DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY Complete Care at Brackenville LLC **DATE SURVEY COMPLETED:** February 14, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An Annual and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 02/11/25 - 02/14/25 Survey Census: 99 Sample Size: 38 Supplemental Residents:7		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of 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.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed February 14, 2025: F554, F565, F578, F700 and F725.	Cross reference plan of correction for 2567 for deficiencies received as a result of survey ending February 14, 2025 Ftags, F554, F565, F578, F700, F725 with an alleged compliance date of March 26, 2025	March 26, 2025

Provider's Signature _____ Title Administrator Date 3/4/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085042	A. BUILDING _____ B. WING _____	C 02/14/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality on 02/11/25 through 02/14/25. The facility was found to be in substantial compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS An Annual and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 02/11/25 - 02/14/25 Survey Census: 99 Sample Size: 38 Supplemental Residents:7	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews, and facility policy review, the facility failed to determine if one of one resident (Resident (R) 66) was assessed as clinically appropriate to self-administer medications of 38 sample residents. The failure of the facility to leave medications at the bedside unattended prior to an	F 554	R66 was immediately assessed for self-administration of medications and was determined to meet the criteria. A physician's order was obtained from the Nurse Practitioner to allow resident R66 to take medications at bedside without supervision. LPN 4 was promptly	3/26/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/07/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 554	Continued From page 1 assessment, created an unsafe environment for the residents and other residents in the area. Findings include: Review of the facility's undated policy titled, "Resident Self Administration of Medications" revealed "It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely ...11. The care plan must reflect resident self-administration and storage arrangements for such medications." Review of R66's electronic medical record (EMR) undated "Admission Record" located under the "Profile" tab, indicated the resident was admitted to the facility on 06/12/22 with diagnoses of diabetes mellitus, arteriosclerotic heart disease, spinal stenosis, and hypertension. Review of R66's EMR quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ADR) of 12/03/24 indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident did not demonstrate any upper extremity impairment and required only set up assistance with oral hygiene and eating. Review of R66's EMR "Care Plan" located under the "Care Plan" tab, indicated a care plan for the resident to self-administer her medications had not been developed. Review of R66's EMR revealed no assessments	F 554	educated by the Director of Nursing on the policy for Resident self-administration of medication. Current residents with a BIMS of 12 or greater have the potential to be affected by this deficient practice. A whole house audit was conducted to identify any other residents that may have been left unattended with medications. Any residents identified were assessed and evaluated for their ability to self-administer medication according to facility policy, and physician's orders were updated accordingly. Root cause: The facility determined current Licensed Nursing staff lack adhering to the Medication self-administration policy and require re-education on this policy. Nurse Practice Educator/Designee will reeducate current licensed nursing staff on the policy for Resident self-administration of medications with a focus on the importance of direct supervision during medication administration. Additionally, current licensed nurses will be educated by Staff Development nurse or designee to conduct a self-administration of medication assessment and notify the Interdisciplinary Team which will then determine if self-administration is appropriate for that resident. Director of Nursing/ Designee will	

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F 554	Continued From page 2 were conducted related to self-administration of medications. During an observation on 02/11/25 at 10:09 AM, Licensed Practical Nurse (LPN) 4 walked out of R66's room. The resident's overbed table had two medicine cups. One cup contained approximately eight pills, and the other cup contained approximately 20 cc's (cubic centimeters) of red liquid. The resident was removing the pills and placing them on top of her overbed table. She was able to identify what each pill was as she removed them from the medication cup. She stated that most of the nurses left them for her to take except the agency nurses, they always waited until she took them all before they left. During an interview on 02/11/25 at 10:15 AM, LPN4 stated that the resident liked to take her own medications. LPN4 stated R44 would pour them out, identify them and let them know if anything was missing. She stated she typically did not leave the residents medications; she watched her take them. LPN4 stated R44 just did not like anyone hovering over her. She stated she was not sure if the resident was assessed, or care planned to take her own medications. During an interview on 02/13/25 at 10:44 AM, the Director of Nursing (DON) stated the nurse should have stayed nearby until the resident took all of her medications. DON stated the resident was capable and preferred to take her own medicine. DON stated she did not keep her medication in her room, the nurse had to give it to her.	F 554	conduct random audits of medication administration to ensure Licensed Nurses are not leaving medications at the bedside for those residents who are not assessed to self-administer medications. Audits will be conducted three times a week across all shifts and nursing units until 100% compliance is achieved, then, weekly audits x 3 weeks across all shifts and nursing units, until 100 % compliance is achieved, then monthly x 3 months, across all shifts and nursing units, until 100% compliance is achieved. Results of the audits will be presented in the monthly QAPI meeting to review trends and to determine if any further action is needed	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)	F 565		3/26/25

