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

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

STATE SURVEY REPORT

ıME OF FACILITY: Brookdale Hockessin

DATE SURVEY COMPLETED: November 7, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced annual and complaint survey was conducted at this facility beginning October 24, 2016 and ending November 7, 2016. The facility census on the entrance day of the survey was 46 residents. The survey sample was composed of five residents. The survey process included observations, interviews, review of resident clinical records, facility documents and facility policies and procedures. **Abbreviations/definitions used in this state report are as follows:** ED – Executive Director DHW – Director of Health and Wellness CNA-Certified Nurse's Aide AD – Assistant Director RN – Registered Nurse LPN – Licensed Practical Nurse FSD – Food Service Director UAI – Uniform Assessment Instrument – an assessment form used to collect information about the physical condition, medical status and psychosocial needs of an applicant/resident in order to determine eligibility for an assisted living facility.	The following is the Plan of Correction for Brookdale Hockessin regarding the Statement of Deficiencies dated November 7, 2016. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.	
3225 **3225.9.0** **3225.9.5.2**	**Regulations for Assisted Living Facilities** **Infection Control** **Minimum requirements for pre-employment require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public**	3229.9.5.2 1. 2 Step PPDs will be administered to Employees E5 and E6 2. All new hires and current associates have the potential to be affected by this deficient practice. A 100% audit of all associate files has been completed by the Business Office Manager/BOM to verify other associates are in compliance. All new hires will be protected by taking the corrective action(s) outlined below in #3. 3. The Business Office Manager and other appropriate management staff were re-educated on the existing policy. The Business Office	2/1/17

'rovider's Signature _____ Title Executive Director Date 1/6/17

IAME OF FACILITY: Brookdale Hockessin

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category. **This requirement is not met as evidenced by:** Based on personnel record review, it was determined that for two (2) of a sample of eleven (11) employees, the facility failed to have the required baseline two-step tuberculin skin test (PPD) done before starting employment. Findings include: Review of personnel records on 10/27/16 revealed E5 (LPN), start date 10/20/16 and E6 (CNA), start date 9/20/16, did not have the required PPD before their start dates. PPDs for both employees were done on 11/3/16 and 11/2/16, respectively.	Manager/HR Director will audit all new hire paperwork ongoing to assure a 2 Step PPD has been completed prior to their first day. The results of these audits will be reviewed with the Executive Director on a monthly basis. No new hire will be permitted to work until the required 2 Step PPD has been completed. 4. The Executive Director /Hiring Manager will be responsible for reviewing new hire paperwork for all associates prior to scheduling the associate for resident care.	
3225.9.6	**The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents as recommended by the Immunization Practice Advisory Committee of the Center for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against influenza must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.** **This requirement is not met as evidenced by:** Based on clinical record review it was determined that the facility failed to ensure that the refusal or administration of influenza vaccinations were documented for two residents (R1and R5) out of 5 sampled. Findings include: 1. Clinical record review revealed that documentation of the administration or refusal of the influenza vaccination for R1 was	3225.9.6 1. No corrective action can be taken for Resident R1 since the findings revealed the absence of administration or refusal of the influenza vaccine in a previous year. The DHW will review the medical record to determine whether the vaccine was administered or refused in 2016. If it is determined that it was not administered or refused, R1 will be offered the vaccine. Resident R5 is no longer in the facility so no corrective action can be taken. 2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3. 3. A 100% audit of current resident files will be conducted by the licensed nurse/designee to verify all current residents have either documentation of refusal (along with being informed of the risks and benefits of refusal) or will be offered the opportunity to obtain the flu vaccine for 2016. DHW / Designee will verify proper documentation is entered in the resident's medical record. Results of	2/1/17

