DELAWARE HEALTH AND SOCIAL SERVICES

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

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe **DATE SURVEY COMPLETED:** February 26, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility beginning February 16, 2024, and ending February 26, 2024. The facility census on entrance day of the survey was 110 (one hundred-ten). The survey sample size totaled 20 (twenty residents). The survey process included observations, interviews, review of resident clinical records, facility documents, facility policies and procedures, and complaint and incident documentation from the State Agency. **Abbreviations/definitions used in this state report are as follows:** AWD – Assistant Wellness Director; ED – Executive Director; CM – Care manager; CNA – Certified Nursing Assistant; LPN – Licensed Practical Nurse; RN – Registered Nurse; WD – Wellness Director; UAI – Uniform Assessment Instrument; Service plan / agreement - document developed with each resident that describes the services to be provided, who will provide the services, when the services will be provided, how the services will be provided, and if applicable, the expected outcome. Uniform Assessment Instrument – assessment to collect information on the physical condition, medical status and psychosocial needs of an	

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	applicant/resident to determine eligibility for an assisted living. **Assisted Living Facilities**	
3225	**Assisted living facility resident assistants shall,**	
3225.16.14	**at a minimum:**	A. Unable to correct the original deficient practice for E8, E9, E10 and E11. Deficient practice for the 3 of the employees listed was corrected on 2/28/24. 4th employee CM has been removed from the schedule until she completes the Fire & Life safety and Emergency Disaster Plan training. B. Potential for every new employee to be impacted. C. Root cause investigation showed that new employee orientation had been held once a month, so all new employees were not getting the required Fire & Life Safety, and Emergency disaster plan training prior their first shift. Moving forward, all new employees will meet with a manager prior to the start of their first shift to be oriented on Fire & Life Safety and Emergency disaster plan. D. All new employees will have a check list that will be signed by the employee and manager that is completing the Day 1 orientation. This form will be kept in the employee file. This was put into practice on 2/27/24. See next page for checklist.
3225.16.14.2	**Participate in a facility-specific orientation that covers the following topics:**	
3225.16.14.2.1	**Fire and life safety, and emergency disaster plans.** This requirement is not met as evidenced by: Based on record review and interview, it was determined that for four (E8, E9, E10 and E11) out of ten sampled staff members, the facility lacked evidence of fire and life safety, and emergency disaster plan training. Findings include: The following staff members have not received their required training: E8 (EE) Hire date 2/12/24. E9 (DS) Hire date 12/13/23. E10 (DS) Hire date 12/28/23. E11 (CM) Hire date 1/14/24. 2/26/24 1:00PM (approximately) – During an interview, E12 (HR Manager) confirmed that the above-mentioned staff members had not completed their fire and life safety, and emergency disaster plan training. She stated that the facility conducts orientation one a month, they will be attending the next orientation on 2/28/24. This surveyor explained the State regulations regarding orientation and that new staff members are to complete orientation prior to their	To be completed no later than 4/26/24

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	first shift, not a month or so later than their start date. 2/26/24 1:10 PM – During an interview, E1 (ED) stated that the facility has always held orientation monthly, regardless of hire date. In addition, E1 expressed that the regulations were unclear and do not specify that staff must attend orientation prior to working in the facility. 2/26/24 2:40PM - Findings were reviewed with E1(Executive Director), E2 (Wellness Director) and E3 (Assistant Wellness Director) at the exit conference. **Records and Reports**	
3225.19.0 **3225.19.1**	**The assisted living facility shall be responsible for maintaining appropriate records for each resident. These records shall document the implementation of the service agreement for each resident.** This requirement is not met as evidenced by: Based on record review and staff interview it was determined that for one (R12) out of twenty (20) sampled residents, the facility failed to maintain accurate documents for each resident. Findings include: Review of R12's clinical record revealed: 2/11/23 – R12 admitted to the memory care unit at the facility. 5/16/23 – A hourly check log revealed that E6 (CNA) had documented R12 as being checked on and in the bedroom at 11:00 PM, 12:00 AM, 1:00 AM, 2:00 AM, 3:00 AM, 4:00 AM and 5:00 AM.	A. We are unable to correct the original deficient practice as it had already occurred to resident R12. B. All residents are at risk for the deficient practice of falsification of documentation. All new employees will be given in-service during General Orientation about accuracy and timely documentation and company code of conduct about documentation, all current employees were also given an in-service on 5/18/23 about falsification of documentation and the anti-abuse policy. C. Root cause investigation was done at the time and it was shown that video footage showed that the resident had fallen and crawled to his bed but that he had not been checked on by employee E6. Employee was immediately terminated and was reported to DHQI. On 5/18/23 after this occurred, all staff were given an in-service about the requirement to

