

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

PRINTED: 06/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/26/2016
NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE COURT AT COUNTRY HOUSE			STREET ADDRESS, CITY STATE, ZIP CODE 4830 KENNETT PIKE WILMINGTON, DE 19807		
(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	
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from May 20, 2016 through May 26, 2016. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 44. The Stage 2 survey sample size was 20. Abbreviations/definitions used in this report are as follows: ED - Executive Director; NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; FMD - Facility Maintenance Director; MDS/Minimum Data Set - standardized assessment form used in nursing homes; DW - Dickinson Woods; RG - Rodney Gardens; UM - Unit Manager; Bladder incontinence - inability to prevent accidental leakage of urine from bladder; Frequent incontinence - 7 or more episodes of bladder incontinence, but at least one episode of continent voiding during a 7 day look back period; Occasional incontinence - less than 7 episodes of bladder incontinence during a 7 day look back period.	F 000			
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	A) The identified areas were quickly brought into compliance. Attachment # <u>1</u> . B) An audit was completed on all resident rooms to identify and correct areas to ensure compliance. Attachment # <u>2a & b</u> .	5/27/16 5/31/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Marguerite Tolson* TITLE *NHA* (X6) DATE *6/23/16*

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.

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F 253	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interviews, It was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for 4 (DW 7, DW 13 RG 2, and RG 16) out of 32 rooms surveyed. Findings include:</p> <p>On 5/20/16 during the Stage 1 review and during the environmental tour on 5/24/16 between 11:00 AM and 11:30 AM, the following were observed:</p> <p>Wing DW 7 - The front door did not close easily;</p> <p>Wing DW 13 - The walls in the bedroom and bathroom were scratched around the bottom perimeter;</p> <p>Wing RG 2 - The first drawer handle on the bedside table was missing;</p> <p>Wing RG 16 - The window sill on the left side was chipped; - The fire suppression sprinkler cap above the night table was loose.</p> <p>Findings were reviewed and confirmed with E7 (FMD) on 5/24/16 at approximately 11:30 during the environmental tour.</p> <p>Findings were reviewed during the exit conference on 5/26/16 at approximately 4:20 PM with E1 (ED), E2 (NHA) and E3 (DON).</p>	F 253	<p>C) An audit will be conducted monthly of all residents rooms to identify any areas needing repair. Attachment # <u>3a</u> & <u>b</u>. Staff were educated to report any observed repairs needed in resident areas to their supervisor promptly. Attachment # <u>4a</u> & <u>b</u>.</p> <p>D) The results of the audit will be reported in the monthly QI meeting until 100% compliance is reached x 3 months. The Plants Operations Supervisor is responsible to ensure compliance.</p>	7/27/16 6/14/16
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315		

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F 315	<p>Continued From page 3</p> <p>stated that R41 was frequently incontinent of urine, a change from her admission assessment.</p> <p>Review of the clinical record revealed a lack of evidence that R41 was reassessed when the 3/9/16 quarterly MDS assessment identified a change in her bladder function.</p> <p>In an interview on 5/26/16 at 11:19 AM, E9 (RN, UM) confirmed the finding. The facility failed to reassess R41's bladder function when the 3/9/16 quarterly MDS assessment identified a change in her bladder incontinence from occasional to frequent.</p> <p>Finding was reviewed with E2 (NHA) on 5/26/16 at 2:30 PM.</p>	F 315		
F 371 SS=E	<p>483 35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interviews, it was determined that the facility failed to prepare, store and serve food under sanitary conditions to prevent the outbreak of food-borne illness. Findings include:</p>	F 371	<p>Part 1 - Food Contact Surfacers</p> <p>A) The pizza slicer and ladle were immediately removed in the presence of the surveyor. After being washed, they were placed in the clean utensil storage container with food contact surface down.</p> <p>B) Utensils in the three food service areas were audited to ensure that none had their contact surfaces up. Attachment # <u>8</u>.</p> <p>C) An In-service will be performed for all food service staff on proper utensil storage & corrective action for improperly stored utensils. An audit will be conducted twice weekly by the Chef Manager to ensure that utensils in the three kitchenettes are appropriately positioned. Attachment # <u>9</u> & <u>10</u>.</p>	<p>5/20/16</p> <p>5/20/16</p>