IAME OF FACILITY: Brookdale Hockessin **DATE SURVEY COMPLETED: November 7, 2016**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	absent for the year 2015. Additionally documentation of the health risks involved due to refusal of the influenza vaccine was absent from the clinical record. These findings were reviewed with E1 (Executive Director, #1), E2 (Executive Director, #2), E3 (Assistant Director) and E4 (Director of Health and Wellness/RN) on 11/7/2016 at approximately 2:45 PM. 2. Clinical record review revealed that documentation of the administration or refusal of the influenza vaccination for R5 was absent for the year 2014. Additionally documentation of the health risks involved due to refusal of the influenza vaccine was absent from the clinical record. These findings were reviewed with E1 (Executive Director, #1), E2 (Executive Director, #2), E3 (Assistant Director) and E4 (Director of Health and Wellness/RN) on 11/7/2016 at approximately 2:45 PM.	the review will be shared with the Executive Director to assure compliance with the regulation. Corrective action will be taken for records found not in compliance which will include documentation of administration or refusal and re-training of staff on the importance of proper documentation. 4. After the review listed in #3 above has been completed, DHW/Designee will be responsible for completing audits of new move-ins as well as annual audits to verify ongoing compliance. Results of these audits will be provided to the Executive Director for review. The Executive Director will be responsible for directing additional corrective action which will include re-training and disciplining of staff that did not document properly based on audit findings	
3225.9.7	**The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless specifically, medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.** **This requirement is not met as evidenced by:** Based on clinical record review it was determined that the facility failed to ensure that refusals or the administration of	3225.9.7 1. The DHW (HWD) Community Nurse and/or designee will offer the pneumococcal vaccine to residents R3 and R4. The administration or refusal of the vaccine will be documented in their medical record. Resident R5 is no longer in the facility, so no corrective action can be taken. 2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3 3. A 100% audit of current resident files will be conducted by the licensed nurse/designee to verify all current residents have either documentation of being offered the Pneumococcal Vaccine (along with being informed of the risks and benefits of refusal) or will be offered the opportunity to obtain the vaccine	2/1/17

NAME OF FACILITY: Brookdale Hockessin

DATE SURVEY COMPLETED: November 7, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	pneumococcal vaccinations were documented for 3 residents (R3, R4 and R5) out of 5 sampled. Findings include: 1. Clinical record review revealed that documentation of the administration or refusal of the pneumococcal vaccination for R3 was absent for the year 2016. Additionally documentation of the health risks involved due to refusal of the pneumococcal vaccine was absent from the clinical record. These findings were reviewed with E1 (Executive Director, #1), E2 (Executive Director, #2), E3 (Assistant Director) and E4 (Director of Health and Wellness/RN) on 11/7/2016 at approximately 2:45 PM. 2. Clinical record review revealed that documentation of the administration or refusal of the pneumococcal vaccination for R4 was absent for the year 2016. Additionally documentation of the health risks involved due to refusal of the pneumococcal vaccine was absent from the clinical record. These findings were reviewed with E1 (Executive Director, #1), E2 (Executive Director, #2), E3 (Assistant Director) and E4 (Director of Health and Wellness/RN) on 11/7/2016 at approximately 2:45 PM. 3. Clinical record review revealed that documentation of the administration or refusal of the pneumococcal vaccination for R5 was absent for the year 2014. Additionally documentation of the health risks involved due to refusal of the pneumococcal vaccine was absent from the clinical record. These findings were reviewed with E1 (Executive Director, #1), E2 (Executive Director, #2), E3 (Assistant Director) and E4 (Director of Health and Wellness/RN) on 11/7/2016 at approximately 2:45 PM. **The resident assessment shall be**	for 2016. Proper documentation will be placed in the resident's medical record. Results of the review will be shared with the Executive Director to assure compliance with the regulation. Corrective action will be taken for records found not in compliance which will include documentation of administration or refusal and re-training of staff on the importance of proper documentation. 4. The DHW (HWD) Community Nurse/Designee will be responsible for completing audits of new move-ins as well as annual audits to verify ongoing compliance. Results of these audits will be provided to the Executive Director for review. The Executive Director will be responsible for directing additional corrective actions which will include re-training and disciplining of staff that did not document properly based on audit findings. 3225.11.4 1. For Resident R1, no corrective action can be taken for the UAI completed on 7/2/2015 since it lacked a date and signature by the resident or responsible party or the RN who completed it. Resident R2 is no longer in the community, so no additional corrective action can be taken. 2. All residents have the potential to be affected by this deficient practice. The DHW (HWD) Community Nurse and other licensed nurses have been provided re-education related to this requirement by 1/15/2017. 3. The DHW (HWD) Community Nurse and/or designee will review resident 100% of current resident's medical records to verify resident UAIs have been signed and dated by	2/1/17

