

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

PRINTED: 02/22/2019  
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>10/25/2018</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
E 000	Initial Comments  An unannounced annual and complaint survey was conducted at this facility from October 11 through October 25, 2018. The facility census the first day of the survey was 164 (one hundred sixty-four). An emergency preparedness survey was also conducted during the same time period. There were no emergency preparedness deficiencies identified based on observation and interviews.	E 000		
F 000	INITIAL COMMENTS  An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from 10/11/18 through 10/25/18. 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 164. The survey sample size was 57.  Abbreviations/definitions used in this report are as follows:  1:1 Supervision - one staff person assigned direct supervision of a resident; Abrasion - wearing away of the skin through some mechanical process (friction or trauma) OR superficial wound caused by rubbing or scraping the skin; ADL - Activities of Daily Living; ADON - Assistant Director of Nursing; Anticoagulant - medication that work to prevent the coagulation (clotting) of blood; Anxiety - an unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/07/2018

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: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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	Continued From page 1 ASA - Aspirin; Aspirate - matter that has been drawn from the body by suction; BIMS - (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15; Bipolar Disorder - mood disorder; BMP - set of eight tests that measure blood sugar and calcium levels, kidney function, and chemical and fluid balance; BNRC - Brandywine Nursing and Rehabilitation Center; BP - Blood Pressure; BUN (blood urea nitrogen)- blood test to see how well your kidneys are working; BVM (Bag Valve Mask) - an airway apparatus used to cover the patient's nose and mouth and begin ventilating the lungs mechanically by squeezing a reservoir of oxygen or air; CBC (Complete Blood Count) - blood test used to evaluate your overall health and detect a wide range of disorders, including anemia, infection and leukemia; cc - cubic centimeter/often referred to as a milliliter (ml) since it is a thousandth of a liter; CMP (complete metabolic panel)- blood test that measures your sugar (glucose) level, electrolyte and fluid balance, kidney function and liver function; CNA - certified nurse's aide; Cognition (Cognitive) - mental process; thinking; COPD (Chronic obstructive pulmonary disease)- a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible; CPR - Cardiopulmonary resuscitation, an emergency procedure that is done when someone's breathing or heartbeat has stopped in hopes of providing time for first responders to	F 000		

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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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	Continued From page 2 arrive; Culture & Sensitivity (C&S) - laboratory test to identify which bacteria is causing the infection and which antibiotic will kill the bacteria; CT Scan - imaging test that takes detailed pictures of the inside of the body; CVA - cerebral vascular accident OR stroke; CXR- chest x-ray; Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation OR loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Diabetes mellitus: More commonly referred to as "diabetes" - a chronic disease associated with abnormally high levels of the sugar glucose in the blood; DON - Director of Nursing; DuoNeb - Nebulizer used to treat and prevent symptoms (wheezing and shortness of breath) caused by ongoing lung disease (chronic obstructive pulmonary disease-COPD which includes bronchitis and emphysema); Dycem- a non-slip material to help stabilize objects; Dyspnea - difficulty breathing; eMAR - Electronic medication administration records; eTAR-Electronic treatment record; Emesis - The action or process of vomiting; Emphysema-long term lung disease; Enteral - involving or passing through the intestine, either naturally via the mouth and esophagus, or through an artificial opening; ER - Emergency Room; Eschar - dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed OR dead tissue forming a hard	F 000			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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	Continued From page 3 scab; usually black in color; eTAR- electronic treatment administration records; Extensive Assistance - While the resident performed part of the activity over the last 7 day period, help of the following type was provided 3 or more times: weight bearing support; full staff performance during part (but not all) of the last 7 days; OR resident involved in activity, staff provide weight-bearing support; Extrapyramidal Symptoms (EPS) - are side effects of antipsychotic medicines. EPS can cause movement and muscle control problems throughout the body; F - Fahrenheit; Flank - area between the ribs and the hip; Fracture - a broken bone; Gastrostomy - a surgical procedure for inserting a tube through the abdomen wall and into the stomach. The tube is used for feeding or drainage; GI - Gastrointestinal; Granulation Tissue - mass of new connective tissue and capillaries formed on the surface of a healing ulcer or wound; Hematoma - collection of blood as a result of trauma, such as a black eye; Hemiplegia - half of the body is paralyzed; HIV - human immunodeficiency virus, a retrovirus which causes AID(Auto Immune Disease); Hypoxia / Hypoxic - inadequate cellular oxygenation OR deficiency in amount of oxygen reaching body tissues; i.e.-that is; L - Liters; Lethargic- abnormal drowsiness; LPN - Licensed Practical Nurse; Maxillary - of or relating to a jaw or jawbone, especially the upper one;	F 000			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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	Continued From page 4 MD - doctor of medicine; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; Mixing Valve (mixer) - a valve receiving water from both a hot-water and a cold-water line and controlling the relative amount of water admitted from each; mg - milligram/a unit of weight; mL - milliliter; A unit of liquid volume or capacity in the metric system, 5 ml equals 1 teaspoon or metric measurement of liquid volume; Mobility- the ability to move or be moved freely and easily; Nebulizer - an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece; Necrosis / Necrotic - tissue death, usually due to interruption of blood supply or injury or dead non-viable tissue; Neuro checks - series of simple questions and physical tests to determine if the nervous system is impaired; Neuropathy -disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness or pain; NHA - Nursing Home Administrator; NRB (Non-rebreather mask) - a device used in medicine to assist in the delivery of oxygen therapy; NSS - normal saline solution, a sterile mixture of salt and water with a salt concentration similar to tears, blood, and other body fluids; Ombudsman - resident representative who investigates reported complaints and helps to achieve agreement between parties; Oncologist - physician who specializes in the prevention, diagnosis and treatment of cancer; Oxycodone - an opioid pain medication,	F 000		

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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	Continued From page 5 sometimes called a narcotic; used to treat moderate to severe pain; Paralysis - loss of voluntary movement; PASSR - Preadmission Screening and Resident Review - screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there; PEG tube - a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate; Piston Syringe - 60 milliliter (ml) syringe with an elongated tip which fits into a feeding tube to administer fluids or medication; Pre and Post Pain Scale- measures pain, usually on scale 0-10 with 10 being the most pain, before (Pre) and after (Post) pain medication to show effectiveness of medication; Pressure Ulcers (PUs) - sore area of skin that develops when the blood supply to it is cut off due to pressure; Prezcofix - medication to treat HIV; PRN - As needed; Psych - short for psychiatrist or psychology; Psychiatrist - a physician who specializes in the diagnosis and treatment of mental disorders; Psychotropic (medication)- any medication capable of affecting the mind, emotions and behaviors; Pulse Oximetry (PO2) - measures blood oxygen saturation levels - desired range 94% to 100%; Q - every; QA - quality assurance; Range of Motion (ROM) - extent to which a joint can be moved safely;	F 000			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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	Continued From page 6 Respiratory Rate - the rate at which breathing occurs; RN - Registered Nurse; RNAC- Registered Nurse Assessment Coordinator; Sacrum- large triangular bone at base of spine; Schizophrenia - mental disorder with false beliefs of being harmed; Serous - a thin, clear, light yellow watery fluid found in many body cavities; Sedimentation - the process of settling to the bottom; Slough - yellow, tan, gray, green or brown dead tissue; Sodium- a mineral and electrolyte found in salt; blood tests show how much is in blood; s/p - status post, a Latin expression that means "condition after"; Stages of pressure ulcers (categorization system used to describe the severity of PUs): Stage I (1) - a reddened area of intact skin usually over a boney prominence, that when pressed does not turn white. This is a sign that a PU is starting to develop. Stage II (2) - skin blisters or skin forms an open sore. The area around the sore may be red and irritated. Stage III (3) - skin develops an open, sunken hole called a crater. There is damage to the tissue below the skin. Stage IV (4) - ulcer has become so deep that there is damage to the muscle and bone and sometimes to tendons and joints. Unstageable (PU) - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound	F 000			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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	Continued From page 7 bed). Deep Tissue Injury (DTI) - Purple or maroon localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue; Stroke (CVA) - a condition involving reduced blood supply to the brain from intracerebral hemorrhage, thrombosis, embolism, or vascular insufficiency; Temp - Temperature; Total assistance - full staff performance of an activity; Urinalysis (UA) - diagnostic test used to detect and assess a disease or illness OR diagnostic test used to determine presence of infection; Urologist - physician who specializes in medical diseases of the male and female urinary tract system; Ventimask - An oxygen mask that provides oxygen enrichment of the inspired air while eliminating rebreathing of the expired carbon dioxide; WBC - White Blood Cell count/laboratory blood test that identifies if an infection is in occurring. x - Times.	F 000			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)  §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.  §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but	F 583		12/26/18	



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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 583	<p>Continued From page 8</p> <p>this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record reviews and interviews, it was determined that for 1 (R121) out of 57 sampled residents, the facility failed to protect their privacy and confidentiality of their medical records. Findings include:</p> <p>1. Review of R121's clinical record revealed:</p> <p>3/17/17 - A physician's order for R121 stated to administer Prezcobix tablet daily for a diagnosis of HIV.</p> <p>10/15/18 at 3:29 PM - An observation revealed that R121's Prezcobix medication container was</p>	F 583	<p>Disclaimer Statement: Preparation and/or execution of this plan of correction (POC) does not constitute admission of or agreement to the facts and deficiencies alleged or conclusions set forth in the statement of deficiencies. Furthermore, no actions taken or to be taken pursuant to this POC are an admission that additional steps should have or could have been taken to prevent any alleged deficiency. The POC is prepared and/or executed solely because it is required by the provision of both Federal and State</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 583	Continued From page 9 left on top of an unattended medication cart in the hallway, which showed the resident's name, name of the medication and the diagnosis. E4 (RN) exited a room and returned to the medication cart. The finding was immediately confirmed with E4.  10/25/18 at 9:19 AM - Finding was reviewed with E1 (NHA) and E2 (DON). The facility failed to maintain R121's privacy and confidentiality of the medical record.	F 583	laws.  A. R121 had no untoward effect and the container was secured immediately. B. All residents have the potential to be affected by the alleged deficiency. C. All licensed staff have been in-serviced on the necessity to protect the confidentiality of resident medications and the rules concerning protected health information (PHI). Privacy, security, and PHI have been added as regular agenda items at the nursing meetings monthly and reinforced at orientation. See attached audit tool and in-service information. D. The unit manager/designee will monitor to ensure protected information is not left unattended daily for 14 days and then weekly times 10 until 100% compliance is achieved for three consecutive. Results will be reported quarterly through the facility QAPI process.		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)  §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.  The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		12/26/18	

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

PRINTED: 02/22/2019  
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>10/25/2018</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 584	<p>Continued From page 10</p> <p>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to have all equipment in good repair. There were raised toilet seats in disrepair in 2 (B5, F6) out of 36 resident rooms reviewed. Findings include:</p> <p>1. On 10/15/18 at 3:04 PM and on 10/23/18 at 1:51 PM, the raised toilet seat in the bathroom of room B5 was observed with peeling paint and having rust.</p>	F 584	<p>Example 1</p> <p>A. The raised toilet seat in the bathroom of room B5 was replaced.</p> <p>B. Residents requiring raised toilet seats have the potential to be affected.</p> <p>C. The preventive maintenance schedule has been revised to include examination for worn raised toilet seats. Items will be replaced as identified.</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 584	Continued From page 11  2. On 10/15/18 at 3:58 PM and on 10/23/18 at 2:01 PM the raised toilet seat in the bathroom of room F6 was observed with peeling paint and rust.  Findings were reviewed with E1 (NHA) on 10/24/18 at 1:55 PM.	F 584	D. The Maintenance Director or designee will review two resident rooms on each hallway (6) daily for 8 days to ensure all rooms are examined, then two times per week for two weeks and then monthly until 100% compliance has been achieved for two consecutive months. Findings will be reported quarterly through facility QAPI process.  Example 2 A. The raised toilet seat in the bathroom of room F6 was replaced. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include examination for worn equipment. Items will be repaired or replaced as identified. D. The Maintenance Director or designee will review two resident rooms on each hallway (6) daily for 8 days to ensure all rooms are examined, then two times per week for two weeks and then monthly until 100% compliance has been achieved for two consecutive months. Findings will be reported quarterly through facility QAPI process.		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4)  §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been	F 585		12/26/18	

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 585	<p>Continued From page 12</p> <p>furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.</p> <p>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:</p> <p>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;</p>	F 585			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 585	Continued From page 13 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency	F 585			

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>10/25/2018</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 585	<p>Continued From page 14</p> <p>confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews and review of the facility's documentation, including the Grievance Policy, the Grievance/Concern Log and sampled Incident Reports, the facility's Grievance Policy failed to include the Federal requirements under §483.10(j)(4). In addition, the facility failed to investigate, summarize the findings and write statements as to whether the grievances were confirmed or not confirmed for 2 out of 4 sampled grievances. Findings include:</p> <p>1a. The facility's "Resident/Family Grievance and Concern Policy", last revised 5/2017, stated, "POLICY: The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal. Per federal regulations, the resident has the right to and the facility must make prompt efforts to resolve grievances that have been brought forth. Brandywine Nursing and Rehab has identified the Social Service Director / Designee as the Grievance Officer.</p> <p>PROCEDURE:</p> <ol style="list-style-type: none"> <li>Any resident, family, staff member or visitor may bring forth any concern or grievance. This information will be forwarded in a timely manner to the Grievance Officer.</li> <li>The grievance will be logged and stored in the Social Services office.</li> <li>The grievance will be forwarded to the Administrator and all appropriate department</li> </ol>	F 585	<p>Example 1A</p> <p>A. The policy has been revised to reflect the requirements specified at 483.10(j)(4) and be consistent with 483.12(c)(1) and the grievance forms have been revised to reflect the requirements. Policy attached.</p> <p>B. All residents have the potential to be affected by the alleged deficiency.</p> <p>C. Full-time, part-time and PRN staff and residents have been informed via posting in prominent locations throughout the facility of the changes to the grievance process to include the items and requirements specified in items 483.10(j)(4)(i) through (vii). A copy of the grievance policy has been provided to all residents.</p> <p>D. All resident grievances will be reviewed by the DON/designee at the weekly High Risk meeting to determine adherence to the policy. Results will be reviewed until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.</p> <p>Example 1B</p> <p>Example 1</p> <p>A. R127 suffered no untoward effect and the TV was replaced by the facility within an hour as verified by the description in</p>	

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

PRINTED: 02/22/2019  
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>10/25/2018</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 585	Continued From page 15 heads specific to the grievance. 4. The Department head responsible for follow-up will respond with steps to resolve the grievance and final disposition. 5. The Grievance Officer will follow-up with the person who brought forth the grievance regarding final resolution."  The facility failed to include in their Grievance Policy the following Federal requirements under §483.10(j)(4): "(i) Notifying resident individually or through postings in prominent locations throughout the facility...the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding the resident's grievance; the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;... (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued..."  1b. Review of 2 out of 4 sampled grievances	F 585	the 2567. B. All residents have the potential to be affected by the alleged deficiency. C. Staff developer will in-service all staff regarding reporting alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property. D. All resident grievances will be reviewed to determine if all allegations of neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property are identified for appropriate reporting by the DON/designee at the weekly High Risk meeting . Results will be reviewed until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.  Example 2 A. R33 suffered no untoward effect and BNRC staff verified R33 was satisfied. B. All residents have the potential to be affected by the alleged deficiency. C. Staff developer will in-service all staff regarding reporting alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property. D. All resident grievances will be reviewed to determine if all allegations of neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property are identified for appropriate reporting by the DON/designee at the weekly High Risk meeting . Results will be reviewed until		



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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 585	<p>Continued From page 16</p> <p>listed on the facility's Grievance/Concern Log from May 2018 to October 2018 lacked evidence of steps taken to investigate the grievances, summaries of the pertinent findings and statements as to whether the grievances were confirmed or not confirmed.</p> <p>- On 10/12/18, a grievance was reported by unknown staff person on behalf of R127. The grievance stated that "another resident (unidentified) entered into this resident (sic) room. The resident knocked over the resident (sic) TV off of the dresser...". The final deposition, dated 10/15/18, stated, "Stop sign placed @ door. TV was replaced by BNRC. Alarm mat added on 10/12/18 also to doorway to alert staff to wandering resident."</p> <p>The facility failed to investigate the grievance, summarize the pertinent findings and write a statement as to whether the grievance was confirmed or not confirmed.</p> <p>- On 10/16/18, a grievance was reported by R39, a resident. The grievance stated, "people wandering in room...". The final deposition, dated 10/17/18, stated, "stop sign placed on door."</p> <p>The facility failed to investigate the grievance, summarize the pertinent findings and write a statement as to whether the grievance was confirmed or not confirmed.</p> <p>10/24/18 at 1 PM - Observations of grievance postings were made throughout the facility. The postings stated, "Any family, visitor, or resident grievances or concerns may be directed to any BNRC employee who will then forward to the Grievance Officer for appropriate follow-up. The</p>	F 585	100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.		

