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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085042		01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRACKENVILLE CENTER	100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707

(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 annual survey was conducted at this facility from January 10, 2017 through January 19, 2017. 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 101. The Stage 2 survey sample size was 26. Abbreviations/definitions used in this report are as follows: ADLs - Activities of Daily Living; ADON - Assistant Director of Nursing; BID - twice a day; CC (cc) - cubic centimeter, unit of length; CNA - Certified Nurse's Aide; DON - Director of Nursing; FMD - Facility Maintenance Director; FR - fluid restriction; HR - heart rate/ pulse, the number of heartbeats per minute; LPN - Licensed Practical Nurse; PT-Physical therapy/therapist; OT-Occupational therapy/therapist; MAR - Medication Administration Record - list of daily medications to be administered; MD - Medical Doctor; MDS (Minimum Data Set) - standardized assessment form used in nursing homes; MG (mg)- milligram, unit of mass; MLs - milliliters, unit of volume; NN- nurse's note; NHA - Nursing Home Administrator; NP- Nurse Practitioner; Pt - patient; QA - Quality Assurance; RN - Registered Nurse;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Center Executive Dir.	2/14/17

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 SBP (Systolic Blood Pressure[BP]) - the top number of the blood pressure reflects pressure in vessels when the heart is beating; < - less than; >-greater then; " - inch/measurement of length; Ancillary - various healthcare services provided to support the doctor; Antibiotic - medication used to treat bacterial infections; Antifungal - medication to treat various fungal infections; Continent - full control of bowel and bladder function; Culture - laboratory test to identify which bacteria is causing the infection and which antibiotic will kill the bacteria; CAA-care area summary- part of the MDS that helps identify problem areas; Cognition-thinking, memory; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Diverticulitis - inflammation of a small, abnormal sac bubbling out of the colon; ER-Emergency room; End stage kidney failure-kidneys stop working; Edentulous-toothless; Frequently incontinent - seven (7) or more episodes of urinary incontinence, but at least one episode of continent voiding during the seven (7) day review time period; Hemodialysis - procedure that removes waste and extra fluid from the body through the blood; H&P-history and physical; Hx-history; Incontinence (Inc.) - loss of control of bladder &/or bowel function; Infectious Disease - doctors who specialize in	F 000		

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F 000	Continued From page 2 infectious disease medicine who are called upon to diagnose unknown infections and assist in managing difficult, unusual or complicated infections; Keflex - antibiotic also known as Cephalexin - MSSA Bacteremia - Methacilin sensitive Staphylococcus Aureus-serious blood infection associated with high mortality; Mixed urinary incontinence- combination of Urge and Stress symptoms. Common in elderly; Metroprolol-medicine for high blood pressure; Norvasc-medicine for high blood pressure; Occasionally incontinent - less than seven (7) episodes of incontinence during the seven (7) day review period; Peri care-washing the genitals and anal area; Pleural Effusion - excess fluid buildup around the lungs; Prosthetic - artificial body part; Pulmonary Embolism - sudden blockage in a lung artery by a blood clot; Prompted voiding-technique of bladder training in which patient is taught to urinate according to a schedule; Stress incontinence- occurs when bladder leaks urine during physical activity or exertion; Urge incontinence- loss of urine with an abrupt and strong desire to urinate; usually loss of urine enroute to toilet; Urinary tract infection - bacteria in the urine; Yeast - type of fungus.	F 000		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced	F 253		

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F 253	Continued From page 3 by: Based on observations and interviews, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for 10 rooms (208, 301, 302, 304, 308, 400, 405, 501, 507 and 607) out of 33 rooms reviewed. Findings include: Observations on 1/10/17 and 1/11/17 during the Stage 1 review, and during the environmental tour with E10 (FMD) and E11 (house keeping) on 1/12/17, between 1:30 PM and 2:30 PM, revealed the following: Room 208 - The resident walker handle bars were dirty; Room 301 - An uncovered bedpan was stored under the bathroom sink; - The urinal hanging on the rail above the toilet had no lid and contained a small amount of urine; - The wall behind the bed was in disrepair; Room 302 - The caulking was separating from the bathroom sink counter; Room 304 - The bathroom sink was slow draining; Room 308 - The paper towel holder was open with the top portion hanging down; - The bathroom sink had no stopper in the drain; Room 400 - The bathroom towel rack was loose;	F 253	Deficient environmental issues identified during the annual survey have been corrected All residents have the potential to be effected by this deficient practice Policy and procedure for environmental rounds and review will be reviewed and revised as necessary NPE(Nurse Practice Educator) or designee will reeducate Maintenance and housekeeping staff on the policy for environmental rounds Maintenance Director or designee will complete environmental audits weekly x's 4 weeks than once 100% audits will be completed monthly x's 3 months to ensure the facility provides housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior Audits will be presented and reviewed by the CQI committee to identify any trends	3/22/17

