

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 09/15/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>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 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).</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 Person Right Medication Right Dose Right Time Right Route Right Reason Right 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, 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 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).</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>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 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).</p>		