## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

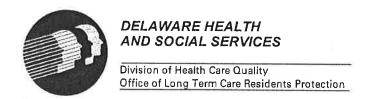
PRINTED: 07/24/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		085004	B. WING				R-C <b>1/18/2024</b>
	STREET ADDRESS, CITY, STATE, ZIP CODE  STREET ADDRESS, CITY, STATE, ZIP CODE  505 GREENBANK ROAD  WILMINGTON, DE 19808					1710/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	SHOULD BE COMPLETION	
{F 000}	and Complaint Su was conducted at 2024 through Janu process included of residents' clinic documentation. The day of the survey sixty-three (163). The facility was fo compliance with 4	Follow-Up Survey to the Annual rvey ending November 8, 2023, this facility from January 15, uary 18, 2024. The survey observations, interviews, review al records and other ne facility census on the first was one hundred and The survey sample size was	{F 00	00}			
×							
ABORATORY	DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

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.

Electronically Signed

02/13/2024



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

## STATE SURVEY REPORT

Page 1 of 1

NAME OF FACILITY: Springs Rehabilitation at Brandywine LLC DATE SURVEY COMPLETED: January 18, 2024

		DATE SORVET CONFEETED. Sandary 16, 2024
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201	An unannounced Follow-Up Survey to the Annual and Complaint Survey ending November 8, 2023, was conducted at this facility from January 15, 2024 through January 18, 2024. The survey process included observations, interviews, review of residents' clinical records and other documentation. The facility census on the first day of the survey was one hundred and sixty-three (163). The survey sample size was twenty-eight (28) residents.  The facility was found to be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities as of January 18, 2024.  Regulations for Skilled and Intermediate Care	
3201.1.0	Nursing Facilities 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.  No deficiencies were identified at the time of the survey.	

Provider's Signature Alabah Malar Title WHA Date 5/7/	2 4
---	-----