STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085042	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Brackenville LLC	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to thoroughly investigate allegations of abuse for four residents (Resident (R) 59, R88, R97, and R106) out of nine residents reviewed for abuse in a total sample of 40. This failure placed residents at risk of further abuse and a diminished quality of life.Findings include:1. Review of the admission Record, located in the Profile tab of the electronic medical record (EMR), revealed that R59 was admitted to the facility on [DATE] with diagnoses that included hemiplegia/hemiparesis (paralysis on one side of the body) following a cerebral infarct (stroke) and major depressive disorder.Review of the quarterly Minimum Data Set (MDS), located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 02/14/26, revealed R59 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R59 was cognitive intact.Review of the facility's investigation related to a 08/16/25 report of verbal abuse revealed R59 had slid to the floor when Certified Nurse Aide (CNA) 5 was assisting R59 back to bed. CNA5 called for assistance, and several CNAs came to assist. R59 asked for the Hoyer lift to get up, and CNA2 said he could get himself up. According to the report, R59 became angry and started cursing and told CNA2 to leave his room. CNA2 then told R59 that it wasn't his room; they then began bickering with each other. CNA2 did not leave R59's room until she was told to leave by the Licensed Practical Nurse (LPN) present. The investigation, provided by the facility, did not contain any resident interviews outside of R59.During an interview on 03/04/26 at 3:30 PM, R59 reported that he did not get along with CNA2, and he didn't think many people did. During an interview on 03/05/26 at 10:35 AM, the Director of Nursing (DON) was asked if she had any documentation to show that she had spoken to other residents on the unit and if they had experienced any verbal abuse by CNA2 and what their response was. The DON stated, I don't remember if I interviewed other residents, but if not in the folder, no. I will double check. No other interviews were located.2. Review of the admission Record, located in the Profile tab of the EMR, revealed R88 was admitted to the facility on [DATE] with diagnoses that included rheumatoid arthritis, hypertension, and peripheral vascular disease.Review of the quarterly MDS, located in the MDS tab of the EMR with an ARD of 02/03/26, revealed R88 had a BIMS score of 14 out of 15, which indicated R88 was cognitively intact.Review of the facility's investigation of a report of verbal abuse on 02/04/26 revealed that R88's roommate was relocated to another room due to the roommate becoming aggressive with R88. On the day the roommate was moved, the roommate's daughter came to R88's room and cursed R88 out. R88 reported the incident to her son, and he reported it to the social worker. The file contained no interviews with other residents outside of R88.During an interview on 03/04/26 at 10:30 AM, R88 reported that she had never been so scared in her life. The lady was so angry, called me a F-ing bitch and said I was going to hell.During an interview on 03/05/26 at 10:35 AM, the DON was asked if she had any documentation to show that she had spoken to other residents on the unit and if they had experienced any verbal abuse by this family member. The DON stated, No. I didn't think it was necessary because this family member always sits at her mother's bedside, and her anger was directed at [R88]. In hindsight I probably should have. 3. Review of R97's admission Record, dated 03/05/26 and found in the EMR under the Profile tab, revealed R97 was admitted to the facility on [DATE]. The resident's diagnoses included (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	type 2 diabetes and epilepsy.Review of R97's quarterly MDS with an ARD of 02/06/25, found in the EMR under the MDS tab, indicated a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R97's Progress Notes, dated 06/18/25 and found in the EMR under the Notes tab, revealed Resident's daughter reported that her mother told her that a male CNA wearing a red shirt was too rough with her and that he was upset with her for having to change her linens.Review of the facility's investigation related to the 06/18/25 report of potential staff to resident abuse revealed an incomplete investigation. Review of the investigation revealed R97 had been interviewed as part of the investigation; however, no additional interviewable residents residing in the same area of the facility and/or with potential knowledge of the incident were interviewed. 4. Review of R106's admission Record, dated 03/05/26 and found in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included type 2 diabetes and heart disease. The resident was discharged from the facility on 08/03/25.Review of R106's quarterly MDS with an ARD of 05/09/25, found in the EMR under the MDS tab, indicated a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R106's comprehensive record revealed nothing in the progress notes or anywhere else in the record to indicate an allegation of potential abuse.Review of the facility's investigation documentation related to a 07/26/25 allegation of potential abuse by R106 revealed the resident reported a staff member entered her room and told the resident she was a poor excuse for a human being and refused to assist her with changing her brief. The investigation documentation revealed an incomplete investigation into the allegation of abuse. There were no additional residents or staff members interviewed related to the allegation, R106 was not physically and psychosocially assessed related to the allegation in a timely manner, and there was no facility review of the employee record of the staff member accused of being potentially abusive toward R106 as part of the investigationDuring an interview with the Administrator and DON on 03/05/26 at 12:19 PM, both confirmed the investigation into R106's allegation of potential abuse had not been thoroughly investigated (to include a thorough assessment of the resident, additional resident and staff interviews related to the allegation, and a facility review of the accused staff member's employee file). Both stated their expectation was that any allegation of potential abuse should be thoroughly investigated according to facility policy. Review of the facility's policy titled, Abuse, Neglect and Exploitation, reviewed/revised 11/24 revealed, An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: . Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.