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

PRINTED: 08/30/2019 FORM APPROVED OMB NO. 0938-0391

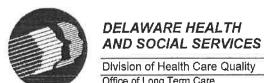
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C 08/28/2019	
		085004	B. WING	B. WING			
NAME OF PROVIDER OR SUPPLIER BRANDYWINE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 GREENBANK ROAD WILMINGTON, DE 19808			_	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					BE	(X5) COMPLETION DATE
F 000	REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) F 000			
LABORATORY	DIRECTOR'S OR PROVID	JER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		IIILE		(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.

Event ID: PYGV11

08/30/2019

Electronically Signed



DHSS - DHCQ 3 Mill Road, Suite 308 Wilmington, Delaware 19806 (302) 577-6661

Office of Long Term Care Residents

Protection

STATE SURVEY REPORT Page 1

NAME OF FACILITY: Brandywine Nursing & Rehabilitation Center 2019

DATE SURVEY COMPLETED: August 29,

Provider's Signature

Title ADMINISTRATOR

_Date 8/30/2019