

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

PRINTED: 09/26/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/01/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD WILMINGTON, DE 19808</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced annual survey was conducted at this facility from July 25, 2016 through August 1, 2016. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 166. The Stage 2 survey sample size was 38.</p> <p>Abbreviations/definitions used in this report are as follows:            NHA - Nursing Home Administrator;            DON - Director of Nursing;            ADON - Assistant Director of Nursing;            RNAC - Registered Nurse Assessment Coordinator;            UM - Unit Manager;            RN - Registered Nurse;            LPN - Licensed Practical Nurse;            CNA - Certified Nurse's Aide;            FMD - Facility Maintenance Director;            SS - Social Services;</p> <p>1:1 Supervision - 1 to 1-one staff person assigned direct supervision of one resident;            Abrasion - superficial wound caused by rubbing or scraping the skin;            ADL / Activities of Daily Living - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing;            Adjustment disorder - group of symptoms such as stress, feeling sad or hopeless, having a hard time coping after a stressful life event;            Agitated / agitation - emotional state of restlessness;            Anxiety / anxious - fear strong enough to interfere with daily life;</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>09/06/2016</b>
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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 000	Continued From page 1 Always incontinent - no episodes of continent voiding; Cognitively intact - able to make own decisions; Combative - ready to fight; Contenance - control of bladder function; Dementia - memory loss and other mental abilities severe enough to interfere with daily life; Depression- mood disorder; Diagnostic tests - procedures performed to confirm, or determine the presence of trauma or disease in an individual; Dumped - leaned back wheelchair seat; e.g.-for example; Frequently incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding; Hematoma - collection of blood as a result of trauma, such as a black eye; Hipsters - impact-absorbing pads worn under clothes to minimize potential damage that can occur from a fall; IDT / Interdisciplinary Team - a group of staff that discuss the patient's plan of care; Incontinent / incontinence - loss of control of bladder function; Insomnia - sleep disorder that is characterized by difficulty falling and/or staying asleep; Intervention - any treatment or approach based upon clinical judgement and knowledge that a nurse performs to enhance patient outcomes; Legally blind - total blindness; Locomotion-move from one place to another; Locomotion off unit - how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair; Locomotion on unit - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair;	F 000			

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F 000	Continued From page 2 MDS / Minimum Data Set - standardized assessment forms used in nursing homes; MDS coding 0-0: independent; does not require setup or physical help from staff. Activity occurred 3 or more times during the 7 day review period; MDS coding 1-0: limited assistance (resident highly involved in activity) and no setup or physical help from staff. Activity occurred 3 or more times during the 7 day review period; MDS coding 2-2: limited assistance (resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance) with one person physical assist. Activity occurred 3 or more times during the 7 day review period; MDS coding 4-2: total dependence (full staff performance every time during entire 7 day review period) with one person physical assist; MDS coding 8-8: activity did not occur or family and/or non-facility staff provided care 100% of the time over the 7 day review period; Moderate cognitive impairment - decisions poor; cues and supervision required; Non-pharmacological - interventions, such as toileting, fluids or snacks, that does not involve the use of any drug or medicine; OOB - out of bed; OOF - out of facility; OOR - out of room; Pericare - washing the genitals and anal area; Psychology - study of behavior and mind; Prompted voiding plan-technique of bladder training in which the patient is instructed to urinate according to a predetermined schedule; Rear anti-tippers - device used to prevent a wheelchair from tipping backwards; Redirection - therapeutic technique used to change a resident's behavior; Restorative walking program - restorative nursing	F 000		

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F 000	Continued From page 3 interventions to promote the resident's ability to adapt and adjust to living as independently and safely as possible; Severe cognitive impairment - never/rarely makes decisions; mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; Skin tear - minor injury that results from the separation of two layers of skin; Therapeutic approach - technique that focuses on changing problematic behaviors, feelings, and thoughts; Urine Analysis - diagnostic test used to determine presence of infection; Velcro alarm seatbelt - safety alarm device that alerts caregivers of attempts of unassisted wheelchair transfers by a resident, who is able to self-release and needs the reminder of a velcro lap belt; Voiding diary-a record of voiding [urinating] for 72 hours or 3 days; X-times; Xanax - medication used for anxiety.	F 000			
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that activities were provided in	F 248	F248 483.15(f) (1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES A. R3 now gets up more frequently and	9/30/16	

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F 248	<p>Continued From page 4</p> <p>accordance with the interests of one (R3) out of 38 Stage 2 sampled residents. Findings include:</p> <p>Review of R3's clinical record revealed the following:</p> <p>4/17/12 - A care plan for the problem of unable to do own ADL's without assistance, last reviewed 7/27/16, included the approach "encourage resident to attend activities of choice and staff to assist resident to activity as to extent required."</p> <p>4/17/12 - A care plan for potential for altered mood, last reviewed 7/27/16, noted the resident refuses to get OOB and included the approach to encourage activities of resident's choice and preference, and assist to activities as needed.</p> <p>8/12/15 - A care plan "prefers to establish own goals," last reviewed 7/27/16, included the goals: "Resident will agree to OOB and OOR stimulation among peers for socialization and mental stimulation at a minimum of 1 x (time) per week," and "Resident will accept 1:1 visits at a minimum of 2 x per week". Care plan approaches included: "Resident will be invited, reminded and escorted to activities of choice: active games (sports)/outside time, socials/special events, and entertainment," and "Resident will be engaged in meaningful activities on a 1:1 setting".</p> <p>10/28/15 - The annual MDS assessment stated R3 had unclear speech, had difficulty communicating some words or finishing thoughts but is able if prompted or given time, and that he is able to understand others. This MDS assessment also stated R3 was totally dependent on two (2) staff for transfers to and from bed. According to the MDS, the resident stated the</p>	F 248	<p>has been in activities on a more regular basis. R3 has been participating in kickball, soccer, bocce ball, going outdoors, and attendance at social and special events. R3 has also been added to a list of residents who wish to have dog visits. Resident continues to refuse to get OOB at times, so one-on-one visits are also offered and have been regularly accepted. R3 also enjoys listening to music with roommate and enjoyed watching the Rio Olympic Games.</p> <p>B. Any resident unable to do ADLs without assistance to attend activities, frequently refuses to get OOB with a care plan to attend activities (one-on-one, group, or both), or is found asleep at the appointed room visit activity has the potential to be affected.</p> <p>C. Activities Director, or designee, will compile a list of residents who need additional encouragement to get OOB, need nursing assistance with ADLs to attend OOR activities, and/or frequently require one-on-one visits to meet their needs. The list will be shared with the Nursing Department so that resident needs are regularly met. Activities Director, or designee will ensure that activities are regularly offered to these identified residents.</p> <p>D. The Activity Director, or designee, will audit 100% of Daily Participation Logs to ensure compliance. Audits will be conducted daily for the first 14 days, then twice weekly, and then quarterly until 100% compliance has been observed for two consecutive quarters. Results will be reported quarterly through the facility</p>		