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F 371	Continued From page 4 The following were observed during the initial kitchen tour on 5/20/16 between 8:15 AM and 9:00 AM: 1. Two pizza slicers and one ladle were stored with food contact surfaces up in the clean utensil storage container near the 3 compartment sink. E6 (Culinary Director) immediately removed the utensils upon discovery by the surveyor. 2. The ice machine filter was dirty with growth on it. E6 immediately cleaned it with a sanitizer wiping cloth. Findings were confirmed with E6 on 5/20/16 at approximately 9:00 AM. Findings were reviewed during the exit conference on 5/26/16 at approximately 4:20 PM with E1 (ED), E2 (NHA) and E3 (DON). 3. During an observation in the assisted dining room on 5/20/16 at 11:50 AM, E8 (Culinary Aide) was observed removing a plate after a resident finished eating. E8 scraped the food remains off the plate into a trash can and placed the dish into the sink. E8 proceeded to only rinse her left hand under running water and then dried her hands. E8 then got a clear, plastic pitcher and went down the hallway, returning at approximately 11:58 AM with a full pitcher of amber colored liquid. E8 failed to properly wash her hands after removing soiled plates. Findings were reviewed during the exit conference on 5/26/16 at approximately 4:20 PM with E1, E2 and E3.	F 371	D) The results of the above audit will be reported by the Chef Manager in the monthly QI meeting until 100% compliance is achieved for three consecutive months. Part 2 - Ice Machine A) The ice machine filter was immediately cleaned. 5/20/16 B) All ice machines facility-wide were immediately inspected for filter cleanliness. Attachment # __11___. 5/20/16 C) All ice machine filters have been put on a quarterly inspection and cleaning schedule. Attachment # __12___. 7/27/16 D) Success will be measured by monthly audits by Chef Manager. Results will be reported to QI committee until compliance has been achieved for three consecutive months. Part 3 A) The culinary staff members present were immediately reminded to perform handwashing per policy after removing soiled plates. 5/20/16 B) The culinary staff on all shifts were educated 5/20/16 on handwashing procedure after clearing soiled plates. Attachment # __13a, b, c, d & e___. 5/20/16 C) An audit will be completed in each kitchenette area on both 7-3 and 3-11 shifts 3x weekly to ensure handwashing is performed after removing soiled 7/27/16 D) The results of the above audit will be reported at the monthly QI meeting by the supervisor or designee until 100% compliance has been reached for three months. The Nutrition Service Manager is responsible for compliance.	7/27/2016



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: WillowBrooke Court at Country House

DATE SURVEY COMPLETED: May 26, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual visit survey was conducted at this facility from May 20, 2016 through May 26, 2016. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 44. The Stage 2 survey sample size was 20.</p> <p>Abbreviations/definitions used in this report are as follows: ED - Executive Director; NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; FMD - Facility Maintenance Director; MDS/Minimum Data Set - standardized assessment form used in nursing homes; DW - Dickinson Woods; RG - Rodney Gardens; UM - Unit Manager; Bladder incontinence - inability to prevent accidental leakage of urine from bladder; Frequent incontinence - 7 or more episodes of bladder incontinence, but at least one episode of continent voiding during a 7 day look back period; Occasional incontinence - less than 7 episodes of bladder incontinence during a 7 day look back period.</p>		
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Provider's Signature Marquette Galore Title NHA Date 6/23/16



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STATE SURVEY REPORT

NAME OF FACILITY: WillowBrooke Court at Country House

DATE SURVEY COMPLETED: May 26, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	Regulations for Skilled and Intermediate Care Facilities		
3201.1.0	Scope		
3201.1.2	<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>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed May 26, 2016: F253, F315 and F371.</p>		
3201.3.0	General Requirements		
3201.3.6	<p>The Division shall be notified, in writing, upon any changes in the administrator, assistant administrator or director of nursing positions.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on interview and review of Long Term Care Residents Protection documents it was determined that the facility failed to notify the Division when changes occurred in the administrator and director of nursing positions for a three month period. Findings include:</p> <p>On June 7, 2016 the Division of Long Term</p>	<p>A) The process of officially notifying the Division was done/started immediately. 6/8/16.</p> <p>B) The residents were not affected by the omission of notification. The Executive Director and NHA have reviewed the State Regulation 3201.3.6, and are now aware to notify the Division of Long Term Care Resident Protection with the change in</p>	

Provider's Signature _____ Title _____ Date _____



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	<p>Care identified that the name of the new NHA (E2) had not been communicated to the Division.</p> <p>During an interview with E2 on June 7, 2016 at approximately 11:10 AM the following was revealed:</p> <p>In March of 2016 E2 became the new NHA, In February of 2016 E3 became the new DON.</p> <p>E2 confirmed that the Division was not notified of the changes in administrator or the director of nursing positions.</p> <p>Findings were reviewed with E2 at the time of the interview.</p>	<p>personnel for the NHA and DON positions 6/23/2016. Attachment #15</p> <p>C) Notifying DLTCRP will be an added item on the orientation check list for the New Hire when hiring NHA and DON. The Business Officer Manager will assure that this is done. Attachment #16</p> <p>D) Notify DLTCRP of changes in NHA and DON position will be added as an item to be reviewed by the Executive Director semi-annual quality assurance compliance and risk management. Attachment #17</p>	

Provider's Signature _____ Title _____ Date _____