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F 565	Continued From page 3 §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to act promptly on the grievances and	F 565	. The administrator met with residents R298, R12, R65, R18, and R57 to discuss	

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F 565	Continued From page 4 recommendations of the resident council group for seven of 12 months of resident council minutes reviewed and to the extent practicable, the facility staff failed to revise or develop new policies related to resident rights, life, and care. These failures resulted in resident concerns going unaddressed. Findings include: During a group meeting on 02/12/25 at 3:51 PM with five residents (R), R298, R12, R65, R18, and R57, each resident attending the group meeting was listed on previous month's resident council meeting notes list of attendees. The group of residents indicated they reported the same concerns at every monthly meeting but did not receive an explanation or resolution to their concerns and continued complaints. The group also reported in agreement that the administrator "took over" in the monthly resident council meeting and was rude to the residents during the meeting. Resident council meeting notes dated March 2024 documented that a resident complained that the towels smell bad and have stains on them when returned from the laundry. No documentation could be provided that the grievance had been addressed or resolved. Residents wanted to know why their grievances and concerns were never addressed or resolved. The Activity Director stated it was out of her hands and that the grievance officer, the Administrator, would let them know. Resident council meeting notes dated May 2024 documented several residents reported the towels smell bad when returned from the laundry.	F 565	their concerns and ensure their concerns were acknowledged and are being addressed and assure them their concerns will be prioritized moving forward. 2.Current residents who attend resident council meetings have the potential to be affected by the deficient practice. The administrator/designee will review the resident council meeting minutes from the last 90 days to identify any outstanding grievances or concerns that have not been addressed or acted upon. Any grievances or concerns identified as not acted on will be assigned to the appropriate manager based on the issue to ensure timely responses for each item. Items will be resolved by 3/26/25. 3 Root Cause: The facility determined grievances and concerns from the Resident Council were not systematically tracked or monitored in a consistent manner, leading to missed follow-up and delayed actions. The facility will implement an enhanced process to track and monitor grievances and concerns received from resident council minutes to ensure the grievances and concerns are addressed in a timely manner. The enhanced process includes an electronic tracking spreadsheet that the administrator logs all grievances in. Each grievance and concern are reviewed daily by Administrator during stand-up morning meeting with the relevant departments to ensure timely follow-up and resolution. The Administrator will educate the current	

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F 565	Continued From page 5 No documentation was provided to indicate the grievance was resolved. Subsequent grievance regarding laundry were reported during the meetings. Resident council meeting notes dated June 2024 documented a grievance that the CNA staff were no longer hanging up clean clothes that returned from the laundry staff that has resulted in piles of clothing on a chair instead of placed in drawers are their closet. No documentation could be provided that indicated the grievance was resolved. Review of resident council meeting notes dated July 2024, voiced complaints of clothing being returned with stains. No documentation was provided to indicate the issue was resolved. Review of resident council meeting notes dated September 2024, documented complaints that resident's towels came back from the laundry looking dirty, smelly, and scratchy. One unnamed resident said she has complained for several months about her toilet leaking under the ring seal, not flushing properly, and running all the time. A complaint regarding the slamming of the kitchen door during council meetings is distracting and would like for "something to be done." A complaint regarding the broken TV in the east dining room and would like for it to be fixed to be used for activities in the dining room. No documentation could be provided that indicated these grievances and concerns had been resolved. Review of resident council meeting notes dated 10/28/24 documented complaints from residents that their laundry is returned with bleach stains	F 565	department heads on the enhanced process to ensure timely follow-up of grievances and concerns and stress the importance of having to be invited to the resident council meetings by the residents to attend. The Administrator was serving as the liaison for Resident Council Minutes in the absence of an Activity Director. The concern of the towels smelling bad and stained will have a grievance initiated and will follow the protocol to address this concern. The concern of nursing staff no longer hanging up clean clothes returned from laundry will have a grievance initiated and follow the protocol to address this concern. The concern about clothes being returned stained with bleach stains will have a grievance initiated and follow the protocol to address this concern. The concern about the toilet not flushing and running all the time will have a grievance initiated and will follow the protocol to resolve the concern. The concern of the slamming kitchen door will have a grievance initiated and will follow the protocol to resolve the concern. The center is in the process of transitioning from one television provider to another, which will eliminate the need for cable boxes.	