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F 248	<p>Continued From page 5</p> <p>following activity preferences were very important: to listen to music you like; to do your favorite activities; and to go outside to get fresh air when the weather is good. Additionally, the following activity preferences were identified as being somewhat important: to have books, newspapers and magazines to read; to be around animals such as pets; to keep up with the news; and to do things with groups of people.</p> <p>Review of R3's Activity Participation Logs revealed the following: April, 2016:</p> <ul style="list-style-type: none"> <li>- There was no evidence that R3 was invited to and/or declined participation to any entertainment, music or special event;</li> <li>- There was one (1) documented participation in "active games/exercise";</li> <li>- There was one (1) documented participation in "outside/outing";</li> <li>- There were no documented pet visits;</li> <li>- There were eight (8) 1:1 visits signed off, however on two (2) of those visits it was noted the resident was asleep.</li> </ul> <p>4/26/16 - An Activity Participation Log documentation note stated, "...asked if he wanted to play kickball in the dining room he said yes. Activity staff asked the nurse to get him up to play kickball. I continued to speak with resident and then stepped out to ask for him to get up again. They said they would...Despite my efforts resident was laying in bed an hour later after the activity finished."</p> <p>May, 2016:</p> <ul style="list-style-type: none"> <li>- There was no evidence that R3 was invited to and/or declined participation to any entertainment, music or special event;</li> <li>- There were no documented evidence of</li> </ul>	F 248	QAPI process.	

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F 248	<p>Continued From page 6 participation or decline in "active games/exercise";</p> <ul style="list-style-type: none"> <li>- There were no documented pet visits;</li> <li>- There were six (6) 1:1 visits signed off, however on three (3) of those visits it was noted the resident was asleep.</li> </ul> <p>June, 2016:</p> <ul style="list-style-type: none"> <li>- There was one (1) documented participation each in a special event and "outside/outing".</li> <li>- There was one (1) documented declined in "active games/exercise";</li> <li>- There were no documented pet visits;</li> <li>- There were eight (8) 1:1 visits signed off, however on two (2) of those visits it was noted the resident was asleep.</li> </ul> <p>The following observations were made of R3: 7/27/16 at 11:50 AM - laying on bed flat on back, asleep. 7/28/16 at 8:30 AM - laying on bed on back, therapist in room with resident, roommate is playing music that is audible to R3. 7/28/16 at approximately 1:00 PM - laying on bed on back, awake, not engaged in any activity.</p> <p>7/29/16 at 1:35 PM - During an interview with E4 (RN/UM) stated that R3 will rarely get OOB.</p> <p>7/29/16 at 1:45 PM - During an interview, E9 (Activity Assistant) stated that she is assigned to provide 1:1 visits for R3. E9 stated that it is hard to get R3 to agree to get OOB, that he refuses a lot, but that he does like bocce ball and kickball. E9 confirmed that at times it is difficult getting the nursing staff to get him OOB for an activity.</p> <p>7/29/16 at 3:50 PM - During an interview, E7 (Activity Director) reviewed the activity calendar</p>	F 248		

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F 248	Continued From page 7 and R3's participation logs with this surveyor. E7 stated there were no special events held in April 2016, and that the pet visits are provided by activity staff with the facility cat. E7 stated that R3 does not like cats, only dogs. E7 stated that there are volunteers that come into the building with dogs, but it is usually in the evening and activity staff is not present to see which residents they visit. E7 stated that R3 did participate in out of facility events the past several months, however, these were not all documented on his participation logs. Finally, E7 stated that she would expect that when the activity assistants are doing 1:1 visits and the resident is asleep that they return later that day or at least by the next day.  The facility failed to provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Review of activity participation logs revealed that R3's activity care plan goals were not being met for 1:1 visits; that there was no evidence of the resident being offered and/or refusing to participate in activities that according to his preferences were important to him such as preferences active games, socials/special events, entertainment and going outdoors.	F 248		
F 253 SS=E	Findings were reviewed with E1 (NHA) and E2 (DON) on 7/29/16 at approximately 4:20 PM. 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		9/23/16

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F 253	<p>Continued From page 8 sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure that all areas were clean and in good repair for 12 rooms (Wing E rooms 11, 12, 14, Wing C rooms 7, 9, Wing F room 3, Wing G rooms 2, 3, 5, 9, 12, and 15) out of 36 rooms and the loading dock in the basement. Findings include:</p> <p>1. Observations on 7/25/16 and 7/26/16 during the Stage 1 review and during the environmental tour with E8 (FMD) on 7/27/16 between 1:15 PM and 2:15 PM revealed the following:</p> <p>Wing E Room 11 - The bathroom door threshold was dirty and in disrepair;</p> <p>Wing E Room 12 - There were unpainted areas on the wall to the right of the B bed; - The sink was slow draining;</p> <p>Wing E Room 14 - There were unpainted areas on the wall to the right of the B bed;</p> <p>Wing C Room 7 - The AC panel was in disrepair; - The bathroom door threshold was worn;</p> <p>Wing C Room 9 - There was a long scratch on the wall to the right of the clock; - The over bed tray table metal frame was dirty;</p>	F 253	<p>Example 1 Wing E Room 11 A. The bathroom door threshold was replaced in Wing E Room 11. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) found. Repairs will be completed as identified. D. The FMD or designee will review two resident rooms on each hallway (6) daily for 14 days, then two times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported through the QAPI process.</p> <p>Wing E Room 12 A. The areas identified in Wing E Room 12 have been painted and the sink was unclogged. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) found. Repairs will be completed as identified. D. The FMD or designee will review two resident rooms on each hallway (6) daily for 14 days, then two times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported through the QAPI process.</p>		