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F 253	Continued From page 4 Room 405 - The small light above the baseboard below the clock on the right wall had chipped paint around bottom; Room 501 - There was a water stain on the ceiling above the curve of the A bed privacy curtains; - There was a urine odor in the bathroom; - The urinal stored in the bathroom contained a small amount of dark concentrated urine; Room 507 - The toilet was running intermittently; Room 607 - There was a urine odor in the bathroom; - The caulking around the toilet was cracked and in disrepair; - The bathroom floor was dirty; - The caulking behind the sink was cracked; - There were cob webs on the bathroom ceiling vent. Findings were reviewed and confirmed with E10 and E11 on 1/12/17 at approximately 2:30 PM. Findings were reviewed with E1 (NHA), E2 (DON), and E7 (ADON) on 1/19/17 at approximately 7:00 PM.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a	F 272		

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F 272	Continued From page 5 resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident,	F 272	Oral assessment for R101 was correct. The MDS was miscoded and will be corrected Facility will review oral assessment of all residents to insure the MDS coding matches the oral assessment. Any errors will be corrected as identified Root cause analysis will be completed to identify the cause of the deficient practice NPE or designee will re-educate all nurses on conducting an oral assessment. NPE or designee will reeducate the CRC and MDS Coordinator on proper coding of the MDS to match the oral assessment Center Nurse Executive or designee will complete audits monthly x's 3 months to insure the oral assessment and MDS coding match Center Nurse Executive will report the findings of the audits to the CQI committee to identify trends and make recommendations	3/22/17

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F 272	Continued From page 6 as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and interviews, it was determined that the facility failed to conduct an accurate and complete comprehensive assessment for two (R101 and R148) out of 26 Stage 2 sampled residents in the areas of urinary incontinence and dental. Findings include: 1. Review of R148's clinical record revealed the following: R148 was admitted to the facility on 10/7/16 with diagnoses that included overactive bladder and dementia. 10/7/16 - The initial/admission Nursing Assessment did not identify R148's urinary continence status, stated the resident used the bathroom for toileting and that a current toileting program or trial was not being used to manage the resident's urinary continence. 10/7/16 through 10/9/16 - A Three-Day Continence Management Diary was completed and noted that R148 was incontinent of bladder on only two (2) occasions, 10/8/16 at 9:00 PM and on 10/9/16 at 7:30 AM. 10/7/16 through 10/9/16 - The CNA's electronic Documentation Survey Report stated that R148 was incontinent of bladder on three (3) occasions: 10/7/16 at 3:34 AM, 10/8/16 at 6:48 AM, and 10/9/16 at 3:36 AM. Additionally, the report stated that R148 was continent on 10/8/16 on the 3-11 PM shift. The Three-Day Continence	F 272	Resident R148 is no longer a resident at the facility All other residents identified as incontinent will have their record reviewed to insure that a Urinary Incontinence Assessment or Incontinence Evaluation has been completed per facility policy Root cause analysis will be completed to determine the cause of the deficient practice NPE or designee will reeducate all nursing staff on the facility policy on Continence Management Center Nurse Executive will complete Incontinent Assessment audits weekly x's 3 weeks until 3 consecutive audits at 100% compliance is achieved then monthly x's 3 months to determine sustainability of the process. Center Nurse Executive will report the findings of the audits to the CQI committee to identify trends and make recommendations	3/22/17

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F 272	Continued From page 7 Management Diary and the electronic Documentation Survey Report had conflicting documentation. 10/14/16 - An expanded Nursing Assessment was completed and stated R148 did not have new onset of urinary incontinence, was occasionally incontinent, used the bathroom for toileting and was not on a current toileting program or trial. 10/14/16 - The admission MDS assessment stated R148's cognitive skills for daily decision making were moderately impaired and that extensive assist of one (1) staff was required for transfers and toilet use. The MDS also stated R148 was frequently incontinent of bladder during the seven (7) day review period and that there was no trial of a toileting program attempted on admission or since urinary incontinence was noted in this facility. There was no evidence that a Urinary Incontinence Assessment or an Incontinence Evaluation were completed according to facility policy. On 1/13/17 at approximately 1:45 PM findings were reviewed with E2 (DON). E2 confirmed that an accurate and complete comprehensive assessment was not completed for R148. 2. Review of R101's annual MDS, dated 2/10/16, coded the resident as having no natural teeth or tooth fragments; he was edentulous. R101 was observed by the surveyor on 1/10/17 at 11:56 AM to have multiple missing teeth with a few natural teeth noted on the bottom.	F 272		

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F 272	Continued From page 8 During an interview with E5 (LPN) on 1/17/17 at 11:35 AM, she stated that R101 had teeth and "can mostly feel them on the bottom." On 1/17/17 at 1:54 PM, R101's daughter was visiting the resident in his room. When asked if R101 has teeth, she opened his mouth and showed that he had a few natural teeth on the bottom and stated that he used to have dentures. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 1/19/17 at approximately 7 PM. The facility failed to comprehensively and/or accurately assess R101's dental status on the 2/10/16 annual MDS assessment.	F 272		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		