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F 565	Continued From page 6 and that towels had a bad smell. No evidence was provided of a written response to address the complaints discussed. This grievance was not discussed in subsequent resident council meetings. Resident council meeting notes dated 01/27/25 documented the concerns of the group regarding transportation problems, specifically cancelled appointments due to late pickup/arrivals, and that transportation van staff drop her off outside of the building for medial appointments, and she can't always gain entry to the building with her motorized wheelchair. The resident council meeting minutes documented that the concern had been resolved, however, the grievance officer provided no evidence of a written response to the concerned resident, not identified. During an interview on 02/14/25 at 6:30 PM, the Activity Director stated she was not familiar with the rules, policies, or regulations regarding resident council meetings and/or how to handle grievances in the facility. She said she has been the activity director in the facility for about 5 weeks and was in the process of learning the role and the expectations of the activity program in the facility. She said she was aware that the resident council was a time for residents to have discussions in a safe environment without fear and intimidation. When asked if she thought the resident council currently being facilitated by the facility administrator appeared to be a safe environment for the residents to discuss concerns or issues, she responded that "somebody needs to be in there to take notes of the meeting." She said it needed to be a staff member. When asked if she had been invited to the resident council in January 2025. She said that she was	F 565	The resident concern of transportation not assisting her to gain entry to appointments will be transported by center staff for future appointments and center staff will assist her into and out of the building for her appointments. Resident Council president will provide permission for any and all invitees to attend Resident Council, including the liaison assigned to take notes. RVP or designee will provide education to NHA and Activity Director on policies specific to resident council meetings and follow up/ resolution of concerns. The Activities Director/designee will audit the Resident Council minutes to identify any grievances or concerns to ensure they are addressed in a timely and effective manner. The audits will be conducted monthly x 3 months or until 100% compliance is achieved. Results of the audits will be presented at the monthly QAPI meeting to review any trends and to determine if any further action is needed and this plan of correction will be reviewed during the next Resident Council meeting.	

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F 565	Continued From page 7	F 565		

not actually invited and that she assumed she was supposed to be there along with the administrator. She said she made notes of the discussions in the January 2025 resident council meeting and was aware of the issues regarding transportation. She said that after the meeting, the notes were kept by the Administrator, and she did not know who was responsible for following up with the residents' concerns and finding a resolution or accommodation to meet the needs of the residents.

During an interview on 02/14/25 at 6:45 PM, the Administrator stated he was the grievance officer for the facility and he thought it was his responsibility to facilitate the monthly resident council meetings. He stated that concerns/grievances reported during the resident council meeting were documented and given to the department director to resolve the grievance. He stated he did not follow-up to ensure the grievance has been resolved or that the outcome was communicated to the residents.

