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 Fenwick Island **DATE SURVEY COMPLETED:** March 24, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from March 19, 2026, through March 24, 2026. The deficiencies contained in this report are based on observations, interviews, record reviews and a review of other facility documentation as indicated. The facility census on the first day of the survey was ninety-one (91). The survey sample totaled fourteen (14) residents. Abbreviations/definitions used in this state report are as follows: AWD – Assistant Wellness Director; BOM – Business Office manager; Cm – Centimeters; ED – Executive Director; Mm – Millimeters; WD – Wellness Director; BIMS – (Brief Interview for Mental Status) – assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions) 08-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); Service plan/agreement – document developed with each resident that describes the services to be provided, who will provide	*B. Eileen Bennett, LNHA Executive Director April 11, 2026*	

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	the services, when the services will be provided, how the services will be provided, and, if applicable, the expected outcome; UAI (Uniform Assessment Instrument) – an assessment that collects information on the physical condition, medical status and psychosocial needs of an applicant/resident to determine eligibility for an assisted living facility.	A. The UAI for R13 was completed on 3/19/2026. B. Residents living in this facility for at least 30 days have the potential to be affected by this deficient practice. An audit of all residents living in this facility 6 months or less will be conducted to determine 30 day assessments were completed timely.(see attachment ONE) Residents without timely 30 day assessments will have an interim assessment completed to identify any discrepancies with the current plan of care. Discrepancies will be applied to the current assessment accordingly. C. Registered Nurses responsible for conducting assessments will be educated on the assessment update schedules.(See attachment TWO) A UAI 30 day update tracker will be implemented to monitor timely completion.(See attachment TWO) Wellness Director or designee will enter the update schedule on the tracker. D. Tracker will be audited weekly for completion until 100% compliance for 4 weeks. Then, audits will continue monthly until 100% compliance for 4 months. Results will be reported quarterly to the Quality Improvement Committee. E. Anticipated date for correction April 24, 2026. *B. Eileen Bennett, LNHA Executive Director April 11, 2026*	
3225.0 **3225.11.0** **3225.11.5** **S/S – D**	**Assisted Living Facilities** **Resident Assessment** **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 was not met as evidenced by:** Based on record review and interview, it was determined that for one (R13) out of fourteen residents sampled for UAI's, the facility failed to complete a UAI assessment 30 days after admission. Findings include: Review of R13's clinical record revealed: 1/19/26 – R13 was admitted to the facility and an initial UAI was completed. 3/19/26 – A review of R13's UAI (Uniform Assessment Instruments) revealed that the 30-day assessment was not completed.		

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	3/19/26 11:15 PM - During an interview, E3 (AWD) confirmed that R13's 30-day UAI assessment was not completed on 2/19/26. E3 completed R13's UAI on 3/19/26. 3/24/26 12:00 PM – Findings were reviewed with E1 (ED), E2 (WD) and E3 during the exit conference.		
3225.13.0 **3225.13.1** **S/S – D**	**Service Agreements** **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 shall participate in the development of the agreement. The resident and 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 was not met as evidenced by:** Based on record review and interview, it was determined that for one (R13) out of fourteen residents sampled for service agreements, it was determined that the facility failed to ensure a service agreement was signed by the facility and the resident. Findings include: Review of R13's clinical record revealed: 1/19/26 – R13 was admitted to the facility. 1/19/26 – An initial UAI (Uniform Assessment Instruments) documented R13 to be cognitively intact with a BIMS score of 15.	A. The service agreement for R13 was signed by the facility on 3/19/26. The service agreement was signed by the resident on 3/19/26. B. All residents have the potential to be affected by this deficient practice. An audit of all current service agreements will be conducted to determine acknowledgement by signature. (ATTACHMENT ONE) Service agreements identified without signature will be reviewed in conference with the resident/responsible person and acknowledged by signature. C. Nurses responsible for reviewing service agreements with resident/responsible person will be educated on the need for acknowledgement by signature.(ATTACHMENT TWO) Service agreement audits will be conducted for acknowledgement by signature for all new admission by the Wellness Director or designee. Identified discrepancies will be reviewed in conference with the resident/responsible person and signature will be obtained. D. Audits will be conducted weekly for signatures until 100% compliance for 4 weeks. Then, audit will continue monthly until 100% compliant for 4 months. Results will be reported quarterly to the Quality Improvement Committee. E. Anticipated date for correction April 24, 2026. *B. Eileen Bennett, LNHA Executive Director April 11, 2026*	