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F 309	Continued From page 9 (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, interviews, review of facility and non-facility documentation, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being for 3 (R3, R39 and R121) out of 26 Stage 2 sampled residents. For R3, the facility failed to provide continuity of care from an acute setting by the failing to address and follow up on R3's Keflex medication, prescribed as a lifetime order by her Infectious Disease doctor, upon her completion of her Diverticulitis treatment on 9/24/16 and upon readmission on 10/17/16. For R121, the facility failed to follow physician orders and incorrectly administered 2 different medications used to treat high BP (Metroprolol and Norvasc) when they were outside of ordered BP and/or HR parameters to hold. For R39, the facility failed to monitor the nursing allottment of the resident's fluid restriction (FR) from 1/6/17 through 1/19/17. Findings include: 1. Review of R3's facility clinical record, facility policy and hospital record revealed the following: The facility's policy entitled "24 Hour Chart Check", last reviewed on 3/1/16, stated, "Licensed nursing staff are responsible for completing a chart check once every 24 hours.	F 309	R3 is deceased and no further reconciliation is possible Facility will review the record of all residents admitted/readmitted since January 1, 2017 to insure the medication reconciliation was completed correctly NPE or designee will re-educate all nurses on the center medication reconciliation policy and procedure Center Nurse Executive will complete Incontinent Assessment audits weekly x's 3 weeks until 3 consecutive audits at 100% compliance is achieved then monthly x's 3 months to determine sustainability of the process. Center Nurse Executive will report the findings of the audits to the CQI committee to identify trends and make recommendations	3/22/17

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F 309	Continued From page 10 The 24 Hour Chart Check includes all physician/mid-level provider orders written in the last 24 hours from the prior Chart Check...The licensed nurse completing the 24 Hour Chart Check identifies and corrects improper orders in the medical record and/or on the Medication Administration Record (MAR)...Purpose: To validate the correctness of orders, proper transcription, and to prevent improper treatment or omission of treatment, medication, ancillary orders, or documentation." R3's hospital record, provided by the facility, from 9/11/16 - 9/19/16 revealed the following: - 9/19/16 at 10:02 AM - an Infectious Disease hospital consult stated that R3 was to continue with the current antibiotic medications prescribed for treatment of diverticulitis then be placed back on Keflex, an antibiotic for chronic suppression of her history since 2013 with MSSA bacteremia of her bilateral knee prosthetic joint infection; - 9/19/16 and untimed - the hospital's Interagency Discharge Orders stated, "...Discharge Diagnosis...Diverticulitis...". The information from the 9/19/16 Infectious Disease consult was not written on R3's Discharge Orders.; - 9/19/16 at 4:59 PM - the hospital's Medication Reconciliation Order Sheet listed different antibiotic medications prescribed for 5 days. Review of R3's facility clinical record revealed the following: 9/19/16 at approx. 9 PM - R3 was admitted to the facility for short-term rehabilitation and continued treatment for Diverticulitis. 9/20/16 through 9/24/16 - The facility's Medication Administration Record (MAR) revealed that R3	F 309	There was no negative outcome to R121 due to doses of medication administered when out of the parameters as ordered by the physician All other residents on blood pressure medications with parameters have the potential to be effected by this deficient practice A root cause analysis will be completed to identify the cause of the deficient practice NPE or designee will re-educate all nurses on administering blood pressure medications with parameters Center Nurse Executive or designee will complete audits daily x's 7 days to insure the blood pressure medications were administered per the parameters based on the doctors order. Once 100% compliance is achieved with the weekly audits than the audits will be completed weekly x's 4 weeks than monthly x's 3 months to determine sustainability of the process Audit results will be presented and reviewed by the CQI committee to identify trends	3/22/17

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F 309	Continued From page 11 received the prescribed two antibiotics for 5 days for diagnoses of a UTI. It was unclear why the facility listed both medications with diagnoses as UTI when she was being treated for Diverticulitis. Although R3 completed her antibiotic treatment for Diverticulitis at the facility on 9/24/16, R3's clinical record lacked evidenced that she was placed back on Keflex medication and lacked evidence of a clinical reason for the discontinuance by the facility. 9/26/16 at 11:50 PM - R3 was sent to the hospital ER for chest pain. 9/27/16 at 4:54 AM - The hospital's ER Discharge/Transfer Instructions stated that R3 had discharged diagnoses of chest pain and pleural effusion and noted that R3 refused to have further testing in the ER. 9/27/16 at 6:30 AM - R3 was readmitted to the facility. 9/27/16 at 10:50 AM - R3 was sent to the hospital ER for shortness of breath and rapid pulse and admitted for a pulmonary embolism and pleural effusion. 9/27/16 through 10/3/16 - Review of the hospital record revealed the following: - the hospital's Medication Reconciliation Order Sheet, dated 9/30/16 at 6:54 PM, stated, "Cephalexin (Keflex)...BID...Patient is to be on this medication chronically per infectious disease..."; and - the hospital's Interagency Discharge Orders, dated 10/1/16, stated, "...Please continue on Keflex...BID CHRONICALLY..."; - the hospital's Interagency Nursing	F 309	There was no negative outcome for R39 due to the lack of monitoring and recording of the allotted nursing allowance of fluids from 1/7/2017 to 1/19/2017 All other residents on fluid restrictions will have the medical record reviewed to determine if there was proper monitoring and recording of the allotted nursing allowance of fluids since January 1, 2017 and if there was any negative outcome due to the deficient practice Root cause analysis will be completed to determine the cause of the deficient practice NPE or designee will re-educate all nurses on monitoring and recording of the allotted nursing allowance of fluids Center Nurse Executive or designee will conduct audits daily x's 7 days to insure allotted fluids are being monitored and recorded properly. Once 100% compliance is achieved than the audits will be completed weekly x's 4 weeks than monthly x's 3 months to determine sustainability of the process Audit results will be presented and reviewed by the CQI committee to identify trends	3/22/17

