

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Brackenville LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29728</p> <p>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 assessment, created an unsafe environment for the residents and other residents in the area.</p> <p>Findings include:</p> <p>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.</p> <p>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 [DATE] with diagnoses of diabetes mellitus, arteriosclerotic heart disease, spinal stenosis, and hypertension.</p> <p>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.</p> <p>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.</p> <p>Review of R66's EMR revealed no assessments were conducted related to self-administration of medications.</p> <p>(continued on next page)</p>

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
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>36917</p> <p>Based on interview and record review, the facility failed to act promptly on the grievances and 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.</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>Resident council meeting notes dated May 2024 documented several residents reported the towels smell bad when returned from the laundry. No documentation was provided to indicate the grievance was resolved. Subsequent grievance regarding laundry were reported during the meetings.</p> <p>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 or their closet. No documentation could be provided that indicated the grievance was resolved.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of resident council meeting notes dated 10/28/24 documented complaints from residents that their laundry is returned with bleach stains 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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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 formally addressed by department managers with a written response to the group attendees regarding the process or resolution within three days of the complaint/grievance.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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 apprised 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.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36917</p> <p>Based on interview, record review, document review, and facility policy review, the facility failed to ensure the accurate code status was 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.</p> <p>Findings include:</p> <p>Review of R49's Admission record located in the electronic medical record (EMR) under the Profile tab revealed an admitted [DATE]. The Brief Interview for Mental Status (BIMS) assessment, dated [DATE] 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.</p> <p>Review of R38's Admission record located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE]. The BIMS assessment, dated [DATE] 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.</p> <p>During an interview on [DATE] 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 [DATE] survey included educating/asking the residents 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.</p> <p>During an interview on 02//,d+[DATE] 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.</p> <p>A policy was not provided prior to survey exit.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>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.</p> <p>Findings include:</p> <p>Review of R9's Face Sheet, located in the electronic medical record (EMR) under the Profile tab revealed the resident was readmitted to the facility on [DATE] with diagnoses which included legal blindness and gout.</p> <p>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 cognition was severely impaired.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35690</p> <p>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.</p> <p>Findings include:</p> <p>Review of R44's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE].</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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].</p> <p>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.</p> <p>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.</p>