AME OF FACILITY: Brookdale Hockessin DATE SURVEY COMPLETED: November 7, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3225.11.4	**completed in conjunction with the resident.** **This requirement is not met as evidenced by:** Based on clinical record review it was determined that the facility failed to complete the UAI (Uniform Assessment Instrument) with dates and signatures in conjunction with 2 residents (R1and R2) out of 5 sampled. Findings include: 1. Review of the annual UAI (Uniform Assessment Instrument) dated 7/2/2015 revealed the absence of the signature and date signed by R1 or her representative and a facility staff RN. These findings were reviewed with E1 (Executive Director, #1), E2 (Executive Director, #2), E3 (Assistant Director) and E4 (Director of Health and Wellness/RN) on 11/7/2016 at approximately 2:45 PM. 2. Review of the UAI completed 30 days after admission and dated 6/27/2015 revealed the absence of the signature and date signed by R2 and/or his representative. These findings were reviewed with E1 (Executive Director, #1), E2 (Executive Director, #2), E3 (Assistant Director) and E4 (Director of Health and Wellness/RN) on 11/7/2016 at approximately 2:45 PM.	the resident or representative and by the nurse who completed the UAI. Corrective action which will include the re-training of staff on how to properly complete a UAI will be taken to assure proper dates and signatures are placed on the UAI. Results of the review will be shared with the Executive Director to assure compliance with the regulation. 4. The DHW (HWD) Community Nurse/Designee will be responsible for completing audits of new move-ins as well as conducting quarterly audits to verify ongoing compliance. Results of these audits will be provided to the Executive Director for review. Based on audit findings, the Executive Director will be responsible for directing additional corrective actions which will include re-training and progressive discipline of staff that did not properly sign and date the UAI.	
3225.11.5	**The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** **This requirement is not met as evidenced by:** Based on clinical record review it was determined that the facility failed to ensure that the UAI (Uninform Assessment Instrument) was updated annually for one	3225.11.5 1. Resident R1 will have their annual UAI updated for 2016. 2. All residents have the potential to be affected by this deficient practice. The DHW (HWD) Community Nurse and other licensed nurses have been provided re-education related to this requirement by 1/15/2017. 3. The DHW (HWD) Community Nurse and/or designee will review 100% of current resident's medical records to verify resident UAIs have been updated annually Corrective action which will include the re-	2/1/17

NAME OF FACILITY: Brookdale Hockessin

DATE SURVEY COMPLETED: November 7, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	resident (R1) out of five sampled. Findings include: Review of the R1's clinical record revealed the absence of an annual UAI effective after 7/2/2016. Instead the current annual UAI located in the clinical record was dated 7/2/2015. These findings were reviewed with E1 (Executive Director, #1), E2 (Executive Director, #2), E3 (Assistant Director) and E4 (Director of Health and Wellness/RN) on 11/7/2016 at approximately 2:45 PM. **Services**	training of staff on how to properly annually update a UAI will be taken to assure that UAIs are updated annually. Results of the review will be shared with the Executive Director to assure compliance with the regulation. 4. The DHW (HWD) Community Nurse/Designee will be responsible for completing audits of new move-ins as well as conducting quarterly audits to verify ongoing compliance with UAI updates. Results of these audits will be provided to the Executive Director for review. Based on the audit findings, the Executive Director will be responsible for directing additional corrective action which will include re-training and progressive discipline of staff that did not properly annually update the UAI.	
3225.12.0 3225.12.1 3225.12.1.3	**The Assisted Living Facility shall ensure that:** **Food service complies with the Delaware Food Code** **This requirement is not met as evidenced by:** Based on observations, interviews and record review, it was determined that the facility failed to comply with sections: 2-301.14 (E) (I), 3-305.11 (A) (2), 3-501.17 (D) (3), 4-501.11, and 4-601.11 of the State of Delaware Food Code. **2-3 Personal Cleanliness** **2-301 Hands and Arms** **2-301.14 When to Wash** FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (E) After handling soiled EQUIPMENT or UTENSILS (I)After engaging in other activities that contaminate the hands. **This requirement is not met as evidenced**	3225.12.1.3 1. Employee F3 and F2 received re-education provided by the Dietary Services Manager. Observations will be conducted in an on-going manner and additional corrective action, up to and including termination, may occur, if deficient practices continue. 2. Residents have the potential to be affected by the alleged deficient practice, therefore all Food Service Associates were re-educated by the Dietary Services Manager/Designee on (date) regarding Proper Hand washing 3. The FSD and/or designee will observe food service employees weekly x 1 month to verify compliance. Observations will occur for 30 days or until 100% compliance with hand washing techniques have been achieved, then ongoing as deemed appropriate by audit findings. Re-training will be provided as necessary and scheduled yearly.	2/1/17