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 585	<p>Continued From page 17</p> <p>Grievance Officer has been designated as the Director of Social Services (or Designee in her absence)." The facility's grievance postings failed to address the resident's right to file grievances anonymously and failed to list the contact information of the grievance official (i.e. name, business address (mailing and email) and business phone number.</p> <p>10/24/18 at 1:25 PM - During a combined interview with the facility's two social workers, E5 and E6, E5 stated that the facility does not have a Director of Social Services at the present time. E5 stated that grievances are handled by them and sometimes the Administrator, Director of Nursing or Assistant Director of Nursing if directly approached by family members. E5 stated that the facility had 2 grievance forms, one for resident/family members and one for the staff. The grievance forms are located in all nurses stations and in the supervisor's book. E5 stated that residents, family members and visitors have to ask staff for the grievance forms. E5 stated that depending on the issue, grievance forms are filled out and dispersed to the appropriate manager to handle. E5 stated that grievances would be handled by the house supervisor on the weekends. E5 stated that they are providing verbal resolution responses to the individuals who file grievances and note the date and time.</p> <p>10/24/18 at 5:36 PM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility's Grievance Policy failed to include the Federal requirements under §483.10(j)(4). In addition, the facility failed to investigate, summarize the findings and write statements as to whether the grievances were confirmed or not confirmed for 2 out of 4 sampled grievances.</p>	F 585			

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>10/25/2018</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 600 SS=H	<p>Free from Abuse and Neglect CFR(s): 483.12(a)(1)</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews and review of facility documentation, it was determined that for 5 (R33, R78, R105, R147, and R215) out of 57 sampled residents, the facility failed to ensure that the residents were free from abuse. R78 sustained verbal abuse from a staff member, which resulted in harm. R33 sustained physical and emotional abuse when a wandering resident entered her room unsupervised and shoved R33 out of the way, which resulted in harm. R215 sustained physical and verbal abuse when R215's roommate pulled her by her ankles to the end of the bed while screaming at her, which resulted in harm. R105 sustained physical abuse when R105's roommate slapped her arm causing redness and tenderness, which resulted in harm. R147 sustained emotional abuse when a wandering unsupervised resident entered her room causing her emotional distress, which resulted in harm. Findings include:</p>	F 600	<p>Example 1</p> <p>A. R78 continues to reside in the facility and E24 no longer works in the facility.</p> <p>B. All residents have the potential to be affected by the alleged deficiency.</p> <p>C. All staff members received re-education on prevention of resident abuse, neglect and mistreatment and respecting resident rights. All staff have been in-serviced regarding workplace stress, staff burnout as it relates to potential for abuse, neglect and mistreatment.</p> <p>D. Social worker/designee will interview two residents per unit to ascertain satisfaction with staff interactions daily for 14 days, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility</p>	12/26/18

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>10/25/2018</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 600	Continued From page 19  1. Review of R78's clinical record revealed:  11/22/16 - Care Plan for ADLs included an approach to "assist resident in bathing as per resident needs."  11/22/16 - Care plan for "potential for alteration in comfort" included a goal for "pain will be diminished" and approaches of assessing "for verbal signs and symptoms of pain" and "assess for possible causes of pain and interventions."  2/27/17 - Care plan for resident to establish own goals, included a problem of the resident refusing "shower or bed baths at times able to make own decisions with care" and approaches of "involve resident in the decision making of ADL" and "honor preferences."  8/7/18 - The quarterly MDS assessment coded R78's BIMS score as a "10" (moderate cognitive impairment- decisions poor, cues/supervision required); there were no behaviors exhibited; and bathing required physical help during part of the activity with one staff person assisting.  9/12/18 3:47 PM - Incident reported to state agency by E3 (ADON). At 11:00 AM, on the same day, E10 (LPN) had been notified that R78 was crying after an encounter with E24 (CNA).  Statements collected by the facility revealed:  --9/12/18 - E10 (LPN) labeled the incident as "staff to resident." E10 (LPN) revealed that R78 stated s/he asked "multiple times" to have the bed lowered to prevent pain and the "CNA (E24) did not answer." R78 began yelling at E24. E24	F 600	QAPI process.  Example 2 A. R33 continues to reside in the facility. Upon interview immediately following the event, resident denied abuse to the nursing staff and suffered no untoward effect. An investigation was completed by BNRC staff. B. All residents have the potential to be affected by the alleged deficiency. C. All staff members received re-education on prevention of resident abuse, neglect and mistreatment and respecting resident rights to include appropriate care plan approaches. IDT will discuss those residents identified as wandering excessively to determine best course of action and communicate and care plan those actions. D. Social worker/designee will interview two residents per unit to ascertain satisfaction with perception of safety in their home and the ADON/designee will review wandering resident MAR documentation and concern forms daily for 14 days, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.  Example 3 A. R215 no longer resides in the facility. Upon review, there is no evidence that R157 interacted with R215 as cited. An investigation was completed by BNRC staff. B. All residents have the potential to be		

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

PRINTED: 02/22/2019  
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>10/25/2018</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 600	<p>Continued From page 20</p> <p>insisted on giving R78 a bed bath and handed R78 a washcloth. R78 "threw washcloth back to CNA." R78 then told E24 to get out of the room and "CNA threw washcloth back to resident." Additionally, E10's (LPN) statement revealed that R78 "requested that the CNA (E24) no longer takes (sic) care of me." E10 (LPN) stated that the resident was "actively crying" after the incident. E10 (LPN) consoled R78.</p> <p>--9/12/18 - E24 (CNA) revealed that R78 "kept saying s/he was hurting" because of positioning of the bed", but E24 (CNA) revealed nothing about adjusting the bed or resident.</p> <p>--9/12/18 - E25 (CNA) labeled the incident as "verbal abuse." E25 (CNA) was present in the room just after the incident. E25 (CNA) revealed that E24 (CNA) stated that she "would be leaving the building if it happened again and beating (R78's) a*% before she left." E25 (CNA) offered to complete R78's care and as E24 (CNA) was leaving the room, R51 and a visitor entered the room. The visitor asked E25 (CNA) "How could we allow the caregivers to treat the patients that way cursing and carrying on?"</p> <p>--9/12/18 - R51's visitor's statement revealed that while in the hallway, they "heard the (E24) CNA get loud and nasty stating, 'if her a*% throws that wet wash cloth back at me again I'm going to throw it back at her a*%.'" In addition, as E24 (CNA) was leaving the room, the visitor stated hearing E24 (CNA) say "my a*% is getting fired today."</p> <p>9/18/18 - A Disciplinary Notice, included at the back of the facility's Incident Report Investigation packet for this incident, noted that E24 (CNA)</p>	F 600	<p>affected by the alleged deficiency.</p> <p>C. All staff members received re-education on prevention of resident abuse, neglect and mistreatment and respecting resident rights to include appropriate care plan approaches. IDT will discuss those residents identified as wandering excessively to determine best course of action and communicate and care plan those actions.</p> <p>D. Social worker/designee will interview two residents per unit to ascertain satisfaction with perception of safety in their home and the ADON/designee will review wandering resident MAR documentation and concern forms daily for 14 days, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.</p> <p>Example 4</p> <p>A. R105 continues to reside in the facility and upon subsequent examination within an hour of the event, no residual redness nor complaint of pain remained. An investigation was completed by BNRC.</p> <p>B. All residents have the potential to be affected by the alleged deficiency.</p> <p>C. All staff members received re-education on prevention of resident abuse, neglect and mistreatment and respecting resident rights to include appropriate care plan approaches. IDT will discuss those residents identified as wandering excessively to determine best course of action and communicate and care plan those actions.</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</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 600	<p>Continued From page 21</p> <p>was terminated for "threatening a resident."</p> <p>10/22/18 3:08 PM - R78 stated, during an interview with the surveyor, that the morning of the incident E24 (CNA) "didn't pay attention to me. E24 (CNA) wanted to wash me and I wanted a different time." R78 stated that E24 (CNA) threw a washcloth at R78 before R78 told E24 (CNA) to leave the room. R78 "felt in trouble" after the incident.</p> <p>10/24/18 1:36 PM - During an interview with the surveyor, E10 (LPN) confirmed that after the incident R78 was "visibly upset" and crying.</p> <p>The facility failed to ensure that R78 was free from verbal abuse resulting in harm.</p> <p>Findings were reviewed with E1 (NHA) on 10/24/18 at 1:55 PM.</p> <p>2. Review of R33 and R157's clinical records revealed:</p> <p>7/27/18- The facility developed a care plan for the problem that R157 wandered into other rooms at times due to dementia. Interventions included for staff to provide redirection and 1:1 supervision.</p> <p>8/3/18- A care plan was developed for the problem that R157 exhibited physical and verbal aggression. The care plan specified that R157 on 8/3/18 had a resident-to-resident altercation where she pulled another resident's legs and was verbally abusive. Interventions for this care plan included for R157 to receive 1:1 supervision.</p> <p>10/8/18- An annual MDS assessment was completed and revealed that R33 was cognitively</p>	F 600	<p>D. Social worker/designee will interview two residents per unit to ascertain satisfaction with perception of safety in their home and the ADON/designee will review wandering resident MAR documentation and concern forms daily for 14 days, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.</p> <p>Example 5</p> <p>A. R147 continues to reside in the facility and has verbalized no concern of fear or safety to BNRC staff.</p> <p>B. All residents have the potential to be affected by alleged deficiency.</p> <p>C. All staff members received re-education on prevention of resident abuse, neglect and mistreatment and respecting resident rights to include appropriate care plan approaches. IDT will discuss those residents identified as wandering excessively to determine best course of action and communicate and care plan those actions.</p> <p>D. Social worker/designee will interview two residents per unit to ascertain satisfaction with perception of safety in their home and the ADON/designee will review wandering resident MAR documentation and concern forms daily for 14 days, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 600	<p>Continued From page 22 intact.</p> <p>10/17/18 at 8:20 AM- A progress note documented that, during medication pass, E26 (RN) heard yelling and screaming coming from a room. E26 went to investigate and R157 was in R33's room. R33 tried to ask R157 to leave and R157 shoved R33 on her left shoulder. R33 was noted to be "extremely upset and shaken." R157 was supposed to be on 1:1 supervision per her care plan when this incident occurred.</p> <p>10/17/18 at 4:02 PM- After the incident occurred, R157 was observed by the surveyor without her care planned 1:1 supervision. R157 was seen walking by herself down the hall by the dining room towards the D/E wing nursing station. R157 then wandered into the nursing station and began putting hand sanitizer on her hands and rubbing it into a chair. At approximately 4:05 PM, staff noticed R157 and began to redirect her.</p> <p>10/18/18 at 10:34 AM- During an interview, R33 stated when R157 came in her room she "tried to get her to leave, but she just pushed past" her. R33 stated that she did not get physically hurt "this time," but she feels "very scared and afraid and does not want her (R157) in her room." R33 stated that residents wandering into her room had been a problem for a while, but R157 was the only wanderer that made her "feel scared" because she was "very strong." She stated, "I can't defend myself against her." R33 stated that she was especially fearful of R157 now because she "recently had a fall and does not want to get hurt again." R33 reiterated that she was "very afraid" and would be talking to her family about this event and stated that she already told staff that she was fearful. The surveyor reported this</p>	F 600			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 600	<p>Continued From page 23</p> <p>information to E2 (DON) who stated that he did not see this as abuse, but he would investigate further.</p> <p>10/18/18 at 3:34 PM- During an interview on 10/18/18, R33 stated that staff had been in her room talking to her about the incident on 10/17/18 with R157. R33 again stated how afraid she was of R157, and commented that R157 always seemed like she was "on a mission and you can't stop her." R33 stated that she worries because she cannot "defend herself" against R157. R33 stated that the interventions the facility puts in place, such as the stop signs across her doorway, do not help her feel safe. R33 stated the stop signs across the door "do not help because they (wandering residents) just take them down." R33 stated that she and her roommate (R147) keep their "door shut at night because they don't want people to come in," but they feel that they should not have to always keep their door shut "just to be safe."</p> <p>10/18/18 at 5:49 PM- A progress note documented that R33 "was still very anxious regarding the situation that had happened yesterday...regarding the other Resident coming into her room." The note stated that R33 was to be reviewed by psych.</p> <p>The facility failed to ensure that R33 was free from physical and emotional abuse resulting in harm, as evidenced by, R157, a known aggressive and wandering resident who was care planned for 1:1 observation, entering R33's room unsupervised and shoving her out of the way causing harm and emotional distress.</p> <p>10/25/18 at approximately 6:30 PM- Findings</p>	F 600			



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

PRINTED: 02/22/2019  
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>10/25/2018</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 600	<p>Continued From page 24</p> <p>were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC).</p> <p>3. Review of R215 and R157's clinical records revealed:</p> <p>7/27/18- The facility developed a care plan for the problem that R157 wandered into other rooms at times due to dementia. Interventions included for staff to provide redirection and 1:1 supervision.</p> <p>8/3/18- An incident statement from an event that occurred at 1:30 PM, stated that E33 (CNA) was walking down the hall and heard R157 saying "stop, stop" in an aggressive tone to R215. E33 entered the room and observed R157 with her hands on R215's ankles pulling her legs to the foot of the bed. R157 then told R215 "If you don't behave I'm going to punch you in the face." E33 immediately intervened, separated the residents, and informed E3 (ADON).</p> <p>8/3/18- An Incident/Accident Report stated that staff witnessed R215 "being verbally abused" by R157 and her legs were "pulled down to the foot of the bed from a fetal position."</p> <p>The facility failed to ensure that R215 was free from physical and verbal abuse resulting in harm, as evidenced by, R215's roommate, R157, a known wandering resident who was care planned for 1:1 supervision, pulling her by her ankles to the end of the bed while screaming at her.</p> <p>10/25/18 at approximately 6:30 PM- Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC).</p> <p>4. Review of R105 and R157's clinical records</p>	F 600			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 600	<p>Continued From page 25 revealed:</p> <p>7/27/18- The facility developed a care plan for the problem that R157 wandered into other rooms at times due to dementia. Interventions included for staff to provide redirection and 1:1 supervision.</p> <p>8/3/18- A care plan was developed for the problem that R157 exhibited physical and verbal aggression. The care plan specified that R157 on 8/3/18 had a resident-to-resident altercation where she pulled another resident's legs and was verbally abusive. Interventions for this care plan included for R157 to receive 1:1 supervision.</p> <p>8/8/18- An incident report summary from an event that occurred at 7:45 AM, documented that the assigned CNA was providing care to R157 when the resident became aggressive and pulled away. R157 then went over to R105 (her roommate) and began going through R105's belongings. R105 tried to stop R157 from taking her personal belongings and R157 reached out and slapped R105 on the right forearm. Staff stepped in and redirected R157 to her side of the room. R105's right forearm was noted to have redness and R105 verbalized that her "right forearm was tender."</p> <p>The facility failed to ensure that R105 was free from physical abuse resulting in harm, as evidenced by, R105's roommate, R157, a known aggressive and wandering resident who was care planned for 1:1 supervision, slapping her arm causing redness and tenderness.</p> <p>10/25/18 at approximately 6:30 PM- Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC).</p>	F 600			

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

PRINTED: 02/22/2019  
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>10/25/2018</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 600	Continued From page 26  5. Review of R147 and R157's clinical records revealed:  7/27/18- The facility developed a care plan for the problem that R157 wandered into other rooms at times due to dementia. Interventions included for staff to provide redirection and 1:1 supervision.  8/3/18- A care plan was developed for the problem that R157 exhibited physical and verbal aggression. The care plan specified that R157 on 8/3/18 had a resident-to-resident altercation where she pulled another resident's legs and was verbally abusive. Interventions for this care plan included for R157 to receive 1:1 supervision.  9/10/18- A quarterly MDS assessment was completed and revealed that R147 was cognitively intact.  10/17/18 at 8:20 AM- A progress note documented that, during medication pass, E26 (RN) heard yelling and screaming coming from a room. E26 went to investigate and R157 was in the room shared by R147 and R33. R33 tried to ask R157 to leave. R157 shoved R33 on her left shoulder. R147 was noted to be "upset" after the incident. R157 supposed to be on 1:1 supervision per her care plan when this incident occurred.  10/17/18 at 4:02 PM- After the incident occurred, R157 was observed by the surveyor without her care planned 1:1 supervision. R157 was seen walking by herself down the hall by the dining room towards the D/E wing nursing station. R157 then wandered into the nursing station and began putting hand sanitizer on her hands and rubbing it into a chair. At approximately 4:05 PM, staff	F 600			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 600	Continued From page 27 noticed R157 and began to redirect her.  10/18/18 at 3:39 PM- During an interview, the surveyor was talking to R147 about her fingernails when R147 stated that today had been a "long day with people coming in and out of the room" talking to her roommate "about what happened the other day" with R157 coming into their room. R147 stated that the incident was "scary" and that R157 makes her feel afraid. She stated that the facility feels like a "prison" because she does not feel safe. R147 stated she does not like to leave her room because someone may wander in and take her personal belongings. R147 stated that she feels bad for her roommate, R33, because she "gets it even worse" because she was in the first bed in their room. The surveyor reported this information to E2 (DON).  The facility failed to ensure that R147 was free from emotional abuse resulting in harm, as evidenced by, R157, a known aggressive and wandering resident who was care planned for 1:1 supervision, entering her room unsupervised and shoving her roommate (R33) causing her emotional distress.	F 600			
F 609 SS=E	10/25/18 at approximately 6:30 PM- Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC). Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		12/26/18	

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

PRINTED: 02/22/2019  
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>10/25/2018</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 609	<p>Continued From page 28</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview, and review of the State of Delaware Division of Healthcare Quality (DHCQ) Incident Reporting Program, it was determined that for three (R33, R105 and R215) out of 57 sampled residents, the facility failed to notify the state agency within 2 hours of potential abuse from multiple resident to resident altercations. Findings include:</p> <p>1. Cross refer F600, example #3</p> <p>Review of R215's clinical record revealed:</p>	F 609	<p>Example 1</p> <p>A. R215 no longer resides in the facility. Upon review, there is no evidence that R157 interacted with R215 as cited. An investigation was completed by BNRC staff. At the behest of the surveyor, BNRC reported the event prior to survey exit.</p> <p>B. All residents have the potential to be affected by the alleged deficiency.</p> <p>C. All staff members received in-service training regarding reporting requirements to the Division.</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>10/25/2018</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 609	<p>Continued From page 29</p> <p>Incident statements from an event on 8/3/18 at 1:30 PM, stated that E33 (CNA) was walking down the hall and heard R157 saying "stop, stop" in an aggressive tone to R215. E33 entered the room and observed R157 with her hands on R215's ankles pulling her legs to the foot of the bed. R157 then told R215 "If you don't behave I'm going to punch you in the face." E33 immediately intervened, separated the residents, and informed E3 (ADON).</p> <p>On 10/24/18, review of the State of Delaware DHCQ Incident Reporting Program revealed no evidence that the incident between R215 and R157 was reported to the state agency.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.</p> <p>2. Cross refer F600, example #4</p> <p>Review of R105's clinical record revealed:</p> <p>An incident report summary from an event on 8/8/18 at 7:45 AM, stated that the assigned CNA was providing care to R157 when the resident became aggressive and pulled away. R157 then went over to R105 (her new roommate) and began going through R105's belongings. The CNA attempted to redirect R157. R105 then tried to stop R157 from taking her personal belongings and R157 reached out and slapped R105 on the right forearm. Staff stepped in and redirected R157 to her side of the room. R105's right forearm was noted to have redness and R105 verbalized that her "right forearm was tender."</p>	F 609	<p>D. ADON/designee will review concerns and incidents to ensure appropriate investigative process and proper reporting occurs daily for 14 days, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.</p> <p>Example 2</p> <p>A. R105 continues to reside in the facility and upon subsequent examination within an hour of the event, no residual redness nor complaint of pain remained. An investigation was completed by BNRC. At the behest of the surveyor, BNRC reported the event prior to survey exit.</p> <p>B. All residents have the potential to be affected by the alleged deficiency.</p> <p>C. All staff members received in-service training regarding reporting requirements to the Division.</p> <p>D. ADON/designee will review concerns and incidents to ensure appropriate investigative process and proper reporting occurs daily for 14 days, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.</p> <p>Example 3</p> <p>A. R33 continues to reside in the facility and upon interview immediately following the event, resident denied abuse to the nursing staff and suffered no untoward effect. An investigation was completed by BNRC staff. At the behest of the surveyor, BNRC reported the event prior</p>	