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F 253	<p>Continued From page 9</p> <ul style="list-style-type: none"> <li>- The closet door first drawer was cracked down the middle;</li> </ul> <p>Wing F Room 3</p> <ul style="list-style-type: none"> <li>- The bathroom door on the inside was badly scraped at the bottom;</li> </ul> <p>Wing G Room 2</p> <ul style="list-style-type: none"> <li>- The bedroom floor was dirty;</li> <li>- There were stains on the ceiling tile;</li> </ul> <p>Wing G Room 3</p> <ul style="list-style-type: none"> <li>- The bathroom floor was dirty;</li> <li>- There was a spill on the wall next to the toilet;</li> </ul> <p>Wing G Room 5</p> <ul style="list-style-type: none"> <li>- The bathroom light was dirty;</li> <li>- The corners of the bathroom floor was dirty;</li> </ul> <p>Wing G Room 9</p> <ul style="list-style-type: none"> <li>- The dresser was missing the handle on the third drawer;</li> <li>- The bedroom and bathroom floors were dirty;</li> <li>- The caulking behind the sink was discolored, cracked and dirty;</li> </ul> <p>Wing G Room 12</p> <ul style="list-style-type: none"> <li>- The bedroom floor was dirty;</li> <li>- The dresser was missing a drawer handle;</li> </ul> <p>Wing G Room 15</p> <ul style="list-style-type: none"> <li>- The bedroom closet had a hole in it;</li> <li>- There was a hole in the wall around the pipe under the bathroom sink;</li> <li>- There were black marks on the walls inside the resident's room door to the left.</li> </ul> <p>2. An observation made on 7/25/16 at 10:00 AM revealed that the metal door leading to the</p>	F 253	<p>Wing E Room 14</p> <ul style="list-style-type: none"> <li>A. The areas identified in Wing E Room 14 have been painted.</li> <li>B. All residents have the potential to be affected.</li> <li>C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) found. Repairs will be completed as identified.</li> <li>D. The FMD or designee will review two resident rooms on each hallway (6) daily for 14 days, then two times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported through the QAPI process.</li> </ul> <p>Wing C Room 7</p> <ul style="list-style-type: none"> <li>A. The AC panel has been repaired and the bathroom door threshold was replaced.</li> <li>B. All residents have the potential to be affected.</li> <li>C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) found. Repairs will be completed as identified.</li> <li>D. The FMD or designee will review two resident rooms on each hallway (6) daily for 14 days, then two times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported through the QAPI process.</li> </ul> <p>Wing C Room 9</p> <ul style="list-style-type: none"> <li>A. The scratch identified was an open wallpaper seam which has been cut and patched. The over bed table frame was cleaned, and the closet drawer has been replaced.</li> </ul>		

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F 253	Continued From page 10 outside located at the loading dock was in disrepair.  Findings were reviewed and confirmed with E8 on 7/27/16 between 1:15 PM and 2:15 PM.  Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) on 8/1/16 at approximately 1:35 PM.	F 253	B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) and items found. Repairs will be completed as identified. D. The FMD or designee will review two resident rooms on each hallway (6) daily for 14 days, then two times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported through the QAPI process. Wing F Room 3 A. The bathroom door in Wing F Room three has been painted. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) or items found. Repairs will be completed as identified. D. The FMD or designee will review two resident rooms on each hallway (6) daily for 14 days, then two times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported through the QAPI process. Wing G Room 2 A. The bedroom floor was cleaned and the ceiling was examined for stains, however there are no ceiling tiles in this room. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include examination		

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F 253	Continued From page 11	F 253	<p>for the deficient practice(s) or items found. Repairs and corrections will be completed as identified.</p> <p>D. The FMD or designee will review two resident rooms on each hallway (6) daily for 14 days, then two times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported through the QAPI process.</p> <p>Wing G Room 3</p> <p>A. The bathroom floor and wall were cleaned.</p> <p>B. All residents have the potential to be affected.</p> <p>C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) or items found. Repairs and corrections will be completed as identified.</p> <p>D. The FMD or designee will review two resident rooms on each hallway (6) daily for 14 days, then two times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported through the QAPI process.</p> <p>Wing G Room 5</p> <p>A. The bathroom light and floor corners were both cleaned.</p> <p>B. All residents have the potential to be affected.</p> <p>C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) or items found. Repairs and corrections will be completed as identified.</p> <p>D. The FMD or designee will review two resident rooms on each hallway (6) daily</p>		

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F 253	Continued From page 12	F 253	<p>for 14 days, then two times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported through the QAPI process.</p> <p>Wing G Room 9</p> <p>A. The dresser handle was replaced, the bedroom and bathroom floors were cleaned and the sink was replaced.</p> <p>B. All residents have the potential to be affected.</p> <p>C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) or items found. Repairs and corrections will be completed as identified.</p> <p>D. The FMD or designee will review two resident rooms on each hallway (6) daily for 14 days, then two times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported through the QAPI process.</p> <p>Wing G Room 12</p> <p>A. The bedroom floor was cleaned and the drawer handle was replaced.</p> <p>B. All residents have the potential to be affected.</p> <p>C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) or items found. Repairs and corrections will be completed as identified.</p> <p>D. The FMD or designee will review two resident rooms on each hallway (6) daily for 14 days, then two times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported through the QAPI</p>	

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F 253	Continued From page 13	F 253	<p>process. Wing G Room 15 A. The bedroom closet has been repaired, the hole below the sink has been patched sink and the wall has been repainted. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) or items found. Repairs and corrections will be completed as identified. D. The FMD or designee will review two resident rooms on each hallway (6) daily for 14 days, then two times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported through the QAPI process.</p> <p>Example #2 A. Quotes to replace the loading dock metal doors have been obtained and they will be replaced in the next few weeks. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) or items found. Doors found to be in disrepair will be fixed or replaced, as necessary. D. The FMD or designee will look at all service area hallway doors at least quarterly. Findings will be reported through the QAPI process.</p>	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		9/30/16

