel sprouts=120.5 F. The food was determined to be unpalatable.  2. On 1/3/12 at 12:59 PM, a test tray was sampled from a cart delivered to the C-wing residents for temperature and palatability. The test tray was delivered on the meal cart and after all residents received and began eating, the test tray was sampled for temperatures and taste. The food temperature was as follows: corn cereal=189.9 degrees Fahrenheit (F). The food was determined to be too hot and potentially unsafe.	F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (con't)  2. All residents have the potential to be affected. 3. A food grade thermometer is placed next to the kitchen microwave to ensure appropriate food temperature prior to delivery of trays. Kitchen staff will be inserviced regarding palatability of food  4. The Food Service Director/designee will audit food tray palatability at least weekly x 4, then monthly x 2 and report findings through the QA process	1-30-12  1-30-12
F 371 SS=C	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	See Following Page	1-30-12

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F 371	Continued From page 15  This REQUIREMENT is not met as evidenced by: Based on observations made in the kitchen and staff interviews, it was determined that the facility failed to prepare, serve and distribute food under sanitary conditions. On 12/28/2011 facility staff failed to test the sanitizing solution for the dishwasher with the correct test strip and failed to have sanitizer in one bucket used to clean food prep surfaces. Findings include:  1. Observations of the dishwasher made during the tour of the kitchen on 12/28/11 at 9:10 AM with E19 (Dietary Staff) revealed the wrong sanitizer test kit was used to test the concentration of the hypochlorite solution in the dishwasher. The sanitizer (chlorine) solution concentration in dishwasher was tested by E19 using a quaternary test strip. E19 detected 100 PPM. In an interview with E19 on 12/28/11, he stated he was aware he was not using the chlorine test kit and had used the test kit provided by the dietary clerical staff. He confirmed he knew it was not the proper test kit when he tested the solution.  In an interview with E20 (Food Service Director) on 12/28/11 at 9:30 AM, he asked E19 to test the chlorine sanitizer in the dishwasher. E20 was observed requesting E19 to make up a new sanitizer solution and discard the solution in the dishwasher at the time. The chlorine sanitizer solution concentration in the dishwasher was tested by E19 using a chlorine test strip provided by E20. A concentration of 200 PPM of chlorine using the proper sanitizer test kit was obtained.	F 371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY  1. Example 1: The high-temperature dishwasher functions correctly and sanitizes the dishware. The chemical sanitizer is used as a backup. Example 2: The sanitizer buckets were emptied and appropriate solution replaced immediately. 2. All residents have the potential to be affected. 3. The Food Service Director has revised the process to check sanitizer solutions. Kitchen staff will be inserviced regarding this process 4. The Food Service Director/designee will audit sanitizer solutions to ensure appropriate levels at least weekly x 4, monthly x 2 and report findings through QA process.	1-30-12 1-30-12 1-30-12 1-30-12

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F 371	Continued From page 16 E20 stated that he stored the test kit in the office to remove potential for damaging the test strip. An interview with E20 on 1/3/12 at lunch revealed he had contacted the sanitizing vendor to check the sanitizing solution in the dishwasher.  2. On 12/30/11 at approximately 1:30 PM, the sanitizer concentration of one red sanitizer bucket in the steam table area in the kitchen, used at the time by dietary staff for cleaning rollers in the tray area of the steam table, was tested using a test strip. The test strip detected zero concentration of sanitizer. In an interview with E20 on 12/30/11, he revealed that the concentration was weak and not at the proper concentration. He was observed asking the staff to change the sanitizer solution.	F 371	See Previous Page	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  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.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  1. Medications described were removed and discarded. 2. All residents have the potential to be affected. 3. The Unit Managers/designee will check bi-weekly to ensure multi-dose vials are dated appropriately. The Pharmacy Consultant will review multi-dose vials monthly to monitor compliance.	1-30-12 1-30-12 1-30-12

