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

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

STATE SURVEY REPORT

NAME OF FACILITY: Brackenville Center

DATE SURVEY COMPLETED: February 11, 2021

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 unannounced COVID-19 Focused Infection Control Survey and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from February 5, 2021 through February 11, 2021. The deficiencies contained in this report are based on interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was 81. The survey sample totaled eight (8) residents including three (3) closed records.		
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	Cross reference plan of correction for CMS 2567 for Annual survey ending February 11, 2021 F657 and F677	

Provider's Signature _____ Title Center Executive Dir Date 2/22/21

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Brackenville Center

DATE SURVEY COMPLETED: February 11, 2021

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	completed February 11, 2021: F657 and F677.		

Provider's Signature _____ Title Interim Executive Dir Date 2/22/21

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 02/11/2021

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
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from February 5, 2021 through February 11, 2021. The deficiencies contained in this report are based on interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was 81. The survey sample totaled eight (8) residents, including three (3) closed records. Abbreviations and definitions used in the report are as follows: CNA - Certified Nurse's Aide; ADON - Assistant Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RN - Registered Nurse; ADL's (Activities of Daily Living) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; COVID-19 (Coronavirus) - a respiratory illness that can be spread person to person; MDS (Minimum Data Set) - an assessment tool used for residents in nursing homes.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		3/10/21

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

Electronically Signed | 02/24/2021

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.

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 02/11/2021

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
F 657	Continued From page 1 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R2) out of eight (8) sampled residents for care plans, the facility failed to revise R2's care plan on ADL care (Activities of Daily Living - daily care activities) to address R2's refusal for nail care. Findings include: Review of R2's clinical record revealed the following: 7/23/20 - R2 was admitted to the facility for short term rehabilitation with diagnoses including left sided weakness.	F 657	A. R2 was discharged home 9/4/2020 B. All other residents will have their medical record reviewed to identify those residents that have a pattern of refusing care C. All residents identified as having a pattern of refusing care that results in a significant change in condition will have their care plan updated to reflect the refusal of care Root cause analysis was completed to determine the cause of the deficient	

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 02/11/2021

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
F 657	Continued From page 2 7/27/20 - R2 had a care plan that R2 required assistance with ADL care. Interventions included that R2 required one (1) staff member's extensive assistance for personal hygiene (grooming). 7/30/20 - R2's admission MDS assessment also stated that R2 required one person extensive assistance with personal hygiene, including nail care. 9/28/20 - A handwritten statement from E4 (CNA) documented, "...refused nail care at every attempt. Discharge 9/4/20...still refused nail care...admitted with long nails and not so clean." 2/10/21 at 12:53 - In an email, E1 confirmed that R2's refusals of having her nails cut was not care planned for. Findings were reviewed during the exit conference on 2/11/21 at 10:00 AM with E1 (NHA) and E3 (ADON).	F 657	practice CNA□s will be reinserviced on reporting resident refusal of care to the nurse in charge of the resident refusing care All nurses will be reinsericed on the center operations policy and procedure for refusals of care that includes documenting resident refusal of care and notifying the healthcare decision maker and the physician The 24 hour report will be audited daily to identify any resident refusal of care. Any pattern of refusal of care identified that results in a significant change in condition will result in the resident being re-assessed and the care plan will be updated as indicated. D. Results of 24-hour report audit will be reviewed during QAPI meetings. QAPI committee will identify trends and make recommendations based on audit refusal	