AME OF FACILITY: Brookdale Hockessin **DATE SURVEY COMPLETED: November 7, 2016**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	by: 1. On 11/4/16, food service staff F3 was observed at 11:05 AM wiping excess water from the counter near the dish machine and then handling clean plates with bare hands without first washing her hands, and placing them in the plate warmers. 2. On 11/4/16, food service staff F2 was observed at 11:25 AM taking a rack with clean water goblets and turning the goblets right side up, holding the goblets at the rim with bare hands without first performing handwashing. **3.3 Protection from Contamination after Receiving** **3-304 Preventing Contamination from Equipment, Utensils, and Linens** **3-304.15 Gloves, Use Limitation** (A) If used, SINGLE-USE gloves shall be used only for one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. **This requirement is not met as evidenced by:** On 10/26/16 during the kitchen inspection between 12:20 PM and 12:40 PM, food service staff F4 was observed in the dish room handling both dirty dishes, which he placed into a rack and ran through the dish machine, and clean dishes after washing, wearing the same pair of gloves. **3.305 Preventing Contamination from the Premises** **3-305.11 Food Storage** (A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD (2) Where it is not exposed to splash, dust, or other contamination **This requirement is not met as evidenced**	The results of the random observations will be reviewed by the Executive Director. 4. The Executive Director and/or designee will conduct random observations for 30 days after 100% compliance as stated above has been achieved. The observations will continue until the Executive Director is assured 100% compliance has been achieved. 3-304.15 1. Employee F4 will receive re-training on the proper use of gloves. 2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3. 3. The FSD will provide in-service training for food service employees on proper use of single use gloves. The FSD and/or designee will observe food service employees to assure compliance. Observations will occur for 30 days or until 100% compliance with infection control methods have been achieved. Re-training will be provided if necessary. The results of the observations will be reviewed by the Executive Director. 4. The Executive Director and/or designee will conduct observations for 30 days after 100% compliance as stated above has been achieved. The observations will continue until the Executive Director is assured 100% compliance has been achieved. 3.305.11 1. The FSD immediately had the bins cleaned and the scoop	2/1/17 2/1/17