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

PRINTED: 02/22/2019  
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>10/25/2018</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 609	Continued From page 30 On 10/24/18, review of the State of Delaware DHCQ Incident Reporting Program revealed no evidence that the incident between R105 and R157 was reported to the state agency.  Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.  3. Cross refer F600, example #2  Review of R33's clinical record revealed:  A progress note from 10/17/18 at 8:20 AM, stated that during medication pass E26 (RN) heard yelling and screaming coming from a room. E26 went to investigate and found R157 in R33's room. R33 tried to ask R157 to leave and R157 shoved R33 on her left shoulder. R33 was extremely upset and shaken.  On 10/18/18 at 9:00 AM, review of the State of Delaware DHCQ Incident Reporting Program revealed no evidence that the altercation between R33 and R157 was reported to the state agency. The facility did not report the incident of alleged resident-to-resident abuse until 10/18/18 at 1:21 PM, after it was brought to the facility's attention by the surveyor.	F 609	to survey exit. B. All residents have the potential to be affected by the alleged deficiency. C. All staff members received in-service training regarding reporting requirements to the Division. D. ADON/designee will review concerns and incidents to ensure appropriate investigative process and proper reporting occurs daily for 14 days, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)  §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-	F 622		12/26/18

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

PRINTED: 02/22/2019  
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>10/25/2018</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 622	Continued From page 31 (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.  §483.15(c)(2) Documentation. When the facility transfers or discharges a	F 622			



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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 622	Continued From page 32 resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure	F 622			

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>10/25/2018</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 622	<p>Continued From page 33</p> <p>a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews and interviews, it was determined that the facility failed to ensure appropriate resident information was communicated to the receiving health care provider for 4 (R60, R141, R164, and R214) out of 57 sampled residents. For R214, the facility failed to include and communicate the required discharge information that was in R214's record to the receiving facility. For R60, R141, and R164, the facility failed to send a copy of care plans when these residents were discharged to the hospital. Findings include:</p> <p>1. Review of R214's clinical record revealed:</p> <p>8/7/18 at 10:30 AM - The facility facsimile (FAX) transmittal form stated that 18 pages were sent to the assisted living facility on behalf of R214. The documents sent were as follows:</p> <ul style="list-style-type: none"> <li>- Facility Cover Page (1 page);</li> <li>- R214's face sheet (2 pages);</li> <li>- R214's admission History &amp; Physical, dated 2/22/18 (6 pages);</li> <li>- R214's Medication Review Report, dated 8/7/18 at 10:03 AM (8 pages); and</li> <li>- R214's Progress Notes, page 10 of 73, dated 8/7/18 at 10:04 AM (1 page).</li> </ul> <p>The facility failed to include and communicate the following required discharge information:</p> <ul style="list-style-type: none"> <li>- Follow-up appointments scheduled, including R214's oncologist appointment on 10/17/18 at 12:20 PM, urologist appointment on 9/6/18 at 10:15 AM, and follow-up with the eye doctor in 5 weeks from the 8/13/18 appointment;</li> <li>- Pertinent information from R214's</li> </ul>	F 622	<p>Example 1</p> <p>A. R214 no longer resides in the facility. E1 spoke with the Administrator prior to the transfer to ensure needs were met for safe and appropriate discharge of R214 to the Assisted Living facility.</p> <p>B. All residents that are transferred from the facility have the potential to be affected by the alleged deficiency.</p> <p>C. Discharge policy has been revised to comply with 483.15(c)(2) Documentation. All staff involved in transfer and discharge have been in-serviced on the required documentation to be sent at transfer. See policy.</p> <p>D. All transfers will be reviewed by the DON/designee to ensure adherence to the procedure and appropriate transition of care until 100% compliance is achieved for three consecutive transfers to another facility or for two months. Results will be reported quarterly through the facility QAPI process.</p> <p>Example 2</p> <p>A. R60 had no untoward effect and continues to reside in the facility.</p> <p>B. All residents transferred to the hospital have the potential to be affected by the alleged deficiency.</p> <p>C. Discharge policy has been revised to comply with 483.15(c)(2) Documentation to ensure a care plan is sent to the hospital upon discharge. See policy.</p> <p>D. All transfers will be reviewed by the DON/designee to ensure adherence to</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 622	<p>Continued From page 34</p> <p>hospitalization from 8/26/18 to 8/28/18;</p> <ul style="list-style-type: none"> <li>- Comprehensive care plan;</li> <li>- Durable power of attorney;</li> <li>- Labs; and</li> <li>- Copy of the facility's discharge summary.</li> </ul> <p>8/29/18 - R214 was discharged to an assisted living facility.</p> <p>10/22/18 at 1:38 PM - During an interview, E6 (Social Worker) confirmed that comprehensive care plans are not sent when a resident was a planned discharge. E6 stated that social work handles the medical equipment needs and home health needs.</p> <p>10/25/18 at 9:19 AM - Finding was reviewed with E1 (NHA) and E2 (DON). The facility failed to include and communicate the required discharge information that was in R214's clinical record to the receiving facility.</p> <p>2. Review of R60's clinical record revealed:</p> <p>R60 was admitted to the facility on 4/26/17 and was discharged to the hospital on 5/11/18 and 6/22/218.</p> <p>Review of R60's clinical documentation lacked evidence that a copy of the resident's care plan was sent to the hospital with R60 on 5/11/18 and 6/22/18.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.</p> <p>3. Review of R141's clinical record revealed:</p>	F 622	<p>the procedure and appropriate transition of care until 100% compliance is achieved for three consecutive transfers to another facility or for two months. Results will be reported quarterly through the facility QAPI process.</p> <p>Example 3</p> <ul style="list-style-type: none"> <li>A. R141 no longer resides in the facility.</li> <li>B. All residents transferred to the hospital have the potential to be affected by the alleged deficiency.</li> <li>C. Discharge policy has been revised to comply with 483.15(c)(2) Documentation to ensure a care plan is sent to the hospital upon discharge. See policy.</li> <li>D. All transfers will be reviewed by the DON/designee to ensure adherence to the procedure and appropriate transition of care until 100% compliance is achieved for three consecutive transfers to another facility or two months. Results will be reported quarterly through the facility QAPI process.</li> </ul> <p>Example 4</p> <ul style="list-style-type: none"> <li>A. R164 no longer resides in the facility.</li> <li>B. All residents transferred to the hospital have the potential to be affected by the alleged deficiency.</li> <li>C. Discharge policy has been revised to comply with 483.15(c)(2) Documentation to ensure a care plan is sent to the hospital upon discharge. See policy</li> <li>D. All transfers will be reviewed by the DON/designee to ensure adherence to the procedure and appropriate transition of care until 100% compliance is achieved for three consecutive transfers to another</li> </ul>		

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

PRINTED: 02/22/2019  
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>10/25/2018</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 622	Continued From page 35  R141 was admitted to the facility on 9/17/12 and was discharged to the hospital on 2/19/18, 7/13/18, 8/4/18, and 9/23/18.  Review of R141's clinical documentation lacked evidence that a copy of the resident's care plan was sent to the hospital with R141 on 2/19/18, 7/13/18, 8/4/18, and 9/23/18.  Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.  4. Review of R164's clinical record revealed:  R164 was admitted to the facility on 8/29/18 from the hospital s/p fall with left rib fractures, right maxillary fracture, and nasal bone fractures. R164 also had diagnoses of dementia and history of a stroke.  On 9/3/18, R164 experienced a significant change in condition and was sent to the ER.  Review of R164's clinical documentation lacked evidence that a copy of the resident's care plan was sent to the hospital with R164 on 9/3/18.  Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.	F 622	facility or two months. Results will be reported quarterly through the facility QAPI process.		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)  §483.15(c)(3) Notice before transfer.	F 623		12/26/18	

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

PRINTED: 02/22/2019  
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>10/25/2018</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 623	Continued From page 36 Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.  §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 623			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 623	Continued From page 37  §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.  §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility	F 623			

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

PRINTED: 02/22/2019  
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>10/25/2018</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 623	<p>Continued From page 38</p> <p>must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews and interview, it was determined that for three (R60, R141, and R164) out of 57 sampled residents, the facility failed to notify the residents and the residents' representatives in writing of facility discharges and the reasons for the discharge, and they failed to send a copy to the ombudsman. Findings include:</p> <p>1. Review of R60's clinical record revealed:</p> <p>R60 was admitted to the facility on 4/26/17 and was discharged to the hospital on 5/11/18 and 6/22/218.</p> <p>Review of R60's clinical record provided no evidence that R60 and R60's representative were notified in writing of the 5/11/18 and 6/22/18 discharges to the hospital. There was also no evidence that a copy of these notices were sent to the ombudsman.</p> <p>During an interview with E1 (NHA) on 4/24/18 at</p>	F 623	<p>Example 1</p> <p>A. R60 had no untoward effect and continues to reside in the facility.</p> <p>B. All residents transferred have the potential to be affected by the alleged deficiency.</p> <p>C. The facility bed hold form has been modified to include all requirements set forth at 483.15(c)(3)Notice before transfer; 483.15(c)(4) Timing of Notice; and 483.15 (c)(5) Contents of Notice. The Administrator will also report all transfers by the 15th of the following month to the Ombudsman using the template prescribed by the office of the Ombudsman and per regulation.</p> <p>D. All notifications (bed hold form and Ombudsman notification) will be reviewed by the DON/designee to ensure adherence to the procedure and appropriate transition of care until 100% compliance is achieved for thirty days of transfers and two months of Ombudsman</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</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 623	<p>Continued From page 39</p> <p>10:56 AM, it was confirmed that the facility failed to notify R60 and R60's representative in writing of the discharges, the reason for the discharges and they failed to send copies to the ombudsman. E1 stated that the facility had not been sending this information when residents were sent to the hospital, because he was unaware that this was required.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.</p> <p>2. Review of R141's clinical record revealed:</p> <p>R141 was admitted to the facility on 9/17/12 and was discharged to the hospital on 2/19/18, 7/13/18, 8/4/18, and 9/23/18.</p> <p>Review of R141's clinical record provided no evidence that R141 and R141's representative were notified in writing of the 2/19/18, 7/13/18, 8/4/18 and 9/23/18 discharges to the hospital. There was also no evidence that a copy of these notices was sent to the ombudsman.</p> <p>During an interview with E1 (NHA) on 4/24/18 at 10:56 AM, it was confirmed that the facility failed to notify R141 and R141's representative in writing of the facility discharges, the reason for the discharges and they failed to send copies to the ombudsman. E1 stated that the facility had not been sending this information when residents were sent to the hospital, because he was unaware that this was required.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and</p>	F 623	<p>notifications. Notifications will be on-going for resident notification, responsible party notification and Ombudsman notification per regulation. Results will be reported quarterly through the facility QAPI process.</p> <p>Example 2</p> <p>A. R141 no longer resides in the facility. B. All residents transferred have the potential to be affected by the alleged deficiency. C. The facility bed hold form has been modified to include all requirements set forth at 483.15(c)(3)Notice before transfer; 483.15(c)(4) Timing of Notice; and 483.15 (c)(5) Contents of Notice. The Administrator will also report all transfers by the 15th of the following month to the Ombudsman using the template prescribed by the office of the Ombudsman and per regulation. D. All notifications (bed hold form and Ombudsman notification) will be reviewed by the DON/designee to ensure adherence to the procedure and appropriate transition of care until 100% compliance is achieved for thirty days of transfers and two months of Ombudsman notifications. Notifications will be on-going for resident notification, responsible party notification and Ombudsman notification per regulation. Results will be reported quarterly through the facility QAPI process.</p> <p>Example 3</p> <p>A. R164 no longer resides in the facility. B. All residents transferred have the</p>		



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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 623	Continued From page 40 E14 (RNAC) on 10/25/18 at approximately 6:30 PM.  3. Review of R164's clinical record revealed:  R164 was admitted to the facility on 8/29/18 and was discharged to the hospital ER on 9/3/18.  Review of R164's clinical record lacked evidence that the ombudsman was notified in writing of R164's discharge to the hospital.  Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.	F 623	potential to be affected by the alleged deficiency. C. The facility bed hold form has been modified to include all requirements set forth at 483.15(c)(3)Notice before transfer; 483.15(c)(4) Timing of Notice; and 483.15 (c)(5) Contents of Notice. The Administrator will also report all transfers by the 15th of the following month to the Ombudsman using the template prescribed by the office of the Ombudsman and per regulation. D. All notifications (bed hold form and Ombudsman notification) will be reviewed by the DON/designee to ensure adherence to the procedure and appropriate transition of care until 100% compliance is achieved for thirty days of transfers and two months of Ombudsman notifications. Notifications will be on-going for resident notification, responsible party notification and Ombudsman notification per regulation. Results will be reported quarterly through the facility QAPI process.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)  §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths,	F 636		12/26/18

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

PRINTED: 02/22/2019  
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>10/25/2018</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 636	Continued From page 41 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 nonlicensed direct care staff members on all shifts.  §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not	F 636			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 636	<p>Continued From page 42 apply to CAHs.</p> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)</p> <p>(iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that the facility failed to ensure that comprehensive and accurate MDS assessments were conducted for 2 (R148 and R164) out of 57 sampled residents. Findings include:</p> <p>1. 6/4/18- R148 was admitted to the facility with diagnoses including dementia with behavioral disturbance.</p> <p>6/8/18 10:53 PM- A nursing progress note stated, R148 "... became combative and verbally abusive during attempts to redirect him out of other resident rooms..."</p> <p>6/11/18 (untimed)- The admission MDS coded R148 with severe cognitive impairment (never/rarely made decisions). R148 triggered for behaviors, however, he was incorrectly not coded for wandering behavior.</p> <p>10/22/18 12:47 PM- E14 (RNAC) confirmed during an interview that R148 was incorrectly coded on his admission MDS, dated 6/11/18; he should have been coded for wandering behavior.</p> <p>Findings were reviewed with E1(NHA) , E2(DON), E3 (ADON), E13 (Staff Educator), and E14</p>	F 636	<p>Example 1</p> <p>A. R148 suffered no untoward effect and continues to reside in the facility. A correction MDS was completed and transmitted.</p> <p>B. Residents who wander have the potential to be affected by the alleged deficiency.</p> <p>C. Social workers have been re-educated regarding appropriate and accurate MDS coding by the RNAC.</p> <p>D. RNAC/designee will audit 5 residents for wandering data entry accuracy weekly for four weeks, then monthly times two until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process.</p> <p>Example 2</p> <p>A. R164 no longer resides in the facility. A correction MDS was completed and transmitted.</p> <p>B. Residents on anti-coagulant therapy have the potential to be affected by the alleged deficiency.</p> <p>C. The LPN assistant has been re-educated regarding appropriate and accurate MDS coding by the RNAC.</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 636	Continued From page 43 (RNAC) during the exit conference on 10/25/18 at approximately 6:30 PM EST.  2. 8/29/18- R164 was admitted to the facility s/p fall with multiple fractures and dementia.  8/29/18- R164 had physician orders written for Lovenox (anticoagulant- blood thinner) 30 mg/0.3 ml inject 0.3 ml subcutaneously 2 times a day.  9/3/1- Review of the Admission/5 Day MDS assessment revealed that the facility failed to code R164 as receiving an anticoagulant.  Findings were reviewed with E1, E2, E3 (ADON), E13 (Staff Educator), and E14 (RNAC) during the exit conference on 10/25/18 at approximately 6:30 PM.	F 636	D. RNAC/designee will audit 5 residents for anti-coagulant data entry accuracy weekly for four weeks, then monthly times two until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process.		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)  §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:  §483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.  §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a	F 644		12/26/18	

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>10/25/2018</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 644	<p>Continued From page 44</p> <p>related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that for one (R155) out of 57 sampled residents, the facility failed to refer R155 to the appropriate state-designated authority for Level II PASARR evaluation and determination after he was diagnosed with Schizophrenia in March 2017. Findings include:</p> <p>Review of R155's clinical record revealed:</p> <p>10/15/16 at 1:30 PM - The PASRR Level I Screen stated that R155 did not require a Level II evaluation due to the absence of a documented serious mental illness (Schizophrenia).</p> <p>3/27/17 - A Psychotropic Reduction Review stated that R155 had a diagnosis of Schizophrenia.</p> <p>3/27/17 - R155's care plan for psychotropic use was revised to add the diagnosis of Schizophrenia.</p> <p>10/22/18 at 9:38 AM - During an interview, E14 (RNAC) confirmed that R155 did not have a PASARR Level II evaluation and determination after being diagnosed with Schizophrenia.</p> <p>10/25/18 at 9:19 AM - Finding was reviewed with E1 (NHA) and E2 (DON). The facility failed to refer R155 to the appropriate state-designated authority for Level II PASARR evaluation and determination after he was diagnosed with Schizophrenia in March 2017.</p>	F 644	<p>A. R155 suffered no ill effect and has been referred for a Level II PASSR evaluation.</p> <p>B. All residents requiring PASSR level II determinations have the potential to be affected by the alleged deficiency.</p> <p>C. On 11/5/18 the division of Medicaid and medical assistance in-serviced staff, including the social workers, on PASSR level I and II requirements. The social workers participate in the Interdisciplinary Gradual Dose Reduction (GDR) monthly meeting led by the staff psychiatrist to identify potential changes that may require a level II PASSR necessity. Residents who have a change in status that meets the PASSR II review requirement shall be referred to the Division of Medicaid and Medical Assistance by the social workers or designee for completion and documentation shall be maintained in the medical record.</p> <p>D. The social workers or designee will review residents identified through IDT meetings that include but are not limited to, care plan meetings and GDR meetings until 100% compliance is achieved for two consecutive months. All residents that develop a condition that requires a level II PASSR will be referred for assessment. This process will be ongoing per regulation. Results will be reported quarterly through the facility QAPI process.</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 656 F 656 SS=D	Continued From page 45 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656 F 656		12/26/18