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	2/19/24 2:45 PM – An interview with E3 (AWD) revealed that the facility investigation included video footage that documented the times. E3 confirmed from the video footage that the R12 had fallen in his bathroom on 5/16/23 at approximately 11:38 PM. E3 also confirmed from the video footage that R12 had then crawled to his bed on 5/16/23 at approximately 11:48 PM. E3 confirmed from the video footage that E6 entered R12's room on 5/17/23 at approximately 5:01 AM, which was 5 hours and 23 minutes after R12 had fallen whereby not doing the hourly checks as was documented and required. E3 confirmed that E6 had not performed the hourly checks for R12 and that the hourly check log was signed off as completed. In the aforementioned note, E6 was noted to not have entered R12's room from 11:38 PM until 5:01 AM and signed off on the hourly check log as if she did. The facility failed to maintain accurate records when E6 falsified documentation. 2/26/24 2:40PM - Findings were reviewed with E1(Executive Director), E2 (Wellness Director) and E3 at the exit conference.	document in an accurate and timely manner as per policy. All staff were also given in-service on the anti-abuse policy (TRUST pledge) sheet attached. General Orientation is done by all Department Heads. The in-service that was done on 5/18/23 was done by Donna Winegar LNHA. D. Starting 4/22/24 the Wellness Director or designee will perform a weekly random audit of 10 resident hourly check sheets to ensure they are being done in a timely manner as per policy. Audit results will be reported to QI x two quarters, this will be for Q2 and Q3. Audits will start on 4/22/24
16 Del. Code Part II Ch. 11, Subchapter III **§1131**	**Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents** **Definitions.** **(12) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following:**	

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	a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety. This requirement is not met as evidenced by: Based on record review and staff interview, it was determined that for two (R9 and R12) out of five sampled residents for neglect, the facility failed to provide services necessary to avoid physical harm. Findings include: Review of R9's clinical record revealed: 10/27/18 – R9 was admitted to the memory care unit at the facility. 3/3/22 – A significant change Uniform Assessment Instrument (UAI) revealed R9 had a problem with her short-term memory, required occasional physical assistance for mobility and has a history of wandering. 3/4/22 – A Service Assessment revealed R9 was to have assistance using an escort with verbal cueing for activities, R9 needed reminders and redirection at least 4 times each shift for behavior management and R9 was residing on the memory care unit of the facility. 5/17/22 – A facility incident report revealed there was a scheduled group field trip on 5/17/22 where R9 had wandered away from the group. R9 was missing for approximately 5 to 10 minutes and was approximately 1000 feet away from the group. 5/18/22 2:45 PM – A nursing note documented by E4 (LPN) stated, R9 "... wandered off... on 5/17, alert, her usual self, sunburn on cheeks, no blistering, no s/s (signs/symptoms) pain...."	A. We are unable to correct the original deficient practice because it has already occurred for resident R9. B. All memory care residents have the potential to be affected by the original deficient practice so there will be a higher staff to resident ratio for group field trips. C. Root Cause investigation was done and it was determined that there needed to be more staff when residents from the memory care unit leave the community on group field trips which include leaving the bus. Starting 4/22/24 there will be a ratio of 1 staff member to 4 residents. Each staff member will be assigned 4 residents and they will be responsible for them and to know of their location at all times. The Inspiritas Coordinator or designee will be responsible for assigning the residents to the staff member and this will be