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F 431	<p>Continued From page 17</p> <p>controls, and permit only authorized personnel to have access to the keys.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and review of facility's policies, it was determined that the facility failed to remove three open multi dose medication vials of vaccines from general use after 30 days and failed to label one multi dose vaccine vial with an open date. Findings include:</p> <p>The medication room for nursing units F and G was inspected at approximately 12:10 PM on 1/4/12. Three (3) vials of Tuberculin (PPD) Skin Test/ Tubersol were found open for use in the medication room refrigerator with the following open dates: 10/13/11, 11/23/11 and 11/23/11. One vial of Influenza Virus Vaccine was also found open for use (half empty) with no date or label of vial being opened. No vial exceeded the manufacturer's expiration date.</p> <p>The facility's pharmacy manual "Policies and Procedures, Pharmacy Services for Nursing Facilities" states in section II (Medication</p>	F 431	<p><b>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BILOGICALS (con't)</b></p> <p>4. The Unit Managers and Pharmacy consultant will review findings and report through the QA process.</p>	1-30-12
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F 431	Continued From page 18 Administration) that Medication in multidose vial may be used (until the manufacturer's expiration date/for the length allowed by state law/ according to facility policy for thirty days) if inspection reveals no problem during that time. The State of Delaware Division of Public Health references the United States Pharmacopeia (USP) General chapter 797 [16/injection safety/provides/references.html#ref16] which states, "If a multi-dose has been open or accessed (e.g., needle-punctured) the vial should be dated within 28 days unless the manufacturer specifies a different (shorter or longer) date for that open vial".  The vials were brought to the attention of E4, Unit Manager at 12:30 PM who was able to verify that the dates exceeded the 30 day use policy. She immediately removed the vials for medication disposal.	F 431	See Previous Page	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to ensure that the emergency call light system for residents in room B8A and B8B (R26 and R100) was functional. The light above the room door was not lighting and the signal and audio were missing outside the room and at the nursing station. The	F 463	483.70(f)(1) RESIDENT CALL SYSTEM-ROOMS/TOILET/BATH  1. Room B8's call bell was reset and was found to be functioning. 2. All residents have the potential to be affected.	1-30-12  1-30-12

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F 463	<p>Continued From page 19 facility corrected the call bell system immediately. Findings include:</p> <p>Observation on 12/28/11 at 1:40 PM revealed that the call bells used by two residents in room B8A and B8B was nonfunctional, not lighting up at the nursing station, no audio at the nursing station or in hallway outside room, or lighting up above the door of the room to alert staff in the hallways. The call bell was pressed at 1:40 PM by R26 and when staff did not show by 1:53 PM, the surveyor proceeded to test the call bell, found it to be nonfunctional and contacted facility staff. E15 (CNA) with E16 (Housekeeping staff) was observed pressing the call light on 12/28/11 at 1:54 PM in resident room B8A and B8B and it did not trigger a light above the door or, a sound in the hallway outside the room or at the nursing station call bell alert panel. E15 and E16 confirmed the call bell was not working, the light above door was not lighting up and there was no sound in the hallway of the B-wing.</p> <p>Additionally, observation of the call bell annunciator system at the nursing station on 12/28/11 at 1:56 PM with E17 (Nurse) and E15, after having pulled the call bell in room B8A and B8B, revealed the phone light flashing intermittently, but not indicating a room number when the call was triggered, and had no sound. E17 confirmed the system was not working properly. She proceeded to contact maintenance.</p> <p>In an interview with E10 (Maintenance Staff) on 12/28/11 at 2:01 PM, revealed that the call bell system for the wings B and C were fixed. E10 stated that he re-set all the call bell systems for both B and C wing resident rooms after he was</p>	F 463	<p>483.70(f)(1) RESIDENT CALL SYSTEM-ROOMS/TOILET/BATH (con't)</p> <p>3. The Maintenance Director/designee will ensure 100% of facility call bells will be checked for proper function weekly as part of an ongoing weekly preventive maintenance program which began 11-3-10. These reports are given to the administrator weekly.</p> <p>4. The Maintenance Director/designee will audit call bell preventive maintenance logs and report findings through the QA process.</p>	<p>1-30-12</p> <p>1-30-12</p>
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F 463	Continued From page 20 alerted of the problem with the emergency call system. E10 stated that when the phone was left off the hook at the nursing station, the call bell system would not function.	F 463	See Previous Page	
F 514 SS=D	483.75(I)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that for one (R186) of 45 residents reviewed, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented. Findings include:  Cross refer to F325 R186 was observed on 1/3/12 during breakfast and lunch. The surveyor calculated that R186 ate only 25% at each of these two meals. The CNA Data sheet for meal consumption at breakfast and lunch on 1/3/12 documented that she had consumed 100%.	F 514	483.75(I)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  1. R186 suffered no untoward effect. 2. All residents could be potentially affected 3. All nursing staff will be educated regarding accuracy and documentation of meal consumption 4. The RD will do random audits to ensure accuracy of meal consumption is documentation bi-weekly x 4, then monthly x 2 and report findings through the QA process.	1-30-12; 1-30-12 1-30-12 1-30-12