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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
F 309	Continued From page 12 Communication Record, dated 10/3/16 at 1:44 PM, stated, "...Pt is to remain on Keflex BID indefinitely"; - the hospital's Discharge Summary, dated 10/3/16, stated, "...The patient was also noted to have a history of MSSA bacteremia in bilateral prosthetic knee joints, for which she has been kept on chronic Keflex suppression...twice a day and was to continue this, but this was stopped after her discharge from Christiana and infectious disease also evaluated the patient and recommended that the patient be resumed on this...". 10/3/16 - R3 was readmitted to the facility. 10/3/16 - The facility's physician telephone verbal order stated, "Keflex...Give...two times a day for Chronic UTIs". 10/3/16 through 10/14/16 - Review of R3's MAR revealed that she received Keflex two times a day for Chronic UTI's. Although the correct diagnosis for R3's Keflex was explained in the hospital's 10/3/16 Discharge Summary, the facility failed to identify and accurately list the correct diagnosis for this medication on her MAR and the physician order. 10/5/16 - R3's History and Physical noted that she had MSSA bacteremia and bilateral knee replacements. The H&P did not list R3's current medications, but rather stated to "See Medication Administration Record (MAR)." Although R3's History and Physical Date Of Service (DOS) was listed as 10/5/16, it was not electronically signed by the physician until 10/31/16 at 11:09 AM. The H&P also stated under the Diagnosis and Assessment section, "...Hx MSSA bacteremia on	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085042		01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 13 life long Keflex - discontinued during this hospitalization. Not sure why...". It was unclear when the above Keflex statement was added to R3's 10/5/16 H&P as Keflex was ordered during her 9/27/16 - 10/3/16 hospitalization and she received it at the facility for diagnosis of chronic UTIs from 10/5/16 through 10/14/16. 10/14/16 through 10/17/16 - R3 was sent to the hospital ER and admitted with diagnoses of yeast UTI and dehydration. Review of the hospital records revealed that R3's facility medications were reconciled, including her current Keflex medication for chronic UTIs. R3 received a different antibiotic during this hospitalization for treatment of a UTI pending culture results, which showed yeast. The antibiotic was discontinued and R3 was ordered an antifungal medication upon discharge for the yeast UTI. No further antibiotics were ordered upon her discharge on 10/17/16. It was unclear during this hospitalization whether the hospital was aware of R3's Keflex lifetime order for chronic suppression of MSSA bacteremia of her bilateral knee prosthetic joints as the facility's MAR stated she was receiving Keflex for chronic UTIs. 10/17/16 - R3 was readmitted to the facility. Review of the facility's 24 Hour Chart Check - Validation Form revealed a handwritten note by E8 (LPN) which stated, "(nurses initials) ? Keflex...". Review of R3's clinical record revealed a lack of evidence that R3's Keflex medication, which was identified by E8 performing a 24 Hour Chart Check on 10/18/16, was followed-up and addressed by the facility. Further review of R3's clinical record revealed that she was not ordered	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 14 nor did she receive Keflex medication from her readmission to the facility on 10/17/16 through 11/28/16. During an interview on 1/17/16 at 3:55 PM, E8 (LPN) confirmed he was the nurse that conducted the 24 Hour Chart Check and wrote "? Keflex". E8 stated that he pulled R3's chart and flagged it so the day shift nurse could follow up by calling the facility doctor for clarification on the medication. During an interview with E2 (DON) and E9 (Scheduler) on 1/19/17 at 3:49 PM, E9 stated that R3 had an appointment scheduled on 10/18/16 with her Infectious Disease doctor, but a family member requested the appointment to be canceled. The appointment was rescheduled for 10/31/16, however the family member asked the facility to cancel the appointment. Findings were confirmed with E2 on 1/19/17 at approx. 1:30 PM. The facility failed to provide the care and services necessary to attain the highest practicable well being for R3 and failed to address and follow up on R3's Keflex medication, prescribed as a lifetime order by her Infectious Disease doctor, upon her completion of her Diverticulitis treatment on 9/24/16 and upon readmission on 10/17/16. 2. Review of R121's clinical record revealed: Review of current physician orders for R121 revealed an order, dated 8/5/16, for Metroprolol 100 mg give one tablet two times a day (9 AM and 9 PM) and hold for SBP < or equal to 110 or HR < or equal to 60. On 8/6/16 a physician order was written for Norvasc 10 mg to be given daily (9	F 309		