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

PRINTED: 02/22/2019  
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>10/25/2018</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 656	<p>Continued From page 46 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R147) out of 57 sampled residents, the facility failed to develop and implement a comprehensive person-centered care plan. The facility failed to develop and implement a care plan to reflect R147's refusal for nail cutting. Findings include:</p> <p>Cross refer F677</p> <p>Review of R147's clinical record revealed:</p> <p>R147 was admitted to the facility on 7/10/15. R147's quarterly MDS, dated 9/10/18, stated that R147 required extensive assistance with personal hygiene, which included nail trimming.</p> <p>R147 had a care plan, last reviewed on 9/26/18, for the problem that R147 was unable to do her own ADL's without assistance. The care plan stated that R147 required extensive assistance with personal hygiene, but lacked specific interventions for nail care.</p> <p>During an interview on 10/11/8 at 10:01 AM, R147 stated that she wanted her fingernails cut and needed staff assistance for nail cutting.</p> <p>R147 was observed on 10/11/18 at 10:01 AM and 10/18/18 at 3:39 PM, with very long fingernails.</p> <p>During an interview on 10/18/18 at 3:48 PM, E28</p>	F 656	<p>A. R147 suffered no untoward effect and continues to reside in the facility. Nails were trimmed as noted in the 2567. B. Residents dependent for ADL care have the potential to be affected by the alleged deficiency. C. All residents dependent for ADL care will have fingernails viewed for appropriate length by the unit manager/designee. All nursing staff have been in-serviced on appropriate ADL care and documentation of refusal. All residents will be care planned for their specific preferences. D. RNAC/designee will review 5 residents for nail care weekly for four weeks, then monthly times two until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</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 656	Continued From page 47 (LPN) stated that she was aware that R147's nails were long and stated that the resident always refused to get her nails cut.  Review of R147's care plan lacked evidence that she refused nail cutting.  The facility failed to develop and implement a care plan for R147's refusal for ADL's, specifically nail care.  Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.	F 656			
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix)  §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of	F 660		12/26/18	



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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 660	Continued From page 48 developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and	F 660			

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

PRINTED: 02/22/2019  
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>10/25/2018</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 660	<p>Continued From page 49</p> <p>data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.</p> <p>(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record review, it was determined that for one (R214) out of 57 sampled residents, the facility failed to revise R214's discharge care plan (last reviewed on 6/20/18) to reflect the resident's current discharge needs, goals, and treatment preference while considering caregiver support. Findings include:</p> <p>Review of R214's clinical record revealed:</p> <p>2/22/18 - R214's Discharge Care Plan, stated, "Un-resolved at this time". The Goal, dated 2/22/18, stated, "Resident will be discharged to a safe environment with appropriate resources within 92 days". The approaches included: "1) develop a discharge plan with resident and family; 2) discuss alternative living options if discharge to home is not feasible; 3) obtain discharge orders; 4) arrange home care services as appropriate; 5) order appropriate medical equipment as needed for home therapy; and 6) arrange appropriate transportation from facility to home". R214's discharge care plan was reviewed and revised on 3/14/18 and 6/20/18.</p>	F 660	<p>A. R214 no longer resides in the facility. E1 spoke with the Administrator prior to the transfer to ensure needs were met for safe and appropriate discharge of R214 to the Assisted Living facility.</p> <p>B. All residents have the potential to be affected by the alleged deficiency.</p> <p>C. All discharge plans will be updated prior to discharge.</p> <p>D. RNAC/designee will monitor all discharges daily for 14 days, then weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will reported quarterly through the facility QAPI process.</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 660	Continued From page 50  8/29/18 - R214 was discharged to an assisted living facility.  The facility failed to revise R214's discharge care plan to reflect the resident's current discharge needs, goals, and treatment preference while considering caregiver support.	F 660			
F 661 SS=D	10/25/19 at 9:19 AM - Finding was reviewed with E1 (NHA) and E2 (DON). Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv)  §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where	F 661		12/26/18	

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

PRINTED: 02/22/2019  
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>10/25/2018</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 661	<p>Continued From page 51</p> <p>the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record review, it was determined that for one (R214) out of 57 sampled residents, the facility failed to develop a complete discharge summary for R214's anticipated discharge on 8/29/18. Findings include:</p> <p>Review of R214's clinical record revealed:</p> <p>8/29/18 at 4:36 PM - A discharge summary nurse's note, completed by E8 (RN, UM), stated, "Resident AAO x 3, denies pain or discomfort. Resident is being discharged to (name of assisted living facility) this afternoon. Resident provided AM care by CNA and tolerated AM and afternoon medications. VS: 98.4 (temperature), 79 (heart rate), 18 (respirations), 137/65 (blood pressure), 97% ra (pulse ox room air). Resident's belongings packed by nursing staff and picked up by resident's (family member name). Post hospital instructions reviewed with RP (family member name). Resident's personal belongings sent with (family member) at 1330 (1:30 PM). Resident left facility at 1500 (3 PM), transported by (facility) van. Interagency clinical sheet, discharge reprot (sic), post hospital reprot (sic) and vaccination record sent with resident. No oxygen provided, resident 97% on room air. This nurse spoke with (name) of (receiving facility name), verbal report given".</p> <p>9/29/18 - A Discharge Summary, completed by E7 (NP), of R214's stay at the facility from 2/22/18 to 8/29/18. The Discharge Summary</p>	F 661	<p>A. R214 no longer resides in the facility. E1 spoke with the Administrator prior to the transfer to ensure needs were met for safe and appropriate discharge of R214 to the Assisted Living facility.</p> <p>B. All discharged residents have the potential to be affected by the alleged deficiency.</p> <p>C. The discharge summary has been revised to reflect the requirements specified at 483.21(c)(2). See attached. Physicians and physician extenders have been in-serviced on the appropriate requirements.</p> <p>D. All discharge summaries will be followed by the DON/designee to ensure adherence to the procedure and appropriate transition of care until 100% compliance is achieved for three consecutive discharges or two months. Results will be reported quarterly through the facility QAPI process.</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</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 661	<p>Continued From page 52</p> <p>stated, R214's admission date, discharge date, attending physician, admission diagnosis "See FaceSheet", admission condition "Stable", discharge diagnoses, discharge condition "improved", summary "Resident was discharged to (receiving facility name), discharge instructions "f/u (follow-up) c (with) facility MD (medical doctor) on admission to (receiving facility name)", and prognosis "fair".</p> <p>With an anticipated discharge, the facility failed to have a discharge summary that included, but was not limited to, the following:</p> <ul style="list-style-type: none"> <li>- A recapitulation of the resident's stay that included, but was not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.</li> <li>- A final summary of the resident's status, from the comprehensive assessment, at the time of the discharge that was available for release to authorized persons and agencies, with the consent of the resident or resident's representative.</li> <li>- A post-discharge plan of care that is developed with the participate of the resident and, with the resident's consent, the resident representative, which will assist the resident to adjust to his/her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</li> </ul> <p>10/25/18 at 9:19 AM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to develop a complete discharge summary for R214's anticipated discharge on 8/29/18.</p>	F 661		

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

PRINTED: 02/22/2019  
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>10/25/2018</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 677 F 677 SS=D	Continued From page 53 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)  §483.24(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, interviews, and review of related clinical information, it was determined that the facility failed to ensure ADL care was provided to 3 (R52, R140, and R147) dependent residents out of 57 sampled residents (not all of the sampled residents are dependent for ADLs). Findings include:  1. Review of R140's clinical record revealed the following:  8/17/18- Significant change MDS coded R140 as totally dependent with one staff person for ADLs (except transfers), including personal hygiene and bathing.  8/22/18- R140's care plan for ADLs was revised and stated she required total assistance with all care and mobility. The care plan did not include approaches for nail care.  9/7/18- 30 day MDS coded R140 as total dependence of one staff person for ADLs (except transfers), including personal hygiene and bathing.  10/16/18 8:21 AM- R140's fingernails were observed extended approximately 1/2" past her fingertips and she was noted to intermittently clench her fists, especially her left hand. This was	F 677 F 677	Example 1 A. R140 suffered no untoward effect and continues to reside in the facility. Nails were trimmed as noted in the 2567. B. Residents dependent for ADL care have the potential to be affected by the alleged deficiency. C. All residents dependent for ADL care will have fingernails viewed for appropriate length by the unit manager/designee. All nursing staff have been in-serviced on appropriate ADL care and documentation of refusal. All residents will be care planned for their specific preferences. D. Unit manager/designee will review 5 residents for nail care weekly for four weeks, then monthly times two until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.  Example 2 A. R52 suffered no untoward effect and continues to reside in the facility. Facial hair was trimmed as noted in the 2567. B. Residents dependent for ADL care have the potential to be affected by the alleged deficiency.	12/26/18	

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

PRINTED: 02/22/2019  
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>10/25/2018</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 677	<p>Continued From page 54 concerning as R140's fingernails could dig into her left palm.</p> <p>10/19/18 8:59 AM- R140's fingernails remained long.</p> <p>10/23/18 11:59 AM- Observed R140 with socks on her hands, so unable to visualize her fingernails.</p> <p>10/24/18 10:54 AM- During an interview with E19 (House Supervisor, RN) she confirmed that R140's fingernails were long and she stated that she'll clip them when done assisting with R140's wound care. E19 stated that she had just noticed that R140's fingernails were long.</p> <p>10/25/18 10:31 AM- Observed that R140's fingernails were cut.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.</p> <p>2. Review of R52's clinical records revealed the following:</p> <p>10/24/17 - R52 was admitted to the facility.</p> <p>7/16/18 - The quarterly MDS assessment documented that R52 required extensive assistance of one staff person for bathing and personal hygiene.</p> <p>10/10/18 - A care plan for ADLs, documented that R52 required total assistance of staff for hygiene and bathing. The goal was that staff will anticipate and meet the needs of the resident to the extent</p>	F 677	<p>C. All residents dependent for ADL care will have facial hair assessed for appropriate length by the unit manager/designee. All nursing staff have been in-serviced on appropriate ADL care and documentation of refusal. All residents will be care planned for their specific preferences.</p> <p>D. Unit managers/designee will review 4 residents dependent for ADL care to determine receipt of appropriate care per day times 14 days, until a review of all residents has been completed. review will continue weekly until 100 compliance is achieved for four consecutive weeks. Results will be reported quarterly at the facility QAPI meeting.</p> <p>Example 3</p> <p>A. R147 suffered no untoward effect and continues to reside in the facility. Nails were trimmed as noted in the 2567.</p> <p>B. Residents dependent for ADL care have the potential to be affected by the alleged deficiency.</p> <p>C. All residents dependent for ADL care will have fingernails viewed for appropriate length by the unit manager/designee. All nursing staff have been in-serviced on appropriate ADL care and documentation of refusal. All residents will be care planned for their specific preferences.</p> <p>D. Unit manager/designee will review 5 residents for nail care weekly for four weeks, then monthly times two until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 677	<p>Continued From page 55</p> <p>required by the resident and as the resident allows for the next 92 days. Interventions included to provide hygiene and bathing to the extent required.</p> <p>10/17/18 and 10/21/18 - CNA ADL Flowsheets, documented that R52 had a shower, as scheduled, on Wednesday, 10/17/18 and Sunday, 10/21/18.</p> <p>10/23/18 at approximately 12:01 PM - R52 was observed with unshaven facial hair.</p> <p>10/23/18 at approximately 4:43 PM - Subsequent observation revealed R52 with unshaven facial hair.</p> <p>10/23/18 at approximately 4:45 PM - An interview with E16 (CNA) revealed that shaving of facial hair was completed during the assigned shower days, on Wednesday and Sunday, as well as, as when needed. E16 confirmed that R52 was unable to shave his own facial hair and was dependent on staff for this activity. E16 stated that he would be shaving R52.</p> <p>10/24/18 at approximately 10:14 AM - R52 observed with his facial hair removed.</p> <p>10/25/18 at approximately 1:30 PM - During an interview with E10 (LPN/UM), the above observations of R52, on 10/23/18 were reviewed. E10 confirmed that R52 was dependent on staff for removal of facial hair and that the facility was unable to provide any evidence that R52 had refused being shaved prior to the 10/23/18 observations.</p> <p>Findings were reviewed with E1 (NHA), E2</p>	F 677	QAPI process.		



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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 677	<p>Continued From page 56</p> <p>(DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.</p> <p>3. Review of R147's clinical record revealed:</p> <p>7/10/15- R147 was admitted to the facility.</p> <p>9/10/18- R147's quarterly MDS stated that R147 required extensive assistance with personal hygiene, which included nail trimming.</p> <p>9/26/18- R147's care plan stated that R147 was unable to do her own ADL's without assistance. The care plan stated that R147 required extensive assistance with personal hygiene, but lacked specific interventions for nail care.</p> <p>10/11/18 at 10:01 AM- R147's nails were observed to be very long. During an interview, R147 stated that she wanted her fingernails cut and needed staff assistance for nail cutting.</p> <p>10/18/18 at 3:39 PM- R147's fingernails were still very long and had not been cut.</p> <p>10/18/18 at 3:48 PM- During an interview E28 (LPN) stated that she was aware that R147's nails were long and that the resident always refused to get her nails cut. E28 stated that staff do not document nail cutting or refusals for R147.</p> <p>The facility failed to maintain good nail grooming services for R147 and failed to document any refusals for care.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30</p>	F 677			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 677	Continued From page 57 PM.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other documentation, it was determined that for three (R60, R141 and R164) out of 57 sampled residents, the facility failed to ensure that the resident received treatment and care in accordance with professional standards of practice. For R60, the facility failed to ensure that the resident's hearing aide was in place according to physician's orders. For R141, the facility failed to ensure that she followed up with a GI (Gastrointestinal) specialist within 4 weeks after hospital discharge per hospital discharge orders. For R164, the facility failed to perform thorough ongoing assessments after the resident fell out of bed, declined significantly in mental status and in his breathing on 9/3/18. After R164's significant change in status without appropriate nursing assessments, there was a delay of approximately 45 minutes in the facility calling 911 for transport to the ER by EMS (Emergency Medical Services). Findings include:  1. Review R141's clinical record revealed the	F 684		12/26/18
			Example 1 A. R141 no longer resides in the facility. B. All residents have the potential to be affected by the alleged deficiency. C. All licensed staff will be in-serviced to ensure follow-up appointments are scheduled as PCP directs. D. Unit manager/designee will audit consults to ensure follow-up appointments are scheduled appropriately daily for 14 days, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI program.  Example 2 A. R60 had no untoward effect and continues to reside in the facility. B. All residents with hearing aides have the potential to be affected by the alleged deficiency. C. Storage containers for hearing aides,	

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

PRINTED: 02/22/2019  
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>10/25/2018</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 684	<p>Continued From page 58 following:</p> <p>R141 was admitted to the facility on 9/17/12 and was discharged to the hospital on 8/4/18 due to bloody emesis.</p> <p>R141 was admitted back to the facility from the hospital on 8/9/18.</p> <p>R141's interagency hospital discharge instructions dated, 8/9/18 at 9:56 AM, stated that R141 was to follow up with GI outpatient within 4 weeks and to call to schedule the appointment.</p> <p>Review of R141's record lacked evidence that R141 followed up with outpatient GI within 4 weeks per the hospital discharge instructions.</p> <p>During an interview on 10/25/18 at 11:05 AM, E8 (Unit Manager) stated that after R141 returned from the hospital on 8/9/18, a GI follow up appointment was not made because E31 (Medical Director) did not want R141 to have a follow up appointment. E8 stated that E31 just wanted to monitor R141.</p> <p>During an interview on 10/25/18 at 2:10 PM, E31 stated that he did not order staff to not follow up with outpatient GI after R141's hospitalization ending on 8/9/18. E31 stated, "Why would I do that?"</p> <p>The facility failed to ensure that R141 followed up with an outpatient GI specialist within 4 weeks per her 8/9/18 hospital discharge instructions.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30</p>	F 684	<p>eyeglasses, and dentures have been placed at each resident bedside to permit access and allow a more home like environment. All staff will be in-serviced regarding the new storage procedure. Licensed staff have been educated on the necessity of proper documentation to satisfy physician orders for placement of hearing aides or document when a resident refuses.</p> <p>D. The unit manager/designee will review nursing documentation and verify placement of hearing aide or refusal daily times 14, weekly times two, then monthly until 100% compliance is achieved for two months. Results will be reported quarterly through the facility QAPI process.</p> <p>Example 3</p> <p>A. R164 no longer resides in the facility.</p> <p>B. Residents receiving anticoagulant therapy who fall have the potential to be affected by the alleged deficiency.</p> <p>C. All licensed staff will be in-serviced regarding appropriate care, on-going assessment of clinical condition and documentation status post fall. Licensed staff will also be in-serviced regarding promptness of activation of EMS when indicated.</p> <p>D. The ADON/designee will review documentation during event investigations to ensure appropriate care, on-going assessment of clinical condition and documentation status post fall and any required EMS notifications daily times 14, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</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 684	<p>Continued From page 59 PM.</p> <p>2. Review of R60's clinical record revealed the following:</p> <p>R60 was admitted to the facility on 4/26/17 with hearing difficulty and hearing aids.</p> <p>On 8/28/18, R60 had a physician's order to put her right hearing aid on in the morning and take it off at bedtime, and to store her hearing aid in the nurse's cart when not in use.</p> <p>Review of R60's October eTAR showed that staff signed off that her right hearing aid was in every day from 10/1/18 to 10/19/18. R60's clinical record lacked evidence that R60 ever refused her right hearing aid.</p> <p>R60 was observed out of bed without her right hearing aid in during the following observations: 10/11/18 at 9:33 AM, 10/15/18 at 9:44 AM, 10/15/18 at 11:37 AM, and 10/18/18 at 10:31 AM.</p> <p>On 10/19/18 at 11:45 AM, it was observed that R60 was sitting in her chair in her room and her hearing aid was not in her right ear. Review of R60's eTAR showed that E26 (RN) had signed off that day that R60's right hearing aid was currently in place.</p> <p>During an interview on 10/19/18 at 11:47 AM, E26 confirmed that R60's right hearing aid was not in place, but she had signed off on the eTAR that it was done. E26 stated that R60 had refused her right hearing aid that day and that she usually refused to have it put in when staff asked. When asked where R60's refusals were documented, E26 stated that it was not documented, but she</p>	F 684	reported quarterly through the facility QAPI process.		