During an interview on 02/14/25 at 6:58 PM, the Regional Operations Manager said she was not aware the Administrator facilitated the resident council meeting each month for the past 11 months, as indicated on the monthly resident council meeting notes. She stated she would provide training to the Administrator and to the Activity Director regarding her expectations and about the regulations for the monthly resident council meeting. She said that she would ensure staff members could only attend the resident council meeting if they were invited to attend and that her expectation of concerns and grievances discussed in the resident council meeting were documented on a concern/grievance form and

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F 565	Continued From page 8 formally addressed by department mangers with a written response to the group attendees regarding the process or resolution within three days of the complaint/grievance. Review of the facility policy "Resident and Family Grievances," dated 04/05/23, provided by the Administrator, stated it was the policy to support each resident's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. The policy documented the administrator was responsible for overseeing the grievance process with "prompt efforts to resolve" grievances including acknowledgment of the complaint/grievance and actively working toward a resolution, issuing written grievance decisions to the resident, and coordinating with state and federal agencies as necessary in light of specific allegations. The policy stated grievances may be voiced in various forums including verbal complaints to a staff member, written complaint to a staff member or grievance official, written complaint to an outside party, and verbal complaints during resident council meetings, may be filed anonymously. The policy stipulated that the grievance official will keep the resident appropriately appraised of progress towards a resolution of the grievance and in accordance with the resident's right to obtain a written decision regarding his or her grievance.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		3/26/25

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F 578	Continued From page 9 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview, record review, document review, and facility policy review, the facility failed to ensure the accurate code status was	F 578	The facility immediately updated the electronic medical record of R49 and R38 with a signed copy of the documentation	

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F 578	Continued From page 10 documented and available for reference for two of 36 sampled residents, (Resident (R)49 and R38). This deficient practice could result in not following the specific residents' wishes documented in the advanced directive. Findings include: Review of R49's "Admission" record located in the electronic medical record (EMR) under the "Profile" tab revealed an admission date of 08/18/20. The "Brief Interview for Mental Status (BIMS)" assessment, dated 11/04/24 and located under the "Documents" tab, revealed R49 scored nine of 15, indicating R49 was moderately cognitively impaired. The documented code status, Full Code, was found in EMR, Resident Profile tab, Face Sheet but no documentation was identified to support the resident's decision. Review of R38s "Admission" record located in the electronic medical record (EMR) under the "Profile" tab, revealed an admission date of 02/13/20. The "BIMS" assessment, dated 12/16/24 and located under the "Documents" tab, revealed R38 scored five of 15, indicating R38 has severe cognitive impairment. R38's documented code status, Full Code, was found in EMR, Resident Profile tab, Face Sheet but no documentation was identified to support the resident's decision. During an interview on 02/12/25 at 1:49 PM, the Administrator said that he was responsible for acquiring advanced directives for each resident. He stated the facility had been cited in the past for not having advance directives for all residents. He said his plan of correction for the 08/26/22 survey included educating/asking the residents	F 578	that already existed in the paper chart at the time of the survey. This document reflects the discussion of code status with the cognitively impaired resident's responsible party. A review of the resident's chart confirmed that all electronic and paper documentation related to code status matches. Current residents with a BIMS of 12 or less have the potential to be affected by the deficient practice. Director of Nursing/designee will conduct an audit to ensure that all required code status documentation reflects the discussion of the cognitively impaired residents code status with the responsible party has been uploaded to electronic chart. Any discrepancies between paper and electronic chart will be corrected. Root cause: While the required documentation was accurately recorded in the paper chart and available at the time of survey the facility did not have a process to ensure these documents were uploaded to the electronic chart. Nurse Practice Educator/Designee will educate current licensed nurses on the new process for uploading the signed documentation relating to code status decision , for those residents with a BIMS of 12 and below, once the form is signed by the responsible party, the admitting nurse will place the form in the designated box for Physician/Nurse practitioners to sign then Medical Records will retrieve the form from the document box and upload to the residents electronic medical chart.	