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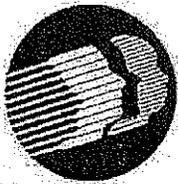
PRINTED: 01/27/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/04/2012
NAME OF PROVIDER OR SUPPLIER  BRANDYWINE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 GREENBANK ROAD WILMINGTON, DE 19808	
(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 514	Continued From page 21	F 514	See Previous Page	
F 520 SS=E	<p>On 1/4/11 at 11:30 AM during an interview with E5 the concern of the inaccuracy of the meal consumption documentation from 1/3/11 was reviewed.</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility documents and interview, it was determined that the facility failed</p>	F 520	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <ol style="list-style-type: none"> <li>The facility QA committee met quarterly and the findings were reviewed with the Medical Director. 1-30-12</li> <li>All residents could be potentially affected. 1-30-12</li> <li>The quarterly QA meeting schedule has been revised and scheduled for the next 4 quarters. The schedule has been approved by the Medical Director. 1-30-12</li> <li>The DON will review and ensure required members of the QA committee are in attendance and report findings through the QA process. 1-30-12</li> </ol>	

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F 520	Continued From page 22 to meet the requirements for the number of Quality Assessment (QA) committee members to be present for quarterly meetings which included the Director of Nursing (DON), a physician and at least three other facility staff members. Findings include:  Review of the facility QA quarterly meeting sign in sheets (which included a physician) revealed that a physician was not in attendance for any of the quarterly meetings held in the 2011 calendar year.  During an interview on 1/4/12, E2 (DON) acknowledged the findings.	F 520	See Previous Page		



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Residents Protection

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Wilmington, Delaware 19806  
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STATE SURVEY REPORT

Page 1 of 3

NAME OF FACILITY: Brandywine Nursing Home

DATE SURVEY COMPLETED: January 4, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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The State report incorporates by reference and also cites the findings specified in the Federal report.

An unannounced annual survey was conducted at this facility from December 27, 2011 through January 4, 2012. The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 160. The Stage II sample totaled forty-five (45) residents.

3201

**Nursing Home Regulations For Skilled Care**

3201.1

**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.**

3201.1.2

**This requirement is not met as evidenced by:**

Cross refer to CMS 2567-L survey date completed 1/4/12, F166, F205, F246, F280, F309, F325, F364, F371, F431, F463, F514 and F520.

For plan of correction, please cross refer to CMS 2567-L survey date completed 1/14/12, F166, F205, F246; F280, F309, F325, F364, F371, F431, F463, F514, and F520

1-30-12

Provider's Signature

Title

Date



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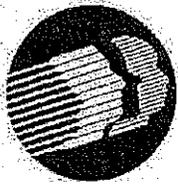
STATE SURVEY REPORT

Page 2 of 3

NAME OF FACILITY: Brandywine Nursing Home

DATE SURVEY COMPLETED: January 4, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.7.5	<p><b>Kitchen and Food Storage Areas.</b> Facilities shall comply with the Delaware Food Code.</p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 3-304.14, 4-302.14, and 4-501.116 of the State of Delaware Food Code. Findings include:</p> <p><b>3-304.14 Wiping Cloths, Use Limitation.</b> (B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114; and</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed, 1/4/11, F371, example 2.</p> <p><b>4-302.14 Sanitizing Solutions, Testing Devices.</b> A test kit or other device that accurately measures the concentration in MG/L of sanitizing solutions shall be provided.</p> <p><b>4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration.</b>  Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device.</p> <p><b>This requirement was not met as</b></p>	



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STATE SURVEY REPORT

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NAME OF FACILITY: Brandywine Nursing Home

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p><b>evidenced by:</b></p> <p>Cross refer to the CMS 2567-L survey report date completed, 1/4/11, F371, example 1.</p>	