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

PRINTED: 02/22/2019  
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>10/25/2018</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 684	<p>Continued From page 60</p> <p>would write a note about it now. The surveyor asked E26 where R60's right hearing aid was currently located. E26 went over to the medication cart to look for the hearing aid and pulled out a black box with a hearing aid inside, but the box was not labelled with a resident's name. E26 stated that she thought the hearing aid in the unlabeled black box was R60's, but she was not sure and would check with other staff. E8 (RN Unit Manager) confirmed that this was R60's right hearing aid.</p> <p>The facility failed to ensure that R60 wore her right hearing aid per physician orders.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 5/30/18 at approximately 6:30 PM.</p> <p>3. Cross refer F773</p> <p>The facility Falls policy and procedure, last revised 2/2014, stated, "... If head injury is suspected, or if the resident is on any anticoagulant therapy, a neuro assessment must be completed... If a head injury is suspected... neuro checks and vital signs will be performed q (every) 15 minutes x 4 (total of 1 hour), then q 30 minutes x 4 (total of 2 hours), then... If any changes in neuro checks, outside resident baseline are found, the doctor will be notified immediately...".</p> <p>The following was reviewed in R164's clinical record:</p> <p>8/29/18- R164 was admitted to the facility from the hospital s/p fall with 8th through 12th left rib fractures, right maxillary fracture, and nasal bone</p>	F 684			

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

PRINTED: 02/22/2019  
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>10/25/2018</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 684	<p>Continued From page 61</p> <p>fractures. R164 also had diagnoses of dementia and history of a stroke.</p> <p>8/29/18 3:29 PM- Nursing progress note stated that R164 was a poor historian and his wife provided the history. Breathing normal and non-labored with a PO2 (pulse oximetry) of 95% on room air.</p> <p>8/29/18 (untimed)- The admission nursing assessment stated R164 had a hemorrhagic (area of bleeding beneath skin) area to the left flank, multiple scabs to the arms and elbows, discoloration to the legs, and bruising around both eyes.</p> <p>8/29/18 9:13 PM- Nursing progress note stated R164 was alert, responsive and able to make his needs known.</p> <p>8/29/18- The facility developed a care plan for R164's potential for injury related to his fractures from fall before admission. Interventions included: resident able to use call bell- no, remind resident of limits and to ask for assistance for transfers and mobility as needed, bed against wall, and landing strips at bedside.</p> <p>8/30/18- The facility developed a care plan for R164's potential for bleeding due to anticoagulant use with an intervention to give medications as ordered. R164 had physician orders, written on 8/29/18, for Lovenox (blood thinner) 30 mg/0.3 ml inject 0.3 ml subcutaneously 2 times a day, Aspirin (prevents platelets from clumping together to form blood clots) 81 mg daily, and Ibuprofen (anti-inflammatory medication with increased risk of bleeding) 600 mg by mouth every 6 hours for pain.</p>	F 684			

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

PRINTED: 02/22/2019  
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>10/25/2018</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 684	Continued From page 62  8/30/18- The facility developed a care plan for R164's alteration in cardiac or respiratory status related to diagnoses including stroke with left sided weakness and left rib fractures. Interventions included: monitor vital signs and PO2 as applicable and O2 (oxygen) as applicable.  8/30/18 5:11 PM- Nursing progress note stated there was a new order for CXR (chest x-ray) 9/6/18 to follow up s/p rib fractures. A CBC and CMP were ordered to "establish care."  8/31/18 2:22 PM- The contracted lab results for R164's CMP and CBC, ordered on 8/30/18, was faxed to the facility. R164's sodium was 150 (normal 135-145), his BUN was 29 (normal 10-26) and R164 had a normal WBC count of 7.4 (4-8- 10.8).  9/1/18 8:30 PM- Nursing progress note stated that R164 had bruises in place on his arms, left side (flank) and face. R164 fed himself, took his medications and was pleasant and cooperative with staff.  9/3/18 1:30 AM- Nursing progress note stated R164 was alert, responsive and able to make his needs known to staff. Was noted walking to restroom one time this shift; was immediately assisted by nurse and re-educated on importance of using the call bell when in need of assistance. R164 demonstrated understanding. Respirations even and unlabored with no shortness of breath or signs/symptoms of distress.  9/3/18 (untimed)- Review of the Admission/5 Day MDS assessment coded R164 with severe	F 684			

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

PRINTED: 02/22/2019  
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>10/25/2018</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 684	<p>Continued From page 63</p> <p>cognitive impairment (never/rarely made decisions), he required 1 person extensive assistance with most ADL's (such as dressing and personal hygiene) and 2 person extensive assistance for transfers and toilet use. R164 required one person limited assistance with walking in his room. Both a wheelchair and a walker were being used.</p> <p>9/3/18 12:46 PM- Nursing progress note stated R164 was observed at 11:25 AM with shallow breathing and a PO2 of 88%. The PO2 was rechecked and oxygen (O2) was placed at 3 L and R164's PO2 came up to 92%. At this time, resident was "lethargic and unable to follow commands... seen by MD (E31- Medical Director) Ordered chest x-ray and O2 @ (at) 3L, wife... on site and informed of changes at 1222 (12:22 PM), will continue to monitor, safety precautions maintained."</p> <p>9/3/18 2:14 PM- O2 sats (PO2) summary listed a PO2 of 92% and it was noted that R164 was receiving O2 via nasal cannula. A warning stated, "Low of 94.0 (94%) exceeded."</p> <p>9/3/18 2:39 PM- Nursing progress note stated that E31 ordered a sip n go program to keep R164 hydrated. Will continue to monitor and pass on to next staff.</p> <p>9/3/18 2:52 PM- Nursing progress note stated, "elevated Sodium. SIP N GO." The elevated sodium being referred to was done on 8/31/18 as it was the only date that R164 had labs drawn since admission to the facility.</p> <p>9/3/18 2:58 PM- Nursing progress note stated that R164 complained of mild pain on left side</p>	F 684			



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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 684	<p>Continued From page 64</p> <p>and a CXR was completed at 2:05 PM, seen by E31 "...placed on sip-n-go program... also placed on 3L O2, O2 sat (PO2) 92% at 2:59 PM. Will make relieving shift aware."</p> <p>9/3/18 3:03 PM- R164's CXR completed at 2 PM showed no active disease, no obvious displaced rib fracture deformities, and no acute fracture seen.</p> <p>9/3/18 (untimed)- Medical visit by E31 (Medical Director and R164's physician): chief complaint- dyspnea, drowsiness and hypoxia. E31 stated that R164 "answers simple questions." Assessment- respiratory failure, on O2.</p> <p>9/3/18 4:28 PM- Nursing progress note stated that a new order was received for STAT CXR for low PO2 and labs for CBC, BMP, and UA C&amp;S were ordered. Although R164 had a serious change in condition noted at 11:25 AM and was seen by E31 (Medical Director), there was no evidence in the electronic vital sign history that a full set of vital signs were taken to include temperature, pulse and respiratory rate.</p> <p>9/3/18 4:10 PM- Post Fall Assessment was initiated and was incorrectly dated 9/2/18. The form stated, "For known or suspected head injury complete neurological observation q (every) 15 min (minutes) x (times) 4, then q 30 min x 4...". The form included:</p> <p>Vital Signs-</p> <ul style="list-style-type: none"> <li>- temperature;</li> <li>- pulse;</li> <li>- respirations; and</li> <li>- blood pressure (BP);</li> </ul>	F 684		

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 684	Continued From page 65  Other- - pain; - ecchymosis (bruising); and - MD aware of change;  Eyes Open- - spontaneously; - to speech; - to pain; - none; and - closed by edema (swelling);  Verbal Response- - oriented and converses; - disoriented and converses; - inappropriate words; - incomprehensible sounds; and - none;  Motor Response- - obeys commands; - localizes pain; - withdraws from pain; and - no response;  Pupils- - right size; - right reaction; - left size; and - left reaction;  Key: Pupil Size- - Pinpoint; - Normal; and - Dilated;  Reaction- - Absent;	F 684			

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

PRINTED: 02/22/2019  
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>10/25/2018</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 684	<p>Continued From page 66</p> <ul style="list-style-type: none"> <li>- Sluggish; and</li> <li>- Brisk;</li> </ul> <p>Limb Movement-</p> <ul style="list-style-type: none"> <li>- right upper extremity (shoulder, arm, wrist, and hand);</li> <li>- right hand grasp;</li> <li>- left upper extremity;</li> <li>- left hand grasp;</li> <li>- right lower extremity (hip, leg, ankle and foot);</li> <li>and</li> <li>- left lower extremity;</li> </ul> <p>Key:</p> <ul style="list-style-type: none"> <li>- Normal;</li> <li>- Weak; and</li> <li>- Absent.</li> </ul> <p>9/3/18 4:25 and 4:30 PM- Post Fall Assessment including neurochecks were completed. The 4:30 PM assessment lacked a BP, however, one was done at 4:25 PM.</p> <p>9/3/18 4:30 PM- Nursing progress note stated, "VS (vital signs) 98.0 (temperature) 18 (respirations) 84 (pulse) 128/72 (blood pressure). Unit Supervisor alerted the Nurse to residents room. He was found lying on his stomach on the landing srip (sic- strip) aligned with his bed... small bruise to left forehead. Full ROM (range of motion) done x (times) 4 extremeties (sic- extremities). Head to toe assessment done. No open areas noted. Resident stated he was okay with no complaints of pain or discomfort. Nuerochecks (sic- neurochecks) WNL (within normal limits). Staff assisted... to wheelchair and set him by the Nurses med (medication) cart."</p> <p>9/3/18 4:40 - 4:45 PM- Post Fall assessment and</p>	F 684			

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

PRINTED: 02/22/2019  
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>10/25/2018</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 684	<p>Continued From page 67</p> <p>neurocheck was not done for R164. The facility failed to do every 15 minute assessments x 4 as per instructions and facility policy.</p> <p>9/3/18 5:00 PM- Post Fall assessment lacked a BP (last done 35 minutes ago) and R164 was oriented and conversive.</p> <p>9/3/18 5:15 PM- Post Fall assessment and neurocheck was not done. The facility failed to do 15 minute assessments x 4 as per instructions and facility policy.</p> <p>9/3/18 5:30 PM- Post Fall assessment lacked a BP (last done 1 hour and 5 minutes ago) and R164 was oriented and conversive.</p> <p>9/3/18 6:00 PM- R164's BP's were previously 128/72 (4:10 PM) and 116/68 (4:25 PM) on the Post Fall assessment. R164's BP was now up to 160/88 (about 1 1/2 hours since last checked) and R164's status changed from "Y" (yes), he was oriented and conversive to "N" (no), that he was no longer oriented and conversive.</p> <p>9/3/18 6:30 PM- Despite the significant change in condition noted at 6:00 PM, there were no other vital signs or neuro checks until now. The Post Fall Assessment stated R164's BP was 200/104 and he remained non-oriented and non-conversive.</p> <p>9/3/18- The Prehospital Care Report by EMS (Emergency Medical Services) stated: -6:43- dispatch notified by facility; -6:44 PM- ambulance was dispatched; -6:49 PM- EMS arrived at the facility; -6:51 PM- EMS arrived to R164 at 6:51 PM. R164 was found in bed with facility staff in attendance.</p>	F 684			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 684	Continued From page 68 Nursing staff reported that 911 was activated due to an observed drop of room air oxygen saturation (PO2) "in the 80's", as well as increased lethargy. The report stated, "pt (patient) was last seen acting normally at approximately 1500 (3:00 PM)... staff reported that the pt had a history of recent falls... reported to have an outpatient X-ray... at approximately 1230 (12:30 PM)... to rule out possible pneumonia... X-ray yielded negative results... On initial contact, pt was alert to verbal stimuli... noted to be pale, and had very shallow respirations. Nursing staff on scene had administered NRB (non-rebreathing) oxygen... prior to EMS arrival, and pt was noted to have 100% O2 saturation (PO2) with NRB. Diminished lung sounds were assessed. However, due to pt's inadequate breathing, BVM (bag valve mask) respirations were performed in order to supplement pt's ventilatory efforts... displayed some verbal capacity, but was incoherent... displayed some purposeful motor function but was not following commands. Pt was noted to withdraw from painful stimuli... As EMS personnel were exiting the room with the pt, nursing staff reported that the pt also sustained a fall from his bed on the day of the incident...'around 3 o'clock' but did not state whether the pt's change in mentation came before or after the fall. Following pt's move onto the stretcher, pt was noted to have worsened spontaneous respiratory effort, despite BMV assistance with high flow oxygen... both ALS (advanced life support) and BLS (basic life support) providers ensured a tight seal (of BMV) around pt's face...". -7:04 PM- EMS left the facility and "... use of lights and sirens... advised... Fireboard that advance notice should be given... for respiratory staff on standby upon arrival... ECG	F 684			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 684	<p>Continued From page 69</p> <p>(electrocardiogram- shows heart rhythm)... acquired, showing no signs of ischemia (lack of oxygen to heart) or infarct (heart attack)... Bilateral (both sides) IV (intravenous) access ports... established..." with blood drawn for lab work and NSS (normal saline solution- IV fluid) administered. Remained lethargic throughout transport. During transport, R164's pulse varied from 76-110, respirations 12 at 6:52 PM, then 6 thereafter, and PO2 98-100%. R164 was opening his eyes to verbal command during transport, he withdrew to pain, and was making incomprehensible sounds, except once when there was no response.</p> <p>-7:15 PM- Arrived in the ER.</p> <p>-9/3/18- Trauma Flowsheet in ER.</p> <p>-7:24 PM- Arrived via EMS being bagged via BVM s/p fall out of bed at 3 PM. Trauma code activated. VS: temperature 100.2- pulse 106- respirations 23- BP 210/87- PO2 100%.</p> <p>-7:32 PM- Physician was on phone with wife who confirmed DNR (do not resuscitate)/DNI (do not intubate- place a breathing tube) status.</p> <p>-7:33 PM- R164's wife stated not to intubate or perform CPR (cardiopulmonary resuscitation) and the trauma code was canceled.</p> <p>-7:52 PM- Placed on nasal cannula (NC) from BVM. NC at 3L.</p> <p>-7:59 PM- PO2 decreasing on NC changed to 40% ventimask.</p> <p>9/3/18 10:48 PM- Nursing progress note stated, "VS 160/88 86 (pulse) 16 (respirations) 98.0 (temperature) SPO2 (PO2) @ (at) 82% on 3L O2 via n/c (nasal cannula). Shortly after evening meal. (sic) Resident Vital signs were being monitored for Nuerochecks (sic). Respirations were uneven and slightly labored. Lungs (sic) sounds diminished. Chest xray results negative.</p>	F 684			

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

PRINTED: 02/22/2019  
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>10/25/2018</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 684	<p>Continued From page 70</p> <p>Resident started on nonrebreather SPO2 (PO2) increased to 97%. E31 (Medical Director) was made aware and a order was given to send resident to the ER. Staff remained with resident until EMTs arrived for transport."</p> <p>Review of the physician order by E31 in the electronic medical record (input by nursing) to send R164 to the hospital on 9/3/18 lacked evidence of a time. However, the vital signs listed in the nursing progress note, dated 9/3/18 and timed 10:48 PM were done at 6:00 PM, when R164 was identified with a significant decline in condition.</p> <p>9/3/18- The facility Incident/Accident Report stated that R164 was trying to get out of bed into his wheelchair and fell at 3:50 PM. R164 was alert and oriented x 1 (to self) and he sustained a small bruise to the left temporal area. According to the report, E31 (Medical Director) was notified at 4:00 PM and his wife at 4:15 PM.</p> <p>9/4/18- The Incident Report Investigation Summary, stated E34, the assigned CNA (unable to locate name in facility list of employees) observed R164 lying on the landing strip and notified the Unit Manager. A witness statement by E34, dated 9/3/18, stated that E34 checked R164 at the beginning of his shift, R164 was lying in bed and E34 offered to toilet R164. E34 stated he then worked for a few minutes in the hallway and found R164 on the floor in the residents room.</p> <p>10/25/18 2:40 PM- E31 (Medical Director) was interviewed. E31 confirmed that he did not write a time on his 9/3/18 note and stated it was in the afternoon. E31 stated that staff told him on 9/3/18</p>	F 684			

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

PRINTED: 02/22/2019  
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>10/25/2018</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 684	<p>Continued From page 71</p> <p>that R164 "doesn't look good" and he evaluated R164. E31 stated that R164 was not in pain, however, he was short of breath and hypoxic, so he was given oxygen to bring his PO2's to 92-93% and a STAT chest x-ray was ordered. E31 stated that he spoke to R164's wife, who was present, and she kept saying that R164 was not himself since he fell and had a stroke a few months ago. E31 stated he thought perhaps R164 had COPD (chronic obstructive pulmonary disease), but the chest x-ray did not confirm this. When shown R164's 8/31/18 sodium of 150 and asked what he thought about it, E31 stated that "it needs to be corrected." When asked what E31 expected with a sodium of 150, he stated, "confusion." E31 confirmed that he did not know about the 8/31/18 sodium until 9/3/18 when he ordered sip-n-go, however, the more critical issue was R164's respiratory status. When shown the difference in BP's on 9/3/18 at 4:25 PM of 116/68 to 6:00 PM of 160/88, and 6:30 PM of 200/104, E31 stated that it could have been due to a massive brain bleed. E31 also confirmed that VS's were not completed post (after) the fall. When E31 was asked what his expectation was once he gave the order to send R164 to the ER, E31 stated that he would expect the resident "to be sent out right away." In response to being told that the facility failed to call 911 for approximately 45 minutes after R164 was identified with a significant decline in condition, E31 stated, "Yeah, I know what you're telling- that's an issue here...".</p> <p>10/25/18 approximately 4:30 PM- findings were reviewed with E1 (NHA) and E2 (DON).</p> <p>10/25/18 at approximately 6:30 PM- Findings were reviewed with E1, E2, E3 (ADON), E13 (Staff Educator), and E14 (RNAC) during the exit</p>	F 684			



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

PRINTED: 02/22/2019  
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>10/25/2018</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 684	Continued From page 72 conference.  Despite the fact that the resident was noted with a change in condition at 11:25 AM on 9/3/18 and despite the fact that the resident experienced a fall at approximately 4:00 PM and despite the fact that the resident suffered a bruise to his left forehead as a result of the fall and despite the fact that the resident was on blood thinners, the facility failed to:  - complete regular assessments on F164 as required by policy after a fall with noted bruising to the left forehead; and - timely transfer of R164 to acute care after another serious change in condition.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)  §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview and review of other documentation, it was determined that for one (R135) out of 57 sampled	F 686	A. R135 had no untoward effect based upon the deficient practice and still resides in the facility.	12/26/18