NAME OF FACILITY: Brookdale Hockessin DATE SURVEY COMPLETED: November 7, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	by: 1. Kitchen observations made from 9:10 AM-9:45 AM on 10/31/16 found three (3) large bins containing dry goods with debris coming from the contents of each bin scattered on top of their respective lids. In addition, lids over the flour and sugar bins were not covering the bins completely, leaving a space of at least 1 inch between lid and bin. A scoop was also observed inside the sugar bin. 2. On 10/28/16 at 9:25 AM, the ice machine was observed to have areas of rust-colored surface on the right hand side of the panel located toward the back of the ice bin. In an interview on 10/28/16 at 12:25 pm, F1 (Food Service Director) stated the ice machine was cleaned every month by maintenance. Review of ice machine year-to-date cleaning schedule revealed monthly dates for cleaning, the last entry made being 10/20/16. 3. On 11/416 at 10:48 AM, the chains suspended from the ceiling and attached to a rectangular heating lamp above the tray line steam table, were observed to be coated with dust. **3-5 Limitation of Growth of Organisms of Public Health Concern** **3-501 Temperature and Time Control** **3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking** (D) A date marking system that meets the criteria stated in ¶¶ (A) and (B) of this section may include: (3) Marking the date or day the original container is opened in a FOOD ESTABLISHMENT, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (B) of this section	removed. The ice machine was cleaned on 10/20/16 and will be cleaned monthly or more frequently as needed. The ceiling chains will be cleaned and monitored for frequent cleaning. 2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3. 3. The FSD will provide training for food service employees on the proper techniques for food storage and equipment cleaning. The FSD and/or designee will observe food service employees for proper food storage and equipment cleaning. The ice machine will be cleaned monthly and documented on ice cleaning logs. Observations will occur for 30 days or until 100% compliance with proper food storage and equipment cleaning has been achieved. Re-training will be provided if necessary. The results of the observations will be reviewed by the Executive Director. 4. The Executive Director and/or designee will conduct observations for 30 days after 100% compliance as stated above has been achieved. The audits will continue until the Executive Director is assured 100% compliance has been achieved. 3-501.17 1. Food will be labeled with the date opened. 2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in	12/1/17

NAME OF FACILITY: Brookdale Hockessin **DATE SURVEY COMPLETED: November 7, 2016**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	This requirement is not met as evidenced by: On 10/31/16, during kitchen inspection from 9:10 AM-9:45 AM, two (2) 1 quart cartons of heavy whipping cream were observed to be open in the walk-in refrigerator with no label indicating the date each one was opened. **4-5 Maintenance and Operation** **4-501 Equipment** **4-501.11 Good Repair and Proper Adjustment** (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. **This requirement is not met as evidenced by:** On 10/31/16 at 9:45 AM, a second inspection of the inside of the ice machine was conducted with E1 (Administrator). E1 confirmed that the panel inside the ice bin had dark brown areas on the surface. Additionally, a thin, black rubber strip on the right hand side of the upper part of the ice machine above the ice bin, was observed protruding from the side of the machine it was nestled in. On 11/4/16 at 11:45 AM, a revisit of the ice machine revealed cold air from inside the machine escaping through the 2 joints (hinges) connecting the cover to the ice bin. Examination of the ice bin cover showed the cover not closing properly at the hinges, creating a space through which particles or liquid could potentially get inside, contaminating the ice cubes. **Service Agreements** **3225.13.0 A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident should participate in the development of the**	#3. 3. The FSD will provide training for food service employees on the proper techniques for food labeling. The FSD will develop a procedure on when to discard our use food based on the labeled open date. The FSD and/or designee will observe food service employees proper labeling and discarding open food items. Observations will occur for 30 days or until 100% compliance procedure has been achieved. Re-training will be provided if necessary. The results of the observations will be reviewed by the Executive Director. 4. The Executive Director and/or designee will conduct observations for 30 days after 100% compliance as stated above has been achieved. The audits will continue until the Executive Director is assured 100% compliance has been achieved 4 – 501.11 1. The inside panel of the ice machine will be cleaned weekly by food service employees. The thin rubber strip was repositioned. The Maintenance Director will examine the hinges and repair if needed. 2. All residents have the	2/1/17

