

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

PRINTED: 04/14/2014  
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>C</b>  <b>03/31/2014</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>
---	---

(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 000	INITIAL COMMENTS  An unannounced complaint visit was conducted at this facility from March 27, 2014 through March 31, 2014. The deficiencies contained in this report are based on interviews and review of residents' clinical records. The facility census the first day of the survey was 165. The survey sample was four which included (2) two active residents and (2) two closed records.	F 000	<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.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;	F 272	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  A. R1's MDS was corrected and sent on 3/31/14. B. All residents have the potential to be affected. A 100% audit of current Hospice residents was completed as of 4/22/14 with corrections completed as identified during audit. All current Hospice residents MDS are coded correctly. C. Staff was re-educated to carefully review section "O" of the MDS for accuracy as it is pre-populated with previous MDS information. Each Hospice MDS will be reviewed by a nurse independently (other than the coder) for accuracy prior to submission.  See Next Page	5-30-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Fred Aibartolo* TITLE *Administrator* (X6) DATE *5-8-14*

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.

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

PRINTED: 04/14/2014  
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>C</b>  <b>03/31/2014</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>		
(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 272	<p>Continued From page 1</p> <p>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and</p> <p>Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to periodically conduct a comprehensive assessment that was accurate for one (R1) out of four sampled residents. Findings include:</p> <p>On 10/5/13, R1 was admitted to hospice services in the facility due to congestive heart failure (heart unable to pump enough blood to meet the body's needs) and dementia (loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning).</p> <p>On 10/15/13, R1 had a significant change Minimum Data Set (MDS) assessment completed. However, section 0, special treatments and programs was incorrectly checked as, "none of the above" instead of "hospice care while a resident".</p> <p>On 3/31/14 at 9 AM, in an interview, E5 (MDS Coordinator) stated, "That was a coding error, it (referring to hospice care while a resident) should have been checked".</p>	F 272	<p>Continued From Previous Page</p> <p>D. RNAC will review Hospice MDS prior to each submission (if applicable) q week x 4, monthly x 2, (Attachment 1) then quarterly and report findings through the QAPI process and continue until 100% compliance is met as determined by the QAPI committee. (Attachment 1)</p>		

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

PRINTED: 04/14/2014  
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>C</b>  <b>03/31/2014</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>		
(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 272	Continued From page 2	F 272	See Previous Page		
F 280 SS=D	<p>The facility failed to accurately assess R1's status on the 10/15/13 significant change MDS regarding hospice services while a resident in the facility.</p> <p>On 3/31/14 at 12:40 PM, E2 (Director of Nursing) confirmed the findings.</p> <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 and interview, it was determined that the facility failed to revise care plans for one (R1) out of four sampled residents.</p>	F 280	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>A. R1 no longer resides at the facility. B. All residents have the potential to be affected. Christiana Care has been contacted regarding the Interagency Transfer form that is auto filled with an "x" for the "Regular Diet" category, independent of the written order.</p> <p>See Next Page</p>	5-30-14	

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

PRINTED: 04/14/2014  
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>C</b>  <b>03/31/2014</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>		
(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 280	<p>Continued From page 3</p> <p>Findings include:</p> <p>R1 had a nutrition care plan, initially developed on 4/23/12 and reviewed on 7/18/13. The plan of action included: "Monitor food and fluid preferences; Encourage food and fluid intake; Provide assistance as needed with food/fluids ...".</p> <p>R1 also had an at risk for dehydration (a condition in which the body has less than normal fluid) care plan, initially developed on 4/23/12 and reviewed on 7/18/13. The plan of action included: "Encourage fluid intake from meal tray and between meals; Keep fluids at bedside if appropriate; Assist with fluid intake as needed ...".</p> <p>However, beginning 9/9/13 and continuing through 11/2013, R1's doctor ordered the resident to have nothing by mouth (NPO) and to be fed only by a feeding tube into the stomach.</p> <p>On 10/24/13, both the nutrition and at risk for dehydration care plans were reviewed but incorrectly continued to have the same plans of action as noted above regarding food and fluids by mouth when R1 was ordered to be NPO.</p> <p>On 3/31/14 at 9 AM, in an interview, E5 (Minimum Data Set Assessment Coordinator) stated that both care plans should have been revised to discontinue any interventions that had to do with oral intake but that those revisions failed to be made.</p> <p>The facility failed to revise the approaches for R1's nutrition and at risk for dehydration care plans related to the doctor's orders for nothing by mouth beginning on 9/9/13. On 3/31/14 at 12:40 PM, E2 (Director of Nursing) confirmed the</p>	F 280	<p>Continued From Previous Page</p> <p>C. The Registered Dietician/representative will review and verify admission diet orders for accuracy upon receipt of interagency form. RD/representative is available 24/7 via telephone should the need arise. Dietary orders (new admissions and current residents) will be communicated by the RD/representative to the care plan coordinator, Dietary Director/kitchen, and appropriate Unit Manager. The Unit manager will ensure the correct diet as verified by the RD is documented on the MAR for each nurse's review. Should discrepancies arise, they will be resolved prior to resident's initial nutritional consumption.</p> <p>D. RD/designee will review 100% of admission/readmission diet orders for accuracy and report through the QAPI process and continue until 100% compliance is met as determined by the QAPI committee. (Attachment 2 )</p>		