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

PRINTED: 02/22/2019  
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>10/25/2018</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 686	<p>Continued From page 73</p> <p>residents, the facility failed to ensure that a resident with a pressure ulcer received the necessary treatment and services, consistent with professional standards of practice. For R135, the facility failed to accurately assess and stage his right heel and sacral pressure ulcers. Findings include:</p> <p>The Wound Ostomy and Continence Nurses Society, WOCN Society Position Statement: Pressure Ulcer Staging, Reviewed/Revised on April 2011, stated, "The staging system, as recommended by the NPUAP ( National Pressure Ulcer Advisory Panel) and WOCN, does not support down-staging or reverse staging of granulating pressure ulcers."</p> <p>National Pressure Ulcer Advisory Panel (NPUAP), Frequently Asked Questions about Pressure Injury Staging, Presented on February 20, 2018, stated, "Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis ...Granulation tissue, slough and eschar are not present ...Unstageable Pressure Injury: Obscured full thickness loss ...if slough or eschar is removed a stage 3 or stage 4 pressure injury will be revealed."</p> <p>Review of R135's clinical record revealed:</p> <p>R135 was admitted to the facility on 12/5/17 with diagnoses that included adult failure to thrive and type II diabetes mellitus.</p> <p>A weekly wound assessment revealed that on 7/14/18, R135 had a new stage 1 right heel pressure ulcer.</p> <p>On 7/23/18, R135 had a weekly wound</p>	F 686	<p>B. All residents with pressure ulcers have the potential to be affected by the alleged deficiency.</p> <p>C. The wound nurse was educated on proper wound staging by the staff developer and RNAC based upon RAI manual, Federal guidelines, and pressure ulcer standard of care.</p> <p>D. ADON/designee will observe all residents with pressure ulcers weekly during staging/measurements to ensure proper staging until 100% compliance is achieved for three consecutive weeks. Results will be reported quarterly via the facility QAPI process.</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 686	<p>Continued From page 74</p> <p>assessment that stated his right heel pressure ulcer declined and documented that R135's pressure ulcer did not have any slough or necrotic tissue and it was unopened. E30 (Wound care nurse) incorrectly staged the wound as unstageable.</p> <p>On 7/30/18, R135 had a weekly wound assessment that documented his right heel pressure ulcer had worsened and it was now open with serous drainage. E30 incorrectly documented the wound stage as a DTI (Deep Tissue Injury).</p> <p>A weekly wound assessment from 8/6/18 documented that R30's right heel pressure ulcer worsened, but was incorrectly back staged to a stage 2. The wound was documented as having no slough or necrotic tissue.</p> <p>On 8/13/18, R135 had a weekly wound assessment that documented that his right heel pressure ulcer had "improved this week," however; E30 documented that the wound had necrotic tissue and staged the wound as unstageable.</p> <p>On 8/20/18, R135 had a weekly wound assessment that documented that his right heel pressure ulcer had improved and it was incorrectly back staged to a stage 2.</p> <p>R135 was in the hospital from 8/21/18 to 9/4/18. A weekly wound assessment revealed that on 9/4/18, after the hospitalization, R135 had a new sacral pressure ulcer. The assessment documented that the wound had slough, granulation tissue, and E30 incorrectly staged the pressure ulcer as a stage 2.</p>	F 686			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 686	Continued From page 75  On 9/10/18, R135 had a weekly wound assessment that documented that his sacral pressure ulcer had worsened this week due to the wound becoming deeper. The pressure ulcer was documented as having no slough, but having granulation tissue. E30 again incorrectly staged the wound as a stage 2.  On 9/17/18, R135 had a weekly wound assessment that documented his sacral pressure ulcer remained unchanged with granulation tissue present. E30 again incorrectly staged the wound as a stage 2.  A weekly wound assessment from 10/15/18 documented that R30's sacral pressure ulcer remained "unchanged this week." The wound was again staged as a stage 2, however, E30 documented that the wound had slough.  On 10/15/18, R135 had a weekly wound assessment that documented that his sacral pressure ulcer remained "unchanged this week." The wound bed was documented as having slough, and E30 again incorrectly staged the wound as a stage 2.  During an interview on 10/25/18 at 1:40 PM, E30 stated that she was not aware that a stage 2 pressure ulcer did not have slough or granulation tissue. In addition, she was not aware that a pressure ulcer could not be back staged, and that an unstageable pressure ulcer always had full thickness skin and tissue loss.  The facility failed to ensure that R135's right heel and sacral pressure ulcers had accurate assessments.	F 686			

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

PRINTED: 02/22/2019  
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>10/25/2018</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 686	Continued From page 76	F 686			
F 689 SS=E	<p>Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.</p> <p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, clinical record reviews and review of other documentation as indicated, the facility failed to ensure that two (R140 and R364) out of 57 sampled residents' environments were as free from accident hazards as possible and they received adequate supervision to prevent accidents. For R140, the facility failed to ensure that R140's environment was as free from accident hazards as possible when R140 sustained a fall with injury from her w/c after being showered in the shower room by one CNA on 7/9/18. R140 was care planned for 2 staff with all care. Additionally, the CNA picked R140 up from the floor after the fall without assistance and before a nurse assessed the resident. R140 was sent to the ER and had a left parietal hematoma (on daily ASA) and a left shoulder abrasion. For R364, the facility failed to maintain safe water temperatures for a cognitively impaired resident</p>	F 689	Past noncompliance: no plan of correction required.	11/28/18	

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 689	<p>Continued From page 77</p> <p>that was at risk for burns. This failure effected R364's room and other resident rooms. Finding include:</p> <p>As a result of a complaint survey conducted from 4/11/18 through 4/25/18 the facility was cited under F689 and submitted a plan of correction which read, "The Interdisciplinary Team (IDT) will conduct a root cause analysis for each wandering resident whose ability to respect boundaries is impaired and discuss interventions appropriate for each resident and implement them as indicated...The RNAC or designee will monitor changes to the care plan as recommended by the IDT regarding wandering residents and determine effectiveness daily for 14 days, weekly times 10, then monthly until 100% compliance is achieved." The facility was put back in compliance for F689 on 10/8/18.</p> <p>1. The facility Fall policy, last revised in 2/2014, stated, "...1. Upon witnessing or finding a resident who has fallen; DO NOT MOVE the resident unless in immediate danger. 2. Immediately call for a nurse and stay with the resident to reassure the resident and monitor for changes in condition. Ask another staff member or use the call bell to alert nurses. If necessary send another resident or visitor to get help. 3. The nurse is to evaluate for possible injuries... 4. Only with guidance from a licensed nurse may the resident be lifted or assisted to sit or stand..."</p> <p>Review of R140's clinical record revealed the following:</p> <p>R140 was admitted to the facility in 2015. Diagnoses for R140 include stroke with left-sided paralysis, anxiety, bipolar disorder, dementia, and extrapyramidal and movement disorder.</p>	F 689			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 689	Continued From page 78  1/20/16- Physician's order for Dycem under R140's wheelchair cushion every shift for safety.  2/16/16- R140 had a physician's order for Aspirin (ASA) 81 mg to be given daily for stroke (to reduce the risk of another stroke by preventing cells from clumping together to form clots).  10/14/16- Review of R140's ADL care plan, listed an approach for 2 person assistance with all care secondary to false accusations.  10/21/16- Review of R140's potential for injury care plan listed approaches for 2 person transfers and to have dycem to the top of R140's wheelchair. The care plan listed numerous falls from 2015 through to 5/12/18. Most of the falls resulted in no injury, including the 5/12/18 fall, and some had minor injuries.  10/23/17- Physician's order for Dycem on top of R140's wheelchair cushion every shift for safety.  12/7/17- R140 had a care plan developed for comfort care due to a decline and R140 wished for no aggressive measures to be done to prolong her life.  5/7/18- R140's quarterly MDS assessment coded R140 as cognitively intact and able to make consistent and reasonable decisions, she required one staff person total assistance with dressing, personal hygiene, and bathing and two staff person total dependence with transfers (how the resident moves between surfaces including to or from: bed, chair, wheelchair, and standing position), and she was unable to walk.	F 689			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 689	<p>Continued From page 79</p> <p>7/9/18 2:25 PM- A progress note, stated, "CNA notified this nurse that resident fell out of chair on to shower room floor from her wheel chair. CNA stated she was calling for help from shower room and no one was coming. CNA stated resident had no clothes on and it was too cold to leave resident on floor. Resident was able to move extremities and denied pain at this time. Nurse in to assess resident and noted bump to top of left side of head, and left shoulder abrasion... MD ordered to send resident to ER for eval. (evaluation). Resident continues on anticoagulants..."</p> <p>7/2018- R140's eMAR revealed that she was receiving a baby ASA daily as stated above.</p> <p>7/9/18 3:18 PM- A progress note, stated, "S/P (status post) fall, ROM performed and neuro checks initiated and within normal limits. Abrasion to left shoulder cleansed with NSS (normal saline solution) and no dressing applied. Ice placed to lump on head for several minutes prior to being picked up by transport."</p> <p>7/9/18 4:22 PM- R140's hospital x-rays of left shoulder: results revealed no acute fracture or dislocation.</p> <p>7/9/18 10:19 PM- R140's hospital CT head without contrast: results revealed "A moderate left parietal scalp hematoma seen... There is no acute intracranial hemorrhage... fluid collection... Impression: No acute intracranial process."</p> <p>7/10/18 9:39 AM- A progress note, stated that R140 returned from ER at 9 AM. Denies pain or discomfort. Skin intact and left shoulder slightly reddened from fall.</p>	F 689			



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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 689	<p>Continued From page 80</p> <p>The fall incident/accident report, witness statements, and reports sent to the state agency were reviewed. The fall occurred on 7/9/18 at 11:40 AM. Follow up information sent to the state agency, dated 7/16/18, E20 stated the floor was cold and she was unable to get assistance "so she got the resident up off the floor because the resident was laughing and seemed fine..." E20 stated "... the wheelchair cushion was in place as well as dycem to the top of the wheelchair cushion and that a towel was placed as she was drying the resident off and applying lotion at the time of the fall." E3 (ADON) asked E20 if she had utilized the call bell cords in the shower room and E20 stated, "... she had not thought of that during the time." E3 discussed the facility fall policy and procedure, specifically concerning staff not picking a resident up off the floor without being assessed by a nurse. E20 stated, "she was aware..."</p> <p>7/9/18- The Incident/Accident Report was completed by E21 (LPN) that was used as a QA tool by the facility, stated, "... Describe exactly what happened: per CNA resident threw herself out of her w/c (wheelchair) on to shower room floor after her shower."</p> <p>7/9/18- The witness statement by E20, stated, "... called for help and the floor was cold and no one came. So, I (name of E20) CNA picked up resident off the floor. I also check (sic) for any marks and bruise (sic) for swelling on resident. Noticed resident had a bump left side of shoulder and head." There was nothing in E20's witness statement that R140 threw herself out of the wheelchair.</p> <p>7/9/18- The witness statement by E21 (LPN),</p>	F 689			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 689	<p>Continued From page 81</p> <p>stated, "... Nurses educated CNA (E20) to use 2 person assist at all times."</p> <p>7/9/18- R140's eTAR was signed on day shift indicating that dycem was in place both under and over the wheelchair cushion as per physician's orders, although the Incident/Accident Report of the same date only mentioned there was dycem on top of the wheelchair cushion.</p> <p>7/12/18- Disciplinary Notice for E20- "... 4. Explanation of Infraction: Failure to provide goods and services as required by state and federal regulations and (name of facility) policies and procedures. Specifically you failed to follow the (name of facility) Falls policy and procedure. 5. Reasoning for Suspension or Termination: A resident fell during a shower and you placed the resident back into her wheelchair without a nurse assessing the resident prior. In addition you failed to follow the residents care plan for transfer status as the resident is a two person assist." This was a suspension effective on 7/16/18.</p> <p>8/17/18- The facility added the approach hoyer lift with 2 person transfers to R140's potential for injury care plan.</p> <p>8/22/18- The facility discontinued the approach 2 person assistance with all care secondary to false accusations to ADL care plan and stated, "not relevant currently."</p> <p>10/15/18- The facility added the approaches that R140 required 2 person hoyer lift for bed and wheelchair and 2 person assist in shower to R140's potential for injury care plan.</p> <p>10/25/18 10:19 AM- During an interview with E21</p>	F 689			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 689	<p>Continued From page 82</p> <p>(LPN), she stated that R140 was in a high backed wheelchair during the time of the fall without foot rests. E21 stated that R140 was placed in a high back wheelchair due to problems with her trunk posture/curved back and R140 used to self propel in the wheelchair with foot rests, but they were removed because her legs got tangled up in them. E21 further stated that R140 had occurrences of "throwing herself out of the wheelchair" and she believed that's what happened on 7/9/18. When asked if E20 still worked in the facility, E21 stated, "no", that E20 found another job.</p> <p>10/25/18 10:55 AM- E20 called surveyor in response to voicemail message left on 10/24/18. E20 stated she left the facility in mid September 2018. E20 stated that she worked with R140 for about 4-5 months. When asked what happened on 7/9/18 when R140 fell in the shower room, E20 stated that R140 was sitting in her wheelchair and "was fine, then she suddenly leaned to the side and somehow came out over the armrest." She stated that she had lotion on her gloves, so when R140 fell she was unable to catch her. When asked about the wheelchair, E20 stated there was dycem in place under and on top of the wheelchair cushion, there were no foot rests in place and "the brakes were on." When specifically asked if there was a towel above the top dycem on the wheelchair, E20 stated, "no." E20 further stated she "was afraid that if she put a towel on top of the dycem it would be slippery." When asked how many people were supposed to shower E140, she stated, "Two, but we were short staffed that day."</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and</p>	F 689			

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

PRINTED: 02/22/2019  
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>10/25/2018</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 689	<p>Continued From page 83</p> <p>E14 (RNAC) on 10/25/18 at approximately 6:30 PM.</p> <p>The facility failed to ensure that R140's environment was as free from accident hazards as possible when R140 sustained a fall with injury from her wheelchair after being showered in the shower room by one CNA on 7/9/18. R140 was care planned for 2 staff with all care. Additionally, the CNA picked R140 up from the floor without assistance and before a nurse assessed the resident.</p> <p>2. Review of R364's clinical record revealed the following:</p> <p>9/13/18- R364 was readmitted to the facility after a hospitalization with diagnoses including dementia.</p> <p>8/17/18- Admission MDS assessment coded R364 as a "7" indicating severe cognitive impairment (never/rarely made decisions).</p> <p>10/16/18 9:20 AM-During room observations it was found that R364's bathroom (resides in F wing) water temperature was uncomfortably hot during a room check causing temporary redness to the surveyor's hands. The surveyor obtained a state issued thermometer to check the water temperature and it was 125.5 degrees F. See below that the water temp. was subsequently readjusted to 121.5 degrees F, which remained a burn risk for cognitively impaired residents.</p> <p>10/16/18 9:25 AM- The survey team dispersed throughout the facility and did random checks of residents' sink water temps, covering all of the units and the shower rooms.</p>	F 689			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 689	Continued From page 84  10/16/18 9:40 AM- E23 (maintenance) was working in the F wing and asked the surveyor if there was something wrong with the water temperatures and then stated there was something wrong with the mixer and water temperatures should be between 105-107 degrees F. E23 stated that water adjustments were made during season changes. When asked how he determined water temperatures, E23 stated that he places his thermometer into the waterflow from the sink, lets the water run a few minutes and he then records the lowest temperature he gets once the temperature levels out.  10/16/18 10:05 AM- the surveyor rechecked R364's room water temp, and E22 (Maintenance Director) checked R364's water at the same time. The surveyor got 106.4 degrees F and E22 got 98.0 degrees F. The surveyor and E22 (Maintenance Director) then did a cold water test with both thermometers and there was a 4 degree difference between them with the state thermometer being higher. The adjusted hot water temp. for R364's sink was 121.5 degrees F at 9:10 AM.  10/16/18 10:20 AM- E22 (Maintenance Director) stated the problem was that hard water deposits cake up on the mixer valve causing it to stick. E22 stated that he changed the water flow to F and G wings (they share the same water tank) to let more cold water in to reduce the water temperatures and now they may be a little on the cool side, but he'd rather have them too cool than too hot. E22 also stated that E27 (contracted plumber) was on his way.	F 689			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 689	<p>Continued From page 85</p> <p>10/16/18 12:11 PM- E22 was interviewed and asked when the facility identified the hot water issue and he stated around 10-10:30 AM when E23 was checking room temps and found hot water. E22 stated that room temps were checked 5 days a week randomly in 4 rooms/shower rooms by E23. E22 stated that he instructed E23 (maintenance) the same as E23 described above, however, to go with the highest temp. reading (in contrast with E23's use of the lowest reading). E22 replied that the facility thermometers were calibrated or had the battery changed when they were checked every 4-6 weeks or if there "was a funny reading" and the batteries lasted about 7-8 months. E22 stated there were no complaints from residents about the water temps. When asked how E22 knew the problem was with the mixing valve, he stated because he had to adjust the restrictor by letting in more cold water to lower the temp. E22 stated the last time there was a problem with the mixer valve was 3 years ago and the whole unit was replaced at that time. E22 also stated that he called E27 (contracted plumber) and E27 would not be here today because E27 was overnighing a new mixing valve.</p> <p>10/16/18 1:40 PM- During an interview, E1 (NHA) was interviewed. E1 confirmed that he was aware of the water issues and what had been done to lower the water temps. E1 confirmed that he would notify unit managers, including 3-11 and 11-7 staff so they can explain the water issue and the temporary correction of the problem to the residents. E1 further stated that he would speak to staff so the residents attending the resident council meeting today would be informed. E1 stated that E22 (Maintenance Director) was getting water temps in the range of 98-107</p>	F 689			

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

PRINTED: 02/22/2019  
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>10/25/2018</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 689	Continued From page 86 degrees F after the restrictor adjustment and that temps. would continue to be monitored until E27 (plumber) comes tomorrow.  10/16/18 3:42 PM- E29 (CNA) assigned on the 3-11 shift to F hall stated she was told that water temps may be down.  10/16/18 3:44 PM- E9 (LPN) assigned on the 3-11 shift to F hall stated she was told there may be water fluctuations with the hot and cold water in the resident rooms. E9 also stated that staff were telling the residents.  10/17/18 10:05- E22 was present and E27 (master contracted plumber) was interviewed. E27 stated that E22 did "exactly what I would have done", which was to temper the water temp. down. E27 explained that the facility had a spare mixer spool that was soaking in vinegar to get rid of the built up deposits, so it was switched out for the current one that is now soaking in vinegar. Additionally, the plumber stated that a third replacement would be ordered and as a preventative maintenance measure, the mixer valve would be replaced every 18 months by E27.  Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.	F 689			
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)  §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 693		12/26/18	

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 693	<p>Continued From page 87</p> <p>enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and</p> <p>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview and review of facility policy and procedures as indicated, the facility failed to ensure that one (R1) out of 57 residents sampled, who was fed by enteral means receives the appropriate treatment and services to prevent complications. Findings include:</p> <p>The facility's nursing policy titled "Medication Administration Via Enteral Feeding Tube," stated, "...5. Prepare all meds (medications) with crushing and adding water before entering resident's room ...12. If the feeding is running, stop the feeding. 13. Put on the gloves. 14. Disconnect tubing; cap tubing to bag with catheter plug and hand over pump. 15. Insert piston syringe into the enteral feeding tube. 16. Check placement of tube by referring to policy and procedure ...'Checking for placement of</p>	F 693	<p>A. R1 suffered no untoward effect and continues to reside in the facility.</p> <p>B. All residents requiring medication delivery via feeding tube have the potential to be affected by the alleged deficiency.</p> <p>C. E9 no longer works at the facility. Staff developer/designee will in-service all licensed staff regarding proper medication administration through a feeding tube.</p> <p>D. Staff developer/designee will observe two residents daily for proper medication administration via feeding tube daily times 14, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.</p>		