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F 274	<p>Continued From page 14</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to conduct a comprehensive assessment for one (R148) out of 38 stage 2 residents within 14 days after the facility should have determined there was a significant change in the resident's physical or mental condition on the 6/1/16 quarterly MDS. R148 declined on the 6/1/16 quarterly MDS in locomotion and walking when compared with the previous, a significant change MDS dated 3/2/16. Findings include:</p> <p>Review of R148's 3/2/16 significant change MDS coded the following:</p> <p>locomotion on unit 0-0 locomotion off unit 1-0 walk in room 2-2</p> <p>Review of R148's 6/1/16 quarterly MDS coded the following:</p>	F 274	<p>F274 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A. Significant change MDS were completed for resident 148 on September 22, 2015, December 3, 2015, and March 2, 2016. A quarterly MDS was completed on June 1, 2016 for resident 148. A significant change MDS was completed on August 8, 2016 to reflect resident 148's change in condition.</p> <p>B. All residents could be affected.</p> <p>C. All OBRA compliant MDS will be compared with in-progress MDS for accuracy and to identify possible significant change by RNAC/designee.</p> <p>D. RNAC/designee will review all OBRA compliant MDS for accuracy daily X 14, then weekly X 2, then Monthly X 2 and report findings through the QAPI process.</p>		

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F 274	Continued From page 15  locomotion on unit 4-2 locomotion off unit 4-2 walk in room 8-8  R148 declined from the 3/2/16 significant change MDS to the 6/1/16 quarterly MDS in locomotion on and off the unit and in walking in his room. The facility miscoded the 6/1/16 quarterly MDS and failed to identify that it should have been coded as a significant change MDS.  Findings were confirmed with E10 (MDS Coordinator) during an interview on 7/29/16 at approximately 9:05 AM.	F 274		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on record review, interview and observations, it was determined that the facility failed to ensure that one (R192) out of 38 Stage 2 sampled residents, who was incontinent of bladder, received appropriate treatment and services to restore as much normal bladder	F 315	F315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER A. A new voiding diary was initiated for resident 192 on July 28, 2016. A toileting program was initiated specifically verbal cueing before and after meals and at HS	9/30/16

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F 315	<p>Continued From page 16</p> <p>function as possible. Although R192 was assessed as continent of bladder on admission, the facility failed to recognize, in a timely manner, that R192 had a decline in bladder status. R192 experienced 37 incontinent episodes from 6/2016 through 7/20/16. Findings include:</p> <p>The facility's policy dated July, 2015, entitled "Incontinence Policy and Procedure: stated, "...Each incontinent resident will be assessed in an effort to improve or maintain bladder function as indicated...Following assessment, individualized goals will be developed and implemented as agreed upon by the IDT. Suggested Methods of Incontinence Reduction: ... Monitoring- the resident is checked by care givers on a regular basis to determine if wet or dry. ... Positive reinforcement- the resident is encouraged to maintain continence.</p> <p>Procedure:</p> <ol style="list-style-type: none"> <li>1. The ...bladder assessment is completed upon admission, quarterly and with any significant change to identify those residents who are incontinent or who have a decline in continence.</li> <li>2. Any resident who scores in the range from 7-14 should have a voiding diary completed...</li> <li>3. Complete the diary for 72 hours, evaluating the resident every 2 hours...</li> <li>4. After 72 hour diary is completed, review the voiding diary to establish an appropriate timed voiding schedule, prompted voiding plan or other plan as determined by the IDT.</li> <li>5. Once a schedule is developed (if any), monitor the plan for five days, using the maintenance form. Modify the schedule as needed.</li> <li>6. Update the care plan and the toileting plan flow sheets as needed. Review with the CNA any follow through as needed."</li> </ol>	F 315	<p>as resident allows on August 4, 2016. Resident has regained continence.</p> <p>B. All residents could be affected.</p> <p>C. The Incontinence policy and procedure has been revised to include a continence status alert. Any three day change in continence within a seven day period will trigger the alert. The Unit Manager will review resident condition to determine possible causes and interventions for the change in continence.</p> <p>D. Unit manager/designee will review continence status alerts and response to same for compliance weekly x 4, then monthly x 2, and report through the QAPI process.</p>	

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F 315	<p>Continued From page 17</p> <p>Review of R192's clinical record revealed:</p> <p>R192 was admitted to the facility on 4/5/16. R192's 5 day MDS admission assessment dated 4/10/16 identified R192 as continent of bladder. R192 had diagnoses that included, dementia, depression, adjustment disorder with mixed disturbance of emotions and conduct, anxiety and legally blind. R192 was also assessed as cognitively intact and ambulated independently, however, R192 needed oversight supervision in transfer and dressing, with limited assistance of one staff in toileting, personal hygiene, and extensive assistance in bathing.</p> <p>Review of a Care Plan, dated 4/20/16, entitled "Resident is continent of bowel and bladder but needs assist to toilet" listed a care plan goal, "Resident will remain continent of ...bladder x 92 days". Interventions included: Assist resident with transfers to toilet upon request or per toilet schedule; Assist with pericare and clothing adjustment as applicable to resident's ability; Assist with devices for toileting if applicable; bedside commode, raised toilet seat, urinal, bedpan;..."</p> <p>The facility initiated a bedside commode for R192's toileting.</p> <p>6/20/16- R192 had 8 incontinent bladder episodes from 6/6/16 through 6/16/16 as per the CNAADL flow sheet.</p> <p>6/29/16 - quarterly MDS assessment identified R192 as continent of bladder in the 7 day look back period from 6/23-29/16. R192 was also</p>	F 315			