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	085042		01/19/2017

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F 309	Continued From page 15 AM) and hold for SBP < 110. Review of MARs revealed the following doses of medication were administered when out of parameters: December 2016- Metropolol- 12/13 (BP 110/66), 12/17 (HR 60), 12/28 (BP 104/59 and HR 59); Norvasc- 12/27 (BP 109/64), 12/28 (104/59); January 1- 11, 2017- Metropolol- 1/5 (BP 104/61) 1/11 (HR 60); Norvasc- 1/5 (BP 104/61). On 12/28/16 and 1/5/17, Metropolol and Norvasc were both given at 9 AM when out of ordered parameters. Nurse's notes were reviewed for the above dates to ensure that documentation was correct on the MARs and the medications were given. Findings were reviewed and confirmed by E2 (DON) during an interview on 1/17/17 at 1 PM. 3. Review of R39's clinical record and facility documents revealed: The facility's policy entitled Fluid Balance, last revised on 3/15/16, stated, "... When a physician/mid-level provider orders a fluid restriction due to specific clinical condition, close monitoring of fluid intake will be provided to maintain adequate hydration... Monitor fluid intake; monitor output if ordered... Document... Intake...'.	F 309		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085042		01/19/2017

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F 309	Continued From page 16 R39 was admitted to the facility on 8/3/16 with diagnoses including end stage kidney failure requiring hemodialysis 3 times a week. Review of physician orders revealed that when R39 was readmitted from the hospital on 1/6/17, he had an order dated 1/7/17 for a 1200 cc per day FR with up to 120 cc per shift allowed for nursing (to give with medications, etc.) and the rest divided between meal trays. The physician order additionally stated, "... if resident consumes fluids in excess of these amounts, notift (sic-should be notify) MD/NP and re-educate resident." Review of the January 2017 MAR revealed that the facility failed to monitor and record R39's allotted nursing allowance of fluid from 1/7/17 through 1/19/17 when identified by the surveyor. Record review revealed the absence of documentation for the 1/7/17 to the 1/19/17 dates. Findings were reviewed and confirmed with E2 (DON) during an interview on 1/19/17 at 5:40 PM.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, it was determined that the facility failed to provide the necessary services to maintain good nail grooming for one (R121)	F 312		

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

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	085042		01/19/2017

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F 312	Continued From page 17 resident, who was unable to carry out this activity, out of 26 Stage 2 sampled residents. Findings include: Review of R121's clinical record revealed: R121 was admitted to the facility on 8/3/16. R121's quarterly MDS, dated 11/10/16, was coded that the resident required extensive one person assistance with personal hygiene, which includes nail trimming. R121 was observed with long fingernails (about 3/4" each) on 1/10/16 at 12 PM. On 1/11/17 at 3:30 PM, R121 was sitting in a w/c in his room. His fingernails remained long. The surveyor asked R121 if it was his preference to have long fingernails and he stated, "no." R121 was observed again on 1/12/17 at 10:35 AM with long fingernails. Review of R121's ADL documentation, completed by CNA's, for December 2016 and January 1-11, 2017 stated that personal hygiene was provided every shift, however, there was no specific documentation of nail trimming. E3 (CNA) was interviewed on 1/12/17 at 10:56 AM. E3 stated that she was familiar with E121. E3 stated she had given R121 bed baths and he was cooperative with care. When asked who was responsible for nail trimming, E3 stated that nurses were. E4 (LPN) was interviewed on 1/12/17 at 11:02 AM. E4 (assigned to R121) stated that both CNA's and nurses were responsible for nail trimming. E4 and the surveyor went to look at R121's nails together and E4 confirmed that	F 312	R121 had his nails trimmed and filed once identified by the surveyor All other residents will have their finger nails checked and trimmed and filed as determined necessary Root cause analysis will be completed to determine the cause of the deficient practice NPE or designee will re-educate al nursing staff on the procedure for maintain resident finger nails at a proper length Unit Manager or designee will complete audits weekly x's 4 weeks until 100% compliance than monthly x's 3 months to insure resident nails are properly trimmed Audit results will be presented and reviewed by the CQI committee to identify trends	3/22/17

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 312	Continued From page 18 R121's nails were long. E4 stated R121's fingernails had not been trimmed "in quite awhile" and she would take care of them today. R121's fingernails were observed again on 1/13/17 at 10:13 AM and found to be trimmed. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 1/19/17 at approximately 7 PM.	F 312		
F 315 SS=E	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085042		01/19/2017

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F 315	Continued From page 19 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, it was determined that for three (R3, R121 and R148) out of 26 Stage 2 sampled residents, the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to restore continence to the extent possible. For R148, the facility failed to ensure an accurate and complete comprehensive assessment and failed to develop a care plan with an individualized toileting plan. For R121, the facility failed to ensure a complete comprehensive urinary assessment upon admission and after a decline from occasional to frequent urinary incontinence on the quarterly MDS. The facility failed to comprehensively assess R121's urinary incontinence status until about 4 and 1/2 months after R121's admission to the facility. For R3, the facility failed to ensure accurate and complete comprehensive assessments of her urinary incontinence on 9/20/16, 9/23/16, 10/3/16 and 10/17/16. Findings include: The facility's policy titled "Continence Management," last revised 3/15/16, stated, "A urinary incontinence assessment...and the Three-Day Continence Management Diary...will	F 315	R148 had an accurate and complete comprehensive assessment completed and had the care plan updated to reflect an individualized toileting plan R121 and R3 will have a urinary evaluation and 3-day diary completed and have the care plan updated to reflect the evaluation All other residents identified as having urinary incontinence will have their record reviewed to determine they have a completed comprehensive assessment and their care plan reflects an individualized toileting plan. Medical records will be updated as necessary Root cause analysis will be completed to determine the cause of the deficient practice The Center Nurse Executive will review the continence management policy and procedure and make any necessary revisions The NPE or designee will reeducate the nurses on the continence management policy that will include the accurate and complete assessment of continence status upon admission, readmission or change in condition and developing an appropriate care plan that includes an individualized toileting program.	3/22/17

