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

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

STATE SURVEY REPORT

NAME OF FACILITY: Complete Care at Brackenville LLC **DATE SURVEY COMPLETED: September 15, 2025**

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 Complaint survey was conducted at this facility on September 11, 2025, through September 15, 2025. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was ninety-eight (98). The survey sample totaled five (5) residents.		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**	Cross Reference plan of correction for 2567 for survey ending September 15, 2025 for F tags F656; F658 and F760	
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 completed September 15, 2025: F656, F658 and F760.		

Provider's Signature _____ Title Administrator Date 10/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRACKENVILLE LLC	100 ST. CLAIRE DRIVE , HOCKESSIN, Delaware, 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
F0000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility on September 11, 2025, through September 15, 2025. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was ninety-eight (98). The survey sample totaled five (5) residents. Abbreviations / definitions used in this report are as follows: ADON - Assistant Director of Nursing; BIMS - (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15. 13-15: Cognitively intact, 08-12: Moderately impaired, 00-07: Severe impairment; DON - Director of Nursing; Intravenous (IV) – within the veins or administration of medications/fluids through a tube directly into a vein; Mg (milligrams) –unit of weight, 1 mg equals 0.0035 ounce; NHA - Nursing Home Administrator; RN - Registered Nurse; Ocular myasthenia gravis (OMG) - a subtype of myasthenia confined primarily to the eye muscles, (causing drooping of the eyelids and double vision) American Journal of Neurology;	F0000		10/30/2025
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each	F0656	R2 was discharged from the facility on 7/25/2025 and therefore, the deficient practice could not be corrected for this resident. Root Cause: The facility did not have a process in place to identify those residents who are refusing medications to initiate and update patient centered care plans to reflect those refusals	10/30/2025

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 reverse for further 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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F0656 SS = D	Continued from page 1 resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R2) out of three residents sampled for care plans, the facility failed to develop a person-centered care plan for the refusal of	F0656	Continued from page 1 Current residents who refuse medications have the potential to be affected by the deficient practice. The Director of Nursing (DON) or designee will conduct a facility- wide audit to identify residents who are refusing medications, to ensure that patient centered care plans are developed and in place. For those residents identified, care plans will be reviewed and updated as needed to reflect medication refusals. Additionally, the nursing leadership team will review all current residents medication administration record (MAR) weekly to identify residents refusing medications to identify ongoing medication refusals and ensure that appropriate patient centered care plans are established and maintained. Nurse Practice Educator (NPE) or designee will provide re-education to nursing leadership including the DON, ADON, Unit Managers, and Supervisors on developing patient centered care plans for residents who have been identified as refusing medications. The Director of Nursing (DON) or designee will conduct audits of medication administration records (MAR) for all residents weekly x 4 weeks or until 100% compliance is achieved and then monthly x 3 months or until 100% compliance is achieved to ensure residents refusing medication have a patient centered care plan in place. Results of the audits will be reviewed during the monthly Quality Assurance (QA) Meeting	

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F0656 SS = D	Continued from page 2 medications. Findings include: 6/27/25 – R2 was admitted to the facility with diagnoses including but not limited to muscle weakness, bladder cancer and ocular myasthenia gravis. R2's admission medications included pyridostigmine bromide oral tablet 60 mg two times a day for the treatment of ocular myasthenia gravis. 7/1/25 – R2's clinical records documented a BIMS score of 15, indicating a completely cognitive intact status. 6/28/25 – 7/22/25 – R2's clinical records documented twenty-eight (28) episodes of refusal of pyridostigmine bromide tablets out of forty-nine (49) opportunities. 9/12/25 11:30 AM – A review of R2's clinical records lacked evidence of a care plan for the refusal of medications. 9/12/25 1:00 PM – During an interview, finding was confirmed with E2 (DON). 9/15/25 3:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (RN).	F0656		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R5) out of three residents sampled for acceptable standards of clinical practice, the facility failed to ensure that R5's medication was administered according to the physician's order. Findings include: An undated facility document entitled, "Rights of Medication Administration," included:Right PersonRight MedicationRight DoseRight TimeRight RouteRight ReasonRight Documentation. 7/14/25 – R5 was admitted to the facility with diagnoses including but not limited to infection of the right lower leg, right heel pressure ulcer, and resistance to multiple antibiotics. 7/14/25 6:34 PM – R5's medications included,	F0658	R5 was discharged from the facility on 8/7/2025 and therefore, the deficient practice could not be corrected for this resident. Root Cause: The facility determined current licensed nursing staff have the need for re-education on the five rights of medication administration due to noted lack of adherence to the 5 rights of medication administration Current residents receiving IV medications have the potential to be affected by the identified deficient practice. On July 21, 2025, the Director of Nursing (DON) conducted a facility-wide audit to identify current residents receiving IV medication to ensure the correct medications were being delivered and administered appropriately. Additionally, the DON completed a review of all medication errors from the past 30 days to determine the number of doses involved and the nursing staff associated with each incident and follow up actions were taken based on audit findings On July 24, 2025, the NPE or designee provided re-education to current licensed nurses and newly hired nurses during orientation on the five rights of medication administration. This training included a focused review of verification procedures related to delivery and administration of IV medications. Additionally on September 16, 2025, the Regional Clinical Consultant provided re-education to the	10/30/2025