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F 315	<p>Continued From page 18</p> <p>documented as continent on the CNA ADL flow sheet.</p> <p>7/25/15 - during the facility entrance tour at 8:30 AM, surveyor noted a urine odor in R192's room and additionally, at 12:30 PM.</p> <p>7/27/16 - at approximately 8:30 AM, the same urine odor was noted.</p> <p>7/27/16 - at approximately 3:30 PM, E15 (3-11 PM CNA) was asked by the surveyor to join her in R192's room. A urine odor was noted in the room, by both E15 and the surveyor. According to E15 (CNA), sometimes R192 wets her bed or pants. Review of the CNA's ADL flow sheet for June 2016 and July 2016 showed a total of 37 urinary incontinence episodes. During an interview with E13 (UM) at approximately 3:45 PM, she stated that she was not aware that R192 had bladder incontinence episodes. According to E13, the CNAs should be reporting this to the nurse on the floor and then to her (UM) and the CNAs did not do so.</p> <p>7/28/16 - E13 initiated an every 2 hour voiding diary for R192.</p> <p>7/29/16 - E14 (7-3 PM CNA) was interviewed at approximately 8:30 AM and stated that between 7:30 -8:30 AM/before breakfast, sometimes she would find R192 wet and/or R192 would tell her that she had an accident. Although E14 stated that CNAs would check each other's documentation every shift, no one reported the findings that R192 was experiencing incontinence of bladder to a nurse or UM.</p> <p>The facility failed to ensure that R192, who entered the facility continent of bladder and developed incontinence of bladder, received</p>	F 315			

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F 315	Continued From page 19 appropriate treatment and services, in a timely manner, to restore as much normal bladder function as possible. Due to a lack of communication between the nursing staff, the facility failed to recognize that R192 had a significant decline in bladder function, they failed to re-assess the resident after this decline, failed to complete a voiding diary to determine voiding patterns, failed to revise the plan of care and lacked evidence that the resident's physician was involved or informed of this decline.	F 315			
F 323 SS=E	Findings were reviewed and confirmed with E2 (DON) on 7/29/16 at 2:06 PM. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for 2 (R172 and R175) out of 38 Stage 2 sampled residents, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision to prevent accidents. For R172, the facility failed to ensure that he received adequate supervision to prevent accidents. For R175, the left side half rail was loose on his bed, which posed an accident	F 323	F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Example 1 A. The facility attempted to balance resident 172's rights with resident safety in an effort to keep him at his highest level of function. As stated in the deficiency, the facility provided interventions appropriate for the circumstances of each event. On 1/1/16 resident fell out of his wheelchair	9/30/16	

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NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD WILMINGTON, DE 19808</b>
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F 323	<p>Continued From page 20 hazard. Findings include:</p> <p>1. Review of R172's clinical record revealed:</p> <p>R172 was admitted to the facility on 12/18/15 for long term placement with diagnoses including dementia with behavioral disturbance and insomnia.</p> <p>R172 was care planned on 12/21/15 for "Potential for injury related to decreased safety awareness, dementia diagnosis, poor balance and needs assistance with mobility".</p> <p>According to a psychology consult on 12/23/15, R172 was evaluated for mood and cognitive status. The consult stated that R172 was "use to being in a position of authority, so he was more likely to comply with tx (treatment) requests if he was 'consulted' rather than 'ordered'..."</p> <p>The admission MDS assessment, dated 12/25/15, stated that R172 was cognitively intact, wandered in and out of other resident's rooms on the unit in his wheelchair, exhibited behaviors towards others and required extensive assistance of one staff person for transfers.</p> <p>- 12/30/15 at 4:46 PM incident report - R172 fell out of bed, which resulted in a left elbow skin tear, an abrasion below his left eye and on his left eyebrow. A late entry nurse's note, dated 12/31/15 at 12:35 AM, stated that R172's spouse approached the nurse at the beginning of evening shift on 12/30/15 with her concern that R172 was moody and agitated. The nurse's note also stated that R172 was attempting to climb out of bed multiple times and everytime staff redirected him the more agitated he became.</p>	F 323	<p>after attempts to redirect and engage the resident failed to calm him. Staff member was disciplined for not timely providing an alarm as care planned. Residents last fall was prior to the survey on July 19, 2016 and resident 172 has had no further falls as IDT interventions are effective.</p> <p>B. All residents have the potential to be affected by the deficiency.</p> <p>C. The High Risk Committee will implement a new threshold for extra review related to frequent resident falls. Residents that experience more than two falls in a thirty day period will be scrutinized by specific members of the IDT to include, but not limited to representatives of Activities, Nursing, Social Services, and Therapy for possibly more intense interventions. ADON/designee will coordinate implementations made by this IDT for compliance.</p> <p>D. ADON/designee will review findings of this IDT weekly x 4, then monthly x 2 and report findings through the QAPI process.</p> <p>Example 2</p> <p>A. The side rail for R175 was secured and is safely functional.</p> <p>B. All residents with side rails have the potential to be affected. All side rails have been examined and are secure and functional.</p> <p>C. All staff will be in serviced regarding reporting loose side rails by Staff Development prior to September 30, 2016.</p> <p>D. Maintenance will observe side rails on 2 beds on each unit (total 6) daily to</p>	
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F 323	<p>Continued From page 21</p> <p>- 1/1/16 at 1:10 AM incident report - R172 was brought to the Greenbank lounge after an unsuccessful attempt to redirect the resident back to bed after toileting. R172 was noted to be aggressive and stated that he did not want to lay down. In the lounge, E16 (CNA) recognized that she did not apply his chair alarm and left R172 unattended to retrieve it in his room. Upon return, E16 found R172 on the floor complaining of head and neck pain. R172 was sent to the hospital emergency room to be evaluated. Diagnostic tests were negative. R172 returned to the facility later that morning at 10:47 AM with a discharge diagnosis of history of falls and his injuries included a hematoma to his left elbow and bruising to his right and left arm and left shoulder. In response to the fall, the facility disciplined E16 for leaving R172 unattended. The facility failed to provide adequate supervision to R172.</p> <p>- 1/5/16, 1/10/16, 1/29/16 and 2/6/16 - R172 fell out of bed with no injury.</p> <p>- 2/7/16 at 5:30 AM incident report - In the Greenbank lounge, R172 was witnessed standing up from his wheelchair to transfer himself to an armchair, fell and kicked the wall causing a hole with his foot. R172's chair alarm sounded and the nurse ran from the nurse's station located outside of the lounge and across the hall, but was unable to reach him in time. However, according to a 2/7/16 nurse's note written at 7 AM after the fall, R172 was noted to be running his wheelchair into the wall multiple times, combative with night shift staff and continued to be agitated. In response to the fall, the facility added a velcro alarm seatbelt to his wheelchair as an intervention. It was unclear why the facility did not provide adequate</p>	F 323	ensure side rails are secure; weekly x 4, and monthly x 2 until 100% compliance has been observed for two consecutive quarters. Maintenance will report findings through the QAPI process.	