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F 315	Continued From page 20 be completed if the patient is incontinent upon admission or re-admission and with a change in condition or change in continence status. Continence status will be reviewed quarterly and with significant change as part of the nursing assessment...PRACTICE STANDARDS 1. Identify patient's continence status and need for management by reviewing the nursing assessment. 2. If patient is incontinent: 2.1...Complete Urinary Incontinence Assessment...2.2...Complete a urinary...incontinence evaluation. 3. Address transient causes for incontinence. 4. Initiate Three-Day Continence Management Diary...if incontinence is not resolved. 5. Develop plan of care based on information from assessments and diaries. 6. Implement revisions to the plan of care as needed...". 1. Review of R148's clinical record revealed the following: R148 was admitted to the facility on 10/7/16 with diagnoses that included overactive bladder and dementia. 10/7/16 - The initial/admission Nursing Assessment did not identify R148's urinary continence status, stated the resident used the bathroom for toileting and that a current toileting program or trial was not being used to manage the resident's urinary continence. 10/7/16 through 10/9/16 - A Three-Day Continence Management Diary was completed and noted that R148 was incontinent of bladder on only two (2) occasions, 10/8/16 at 9:00 PM and on 10/9/16 at 7:30 AM.	F 315	Center Nurse Executive or designee will complete audits weekly x's 3 weeks until 100% compliant than monthly x's 3 months to determine accurate and complete assessments of continence status and individualized toileting programs are in place. Audit results will be presented and reviewed by the CQI committee to identify trends	3/22/17

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	085042		01/19/2017

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F 315	Continued From page 21 10/7/16 through 10/9/16 - The CNA's electronic Documentation Survey Report stated that R148 was incontinent of bladder on three (3) occasions: 10/7/16 at 3:34 AM, 10/8/16 at 6:48 AM, and 10/9/16 at 3:36 AM. Additionally, the report stated that R148 was continent on 10/8/16 on the 3-11 PM shift. The Three-Day Continence Management Diary and the electronic Documentation Survey Report had conflicting documentation. 10/10/16 - A care plan for the problem "at risk for skin breakdown as evidenced by limited mobility...incontinence of bladder" was initiated. One intervention stated, "Provide peri care/incontinence care as needed." 10/14/16 - An expanded Nursing Assessment was completed and stated R148 did not have new onset of urinary incontinence, was occasionally incontinent, used the bathroom for toileting and was not on a current toileting program or trial. 10/14/16 - The admission MDS assessment stated R148's cognitive skills for daily decision making were moderately impaired and that extensive assist of one (1) staff was required for transfers and toilet use. The MDS also stated R148 was frequently incontinent of bladder during the seven (7) day review period and that there was no trial of a toileting program attempted on admission or since urinary incontinence was noted in this facility. The CAA portion of the MDS triggered urinary incontinence as a potential problem area, which the facility noted it would care plan for. There was no evidence that the facility developed	F 315		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085042		01/19/2017

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F 315	Continued From page 22 an individualized care plan for R148's urinary incontinence based on assessments and resident needs. There was no evidence that a Urinary Incontinence Assessment or an Incontinence Evaluation were completed according to facility policy. The facility failed to accurately and completely assess R148's urinary continence status, and failed to develop an individualized toileting plan in an attempt to restore continence to the extent possible. On 1/13/17 at approximately 1:45 PM findings were reviewed with E2 (DON). E2 confirmed that a comprehensive assessment was not completed and that a care plan with an individualized toileting plan was not developed for R148. 2.Review of R121's clinical record revealed the following: R121 was admitted to the facility on 8/3/16 with diagnoses including anxiety and major depression with previous suicide attempts. 8/3/16 - The initial/admission Nursing Assessment urinary section was not completed; there was no identification of R121's urinary continence status, his current toileting method or whether a current toileting program or trial was being used to manage the resident's urinary continence. 8/3/16 through 8/5/16 - The CNA's electronic Documentation Survey Report stated that R121 was incontinent of bladder on 3 occasions.	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085042		01/19/2017