NAME OF FACILITY: Brookdale Hockessin

DATE SURVEY COMPLETED: November 7, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	agreement. The resident and the facility shall sign the agreement and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement. **This requirement is not met as evidenced by:** Based on clinical record review it was determined that the facility failed to complete service agreements for two residents (R2 and R3) out of five sampled. Findings include: 1. Review of R2's clinical record revealed that the initial service agreement was developed without a signature and the date signed by R2 and/or her representative and a facility staff member. These findings were reviewed with E1 (Executive Director, #1), E2 (Executive Director, #2), E3 (Assistant Director) and E4 (Director of Health and Wellness/RN) on 11/7/2016 at approximately 2:45 PM. 3. Review of R3's clinical record revealed that the initial service agreement dated 5/27/2016 was developed without a signature and date signed by R3 and/or his representative and a facility staff member. These findings were reviewed with E1 (Executive Director, #1), E2 (Executive Director, #2), E3 (Assistant Director) and E4 (Director of Health and Wellness/RN) on 11/7/2016 at approximately 2:45 PM.	potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3. 3. The FSD Director or designee will check the ice machine daily for cleanliness, gasket and hinge placement. Corrective action will be taken. 4. The Executive Director or designee will conduct weekly inspections of the ice machine for three months to determine compliance with #3 above. 3225.13.1 1. Resident R2 is no longer in the community; no corrective action can be taken. Resident R3 will have a new service agreement executed and dated and signed by the RN and resident or resident representative. 2. All residents have the potential to be affected by this deficient practice. The RN/DHW (HWD) Community Nurse/Designee was provided re-education of this requirement by the Executive Director. 3. The DHW (HWD) Community Nurse and/or designee will audit 100% of current resident medical records to determine whether resident service agreements have been dated and signed by the community staff member, resident and/or representative. Additional corrective action	3/1/17
3225.13.5	**The service agreement shall be developed and followed for each resident consistent with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.** **This requirement is not met as evidenced by:** Based on clinical record review it was determined that the facility failed to implement a service agreement with goals		

NAME OF FACILITY: Brookdale Hockessin **DATE SURVEY COMPLETED: November 7, 2016**

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	and interventions that addressed actual falls sustained by one resident (R1) out of 5 sampled. Findings include: Clinical record review of the service agreement revealed that the facility failed to include goals with time frames and specific interventions to address two falls sustained by R1. Additionally the facility failed to review and revise the service agreement and to develop, implement and monitor the effectiveness of goals and interventions that addressed the fall risk and actual falls sustained by R1. These findings were reviewed with E1 (Executive Director, #1), E2 (Executive Director, #2), E3 (Assistant Director) and E4 (Director of Health and Wellness/RN) on 11/7/2016 at approximately 2:45 PM.	Additional corrective action which will include staff re-training will be taken if necessary as well as disciplinary actions to assure that service agreements have been updated correctly. Results of the will be shared with the Executive Director to verify compliance with the regulation. 4. Based on audit findings, the Executive Director will be responsible for directing additional corrective actions, which will include progressive discipline to assure ongoing compliance.	
3225.13.6	**The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated.** **This requirement is not met as evidenced by:** Based on clinical record review it was determined that the facility failed to ensure that a service agreements was reviewed and revised in conjunction with each UAI for one resident (R1) out of 5 sampled. Findings include: Review of R1's clinical record revealed the service agreement dated 11/4/2015 was developed approximately four months after completion of the annual UAI dated 7/2/2015. Further review of the clinical record revealed no presence of a service agreement developed within 10 days and in conjunction with the annual UAI dated 7/2/2015. Additionally the service agreement dated	3225.13.25 1. Resident R1's service agreement will be updated with specific goals and interventions to address the potential for future falls. 2. All residents at risk for falls have the potential to be affected by this deficient practice. The DHW (HWD) Community Nurse/ designee has re-educated the appropriate staff on the requirements for all service agreements, as well as the existing Falls Management requirements. All residents will be protected by taking the corrective action(s) outlined below in #3. 3. Residents who have fallen in the past 30 days or who are at risk for falls will have their service plans audited by the DHW (HWD) Community Nurse/Designee to verify appropriate requirements are present. Corrective action which will include staff re-training will be taken to assure that service agreements have been updated correctly. Results of the review will be shared with the Executive Director to assure compliance with the regulation. 4. Based on audit findings, The Executive Director will be	2/1/17