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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 693	Continued From page 88 gastrostomy ...tubes.' ...18. Pour liquid medication (one at a time) or water with crushed tablets into syringe and allow it to flow by gravity feed. Follow with 15 ml water flush ...".  The facility's policy titled, "Checking for Placement of Gastrostomy ...Tube" stated, "...Procedure For Checking Gastric Contents To Ensure Proper Placement Of A Gastrostomy Tube: 1. Attach a 60 cc catheter tipped syringe to the feeding port. 2. Aspirate gastric contents. 3. When gastric contents are observed, tube placement is correct. 4. Return gastric contents to the stomach ...".  During the medication pass observation on 10/11/18 at approximately 9:10 AM the following was observed: E9 (LPN) was observed administering four Oxycodone 5 mg tablets (total 20 mg), which had been crushed and mixed with water, to R1. E9 washed her hands, donned gloves and disconnected R1's feeding tube. E9 connected a 60 cc syringe filled with plain water and flushed the feeding tube by injecting water using the syringe plunger. E9 then proceeded to administer the crushed Oxycodone mixed in water in the same manner.  E9 failed to check placement of the feeding tube prior to administering the Oxycodone and failed to administer the medication via gravity according to facility policy.  During an interview on 10/11/18 at approximately 5:45 PM, findings were reviewed and confirmed by E1 (NHA) and E2 (DON).	F 693			
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		12/26/18	

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

PRINTED: 02/22/2019  
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>10/25/2018</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 695 SS=D	<p>Continued From page 89</p> <p>CFR(s): 483.25(i)</p> <p>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined that for one (R60) out of 57 sampled residents, the facility failed to ensure that R60 was provided respiratory care consistent with her physician orders. Findings include:</p> <p>Review of R60's clinical record revealed the following:</p> <p>R60 was admitted to the facility on 4/26/17 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD).</p> <p>On 5/14/18, R60 had a physician's order for DuoNeb solution 0.5-2.5 MG/3 ML (nebulizer) 1 vial inhale orally two times a day for wheezing.</p> <p>On 5/15/18, R60 had a physician's order to change her nebulizer set (mask and tubing) every Tuesday evening for infection control.</p> <p>Review of R60's eTAR revealed that staff documented that R60's nebulizer set was changed on 10/2/18, 10/9/18, and 10/16/18.</p>	F 695	<p>A. R60 had no untoward effect and continues to reside in the facility.</p> <p>B. All residents receiving nebulizer treatments have the potential to be affected by the alleged deficiency.</p> <p>C. All licensed staff will be in-serviced by the staff developer on the proper administration of nebulizer treatments to include changing nebulizer mask and tubing in a timely manner.</p> <p>D. The 3-11 shift is tasked with changing nebulizer masks and tubing. The 3-11 supervisor will observe ten residents for proper nebulizer treatments and change of mask and tubing daily times 14, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</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 695	Continued From page 90 During an observation on 10/19/18 at 11:45 AM, R60 was sitting in a chair in her room with no staff members present. R60's DuoNeb nebulizer treatment was running and the mask was hanging off the left side of the residents face, therefore, R60 was not receiving her nebulizer treatment. In addition, the nebulizer set had the date 10/2 written on it.  During an interview on 10/19/18 at 11:46 AM, E8 (RN Unit Manager) confirmed that R60's nebulizer treatment was running and was not on the residents face and confirmed that R60's nebulizer set stated that it was last changed on 10/2/18. E8 then removed R60's nebulizer and changed the nebulizer set.  The facility failed to provide R60 with her ordered respiratory care as evidenced by an observation of R60's nebulizer treatment being administered incorrectly and R60's nebulizer set was not changed per physician's orders.  Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k)  §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. This REQUIREMENT is not met as evidenced by:	F 697		12/26/18

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>10/25/2018</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 697	<p>Continued From page 91</p> <p>Based on observation, interview and review of the clinical record, it was determined that the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive care plan, and the residents goals and preferences for one (R140) out of 57 sampled residents. Findings include:</p> <p>Review of R140's record revealed the following:</p> <p>R140 was admitted to the facility in 2015. Diagnoses for R140 included stroke with left-sided paralysis, anxiety, bipolar disorder, dementia, and extrapyramidal and movement disorder.</p> <p>11/23/15- A potential for alteration in comfort care plan was developed for R140 related to neuropathy and a history of back pain with interventions including: assess for verbal and nonverbal signs and symptoms of pain, medicate for pain as ordered, assess for non-verbal signs of pain such as "grimacing, non-verbal sounds, crying, moaning, groaning, wincing,...". The care plan was last revised on 8/22/18.</p> <p>12/17/17- A comfort care plan was developed for "decline noted per resident wishes for no aggressive measures." The care plan goal stated, "resident will remain comfortable, maintain personal dignity and allow nature to take its course through disease process x 92D." Interventions included: monitor for pain/discomfort and medications as ordered. The care plan was last revised on 8/22/18.</p> <p>8/6/18- A physician's order for R140 was written for Tylenol Extra Strength (ES) 500 mg give 2</p>	F 697	<p>A. R140 continues to reside in the facility and medication administration has been adjusted per physician order.</p> <p>B. All residents receiving wound care may be affected by the alleged deficiency.</p> <p>C. All licensed staff will be in-serviced by the staff developer regarding appropriate pain management to include identifying specific resident related, non-verbal expression of pain versus other behaviors. Licensed staff will also be in-serviced on documentation of administration and effectiveness of medication per physician order.</p> <p>D. Unit manager/designee will monitor pain management orders related to wound care to ensure appropriate order is in place daily times 14, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</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 697	<p>Continued From page 92</p> <p>tablets (1,000 mg) every 6 hours as needed via PEG tube for moderate pain.</p> <p>8/11/18 eTAR- Wound treatment (tx) done.</p> <p>8/11/18 eMAR- No Tylenol ES was administered.</p> <p>8/12/18- Admission Wound Assessment: R140 returned from the hospital with an unstageable pressure ulcer (PU) of the sacrum with slough first noted on 8/10/18.</p> <p>8/13/18- Skin/wound progress note (late entry at 1:25 PM) stated, "... resident showed grimacing during treatment but was unable to communicate when asked if she was in pain. PRN Tylenol was given for pain at 1112 (11:12 AM). RP (responsible party), ADON (E3) and DON (E2) were notified. Voicemail was left for wound physician at 1330 (1:30 PM). Waiting for call."</p> <p>8/14/18, 8/15/18, 8/16/18, 8/17/18, 8/19/18, and 8/20/18- eTAR: wound tx's done.</p> <p>8/15/18- New physician's order for Gabapentin (nerve pain medication) 600 mg give one tablet via PEG tube 3 times a day for pain.</p> <p>8/14/18, 8/16/18, 8/19/18, and 8/20/18- There here was no documentation in the eMAR that PRN Tylenol ES was given for pain.</p> <p>8/20/18- Weekly Wound Assessment: "... wound is now worse this week... tolerated treatment with some grimacing."</p> <p>9/4/18, 9/5/18, 9/6/18, 9/7/18, and 9/10/18- eTAR: Wound tx's done.</p>	F 697		

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

PRINTED: 02/22/2019  
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>10/25/2018</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 697	<p>Continued From page 93</p> <p>9/4/18, 9/5/18, 9/6/18, 9/7/18 and 9/10/18- There was no documentation in the eMAR that prn Tylenol ES was given for pain.</p> <p>9/10/18- Weekly Wound Assessment: "... Resident showed signs of pain with grimacing. Pain management is in place." R140's sacral wound visually appears to be stage 4.</p> <p>9/12/18 and 9/14/18- eTAR: Wound tx's done.</p> <p>9/12/18 and 9/14/18- eMAR: There was no documentation that prn Tylenol ES was given for pain.</p> <p>9/17/18- Weekly Wound Assessment: "... Resident shows signs of pain by moaning and grimacing. Pain management is in place; Tylenol ES (extra strength) 1000 mg PEG Q (every) 6H (hours) PRN (as needed) and Gabapentin 600 mg PEG TID (3 times a day)."</p> <p>9/21/18 and 9/24/18- eTAR: Wound tx's done.</p> <p>9/21/18 and 9/24/18- eMAR: There was no documentation that prn Tylenol ES was given for pain.</p> <p>9/24/18- Weekly Wound Assessment: "... Resident shows signs of pain by moaning and grimacing... Continue with current interventions."</p> <p>9/26/18, 9/28/18 and 10/1/18- eTAR: Wound tx's done.</p> <p>9/26/18, 9/28/18 and 10/1/18- eMAR: There was no documentation that PRN Tylenol ES was given for pain.</p>	F 697			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 697	<p>Continued From page 94</p> <p>10/1/18- Weekly Wound Assessment: "... Resident shows signs of pain by moaning and grimacing... Continue with current interventions."</p> <p>10/3/18, 10/5/18 and 10/8/18- eTAR: Wound tx's done by E30 (wound care nurse).</p> <p>10/3/18, 10/5/18 and 10/8/18- eMAR: There was no documentation that PRN Tylenol ES was given for pain.</p> <p>10/8/18- Weekly Wound Assessment: " wound... worse this week... Resident shows signs of pain by moaning and grimacing. Pain management is in place..."</p> <p>10/10/18, 10/12/18 and 10/15/18- eTAR: Wound tx's done by E30.</p> <p>10/10/18, 10/12/18 and 10/15/18- eMAR: There was no documentation that PRN Tylenol ES was given for pain.</p> <p>10/15/18- Weekly Wound Assessment: "... Resident shows signs of pain by moaning and grimacing. Pain management is in place; Tylenol ES (extra strength) 1000 mg PEG Q (every) 6H (hours) PRN (as needed) and Gabapentin 600 mg PEG TID (3 times a day)."</p> <p>10/24/18- eMAR: R140 received Tylenol ES 1,000 mg via PEG tube at 10:26 AM.</p> <p>10/24/18- Wound care was observed with E30 (wound care nurse) from 10:47 AM- 11:30 AM. Although R140 received prn Tylenol at 10:26 AM, prior to the start of wound care, she had facial grimacing and moaning during the end of the wound tx, about 55 minutes after Tylenol was</p>	F 697			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 697	Continued From page 95 given.  10/25/18- E30 was interviewed at 8:08 AM and stated the Weekly Wound Assessments are an accumulation of what she observed the previous week. E30 stated that she keeps daily notes also. When asked about pain, E30 stated that she tells staff during or after the wound tx if R140 seems to be in pain. E30 confirmed that by writing pain indicators in Weekly Wound Assessments, there was pain during at least 1 of the wound tx's. E30 stated that she does not look to see if R140 receives Tylenol ES prior to wound tx's.  Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.  The facility failed to ensure that effective pain management was provided to R140, consistent with professional standards of practice, the comprehensive care plan, and the resident's goals and preferences.	F 697			
F 744 SS=E	Treatment/Service for Dementia CFR(s): 483.40(b)(3)  §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the clinical record and other documentation as indicated, it was determined that for two (R157 and R72) out of 57 sampled residents, the facility	F 744	A. The "1:1 supervision" referenced was inadvertently written in the wrong resident care plan on 8/3/18 and was not meant for R157. Upon review, there is no evidence	12/26/18	



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

PRINTED: 02/22/2019  
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>10/25/2018</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 744	<p>Continued From page 96</p> <p>failed to ensure that residents diagnosed with dementia received the appropriate treatment and services to attain or maintain their highest practicable physical, mental and psychosocial well-being. For R157, a resident with dementia, the facility failed to implement her care-planned intervention for 1:1 supervision on numerous occasions. This resulted in multiple resident-to-resident altercations. For R72, a resident with dementia who had fluctuating disorganized thinking and a known history of falling, the facility failed to ensure that individualized care and services were provided to her during the evening shift of 9/9/18 to ensure her safety. Findings include:</p> <p>Cross refer F600</p> <p>Review of R157's clinical record revealed:</p> <p>R157 was admitted to the facility on 7/24/18 with diagnoses that included dementia.</p> <p>The facility developed a care plan on 7/27/18 for the problem that R157 wandered into other rooms at times due to dementia. Interventions included for staff to provide redirection and 1:1 supervision.</p> <p>An incident statement from an event on 8/3/18 at 1:30 PM stated that E33 (CNA) was walking down the hall and heard R157 saying "stop, stop" in an aggressive tone to R215. E33 entered the room and observed R157 with her hands on R215's ankles pulling her legs to the foot of the bed. R157 then told R215 "If you don't behave I'm going to punch you in the face." E33 immediately intervened, separated the residents, and informed E3 (ADON). The incident report summary from</p>	F 744	<p>that R157 interacted with R215 as cited. The "1:1" in a care plan refers to staff interacting directly with the resident for re-direction, as explained to the surveyor. R157 was placed on "1:1 staff supervision" on 10/18/18. Facility proactively sent R157 to a behavioral facility on 10/19/18 and R157 returned 10/29/18 on "1:1 staff supervision." On 11/1/18 the care plan was revised to "close supervision by staff" to reflect the requirements in the State Operations manual.</p> <p>B. All residents have the potential to be affected by the alleged deficiency.</p> <p>C. E32 was re-educated by the RNAC on accuracy of care plan documentation. Staff has been in-serviced that close supervision by staff is the correct terminology per State Operations Manual (SOM). Close supervision by staff may be a nursing intervention or may be ordered by the physician depending upon individual requirement. This close observation by staff may be on-going, infrequent, or event specific as determined by the IDT and/or immediate nursing judgment.</p> <p>D. RNAC/designee will audit 5 residents for appropriate care plan documentation for close supervision by staff weekly for four weeks, then monthly until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 744	<p>Continued From page 97</p> <p>this event stated that R157 was placed on 1:1 supervision and her room was changed.</p> <p>Review of R157's care plan showed that on 8/3/18, after the incident with R215, a care plan was developed for the problem that R157 exhibited physical and verbal aggression. The care plan specified that R157 on 8/3/18 had a resident-to-resident altercation where she pulled another resident's legs and was verbally abusive. Interventions for this care plan included for R157 to receive 1:1 supervision.</p> <p>An incident report summary from an event on 8/8/18 at 7:45 AM stated that the assigned CNA was providing care to R157 when the resident became aggressive and pulled away. R157 then went over to R105 (her new roommate) and began going through R105's belongings. The CNA attempted to redirect R157. R105 then tried to stop R157 from taking her personal belongings and R157 reached out and slapped R105 on the right forearm. Staff stepped in and redirected R157 to her side of the room. R105's right forearm was noted to have redness and R105 verbalized that her "right forearm was tender." R157 had a room change after this incident and was to be provided 1:1 supervision.</p> <p>Review of R157's care plan showed that on 8/8/18, after the incident with R105, R157's care planned problem of exhibiting physical and verbal aggression was updated to include this resident-to-resident altercation. Interventions to review R157's medications and a room change were added. The intervention for 1:1 supervision was still active at this time.</p> <p>A progress note from 10/17/18 at 8:20 AM stated</p>	F 744			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 744	<p>Continued From page 98</p> <p>that during medication pass E26 (RN) heard yelling and screaming coming from a room. E26 went to investigate and R157 was in R33's room. R33 tried to ask R157 to leave and R157 shoved R33 on her left shoulder. R33 was extremely upset and shaken. R147, who shared a room with R33, was also "upset". R157 was difficult to redirect, but was removed from the room. R157 was care planned to be on 1:1 supervision at the time of this incident.</p> <p>On 10/17/18 at 4:02 PM, R157 was observed without 1:1 supervision. R157 was walking by herself down the hall by the dining room towards the D/E wing nursing station. R157 then wandered into the nursing station and began putting hand sanitizer on her hands and rubbing it into a chair. At approximately 4:05 PM, staff noticed R157 and began to redirect her.</p> <p>A progress noted dated 10/19/ 18 at 1:12 PM, stated that R157 was transferred to a psychiatric facility at 1:00 PM accompanied by nursing staff.</p> <p>Review of R157's clinical record lacked evidence of daily documentation of R157 being provided 1:1 supervision from 7/27/18 to 10/19/18.</p> <p>During an interview on, 10/23/18 at 1:57 PM, E32 (RN MDS Coordinator) stated that she created and updated R157's care plans. E32 stated that she did not realize she had not discontinued R157's 1:1 supervision intervention, but agreed that since it was written in the care plan staff should have been providing 1:1 supervision to R157.</p> <p>During an interview on 10/25/18 at 2:14 PM, E13 (Staff development) stated there were not any</p>	F 744			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 744	<p>Continued From page 99</p> <p>logs or documentation showing that R157 was provided 1:1 supervision while at the facility. E13 reviewed the facility staffing schedules since R157's admission and handed the surveyor a post-it note containing the dates a staff member was assigned to provide 1:1 supervision to R157. The dates listed were 8/11/18-8/24/18 and 10/25/18 to current.</p> <p>The facility failed to implement R157's care-planned intervention for 1:1 supervision, which resulted in multiple resident-to-resident altercations. This failure resulted in R157 not achieving her highest level of functioning.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.</p> <p>2. Review of R72's clinical record revealed:</p> <p>8/6/12 - R72 was care planned for potential for injury related to...h/o (history of) falls c (with) fx (fracture), gets up unattended, poor balance...wanders, dementia (last reviewed on 10/10/18). The interventions included, but were</p>	F 744			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 744	<p>Continued From page 100</p> <p>not limited to: remind resident of limits and to ask for assistance for transfers and mobility as needed.</p> <p>8/17/12 - R72 was care planned for alteration in thought process &amp; communication (last reviewed on 10/10/18). The interventions included, but were not limited to: "...7) Cues and re-orientation as needed with care &amp; ADL's (activities of daily living)...11) Observe for changes in cognitive status...".</p> <p>8/6/18 - R72's 5-day Medicare MDS assessment stated that she was severely cognitively impaired, had fluctuating disorganized thinking, required extensive assistance of one staff person for transfers, had a history of falls and had one fall since the prior assessment.</p> <p>9/9/18 at 10:40 PM - The facility's Incident Report stated, "I was asked by aide, 'Where is (R72, resident's name)?' The aid and myself entered the resident's room together and saw resident sitting on the floor leaning on the bed (on her right side)." The following statements were obtained: - E35 (LPN) stated, "Around 10:10 PM, another nurse informed me that R72 almost fell off from her wheelchair at the lounge on E-Wing. R72 was then kept next to the med cart in the hallway within sight for safety. I left R72 for few minutes to administer meds. Exiting from that resident's room, I heard CNA asking for R72. I went to her room and found her on the floor sitting and leaning against the bed." In response to the question, What care did you provide for the resident on the date of the incident, E35 stated, "Resident was monitored for safety during the shift...". - E36 (LPN - orientee) stated, "I saw resident in</p>	F 744			