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F 323	<p>Continued From page 22</p> <p>supervision when R172 was exhibiting the above behaviors.</p> <p>- 2/16/16 - R172 fell out of bed [reference to R172's bed refers to a bed in the lowest position, here and as listed below] with no injury.</p> <p>- 2/27/16 at 3:50 AM incident report - R172's bed alarm sounded and staff found him on his knees on the fall mat next to his bed. R172 was not injured. After the fall in his bedroom, R172 was placed in his wheelchair and brought to the Greenbank lounge. R172 continued to be anxious and agitated (yelling, cursing and hitting staff). Redirection and other non-pharmacological interventions were not effective so R172 was medicated with Xanax at 3:54 AM. At 4:20 AM, R172 was observed trying to hit a CNA and then proceeded to push himself in his wheelchair backwards which ended up tipping over. R172 sustained a hematoma with bruising on the back of his head. In response to the fall, rear anti-tippers were added to R172's wheelchair. It was unclear how the facility's therapeutic approach and supervision of R172 were effective when R172 continued to exhibit the above behaviors prior to his second fall, which resulted in an injury.</p> <p>- 3/3/16 - R172 fell out of bed with no injury.</p> <p>- 3/9/16 at 6:10 AM incident report - In the Greenbank lounge, E17 (CNA) heard an alarm sounding in the lounge while walking down F wing hallway and observed R172 attempting to transfer himself from his wheelchair to a lounge chair and fell. R172 was not injured. In response to the fall, the facility requested a medication review to address R172's insomnia and added hipsters as</p>	F 323			

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F 323	<p>Continued From page 23 an intervention.</p> <p>The quarterly MDS assessment, dated 3/25/16, stated that R172 had severe cognitive impairment and he exhibited inattention, disorganized thinking, physical and verbal behaviors. In addition, R172 rejected care daily, required extensive assistance of one staff person for transfers and experienced multiple falls since the 12/25/15 assessment.</p> <p>- 4/3/16 at 2:04 AM - A nurse's note stated that R172 had increased anxiety and agitation and was exhibiting verbal and physical behaviors. An incident report, dated 4/3/16 at 4:30 AM, stated while in the Greenbank lounge, R172's velcro alarm seatbelt was just re-applied by E18 (LPN) as R172 had been playing with it. E18 returned to the nurse's station located outside the lounge and across the hall, when R172's alarms sounded and she witnessed through the lounge window that R172 opened his seatbelt again and slid out of his wheelchair to the floor. E18 was not able to reach R172 in time. R172 was not injured. In response to the fall, the facility "dumped" his wheelchair seat as an intervention. The facility lacked evidence of adequate supervision of R172 in the Greenbank lounge when he was identified with a history of falls, continued to exhibit behaviors and was not able to be redirected.</p> <p>- 4/15/16 and 4/21/16 - R172 fell out of bed with no injury.</p> <p>- 4/27/16 at 8:45 AM incident report - In the Greenbank lounge, E19 (Unit Clerk) observed "feet in the window" from the nurse's station. R172 was found on the floor on his back while still seated in his wheelchair, alarms sounded and</p>	F 323			

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F 323	<p>Continued From page 24</p> <p>the wheelchair's rear anti-tippers shifted on the right side and bent upwards on the left side. R172's wheelchair flipped backwards despite having rear anti-tippers on his wheelchair. While R172 stated he hit his head on the wall, no injuries were identified. In response to the fall, the facility requested therapy to do a wheelchair seating evaluation and the clamped on rear anti-tippers were replaced with stronger anti-tippers that inserted into the wheelchair's metal frame. Despite having multiple physical interventions in place to prevent R172 from having an accident, the facility lacked evidence of adequate supervision of R172, who had a history of multiple falls and uncooperative behaviors.</p> <p>- 5/10/16 at 1:40 PM - A nurse's note stated that R172 was alert and oriented to self with confusion. An incident report, dated 5/10/16 at 6:30 PM, stated that E20 (CNA) heard R172's wheelchair alarms sounding and found R172 on the floor in his bathroom with his wheelchair behind his head. R172 stated that he was trying to toilet himself and was wearing non-skid footwear. E20 stated that she toileted R172 after dinner. R172 was not injured. In response to the fall, the facility ordered a urine analysis, which was negative, re-educated him on asking for assistance to toilet and placed non-skid strips in front of the toilet as an intervention. The facility lacked evidence of adequate supervision of R172.</p> <p>- 5/22/16 at 7:15 PM incident report - In the Greenbank lounge, R172 was found on the floor laying on his left side with his head in front of the wheelchair and wheelchair alarms sounding. R172 stated he was trying to transfer from his wheelchair to the lounge chair when his left foot</p>	F 323			

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F 323	<p>Continued From page 25</p> <p>got caught on the wheelchair and he fell. R172 was not injured. In response to the fall, the facility updated R172's care profile to include offering R172 to sit in a lounge chair after dinner. The facility lacked evidence of adequate supervision of R172, who repeatedly fell.</p> <p>- 5/26/16 - R172 fell out of bed with no injury.</p> <p>The quarterly MDS assessment, dated 6/22/16, stated that R172 had moderate cognitive impairment and he exhibited inattention, disorganized thinking, physical and verbal behaviors. In addition, R172 rejected care, required extensive assistance of one staff person for transfers and experienced multiple falls since the 3/25/16 assessment.</p> <p>- 6/26/16 - R172 fell out of bed resulting in a skin tear to his right knuckles and left arm.</p> <p>- 6/26/16 at 4:50 PM incident report - In the Greenbank lounge, E21 (LPN) heard an alarm sounding while she was performing medication administration and went to investigate. E21 found R172 next to his wheelchair and the armchair. R172 was seated in a lounge armchair prior to the fall with his wheelchair pressure alarm placed under him. R172 complained of a headache and back pain. R172 was sent to the hospital emergency room for evaluation. Diagnostic tests were negative. R172 returned to the facility on 6/27/16 at 1:30 AM with a discharge diagnosis of a history of falls. In response to the fall, the facility requested a medication review and changed his restorative walking program from once a day to two times a day. It was unclear how the facility was providing adequate supervision of R172, who continued to be at high risk for falls and</p>	F 323		

