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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35690 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 admitted [DATE]. 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 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 [ROOM NUMBER]. She entered room [ROOM NUMBER] at this time and came out of the room at 9:39 AM. While standing near room [ROOM NUMBER], 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. (continued on next page)

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.

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

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	02/14/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.