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F 315	Continued From page 23 8/3/16 - The facility developed an ADL care plan which stated that R121 required 1 person assistance with personal hygiene and that R121 required prompted voiding based on assessment of 3 day voiding diary. Uncertain when the prompted voiding was added to the care plan. 8/10/16 - The admission MDS assessment stated R121's cognitive skills for daily decision making was a "9" or moderately impaired and that 1 person extensive assistance was required for transfers and toilet use. R121 was coded as having occasional urinary incontinence during the 7 day review period and a toileting trial was not attempted since admission. The CAA portion of the MDS triggered urinary incontinence as a potential problem area, which the facility noted it would care plan for. 8/15/16 - A Three-Day Continence Management Diary (will refer to as 3 day voiding diary) was initiated on 3-11 PM shift, however, it was incomplete; only 12 two hour checks were completed out of 36 opportunities. There was no evidence that a Urinary Incontinence Assessment or an Incontinence Evaluation were completed on admission. 11/4/16 through 11/10/16 - The CNA's electronic Documentation Survey Report stated that R121 was incontinent of bladder on 8 occasions. 11/10/16 - The quarterly MDS assessment stated R121's cognitive skills for daily decisionmaking was a "12" (improved since admission) or moderately impaired and that 2 person extensive assistance was required for transfers and 1	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 315	Continued From page 24 person extensive assistance was required for toileting. R121 was coded as having frequent urinary incontinence (declined since admission) during the 7 day review period and a toileting trial was not attempted since admission when urinary continence was noted. There was no evidence that a Urinary Incontinence Assessment, 3 day voiding diary and/or Incontinence Evaluation was initiated after this decline in urinary status. 12/13/16 - A 3 day voiding diary was initiated on 3-11 PM shift, however, it was incomplete; 31 two hour checks were completed out of 36 opportunities. The documented entries showed no urinary incontinence. 12/13/16 through 12/16/16 - The CNA's electronic documentation Survey Report stated that R121 was incontinent of bladder on 1 occasion. 12/18/16 - Urinary Incontinence Nursing Interventions listed as "admission" (R121 was admitted about 4 1/2 months ago) stated that R121 had mixed urinary incontinence, the facility identified prompted voiding as the management program for R121's urinary incontinence and the plan was agreed upon by R121. 12/19/16 - A Urinary Incontinence Evaluation was completed and stated that R121's urinary incontinence was not new, there was no change in urinary status, R121 wore pads for stress incontinence, and transient/reversible factors included mobility. Actions stated if no clinical symptoms or transient/reversible causes identified or unable to be reversed, urinary incontinence was persistent and to initiate a 3 day	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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BRACKENVILLE CENTER	100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707

(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 315	Continued From page 25 voiding diary and complete Urinary Incontinence Nursing Interventions (although the latter appears to have be completed first). 12/19/16 through 12/22/16 - A 3 day voiding diary was completed. R121 was dry or continent on all entries. 12/19/16 through 12/22/16 - The CNA's electronic documentation Survey Report stated that R121 was incontinent of bladder on 1 occasion which reflects occasional urinary incontinence. 1/1/17 through 1/11/17 - The CNA's electronic documentation Survey Report stated that R121 was incontinent of bladder on 2 occasions which reflects occasional urinary incontinence. Findings were reviewed and confirmed with E2 (DON) during an interview on 1/17/17 at 4:09 PM. E2 stated that she identified in December that R121 had not had an admission Urinary Assessment. She stated R121's doing better now and has less urinary incontinence. E2 further stated that the facility should have followed up in 5 days to see if the prompted voiding plan was effective. 3. Review of R3's clinical record revealed the following: R3 was admitted to the facility on 9/19/16. 9/19/16 at 9:41 PM - The nursing admission assessment stated that R3 had urinary incontinence and R3 was aware to call for assistance to use the bathroom. 9/20/16 - R3 was care planned for extensive assist of 1-2 staff for toileting and incontinence	F 315		

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F 315	Continued From page 26 care as needed. 9/20/16 through 9/22/16 - A Three-Day Continence Management Diary was initiated. While the diary was incomplete, it noted that R3 was incontinent of bladder on only one (1) occasion, 9/21/16 at 6:30 PM. 9/20/16 through 9/22/16 - The CNA's electronic Documentation Survey Report stated that R3 was incontinent of bladder on four (4) occasions: 9/20/16 at 3:42 AM, 9/20/16 at 2:07 PM, 9/21/16 at 9:50 PM and 9/22/16 at 6:28 AM. The Three-Day Continence Management Diary and the electronic Documentation Survey report had conflicting documentation. 9/22/16 - A Urinary Incontinence Evaluation was completed and stated that R3's urinary incontinence was not new and R3 had urgency and frequency symptoms and mobility restrictions. The evaluation stated that R3's urinary incontinence was unable to be corrected and to initiate a Three-Day Continence Management Diary and to complete the Urinary Incontinence Nursing Interventions. 9/23/16 through 9/26/16 - A second Three-Day Continence Management Diary was initiated. However, R3's diary was incomplete as it was missing the 7-3 PM shift documentation on 9/26/16. 9/23/16 through 9/26/16 - The CNA's electronic Documentation Survey Report stated that R3 was continent of bladder. 9/27/16 - A Urinary Incontinence Nursing Interventions form was completed and stated that	F 315		