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F 323	<p>Continued From page 26 repeatedly fell.</p> <p>- 6/27/16 at 2:15 PM - A nurse's note stated that R172 "needs redirection and 1:1 supervision". An incident report, dated 6/27/16 at 4:15 PM, stated that R172 was with visitors in the Greenbank courtyard. A visitor alerted staff at the nurse's station that R172 was on the ground outside. R172 was found laying on his left side next to his wheelchair with the wheelchair alarms sounding. R172 stated that he wanted to walk across the yard and fell. R172 sustained a skin tear on his left forearm and bruise on his left elbow. In response to the fall, a urine analysis was ordered, which was negative. It was unclear as to why the facility noted that R172 needed 1:1 supervision two hours prior to the fall, but did not implement it.</p> <p>- 7/16/16 and 7/19/16 - R172 fell out of bed with no injury.</p> <p>In an interview on 8/1/16 at 10:34 AM, E4 (RN, UM) confirmed that R172 was at high risk for falls and repeatedly fell. When asked by the surveyor if the facility staff discussed supervision as an intervention, E4 stated no.</p> <p>Findings were reviewed with E2 [DON] and E4 on 8/1/16 at 10:44 AM. The facility failed to ensure that R172, who had a history of repeated falls and uncooperative behaviors, received adequate supervision to prevent accidents.</p> <p>2. Review of the admission MDS dated 4/8/16 revealed that R175 required extensive assistance and required 1 person physical assist for bed mobility.</p>	F 323			

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F 323	Continued From page 27 An observation made on 7/27/16 at 1:15 PM, revealed that R175's left side half rail was loose and it moved inwards towards the bed. The loose half rail could create a gap between it and the mattress and cause the resident to be trapped between them.  Finding was reviewed and confirmed with E8 (FMD) on 7/27/16 at approximately 1:15 PM.	F 323			
F 356 SS=C	Findings were reviewed with E1 (NHA), E2, and E3 (ADON) on 8/1/16 at approximately 1:35 PM. <b>483.30(e) POSTED NURSE STAFFING INFORMATION</b>  The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.  The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.  The facility must, upon oral or written request, make nurse staffing data available to the public	F 356		8/2/16	

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F 356	Continued From page 28 for review at a cost not to exceed the community standard.  The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.  This REQUIREMENT is not met as evidenced by: Based on observations, review of facility documentation and interview, it was determined that for 6 out of 6 days, the facility failed to post the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift in a prominent place readily accessible to residents and visitors. Findings include:  From 7/25/16 through 8/1/16, observations were made at 3 nursing stations which revealed that the daily staff postings were located in plastic holders near the nursing stations affixed to the walls at standing height level. Residents in wheelchairs were unable to view the staff postings. Review of the postings lacked evidence of the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift.  Findings were confirmed during an interview with E2 (DON) on 8/1/16 at 10:44 AM.	F 356	<b>F356 483.30(e) POSTED NURSE STAFFING INFORMATION</b> A. The daily staffing information was revised on September 1, 2016 to include facility name, current date, resident census, total number and the actual hours worked for RNs, LPNs, and CNAs directly responsible for resident care per shift. It remains in a clear and readable format, readily accessible to residents and visitors. Each units staffing sheet holder has been relocated to be readily visible to those in wheel chairs as well as those ambulatory. B. All residents have the potential to be affected. C. Staffing coordinator/designee will post the schedule daily in the appropriate location by unit. D. DON/designee will monitor placement of schedule daily x 14, then weekly x 2, then monthly x 2 to ensure compliance. DON/designee will report findings through QA process.	
F 412 SS=D	<b>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</b>  The nursing facility must provide or obtain from	F 412		9/30/16

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F 412	<p>Continued From page 29</p> <p>an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, it was determined that the facility failed to ensure dental services were obtained to meet the needs for one (R82) out of 38 Stage 2 sampled residents regarding dentures. Findings include:</p> <p>Review of R82's clinical record revealed the following:</p> <p>8/26/15 - A dental consult report stated R82 had X rays, an exam and gross scaling, and to return for cleaning.</p> <p>10/19/15 - A dental consult report stated R82 had his lower teeth cleaned.</p> <p>11/16/15 - A dental consult report stated R82 had preliminary impressions made for full upper and partial lower dentures. The recommendations included returning for final impressions.</p> <p>12/7/15 - A dental consult report stated R82 had his gums evaluated and teeth cleaned. A letter included with the consult stated that R82 had an appointment scheduled on 12/18/15.</p>	F 412	<p>F412 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>A. Resident suffered no untoward effect and after multiple attempts to encourage follow-up, R82 agreed to services on 8/29/16 and impressions (full upper, partial lower) were taken. Completed denture date is still pending.</p> <p>B. All residents with dental needs may be affected.</p> <p>C. A new process to track scheduling of dental appointments has been created. Information regarding appointment logistics to include return consults will be made available through a shared drive of the facility computer system. Those responsible for scheduling appointments, and reviewing consults, i.e. social services, unit managers, unit clerks or designee will review the shared drive daily to ensure resident recommendations and follow-ups are completed.</p> <p>D. Social Services or designee will audit 100% of residents requiring dental appointments to ensure appropriate tracking of follow-up needs through the</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/01/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD WILMINGTON, DE 19808</b>		
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F 412	Continued From page 30  12/7/15 through 7/27/16 - Review of the clinical record lacked evidence that R82 had gone to any dental appointments.  3/15/16 - The annual MDS assessment stated R82 was independent for daily decision making skills and that he had no oral or dental problems.  6/15/16 - A social services note stated, "...He had a dental appt on 12/7/15...".  6/22/16 - The care plan for potential for complications related to poor dentition was last reviewed, and included the approach to encourage dental exams and assist with appointments for exam or cleaning.  7/25/16 at 11:28 AM - R82 stated during an interview that he had no problems with his teeth or gums. R82 was observed to have only five (5) lower teeth. When asked if he had dentures, he stated that he had seen the dentist and was "waiting for dentures.". R82 denied any difficulties with eating or chewing.  7/27/16 at 3:40 PM - During an interview, E5 (LPN/UM) stated that R82 did not have dentures. Upon review of the dental consults, E5 stated she would call the dental clinic to determine what happened with R82's dentures.  7/28/16 at 10:30 AM - E5 and E11 (Unit Clerk) were interviewed regarding R82's dentures. E11 stated that she completes the scheduling for follow ups when residents get back from their appointments. E11 stated that she scheduled the dental appointment for 12/18/15, but was unable	F 412	shared drive. Results will be reported through the QAPI process until 100% compliance is achieved for two consecutive quarters.		