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	1/19/26 – A service agreement completed for R13 lacked the necessary signatures from R13 and the facility. 3/20/26 10:00 AM – During an interview, E2 (WD) confirmed that there was no documentation that R13 or the facility signed the service agreement. 3/24/26 12:00 PM – Findings were reviewed with E1 (ED), E2 and E3 (AWD) during the exit conference.	A. The incident with R1 occurred on 2/21/2026 was facility reported on 2/22/26. The incident with R10 occurred on 12/1/2025 was facility reported on 12/4/2025. B. Residents involved in incidents which meet the Division criteria as reportable have the potential to be affected by this deficient practice. Audit will be conducted on incident reports since March 1, 2026 for confirmation of incident date/times and date/time reported. (ATTACHMENT FIVE) Identified discrepancies will be addressed by focused coaching with the responsible team member. C. In service education will be provided to team members indicating the immediate notification of reportable event requirements to the Division which shall be within 8 hours of the occurrence and the process for completing the report.(ATTACHMENT SIX) Incident report reviews will be conducted shift to shift (every 8 hours or less) to confirm incidents were reportedly timely with confirmation indicated on the 24 hour report.(ATTACHMENT SEVEN) D. Timely report confirmation will be audited weekly by the Wellness director or designee until 100% compliant for 4 weeks. (ATTACHMENT FIVE) Audits will then continue monthly until 100% compliant for 4 months. (ATTACHMENT EIGHT) Progress will be reported quarterly to the Quality Improvement Committee. E. Anticipated date for correction is April 24, 2026. *B. Eileen Bennett, LNHA Executive Director April 11, 2026*	
3225.19.0	**Records and Reports**		
3225.19.6	**Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.**		
3225.19.7	**Reportable incidents include:**		
3225.19.7.6	**Death of a resident in a facility or within 5 days of transfer to an acute care facility.**		
3225.19.7.7	**Significant injuries.**		
3225.19.7.7.4	**Injury sustained by a resident dependent on staff for toileting, mobility, transfer and/or bathing.**		
S/S – D	**This requirement was not met as evidenced by:** Based on interview, record review and a review of facility documents, it was determined for two (R1 and R10) out of eleven residents reviewed for facility reported incidents, the facility failed to submit reportable incidents to the State Agency within eight hours. Findings include:		

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	1. Review of R1's clinical record revealed: 7/2/25 – R1 was admitted to the facility. 2/11/26 – A service plan for R1 documented that care managers were to assist her with toileting needs. The service plan also documented that R1 was an assist of one staff for all transfers. 2/22/26 11:48 AM – An incident report from the facility was submitted to the State Agency and documented that R1 was transferring from the wheelchair to the toilet when her leg was caught, resulting in a skin tear. 2/27/26 – The facility's 5-day follow-up report documented that R1 was transferred to the emergency room, where the skin tear was 8cm long and 1mm deep and required 8 stitches. 3/23/26 1:54 PM – During an interview, E2 (WD) confirmed that the incident occurred on 2/21/26 at 6:30 PM and the report was submitted on 2/22/26 at 11:48 AM. The facility did not submit the report to the State Agency within the eight-hour timeframe. 2. Review of R10's clinical record revealed: 4/17/25 - R10 was admitted to the facility. 12/4/25 8:23 AM – An incident report from the facility was submitted to the State Agency, documenting that R10 had expired. 3/23/26 11:59 AM - During an interview, E2 (WD) stated that the incident occurred on 12/01/2025 at 9:50 PM and the report was	*B. Eileen Bennett, LNHA Executive Director April 11, 2026*	

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	submitted on 12/04/2025 at 8:23 AM. She confirmed the incident was not reported to the State Agency within 8 hours. The facility did not submit the report to the State Agency within the eight-hour timeframe. 3/24/26 12:00 PM – Findings were reviewed with E1 (ED), E2 and E3 (AWD) during the exit conference.		
3105.0 **3105.10.0** **3105.10.4** **S/S – D**	**Criminal History and Drug Testing for Nursing and Similar Facilities** **Further Facility/Employer Responsibilities** **The employer must ensure that no Applicant is employed without first receiving the results of the Applicant's mandatory drug test.** **This requirement was not met as evidenced by:** Based on a review of facility documentation and interview, it was determined that the facility failed to ensure that one (E5) out of nine sampled staff members reviewed had confirmation of drug screening. Findings include: 3/14/25 – The hire date of E5 (Server). The facility lacked documentation that a drug screening had been completed. 3/23/26 1:15 PM – An interview with E1 (ED) confirmed that E5 did not have a pre-employment drug screening. E1 stated that the facility's previous company did not require them.	A. A drug screening will be conducted on E5 week ending 4/18/26. The results will be maintained in the E5 employee file. B. Applicants for employment between 11/2023 and 11/2024 had the potential to be affected by the deficient practice. An audit will be conducted by the Human Resources manager or designee to confirm that all new team members hired between 11/2023 and 11/2024 have confirmation of drug screening prior to hire.(ATTACHMENT NINE) Identified discrepancies will constitute the need for a drug screening to be performed with results documented in the employee file. C. In service education will be provided to all hiring managers on policy regarding required pre-employment drug screening.(ATTACHMENT TEN) Payroll Change form will be revised to include indication that drug screening has been completed prior to hire.(ATTACHMENT ELEVEN) Drug screening completion will be confirmed by notation and signature of both the hiring manager or designee and the executive director or designee on the Payroll Change form authorizing the progression of the hiring process. D. Each Payroll Change form will be reviewed for 100% compliance as a standard of practice without interruption. Applicant hiring process will be postponed until criteria has been met at 100%. Monthly reviews for completion will be reported to the Quality Improvement Committee for 12 months. *B. Eileen Bennett, LNHA Executive Director April 11, 2026*	

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	3/24/26 12:00 PM – Findings were reviewed with E1, E2 (WD) and E3 (AWD) during the exit conference.		

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