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F 315	Continued From page 27 R3 had urge incontinence. A prompted voiding management program was selected and discussed with R3. 9/27/16 through 10/3/16 - R3 was hospitalized and readmitted to the facility. 10/3/16 at 3:16 PM - A readmission Nursing Assessment stated that R3 had urinary incontinence and used a bedpan. 10/3/16 through 10/6/16 - A Three-Day Continence Management Diary was initiated starting 3-11 PM shift on 10/3/16. While R3's diary was incomplete, it noted that she was incontinent of bladder on four (4) occasions, 10/3/16 at 3:30 PM, 10/4/16 at 8:15 PM, 10/5/16 at 8:30 PM and 10/6/16 at 8:00 PM. 10/3/16 through 10/6/16 - The CNA's electronic Documentation Survey Report stated that R3 was incontinent of bladder on two (2) occasions: 10/4/16 at 10:59 PM and 10/6/16 at 10:44 PM. Additionally, the report stated that R3 was continent on the 3-11 PM shifts on both 10/3/16 and 10/5/16. The Three-Day Continence Management Diary and the electronic Documentation Survey report had conflicting documentation. 10/6/16 - A Urinary Incontinence Evaluation stated that R3 did not have a change in urinary status and no restrictions. The evaluation stated that R3's urinary incontinence was unable to be corrected and to initiate a Three-Day Continence Management Diary and complete the Urinary Incontinence Nursing Interventions. 10/11/16 - A Urinary Incontinence Nursing	F 315		

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F 315	Continued From page 28 Interventions form stated R3 had urge incontinence, bladder retraining and scheduled toileting were selected as the management program and discussed with R3. 10/11/16 - R3 was care planned for occasional bladder incontinence with the potential for improved control or urinary elimination management. The approaches included: to assist R3 to the toilet at scheduled times (upon arising, before and after meals, at bedtime and as needed); complete a voiding diary and evaluate for patterns of incontinence; complete an incontinence assessment according to policy and procedure; discuss and plan voiding schedule with R3; monitor for signs and symptoms of infection and report to physician; monitor output for odor, color, consistency and amount; provide access to the bathroom; provide privacy and comfort and PT/OT as needed. 10/14/16 through 10/17/16 - R3 was hospitalized and readmitted to the facility. 10/17/16 at 3:04 PM - The urinary section of R3's readmission Nursing Assessment was blank. 10/17/16 through 10/20/16 - A Three-Day Continence Management Diary was initiated upon R3's readmission to the facility. While R3's Diary was incomplete, it noted that she was continent of bladder. 10/17/16 through 10/20/16 - The CNA's electronic Documentation Survey Report stated that R3 was incontinent of bladder on one (1) occasion: 10/19/16 at 10:40 PM, despite the Three-Day Continence Management Diary stating that R3 was continent on the 3-11 PM shift on 10/19/16.	F 315		

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F 315	Continued From page 29 Following R3's 10/17/16 readmission, review of the clinical record revealed lack of evidence that the facility failed to comprehensively assess R3's urinary incontinence as evidenced by failure to complete a Three-Day Continence Management Diary, a Urinary Incontinence Assessment and Urinary Incontinence Nursing Interventions. During an interview with E2 (DON) and E6 (QA) on 1/17/17 at 2:10 PM, E6 confirmed the findings. The facility failed to provide appropriate treatment and services to restore R3's continence to the extent possible by: - failure to complete the Three-Day Continence Management Diaries initiated on 9/20/16, 9/23/16, 10/3/16 and 10/17/16; - failure to identify the conflicting documentation between the Three-Day Continence Management Diaries and the CNA's electronic Documentation Survey Report on 9/20/16, 10/3/16 and 10/17/16; and - failure to comprehensively assess R3's urinary incontinence upon her 10/17/16 readmission to the facility.	F 315		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use	F 323		

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F 323	Continued From page 30 appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to prevent accident hazards for 2 (301, and 304) rooms out of 33 rooms surveyed. Findings include: Observations on 1/10/17 and 1/11/17 during the Stage 1 review, and during the environmental tour with E10 (FMD) and E11 (house keeping) on 1/12/17, between 1:30 PM and 2:30 PM, revealed the following: Room 301 - The toilet seat in the bathroom was loose; Room 304 - The toilet seat in the bathroom was loose; Findings were reviewed and confirmed with E10 and E11 on 1/12/17 at approximately 2:30 PM Findings were reviewed with E1 (NHA), E2 (DON) and E7 (ADON) on 1/19/17 at approximately 7:00	F 323	Toilet seats were tightened in rooms 304&301 All other toilet seats were checked and tightened Policy and procedure for environmental rounds and review will be reviewed and revised as necessary Maintenance Director or designee will complete environmental audits weekly x's 4 weeks than once 100% audits will be completed monthly x's 3 months to determine the facility provides housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior Audits will be presented and reviewed by the CQI committee to identify any trends	3/22/17

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F 323	Continued From page 31 PM.	F 323		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Brackenville Center

DATE SURVEY COMPLETED: January 19, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by references and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from January 10, 2017 through January 19, 2017. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was one hundred and one (101). The survey sample totaled twenty-six (26).		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**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 the Regulation, as fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by: F253, F272, F309, F312, F315 and F323.**	Cross reference plan of correction for CMS 2567 for Annual survey ending January 13, 2016 F253, F272, F309, F312, F315 and F323	3/22/17

Provider's Signature _____ Title Center Executive Dir Date 2/14/17