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F 578	Continued From page 11 about their Advance Directives if they had a "BIMS" score of 13 of 15 or greater, indicating cognitively intact. If the BIMS score is less than 13 of 15, indicating the resident is cognitively impaired, the facility would contact the family. The Administrator said he was responsible for obtaining the Advance Directive from the resident or the family. He stated he had not acquired the advanced directive from the family member of R38 and R49. He said when an advanced directive is not acquired and is not documented in the EMR, the default code status is Full Code, indicating Cardiopulmonary Resuscitation (CPR) would be administered to the resident. During an interview on 02//12/25 at 2:10 PM, Licensed Practical Nurse (LPN) 2 stated without a code status or advanced directive, CPR would be administered to a resident in an emergency. She stated the Code Status of each resident was located in the EMR, "Profile" header and defaulted to Full Code if the advanced directive or Do Not Resuscitate (DNR) form was missing from the EMR. A policy was not provided prior to survey exit.	F 578	This process is already in place for other documents, this document is being added to the current process. Director of Nursing/ Designee will conduct audits on newly admitted residents with a BIMS of 12 or less or those residents with a change in code status to ensure Licensed Nurses are adhering to the new procedure. This will include verifying the code status documentation is properly completed and uploaded to the resident's electronic chart. Audits will be weekly x 3 weeks or until 100 % compliance is achieved, then monthly x 3 months or until 100% compliance is achieved. Results of the audits will be presented in the monthly QAPI meeting to review trends and to determine if any further action is needed	
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of	F 700		3/26/25

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F 700	Continued From page 12 entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents received alternative measures prior to installation of side rails for one of one resident reviewed for side rails (Resident (R) 9) of 38 sampled residents. The lack of alternate side rail measures could lead to potential safety concerns related to bed rail use for residents with bed rails. Findings include: Review of R9's "Face Sheet," located in the electronic medical record (EMR) under the "Profile" tab revealed the resident was re-admitted to the facility on 06/24/23 with diagnoses which included legal blindness and gout. Review of R9's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/14/25 and located in the resident's EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of seven out of 15, which indicated the resident's	F 700	R9 plan of care was reviewed, and it was determined the alternative of elevating the head of the bed proved to be ineffective. R9 is not able to assist with bed mobility without the aid of bilateral ¿ siderails. Assessment and care plan updated to reflect the alternative intervention. Current residents utilizing ¿ side rails have the potential to be affected by the deficient practice. The Director of Nursing/Designee will conduct a facility-wide audit to identify current residents using bed rails. Each resident will be reassessed for the need for bed rails, ensuring that alternative interventions are attempted and documented prior to their use. Any necessary changes will be made to care plans, and physician orders will be updated accordingly. Root Cause: The facility determined current license nurses need re-education	

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F 700	Continued From page 13 cognition was severely impaired. Review of R9's "Care Plan," dated 06/05/23 and located in the resident's EMR under the "Care Plan" tab, revealed "The resident required assistance and was dependent with ADL [activities of daily living] care related to bed mobility." Interventions in place were 1/4 side rails per physician orders for safety during care and to assist with bed mobility. Review of R9's "Bed Rail Evaluation," dated 10/09/23 and located in the EMR under the "Assessments" tab, revealed no alternates were attempted prior to the placement of the siderails. Further review revealed the outcome for failed alternatives was "bedrails requested." During an observation on 02/11/25 at 10:24 AM R9 was lying in the bed with head of bed upright. Side rails in place on both sides of the bed. During an interview on 02/14/25 at 8:18 AM the Director of Rehab (DOR) said therapy had no role in determining if a resident required the use of bed rails. She also stated that therapy did not access R9 for the need of bed rails. During an interview on 02/14/25 at 8:34 AM, the Assistant Director of Nursing (ADON) stated she completed R9's bed rail assessment in July 2024. She stated all residents were assessed on admission for bedrail use and thereafter on a routine basis, but she was unsure how often. She thought every three to six months. She said she was unsure what alternates were attempted prior to using the bedrails and that the family probably requested them to be used for the resident.	F 700	on F700 regulations, emphasizing the requirement to attempt and document alternative interventions before utilizing bed rails. Nurse Practice Educator/designee will re-educate current licensed nursing staff on F700 with the focus on attempting alternative interventions prior to utilizing bed rails. The Director of Nursing/designee will conduct an audit of 20% of the resident population and any new admission to determine whether alternative interventions were attempted prior to putting bed rails in place. Audits will be weekly x 3 weeks or until 100 % compliance is achieved, then monthly x 3 months or until 100% compliance is achieved. Results of the audits will be presented in the monthly QAPI meeting to review trends and to determine if any further action is needed	