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F0658 SS = D	Continued from page 3 "Daptomycin-sodium chloride intravenous solution, give 800 mg intravenously daily…." 7/15/25 – R5's clinical record documented a BIMS score of 15, indicating a cognitively intact status. 7/21/25 11:00 AM – R5's clinical record documented, "…Resident was ordered Daptomycin 800mg IV 1xday, Nurses were administering Daptomycin 850mg IV daily with wrong patient identifiers on IV bag as sent by pharmacy despite not matching order…" 9/12/25 11:30 AM – During an interview E2 (DON) stated, "I received a telephone call from the supervisor on Sunday 7/20/25, that the pharmacy called and said that medication meant for another patient at another facility was delivered to our facility. The supervisor stated that there were two bags of daptomycin 850mg/ml were in the fridge. I told the staff to remove the medication bags from the fridge. The supervisor sent me pictures of the medication bags. I saw that the original name on the bags was crossed out and our patient's name was written on them. I also saw that the dose of medication was different from our resident's order. We identified three nurses involved in the medication error. All three of them were educated and counseled on the rights of medication administration." 9/12/25 12:00 PM – During a telephone interview P1 (IV Pharmacist) stated, "On 7/15/25, we sent out 3 bags of iv daptomycin to be used for Tuesday, Wednesday and Thursday [for R5]. On 7/18/25, we sent 4 more bags for Friday, Saturday, Sunday and Monday. On Sunday 7/20/25, we received a call from another facility asking for their medications. Our investigation revealed that the courier had inadvertently delivered the 4 bags to the wrong facility. We asked this facility to check and remove the incorrect bags from their fridge. We are working on quality control to prevent this from happening again." 9/12/25 12:30 PM – E2 provided the Surveyor with documentation of counseling for E4 (former weekend RN supervisor) and E5 (former RN.) The Surveyor asked for evidence of counseling for the third nurse involved in the medication error. E2 stated, "She said she gave the correct medication, and I have no way of proving that she did not." During an interview, the Surveyor asked E7 (RN) about the medication that was administered to R5 on 7/18/25. E7 stated, "I don't remember what he got." 9/12/25 12:45 PM – A review of pharmacy medication delivery receipt revealed that four bags of iv	F0658	Continued from page 3 Director of Nursing (DON) on the proper steps for thoroughly investigating medication errors. This included ensuring an accurate account of dosing errors and identifying nursing staff involvement to support appropriate corrective actions The Director of Nursing (DON) or designee will conduct audits of residents receiving IV medications weekly x 4 weeks until 100% is achieved then monthly x 3 months until 100% compliance is achieved. These audits will ensure that the correct medication and dosage are being delivered to each resident. Additionally, the DON will review all medication errors to verify dosage accuracy and identify nursing staff involved, ensuring that the appropriate follow up actions are implemented. The results of the audits will be reviewed during the monthly Quality Assurance (QA) meetings	

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F0658 SS = D	Continued from page 4 daptomycin were prepared to be delivered to the facility on 7/18/25 at 4:28 AM (doses for the next 4 days.) R5's counseling documented medication errors for 7/17/25 and 7/19/25. The surveyor asked E2 if the facility's investigation revealed how many doses of the incorrect medication was administered to R5. E2 stated, "We think it was one incorrect dose but there were two remaining bags that were removed from the fridge." A review of R5's medication administration records revealed that iv daptomycin was administered on 7/18/25 and one on 7/19/25. The facility failed to thoroughly investigate the medication error incident to determine exactly how many doses of the incorrect medication was administered and how many nurses were involved in the incident. 9/12/25 1:00 PM – During a telephone interview E5 stated, "I saw that the medication was labeled with another patient's name, but I thought it would be okay if scratched out that name and put my resident's name on it. I asked the supervisor to initial her name next to mine on the bag. I did not realize that the dosage was incorrect until later when I was told by the DON." 9/12/25 1:30 PM – During an interview, the Surveyor asked E2 about the facility's process of accepting medications from the pharmacy. E2 stated, "The nurse must sign for any narcotics. If the iv medications must be refrigerated, they are put in the fridge and checked before they are administered. The pills are checked before they are put on the medication carts." The facility failed to ensure that R5's iv medication was administered according to accepted standards of clinical practice. 9/12/25 2:30 PM – During an interview, finding was confirmed with E2 (DON). 9/15/25 3:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (RN).	F0658		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by:	F0760	R5 was discharged from the facility on 8/7/2025 and therefore, the deficient practice could not be corrected for this resident. Root Cause: The facility determined current licensed nursing staff have the need for re-education on the five rights of medication administration due to noted lack of adherence to the 5 rights of medication administration	10/30/2025