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	2/23/24 11:52 AM – An interview with E1 (NHA) and E2 (DON) confirmed that during the field trip on 5/17/22, R9 had wandered away for about 5 to 10 minutes, that C1 (non-facility member) had brought her back to the group and R9 was unharmed. The facility's lack of attention to the safety of R9 resulted in her wandering away and her whereabouts became unknown to staff for 5- 10 minutes. Review of R12's clinical record revealed: 2/11/23 – R12 admitted to the memory care unit at the facility. 3/12/23 – A 30-day Uniform Assessment Instrument (UAI) revealed R12 was independent with assistive device for mobility and unable to toilet self or self-manage incontinence. 3/12/23 – A Service Assessment revealed R12 was on 1-hour checks for a fall risk safety intervention. He required total care for toileting. 5/16/23 – A hourly check log revealed that E6 (CNA) had documented R12 as being checked on and in the bedroom at 11:00 PM, 12:00 AM, 1:00 AM, 2:00 AM, 3:00 AM, 4:00 AM and 5:00 AM. In the above note, R12 was checked on hourly. 5/17/23 5:10 AM – A facility incident report revealed that R12 was found lying on his back on the floor beside his bed with an abrasion to the back of his head on the upper right side and a skin tear to his left elbow.	documented on the Trip outing form, see attached. D. Starting 4/22/24 the new outing form will be used, they will be kept on file for each quarter in the Assistant Wellness Directors office. The outing documents will be reviewed at QI for two quarters for Q2 and Q3 A. We are unable to correct the original deficient practice because it has already occurred for resident R12. B. All Memory care residents have the potential to be affected, therefore all new employees will be given training during General Orientation, prior to them being assigned any shifts, about the TRUST pledge and timely and accurate documentation. C. Root cause investigation was done at the time and it was shown that video footage showed that the resident had fallen and crawled to his bed but that he had not been checked on by employee E6. Employee was immediately terminated and was reported to DHQI.

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	5/17/23 2:15 PM – A late nursing note by E4 (LPN) documented that R12 was not ambulating, had poor oral intake, in a lot of pain and had a change in mental status. R12 was sent to the emergency department for evaluation and left the unit at 9:55 AM. 5/17/23 10:00 PM – A nursing note by E5 (LPN) documented that R12 was admitted to the hospital for heart monitoring. 5/20/23 2:45 PM – A nursing note by E4 documented that R12 had passed away in the hospital. 2/19/24 2:45 PM – An interview with E3 (AWD) revealed that the facility investigation included video footage that documented the times. E3 confirmed from the video footage that the R12 had fallen in his bathroom on 5/16/23 at approximately 11:38 PM. E3 also confirmed from the video footage that R12 had then crawled to his bed on 5/16/23 at approximately 11:48 PM. E3 confirmed from the video footage that E6 entered R12's room on 5/17/23 at approximately 5:01 AM, which was 5 hours and 23 minutes after R12 had fallen whereby not doing the hourly checks as was documented and required. The facility's lack of attention to R12's toileting needs from the failure to do hourly checks resulted in an unwitnessed fall in the bathroom where R12 did not receive assistance for 5 hours and 23 minutes afterwards. 2/26/24 2:40PM - Findings were reviewed with E1 (Executive Director), E2 (Wellness Director) and E3 at the exit conference.	On 5/18/23 after this occurred, all staff given an in-service about doing visible hourly safety checks on all memory care residents. D. Staring 4/22/24 all hourly check sheets will be audited by the Assistant Wellness Director or designee and reported at QI for two quarters, Q2 and Q3. In addition the hourly check sheets will be discussed at the weekly Fall meeting between the WD and AWD. To start 4/22/24

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