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F 700	Continued From page 14 During an interview on 02/14/25 at 2:31 PM, the Director of Nursing (DON) stated bed rail assessments were completed on admission and that all residents were asked if they wanted bedrails. She stated that it was a resident's right to have the bedrails if they requested them and she did not know that regulation required alternates to be explored prior to their use. Review of the facility's policy titled "Use of Bed Rails" revised 03/14/23 revealed it is the policy of the facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails.	F 700		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F 725		3/26/25

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F 725	Continued From page 15 (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure call lights were answered timely for one of 38 sample residents (Resident (R) 44) reviewed for staffing. This failure had the potential to put the residents at risk. Findings include: Review of R44's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab, revealed an admission date of 03/03/23. Review of R44's admission "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 11/20/24, revealed R44 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated the resident was cognitively intact. She was dependent on staff for toileting, bathing, and dressing. During a continuous observation on 02/13/25 from 9:16 AM until 9:54 AM, R44's call light remained on. During this time, Licensed Practical Nurse (LPN) 1 stood by the medication cart from 9:16 AM to approximately 9:35 AM, which was parked by R44's room. Certified Nurse Aide (CNA) 9 walked down the hall and donned	F 725	R44s call bell was responded to and needs met. The Director of Nursing, upon being informed of the delay in call bell response time immediately reminded staff of the importance of responding to bells promptly. Current residents have the potential to be affected by the deficient practice. Root cause: Staff overly focused on other tasks resulting in not consistently responding to call lights. Nurse Practice Educator/designee will provide re-education to current staff on the importance of timely call bell response. The Director of Nursing/Designee will conduct audits across all shifts and all nursing units to ensure the staff responds timely to call bells of current residents, including the affected resident. Any delays will be tracked and addressed promptly. Audits will occur across all shifts and units daily until 100% compliance is achieved, then 3 times weekly until 100% compliance is achieved, then monthly until 100% compliance is achieved. Results of the audits will be presented in the monthly QAPI meeting to review trends and to	

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F 725	Continued From page 16 personal protective equipment (PPE) and entered another resident's room. R44's call light remained on. At 9:36 AM, CNA8 donned PPE, while standing in front of room 501. She entered room 501 at this time and came out of the room at 9:39 AM. While standing near room 504, CNA7 said to CNA 8 to let CNA9 know that R44's call light was on. During an interview at 9:46 AM, CNA7 stated CNA9's assignment included R44. He said even though a CNA may be assigned to a section, CNAs would help other CNAs. At 9:50 AM, LPN1 returned to her cart, which remained parked next to R44's room. During the continuous observation, the Activities Director (AD) walked by R44's room twice without answering the call light. At 9:54 AM, two housekeepers stood outside the room, and did not answer the call light. During an observation on 02/13/25 at 9:56 AM, CNA9 and LPN1 entered R44's room and turned off the call light. LPN1 stated a call light should not be left on for 38 minutes. She stated they tried to have call lights answered in less than five minutes. LPN1 stated all staff should answer call lights, even if they could not help the residents, they could get staff who could. CNA9 said he was assigned to R44's room but was helping another resident who had an appointment. CNA9 agreed the call light had been left on for too long. During an interview on 02/13/25 at 10:20 AM, R44 stated it was "pretty common that I have to wait for call lights to be answered." She stated this time she needed her phone plugged in. She said while she was waiting, she tried to do it herself, but she almost fell so she had to wait. She stated when she had to wait a long time to get her light answered and she had to go to the bathroom, it really made her angry.	F 725	determine if any further action is needed.	

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F 725	Continued From page 17 During an interview on 02/13/25 at 10:18 AM, Registered Nurse (RN) 3, who was observed sitting at the nurses' station during the continuous observation, approximately four feet from the visual call light monitoring system, stated everyone was responsible for answering lights, even if they could not help the resident, they could pass the message on to the appropriate staff. She stated, "we have the intercom system right here, so we know [which resident is calling]." During an interview on 02/14/25 at 4:00 PM, the Director of Nursing (DON) stated call lights should be answered by all staff, even if they could not help the residents, they could get someone who could. She stated if call lights go unanswered for too long, the resident may have an emergency situation which could put the resident at risk. Review of the facility's policy titled, "Call Lights: Accessibility and Timely Response," dated 03/14/23, revealed "All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified."	F 725		