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F0760 SS = D	Continued from page 5 Based on record review and interview, it was determined that for one (R5) out of three residents sampled for medication administration, the facility failed to ensure that R5's medication was administered per the physician's order. Findings include: Based on record review and interview, it was determined that for one (R5) out of three residents sampled for medication administration, the facility failed to ensure that R5's medication was administered per the physician's order. Findings include: 3/13/23 – A facility documented entitled, "Medication Administration", and updated 6/3/24, documented, "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice…." 7/14/2025 – R5 was admitted to the facility with diagnoses including but not limited to infection of the right lower leg, right heel pressure ulcer, and resistance to multiple antibiotics. 7/14/25 6:34 PM – R5's medications included, "Daptomycin-sodium chloride intravenous solution, give 800 mg intravenously daily…." 7/15/25 – R5's clinical record documented a BIMS score of 15, indicating a cognitively intact status. 7/21/25 11:00 AM – R5's clinical record documented, "…Resident was ordered Daptomycin 800mg IV 1xday, Nurses were administering Daptomycin 850mg IV daily with wrong patient identifiers on IV bag as sent by pharmacy despite not matching order…" 9/12/25 11:30 AM – During an interview E2 (DON) stated, "I received a telephone call from the supervisor on Saturday, 7/20/25 that the pharmacy called and said that medication meant for another patient at another facility was delivered to our facility. The supervisor stated that there were two bags of daptomycin 850mg/ml were in the fridge and sent me pictures of the medication bags. I saw that the previous name on the bags was crossed out and our patient's name was written on them. We identified three nurses involved in the medication error. All three of them were educated and counseled on the rights of medication administration." 9/12/25 12:00 PM – During a telephone interview P1 (IV Pharmacist) stated, "On 7/15/25, we sent out 3 bags of iv daptomycin to be used for Tuesday, Wednesday and Thursday [for R5]. On 7/18/25, we sent 4 more bags for	F0760	Continued from page 5 Current residents receiving IV medications have the potential to be affected by the identified deficient practice. On July 21, 2025, the Director of Nursing (DON) conducted a facility-wide audit of all current residents receiving IV medication to verify that the correct medication and dosages were being administered. No additional residents were found to have received the incorrect medication. The Nurse Practice Educator (NPE) or designee will re-educate current licensed nurses on the five rights of medication administration, with a focused emphasis on cross checking physician orders with pharmacy-delivered labels. The Director of Nursing (DON) or designee will conduct weekly audits of current residents receiving IV medications to ensure the correct medication is administered and that the pharmacy label accurately reflects the correct dose and resident. Additionally, the Nurse Practice Educator (NPE) or designee will conduct random observations of licensed nurses administering medications across all shifts. Both audits will be performed weekly for four weeks or until 100% compliance is achieved, and then monthly for three months until 100% compliance is achieved. The results of the audits will be reviewed during the monthly Quality Assurance (QA) meetings.	

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F0760 SS = D	Continued from page 6 Friday, Saturday, Sunday and Monday. On Sunday 7/20/25, we received a call from another facility asking for their medications. Our investigation revealed that the courier had inadvertently delivered the 4 bags to the wrong facility. We asked this facility to check and remove the incorrect bags from their fridge. We are working on quality control to prevent this from happening again." 9/12/25 12:30 PM – E2 provided the surveyor with documentation with counseling for E4 (former weekend supervisor) and E5 (former RN.) The Surveyor asked for evidence of counseling for the third nurse involved in the medication error. E2 stated, "She said she gave the correct medication, and I have no way of proving that she did not." During an interview, the Surveyor asked E7 (RN) about the medication that was administered to R5 on the previous day. E7 stated, "I don't remember what he got." 9/12/25 12:45 PM – A review of pharmacy medication delivery receipt revealed that four bags of iv daptomycin were prepared to be delivered to the facility on 7/18/25 at 4:28 AM (doses for the next 4 days.) R5's counseling documented medication errors for 7/17/25 and 7/19/25. The surveyor asked E2 if the facility's investigation revealed how many doses of the incorrect medication was administered to R5. E2 stated, "We think it was one incorrect dose but there were two remaining bags that were removed from the fridge." A review of R5's medication administration record revealed that iv daptomycin was administered on 7/18/25 and one on 7/19/25. 9/12/25 1:00 PM – During a telephone interview E5 stated, "I saw that the medication was labeled with another patient's name, but I thought it would be okay if scratched out that name and put my resident's name on it. I asked the supervisor to initial her name next to mine on the bag. I did not realize that the dosage was incorrect until later when I was told by the DON." The facility failed to ensure that R5's iv antibiotic medication was administered according to the physician's order when they administered 850mg of daptomycin instead of 800mg for two or three doses. 9/12/25 2:30 PM – During an interview, finding was confirmed with E2 (DON). 9/15/25 3:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (RN).	F0760		