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

PRINTED: 02/22/2019  
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>10/25/2018</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 744	<p>Continued From page 101</p> <p>hallway sitting in her w/c. When I came out of another residents (sic) room after providing care, the Aide (CNA) asked me 'Where is (R72, resident's name)?' The Aide and myself entered the resident's room and saw R72 sitting on the floor on her right side with her head leaning against the mattress. The resident was facing the door." In response to the question, What care did you provide for the resident on the date of the incident, E36 stated, "...I administered medication. After the fall, I assisted the resident off the floor to the bed. I assisted the nurse to perform ROM (range of motion), neuro checks. I took vital signs."</p> <p>- E37 (CNA) stated, "R72 was taken back and forth to the restroom, night gown on and sitting in the hallway. I went to empty laundry and came back and asked the nurses where was she. I opened room door and she was by the bed on the floor."</p> <p>9/10/18 - The facility's investigation summary stated, "...Resident reported to staff that she was attempting to transfer herself to bed and lost her balance. Prior to the fall the resident had been observed by another nurse to be almost falling out of her W/C (wheelchair) in the...lounge; resident was then closely monitored sitting next to the assigned nurse's medication cart. While administering medications to another resident, (R72) self propelled into her room. When nurse returned from administering medication and (R72) was no longer there, she called to the CNA and they entered room...9/10/18...spoke with resident who...denied recollection of the fall...".</p> <p>10/23/18 at 11:42 AM - During a telephone interview, E35 (LPN) stated that another nurse brought it to her attention that R72 was almost</p>	F 744			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 744	<p>Continued From page 102</p> <p>falling off her wheelchair in the lounge so E35 took the resident back to her med cart to keep a close eye on the resident. E35 stated that she knew R72 was a fall risk as the resident had a splint on her hand from a previous fall and she wasn't able to do the things she use to do. E35 stated that based on what was observed in the lounge earlier, she wanted to keep a close eye on the resident. E35 stated that she had a nurse orientee with her that night, but was unable to recall the nurse's name. E35 stated that she offered R72 food and drink, but the resident refused. E35 stated that she asked R72 if she wanted to go to bed, and resident said no. E35 stated that she was administering meds and that she went into room 2 without the nurse orientee. When asked by the surveyor if she asked another staff member to keep an eye on the R72, E35 stated no. E35 stated that she thought someone would be in the hallway or at the nurses station. E35 stated she was unclear, but thought her nurse orientee came out of room 1 when she exited room 2 after administering meds. E35 stated that she stepped away from the med cart for only a few minutes. E35 stated that when she returned, the CNA (unable to recall the name) asked her where was R72. E35 stated that the nurse orientee, CNA and she went to R72's room (room 7, which was at the opposite end of the hallway) and found her on the floor. E35 asked R72 what she was doing, R72 responded that she was going to bed.</p> <p>10/23/18 at 3:24 PM - During a telephone interview, E37 (CNA) stated that she knew R72 very well and remembered the incident. E37 stated that R72 was very strong willed and very independent. E37 stated that R72 does not like you to "hover over her" and she wants to do what</p>	F 744			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 744	Continued From page 103 she wants to do. E37 stated that R72 can propel her wheelchair very fast. E37 stated that night, she wanted to keep an eye on R72 and she asked the nurse and the nurse orientee to keep an eye on R72 while she emptied the laundry. E37 stated that when she returned, she asked where R72 was and they found her in her room on the floor.  10/25/18 at 6:30 PM - Finding was reviewed with E1 (NHA) and E2 (DON). Despite the fact that R72 had been reported as almost falling from her wheelchair and despite the fact that staff felt that R72 needed to be closely monitored and despite the fact that R72 was a fall risk, the facility failed to ensure that individualized care and services were provided to R72 to ensure her safety and prevent a fall.	F 744			
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)  §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		12/26/18	



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

PRINTED: 02/22/2019  
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>10/25/2018</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 755	<p>Continued From page 104 pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for 4 out of 7 medication carts, the facility failed to accurately reconcile the transfer of controlled drugs from one shift to another on multiple occurrences between 10/1/18 and 10/16/18. Findings include:</p> <p>On 10/17/18 at 1:44 PM, during a review of the narcotic book for the F wing medication cart, it was observed that the sign off sheet for October was missing 13 signatures. This was confirmed with E10 (UM).</p> <p>On 10/17/18 at 2:01 PM, during a review of the narcotic book for the E wing medication cart, it was observed that the sign off sheet for October was missing 10 signatures. This was confirmed with E11 (RN) .</p> <p>On 10/17/18 at 2:12 PM, during a review of the narcotic book for the C wing medication cart, it was observed that the sign off sheet for October was missing 8 signatures. This was confirmed</p>	F 755	<p>A. No residents suffered any untoward effect, and all individual count sheets were accurate.</p> <p>B. All residents receiving controlled substances have the potential to be affected by the alleged deficiency.</p> <p>C. Staff developer/designee will in-service all licensed staff regarding controlled substance reconciliation. Staff will document in the electronic record assumption of cart at change of shift to include accurate narcotic count.</p> <p>D. Unit manager/designee will monitor narcotic reconciliation documentation daily times 14, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</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 755	Continued From page 105 with E10 (LPN).  On 10/17/18 at 2:32 PM, during a review of the narcotic book for the B wing medication cart, it was observed that the sign off sheet for October was missing 4 signatures. This was confirmed with E18 (Agency Nurse).  The facility failed to ensure accurate reconciliation of the transfer of controlled drugs from one shift to another.  Findings were reviewed with E2 (DON) on 10/17/18 at 5:00 PM.	F 755			
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)  The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of nursing practice guidelines, it was determined that for one (R1) out of 57 sampled residents, the facility failed to ensure residents were free of significant medication errors. Findings include:  The AJN (American Journal of Nursing), Drug Administration Through an Enteral Feeding Tube, October 2009, stated, "...How well a given drug mixes into solution must be taken into account, or incomplete dosing might result. For example, sedimentation may be evident. To ensure that the patient receives the intended dosage ... the medicine cup, or oral syringe (or any combination of these) used in preparing the dose should be rinsed and the rinse solution administered ..."	F 760	A. R1 suffered no untoward effect and continues to reside in the facility. B. All residents requiring medication delivery via feeding tube have the potential to be affected by the alleged deficiency. C. E9 no longer works at the facility. Staff developer/designee will in-service all licensed staff regarding proper medication administration through a feeding tube. D. Staff developer/designee will observe two residents daily for proper medication administration via feeding tube daily times 14, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be	12/26/18	

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 760	<p>Continued From page 106 (<a href="https://www.nursingcenter.com/cearticle?an=00000446-200910000-00027&amp;Journal_ID=54030&amp;Issue_ID=935375">https://www.nursingcenter.com/cearticle?an=00000446-200910000-00027&amp;Journal_ID=54030&amp;Issue_ID=935375</a>)</p> <p>During a medication pass observation on 10/11/18 at approximately 9:10 AM the following was observed:</p> <p>E9 was observed administering four Oxycodone 5 mg tablets (total 20 mg), which had been crushed, to R1 via a G-tube for pain. After crushing the medication, E9 placed the crushed medication into a 120 ml cup and poured approximately 90 ml water in to it. E9 drew up the water and medication into a 60 cc syringe and injected it into the feeding tube. E9 drew up the remainder of the water and medication and injected it into the feeding tube. E9 then drew up approximately 50 ml water from a container and flushed the feeding tube. After capping the feeding tube, E9 discarded the 120 ml cup which had contained the water and medication. The surveyor immediately asked to see the cup. Upon viewing the interior of the cup, both E9 and the surveyor observed medication residue inside the cup. E9 proceeded to add water to the cup, swirled it around, drew up the medication and injected it into the feeding tube.</p> <p>During an interview immediately afterwards, E9 stated that next time she needed to put the light on in the room so she could see better. E9 stated that R1 did not like to have her over bed light put on.</p> <p>The facility failed to ensure that R1 received the entire dose of Oxycodone that was ordered by the physician. Failure to ensure there was no medication residue left in the cup created the</p>	F 760	reported quarterly through the facility QAPI process.		

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

PRINTED: 02/22/2019  
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>10/25/2018</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 760	Continued From page 107 potential for ineffective pain control for R1, resulting in a significant medication error.	F 760			
F 773 SS=D	Findings were reviewed and confirmed by E1 (NHA) and E2 (DON) during an interview on 10/11/18 at approximately 5:45 PM. Lab Srvc Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii)  §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined for one (R164) out of 57 sampled residents, the facility failed to promptly notify the ordering physician or nurse practitioner of significant laboratory (lab) results. For R164, an abnormal sodium, completed on 8/31/18, was not reported to E31 (Medical Director) until 9/3/18 when R164 declined and was sent to the ER for a significant change in status. Findings include:  Cross refer to F 684, example #3  Review of R164's record revealed the following:	F 773	A. R164 no longer resides in the facility. B. All residents have the potential to be affected by the alleged deficiency. C. All licensed staff will be in-serviced regarding notification of significant abnormal lab results to the physician/physician extender in a timely manner. Significant abnormal lab results will be communicated to the physician directly or by electronic communication and that interaction will be documented on the lab slip. D. Unit manager/designee will monitor lab results to include physician notification	12/26/18	

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 773	<p>Continued From page 108</p> <p>8/31/18- Review of the Order Recap Report for R164 listed a physician order by E31 for a CBC and a CMP (lab tests) one time only on 8/31/18.</p> <p>8/31/18- The blood specimen for the labs was collected at 12:43 PM and the results were faxed from the contracted lab to the facility at 5:10 PM. R164's CMP listed a high sodium level of 150 (normal range 135-145).</p> <p>9/3/18 12:46 PM- A nursing progress note, stated R164 was lethargic, unable to follow commands, and was seen by E31 (Medical Director).</p> <p>9/3/18 2:39 PM- A nursing progress note, stated E31 gave a "verbal order for sip-n-go program to keep resident hydrated..." The Order Recap Report stated, "Sip N Go. Offer at least 120 cc of water or appropriate fluid to resident Q (every) 1 hour and document total ml consumed. every (sic) hour for Fluid deficit for 4 days."</p> <p>9/3/18 2:52 PM- A nursing progress note, stated, "elevated Sodium. SIP N GO."</p> <p>9/3/18 4:28 PM- A nursing progress note, stated, "received a new order for... Labs: CBC, BMP..."</p> <p>9/4/18- A note was written on the bottom of the CMP dated 8/31/18 to recheck a CBC with the next lab draw. It remains uncertain who initialed the lab result.</p> <p>10/25/18 2:54 PM- E31 (Medical Director) was interviewed. When E 31 was shown 164's 8/31/18 sodium result of 150, E31 stated that his reaction was "it needs to be corrected, means not adequate intake."</p>	F 773	<p>daily times 14, weekly times two, then monthly until 100% compliance is achieved for two consecutive months. Results will be reported quarterly through the facility QAPI process.</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</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 773	Continued From page 109 Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.	F 773		
F 791 SS=D	The facility failed to report R164's abnormal lab value for a sodium of 150 (135-145), dated 8/31/18, to the physician (E31) until 9/3/18 when the resident experienced a significant decline in health.  Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5)  §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.  §483.55(b) Nursing Facilities. The facility-  §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;  §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;  §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of	F 791		12/26/18

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

PRINTED: 02/22/2019  
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>10/25/2018</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 791	<p>Continued From page 110</p> <p>what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;</p> <p>§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and</p> <p>§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for 2 (R141 and R156) out of 57 sampled residents, the facility failed to assist residents in obtaining dental services. Findings include:</p> <p>1. Review of R156's clinical records revealed the following:</p> <p>6/15/18 - R156 was admitted to the facility.</p> <p>6/15/18 - An oral evaluation, completed by E15 (LPN/UM) documented that R156 never wore dentures, but had missing teeth. R156 denied pain during the oral exam and had her own teeth.</p> <p>Although R156 was admitted with a partial upper denture, the above oral evaluation inaccurately documented that R156 never worn dentures.</p> <p>6/26/18 - A care plan was written for the potential</p>	F 791	<p>Example 1</p> <p>A. R156 had no untoward effect, continues to reside in the facility, and received the dentures on 11/4/18.</p> <p>B. All residents requiring dentures have the potential to be affected by the alleged deficiency.</p> <p>C. A policy was developed to ensure appropriate routine/emergency dental services are available as required at 483.55.</p> <p>D. Social worker/designee will monitor all residents requiring dental services as identified through grievances, requests by residents, inquiries from family members or clinical indications by staff for lost items, routine services and emergent needs (to be provided within three days per regulation) for appropriate follow-up weekly until 100% compliance is achieved for four consecutive weeks. Results will</p>		

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 791	<p>Continued From page 111</p> <p>for complications related to absence of teeth and R156 having an upper partial plate denture. The goal was that R156 would not have pain, signs or symptoms of infection, or weight loss within the next 92 days.</p> <p>8/27/18 - A resident lost and found form documented that R156's upper denture was missing and was last seen on 8/26/18.</p> <p>8/27/18 through 8/30/18 - Review of progress notes, lacked evidence that the facility promptly (within 3 days), referred R156 for dental services after the facility became aware of R156's missing denture. In addition, the facility failed to have evidence, that R156 was assessed, to ensure she was able to eat and drink adequately while awaiting dental services.</p> <p>9/6/18 - Consultation completed by E17 (Contracted Dentist) documented that R156 verbalized to E17, that she had worn an upper partial denture, however, R156 lost it. The plan was for E17 to send an estimate of the cost to replace the missing denture to the facility.</p> <p>10/16/18 - An electronic mail from E17, documented that R156's replacement denture was almost completed.</p> <p>10/23/18 at approximately 2:45 PM - An interview with E5 (Social Worker) revealed the facility did not currently have a policy on lost or missing dentures, however, E5 verbalized that the facility will be responsible for payment for the new denture.</p> <p>10/23/18 at approximately 3:10 PM - An interview with E1 (NHA) revealed the facility had a missing</p>	F 791	<p>be reported quarterly through the facility QAPI process.</p> <p>Example 2</p> <p>A. R141 continued to refuse dentures and no longer resides in the facility.</p> <p>B. All residents requiring dentures have the potential to be affected by the alleged deficiency.</p> <p>C. A policy was developed to ensure appropriate routine/emergency dental services are available as required at 483.55.</p> <p>D. Social worker/designee will monitor all residents requiring dental services as identified through grievances, requests by residents, inquiries from family members or clinical indications by staff for lost items, routine services and emergent needs (to be provided within three days per regulation) for appropriate follow-up weekly until 100% compliance is achieved for four consecutive weeks. Results will be reported quarterly through the facility QAPI process.</p>		



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

PRINTED: 02/22/2019  
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>10/25/2018</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 791	<p>Continued From page 112</p> <p>items policy, however, E1 confirmed the facility had not developed a policy, which identified circumstances when the loss or damage of dentures was the facility's responsibility and when the facility may not charge a resident for the loss or damage of dentures, determined in accordance with facility policy to be the facility's responsibility. Additionally, what actions would be taken, including promptly referring the resident for dental services and to perform an assessment of his/her ability to eat and drink adequately while awaiting dental services.</p> <p>Findings were reviewed with E1, E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC) on 10/25/18 at approximately 6:30 PM.</p> <p>2. Review of R141's clinical record revealed the following:</p> <p>9/17/12 - R141 was admitted to the facility.</p> <p>4/16/18 at 12:56 PM- A progress note stated that R141 went to a dental appointment for her dentures follow up. The note stated that R141's final impressions for her dentures were completed.</p> <p>10/15/18 at 10:26 AM - During an interview R141 stated that she saw a dentist months ago and was supposed to get dentures, but she still had not received them.</p> <p>10/23/18 at 4:44 PM- During an interview E5 (Social Services) and E6 (Social Services) stated that they were not employed at the facility back in April, when R141 had her final impressions for her dentures completed, and were unsure what</p>	F 791			

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

PRINTED: 02/22/2019  
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>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 GREENBANK ROAD</b> <b>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 791	<p>Continued From page 113</p> <p>happened with R141 getting her dentures. E5 stated that the dental office was called today and an appointment was set up for R141 to get her dentures on 10/24/18. E5 stated that R141's dentures bill was paid in full in August 2018, but the dental office never called saying the dentures were ready.</p> <p>10/23/18 at 4:49 PM - During an interview E13 (Staff Development) stated that due to the change in social service staff around May 2018 R141's dentures information was not passed on to the new employees. E13 stated that the dental office never called the facility to say that R141's dentures were ready, and the facility did not call the dental office to find out what was going on.</p> <p>The facility failed to assist R141 in obtaining dental services as evidenced by the facilities lack of follow up to ensure that R141 received her dentures.</p> <p>10/25/18 at approximately 6:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E13 (Staff Educator), and E14 (RNAC).</p>	F 791			



**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Health Care Quality  
Office of Long Term Care  
Residents Protection

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

**STATE SURVEY REPORT**

**NAME OF FACILITY: Brandywine Nursing & Rehab Center DATE SURVEY COMPLETED: October 25, 2018**

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><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from 10/11/18 through 10/25/18. 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 164. The survey sample size was 55.</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 the CMS 2567-L survey completed October 25, 2018: F583, F584, F585, F600, F609, F622, F623, F636, F644, F656, F660, F661, F677, F684, F686, F689, F693, F695, F697, F725, 744, F755, F760, F773 and F791.</p>	<p>Disclaimer Statement: Preparation and/or execution of this plan of correction (POC) does not constitute admission of or agreement to the facts and deficiencies alleged or conclusions set forth in the statement of deficiencies. Furthermore, no actions taken, or to be taken pursuant to this POC are an admission that additional steps should have or could have been taken to prevent any alleged deficiency. The POC is prepared and/or executed solely because it is required by the provision 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 10/25/2018 for F583, F584, F585, F600, F609, F622, F623, F636, F644, F656, F660, F661, F677, F684, F686, F689, F693, F695, F697, F725, 744, F755, F760, F773 and F791.</p>	<p>12/26/2018</p>

Provider's Signature 

Title ADMINISTRATOR

Date 12/7/2018