NAME OF FACILITY: Brookdale Hockessin

DATE SURVEY COMPLETED: November 7, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	11/04/2015 was incomplete without the signature and date signed by R3 and/or her representative and a facility staff member. These findings were reviewed with E1 (Executive Director, #1), E2 (Executive Director, #2), E3 (Assistant Director) and E4 (Director of Health and Wellness/RN) on 11/7/2016 at approximately 2:45 PM.	responsible for directing additional corrective actions which include will be progressive discipline of staff. 3225.18.2 1. No corrective action can be taken for the fire drills with missing attendance records since the timeframe has passed. 2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3. 3. Required fire drills will be conducted according to regulation and staff attendance will be recorded after each drill. The Director of Maintenance will review Fire Drill Reports to determine whether staff attendance has been recorded. Corrective action will be taken to record staff attendance. A report will be given to the Executive Director after each Fire Drill. 4. The Executive Director will continue to review Fire Drill Reports until 100% compliance has been achieved.	2/1/17
3225.18.0 3225.18.2	**Emergency Preparedness** **Regular fire drills shall be held at least quarterly on each shift. Written records shall be kept of attendance at such drills.** **This requirement is not met as evidenced by:** Based on review of fire drill records it was determined that the facility failed to maintain documentation of all fire drills. Findings include: Review of fire drill records for the year 2015 revealed that the facility failed to maintain fire drill records for the following shift: 7-3 shift for the first quarter of 2015 Review of facility fire drill records from October 2014 through September 2016 revealed that the facility failed to maintain written records of attendance for the following fire drills: April 2015, 7-3 shift February 2015 February 2016, 3-11 shift These findings were reviewed with E1 (Executive Director, #1), E2 (Executive Director, #2), E3 (Assistant Director) and E4 (Director of Health and Wellness/RN) on 11/7/2016 at approximately 2:45 PM.		
3225.18.3	**Each facility shall develop and maintain all-hazard emergency plans for evacuation and sheltering in place. The plan must be submitted to the Division and DEMA in a digital format and it must conform to the template prescribed by the Division.** **This requirement is not met as evidenced**	3225.18.3 1. A separate emergency food inventory and water supply is being maintained by the facility. 2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3. 3. The FSD and/or designee will conduct a monthly review of emergency food and water inventory to determine whether the existing inventories are adequate to meet the needs of the residents. The emergency food will match the emergency menu which is kept with the emergency food supplies. The	2/1/17

NAME OF FACILITY: Brookdale Hockessin

DATE SURVEY COMPLETED: November 7, 2016

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	by: Based on observation, interview and record review, the facility failed to ensure that an emergency plan is developed and implemented for the foodservice department. Findings include: During the inspection of the food service pantry on 10/26/16 at 12:40 PM with E1 (Administrator) and F1 (Food Service Director), a set of emergency menus was observed posted in the back of the room between two food storage racks. When asked about the food service department's emergency inventory in an interview with F1 (Food Service Director) and E1 (Administrator) on 10/26/16 at 12:45 PM during the inspection, F1 (Food Service Director) stated the department did not have a separate inventory for emergency; instead, the department would just use existing food inventory. E1 (Administrator) stated there was no emergency drinking water stored in the kitchen due to limited space. F1 (Food Service Director) and E1 (Administrator) were unable to give information on the number of people the department planned to provide meals/water for in an emergency and did not know about the amount of water to plan for each person and for how many days. Review of the Brookdale Senior Living emergency preparation policies (16.02) revealed each community (Brookdale facility) shall be responsible for the development of emergency plans for the Dining Services department that shall include emergency menu cycles, emergency contacts, an emergency supply of food and water that will be maintained and rotated on a regular basis.	FSD will take corrective action to update the inventories if needed. The Monthly reviews will be shared with the Executive Director. 4. The Executive Director will conduct audits of the emergency food and water inventories until 100% compliance has been achieved. 3225.19..2 1. Resident R1's service agreement will be reviewed to address the physical needs of the resident and appropriate goals will be established to provide for a safe environment. 2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3. 3. The DHW (HWD) Community Nurse and/or designee will review 100% of current resident service agreements to verify appropriate goals and interventions are in place to provide a safe environment for residents. Corrective action which will include staff re-training will be taken to assure that service agreements have been updated correctly. Results of the review will be shared with the Executive Director to assure compliance with the regulation. 4. The Executive Director will review initial audit findings and direct additional corrective action including progressive discipline of staff based on audit findings. ED will further conduct audits of 10% of the service plans until 100% compliance has been achieved.	2/1/17
3225.19.0 3225.19.5	**Records and Reports** **Incident reports, with adequate documentation, shall be completed for each incident. Records of incident reports shall be retained in the facility files for the**		