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>C</b>  <b>03/31/2014</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>	
(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	<p>Continued From page 5</p> <p>Review of the 9/2013 flow sheet for percentage (%) of meal consumption revealed that from 9/8/13 through 9/14/13, R1 had 0 % meal consumption.</p> <p>On 3/27/14 at 3:58 PM, E5 (Licensed Practical Nurse) was interviewed. During this interview, E5 (Licensed Practical Nurse) reviewed her weekly nurse's note, dated 9/14/13 and timed 9:45 PM. When asked how she determined that R1 consumed 20% of meals in the past week, E5 stated that she got it from the 9/2013 flow sheet for percentage of meal consumption. E5 then reviewed that 9/2013 flow sheet from 9/8/13 through 9/14/13 and acknowledged that the nurse's note was incorrect because R1 had no meal consumption during that week. Additionally, E5 stated that she did not give R1 anything by mouth.</p> <p>The facility failed to have an accurate record for R1 in the nurse's note, dated 9/14/13. On 3/31/14 at 12:40 PM, E2 (Director of Nursing) confirmed the findings.</p> <p>2. R2 was admitted to the facility on 11/1/13.</p> <p>On 3/28/14 at approximately 9:30 AM, review of R2's clinical record revealed the 11/4/13 admission History and Physical (H &amp; P) was incomplete and there were no physician's progress notes. During an interview with E4 (Unit Manager) on 3/28/14 at approximately 9:45 AM, she confirmed the above findings. E4 stated that she believed the physician did his notes electronically and that she would check on it.</p> <p>On 3/31/14 review of R2's clinical record revealed a detailed electronic H &amp; P, dated 11/4/13.</p>	F 514	<p>Continued From Previous Page</p> <p>The Unit manager will ensure the correct diet, as verified by the RD, is documented on the MAR for each nurse's review. Should discrepancies arise, they will be resolved prior to resident's initial nutritional consumption.</p> <p>D. The Unit Managers/designee will audit 100% of each unit's resident's first 48 hours of nurse's notes and CNA flow sheets to compare the documentation with the current diet order to ensure continuity weekly x 4 and monthly x 2. Findings will be reported through the QAPI process and continue until 100% compliance is met as determined by the QAPI committee. (Attachment 3)</p> <p>A. R2 has been seen and evaluated by E10 and physician and these events have been documented in R2's record.</p> <p>B. All residents have the potential to be affected. A 100% audit was completed in February 2014 (prior to the survey) that identified residents affected.</p> <p>See Next Page</p>	

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

PRINTED: 04/14/2014  
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>C</b>  <b>03/31/2014</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>		
(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	<p>Continued From page 6</p> <p>Additionally, there was a transfer of service note, dated 12/5/13 and a recertification note, dated 1/9/14, both of which had "Late Entry" written on them.</p> <p>In an interview with E4 on 3/31/14 at 8:05 AM, she stated the 12/5/13 and 1/9/14 notes were completed in the afternoon on 3/28/14 by E10, Nurse Practitioner (NP). E4 stated that the NP had seen the resident frequently during the past three months.</p> <p>The facility failed to ensure that R2's clinical record was maintained in accordance with accepted professional standards and practices that are complete and accurately documented.</p> <p>Findings were acknowledged by E2 (Director of Nursing) during the exit conference on 3/31/14 at approximately 4:30 PM.</p>	F 514	<p>Continued From Previous Page</p> <p>C. A Matrix ( Attachment 4) has been developed to track and cue the physician/NP when History and Physicals and re-certifications are due. This Matrix is to be maintained at each unit by the Unit Manager/designee. As of 4/17/14, upon admission, the most recent Hospital H &amp; P is to be placed on the resident record for physician review and reference.</p> <p>D. RNAC/designee will review for H &amp; P compliance, at least quarterly during the MDS process (Attachment 4a). Unit Managers will review Matrix daily for their specific unit. Unit Manager will compare resident record for compliance weekly x 4, then monthly x 2 (Attachment 4b). Medical Director/ designee will review H &amp; P compliance during weekly rounds. Findings will be reported through the QAPI process and continue until 100% compliance is met as determined by the QAPI committee.</p>	



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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

STATE SURVEY REPORT

Page 1 of 2

NAME OF FACILITY: Brandywine Nursing & Rehabilitation Center      DATE SURVEY COMPLETED: March 31, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	--	--

<p><b>3201</b></p> <p><b>3201.1.0</b></p> <p><b>3201.1.2</b></p>	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced complaint survey was conducted at this facility from March 27, 2014 through March 31, 2014. The deficiencies cited in this report are based on record reviews and staff interviews. The census the first day of the survey was 165. The sample size included two (2) active records and two (2) closed records.</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>See next page for Plan of Correction</p>
--	--	---

Provider's Signature *Fred DiPorto* Title Administrator Date 5-8-14



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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: March 31, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	--	--

	<p><b>This requirement is not met as evidenced by:</b></p> <p>Cross refer to the CMS 3567-L survey ending 3/31/14, F272, F280 and F514.</p>	<p>For plan of correction, please cross refer to the CMS 2567-L Survey Report Date ending 3/31/14, F272, F280, and F514.</p>
--	---	--

Provider's Signature *Frederick A. Bartol* Title Administrator Date 5/8/14