



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: Complete Care at Brackenville LLC

DATE SURVEY COMPLETED: April 3, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>An unannounced follow-up survey, for the annual and complaint survey ending February 2, 2024, was conducted at this facility from April 1, 2024 through April 3, 2024. The facility census the first day of the survey was ninety one (91). The survey sample size was twenty (20) residents. The survey process included observations, interviews, review of residents' clinical records and other documentation.</p> <p>The facility was in substantial compliance with 42 CFR Part 483 Subpart B Requirements for Long Term Care Facilities as of March 19, 2024.</p> <p>Regulations for Skilled and Intermediate Care Nursing Facilities</p> <p>Scope</p> <p>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.</p> <p>No deficiencies were identified at the time of the survey.</p>	

Provider's Signature 

Title Administrator

Date 5/8/24

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

PRINTED: 05/02/2024
FORM APPROVED
OMB NO. 0938-0391

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 R-C 04/03/2024
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT BRACKENVILLE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
{E 000}	Initial Comments	{E 000}			
{F 000}	<p>INITIAL COMMENTS</p> <p>An unannounced follow-up survey, for the annual and complaint survey ending February 2, 2024, was conducted at this facility from April 1, 2024 through April 3, 2024. The facility census the first day of the survey was ninety one (91). The survey sample size was twenty (20) residents. The survey process included observations, interviews, review of residents' clinical records and other documentation.</p> <p>The facility was in substantial compliance with 42 CFR Part 483 Subpart B Requirements for Long Term Care Facilities as of March 19, 2024.</p>	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/18/2024

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.