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3225.19.5.1 3225.19.7 3225.19.7.2	**following:** **All reportable incidents.** **Reportable incidents include:** **Neglect as defined in 16 Del.C. §1131 Section 1131 Definitions.** When used in this subchapter the following words shall have the meaning herein defined. To the extent the terms are not defined herein, the words are to have their commonly accepted meaning. **(10) "Neglect" shall mean:** **a. Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals and safety.** **This requirement is not met as evidenced by:** Based on clinical record review and review of facility documents it was determined that the facility failed to provide a safe environment for one resident (R1) out of five sampled who had a history of falls. Findings Include: Review of the clinical record revealed that R1 had diagnoses that included high blood pressure, osteoarthritis, glaucoma, legal blindness and depression. R1 was also receiving hospice care. According to the annual UAI dated 7/2/2015 R1 was oriented to place and person. Although R1 was assessed with intact short-term memory and long-term memory and hearing aids were used because of hard of hearing. The annual UAI dated 7/2/2015 also revealed that R1 required physical assistance while seated in a wheelchair for mobility and standby/transfer assistance during toileting and transfers. The section of the UAI, Fall Risk Assessment, revealed R1 was at risk for falls due to orthostatic hypotension, osteoporosis, impaired balance and a history of TIAs (transient ischemic attacks/mini	3225.19.7.5 1. Resident R 5 is no longer in the facility. No correct action can be taken. 2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3. 3. The Executive Director reviewed the Elopement Policy and Procedure and will provide in-service training to staff which will include a review of when to complete and submit an incident report. Quarterly Elopement Drills will be conducted by the director of Maintenance as a means to determine compliance with policy and procedure. Corrective action will be taken if needed including staff re-training. 4. The Executive Director will review the Elopement Drill Reports as a means of determining ongoing compliance.	a/1/17

NAME OF FACILITY: Brookdale Hockessin

DATE SURVEY COMPLETED: November 7, 2016

SECTION	STATEMENT OF DEFICIENCIES **Specific Deficiencies**	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	stroke). Further review of the clinical record revealed nurse's note dated 2/6/2016 and timed 8:15 PM that stated (R1 was found sitting on the floor with lower legs and feet under the side of her bed. R1 sustained no injury. Another nurse's note documented 4/13/2016 at 5:15 AM revealed that during morning care, E8 (CNA) observed R1 had sustained a bruised right knee. E7 (LPN) also observed that R1's right knee was swollen and asked if she had fallen. According to the nurse's note R1 responded "yes but would not say when." Another nurse's note documented by E7 at 7:30 AM on 4/13/2016 stated that a bruise was also noted laterally to R1's right eye. X-rays of R1's skull and right knee ordered by her physician and obtained during the day shift, 4/13/2016, revealed no fractures. On 4/14/2016 R1 was moved to a hospice unit located within an acute care facility for pain management and returned to the assisted living facility on 4/20/2016. An investigation conducted by the facility of the injuries sustained by R1 on 4/13/2016 was completed by the facility with unknown etiology of the incident. The facility failed to provide a safe environment for R1 who sustained one fall without injury and a second fall with injuries. This finding was reviewed with E1 (Executive Director, #1), E2 (Executive Director, #2), E3 (Assistant Director) and E4 (Director of Health and Wellness/RN) on 11/7/2016 at approximately 2:45 PM.		
3225.19.7.5	**Resident elopement.** **This requirement is not met as evidenced by:** Based on review of the clinical record and facility documents it was determined that the facility failed to complete and to report an incident with adequate documentation of elopement for one resident (R5) out of 5		

NAME OF FACILITY: Brookdale Hockessin

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	sampled. Findings include: Review of R5's clinical record revealed a nurse's note dated 6/4/2014 and timed 6:00 AM that stated "...nurse heard alarm on front door and observed R5 past lobby door outside...attempted to redirect R5 back inside facility...R5 ambulated back into facility...proceeded to own room". This finding was reviewed with E1 (Executive Director, #1), E2 (Executive Director, #2), E3 (Assistant Director) and E4 (Director of Health and Wellness/RN) on 11/7/2016 at approximately 2:45 PM.		