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F 412	Continued From page 31 to recall whether it was an issue with no transportation or if the resident didn't want to go. According to E11, the transportation would have been provided by the facility's van. E5 stated that she reviews the consult page to see if there are any new orders written. E5 stated she called the dental clinic yesterday and obtained a new appointment for R82. E5 also stated that she had spoken with R82, who confirmed he would like to try having dentures.  7/28/16 at approximately 11:40 AM - During an interview, E12 (SS) stated that she called the dental clinic this morning. E12 stated that according to the dental clinic, a bill was generated in their system (clinics) when the preliminary impressions were done on 12/7/15, but they (clinic) did not have any documentation that a bill was sent to the facility. E12 stated that when the bill is received by the facility, it goes to Social Services and they arrange payment. E12 stated since social services never received a bill, they were not aware of R82's dentures.  The facility failed to ensure that R82 had a follow up at the dental clinic for dentures. Preliminary impressions were completed on 11/6/15 for full upper and partial lower dentures and an appointment was scheduled for 12/18/16. Although it is unclear why R82 did not make the 12/18/15 appointment, there was no evidence of any further follow up by the facility until 7/27/16 when the concern was brought to their attention.  Findings were confirmed with E1 (NHA) and E2 (DON) during an interview on 7/28/16 at approximately 1:00 PM.	F 412		
F 463	483.70(f) RESIDENT CALL SYSTEM -	F 463		9/30/16

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F 463 SS=D	Continued From page 32 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 observation and interview, it was determined that the facility failed to ensure that all call bells were functioning in the facility for residents who were capable of using them. Findings include:  An observation made on 7/26/16 at 11:57 AM revealed that the bedside call bell for R192 was not working when activated. The resident was not cognitively impaired and was capable of using the call bell.  Finding was reviewed with E8 (FMD) on 7/27/16 at approximately 1:15 PM.  Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) on 8/1/16 at approximately 1:45 PM.	F 463	F463 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH A. The nurse call system for R192 was examined and found to be working properly prior to the survey exit. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all nurse call bells. Repairs will be completed as identified. D. The FMD, or designee, will audit 100% of resident rooms and common areas by examining 6 rooms daily for 14 days, then two times per week for two weeks, and then 3 times per month until 100% compliance is achieved. Results will be reported quarterly through the QAPI process.	
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS  The facility must provide one or more rooms designated for resident dining and activities.  These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be	F 464		8/2/16

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F 464	<p>Continued From page 33</p> <p>adequately furnished; and have sufficient space to accommodate all activities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure that a room designated for resident dining was adequately furnished for 12 (R15, R65, R78, R81, R97, R101, R103, R116, R118, R146, R177, and R197) out of 38 Stage 2 sampled residents. Multiple observations revealed residents eating off of overbed tray tables in the C wing lounge. Findings include:</p> <p>Dining observations of the C wing lounge revealed two (2) tables pushed together accommodating seating for only six (6) residents. Observations revealed other residents seated at overbed tray tables along the wall eating their meals as follows:</p> <p>7/25/16 at 11:50 AM - Three residents (R65, R81, and R101) were observed eating lunch off of overbed tray tables.</p> <p>7/26/16 at 8:10 AM - Five residents (R65, R103, R116, R177, and R197) were observed eating breakfast off of overbed tray tables.</p> <p>7/27/16 at 11:58 AM - Four residents (R65, R78, R97, and R118) were observed eating lunch off of overbed tray tables.</p> <p>7/28/16 at 8:14 AM - Four residents (R15, R65, R97, and R146) were observed eating breakfast off of overbed tray tables.</p>	F 464	<p>F464 483.70(g) REQUIREMENTS FOR DINING &amp; ACTIVITY ROOMS</p> <p>A. After review of the dining area concern with the survey team leader, two additional tables were immediately brought to the C-wing lounge and the room was re-configured to permit appropriate seating for twelve residents at mealtimes.</p> <p>B. All residents who eat in a common room have the potential to be affected.</p> <p>C. Dining tables and seating arrangements throughout the facility were reviewed according to the number of residents served to ensure appropriate furnishing.</p> <p>D. The resident common dining rooms and lounges will be evaluated as resident needs and population change to ensure 100% compliance at all times. Configuration will be reviewed at least monthly and reports will be submitted quarterly through the QAPI process until 100% compliance is achieved.</p>	

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F 464	Continued From page 34 7/28/16 at 11:50 AM - Three residents (65, R81 and R146) were observed eating lunch off of overbed tray tables.  The facility failed to ensure that dining areas are adequately furnished to meet resident's physical and social needs.  On 7/28/16 at 1:30 PM during an interview, findings were confirmed by E1 (NHA) and E2 (DON).	F 464			



**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS/STC  
SEP 09 2016

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-6661

**STATE SURVEY REPORT**

NAME OF FACILITY: Brandywine Nursing & Rehabilitation Center

DATE SURVEY COMPLETED: August 1, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>An unannounced annual survey was conducted at this facility from July 25, 2016 through August 1, 2016. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 166. The Stage 2 survey sample size was 38.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>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.</b></p> <p><b>This requirement is not met as evidenced by:</b> Cross-refer to CMS 2567-L survey date completed August 1, 2016: F248, F253, F274, F315, F323, F356, F412, F463, and F464.</p>	<p><b>Disclaimer Statement:</b> 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>Please refer to the electronic POC on the 2567-L survey report submitted via the Aspen web portal for the survey ending 8/1/16 for F248, F253, F274, F315, F323, F356, F412, F463 and F464.</p>	<p>9-30-2016</p>

Provider's Signature

Title

ADMINISTRATOR

Date

9/6/2016