

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

PRINTED: 03/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE COURT AT COKESBURY VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 728 LOVEVILLE ROAD HOCKESSIN, DE 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
--------------------	--	---------------	---	----------------------

F 000

INITIAL COMMENTS

An unannounced annual survey was conducted at this facility from February 19, 2015 through February 25, 2015. 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 42. The Stage 2 sample totaled 27 residents.

Abbreviations used in this report are as follows:

NHA - Nursing Home Administrator;
DON- Director of Nursing;
PT - Physical Therapy;
CNA - Certified Nurse's Aide;
MDS - Minimum Data Set-standardized assessment form used in nursing homes;
S-Student Nurse;
DCS - Director of Culinary Services.

F 000

Cokesbury Village continually strives to provide quality services to our residents through our Quality Assurance Performance Improvement Process. The following are our latest efforts to improve our community. preparation and/or execution of this plan of correction does not constitute admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law.

F 241

483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, it was determined that the facility failed to care for residents in a manner and in an environment that maintains or enhances each resident's dignity for three (R28, R48 and R60) out of 27 Stage 2 sampled residents. On two (2) separate dining observations nursing students were observed

F 241

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **3/25/15**

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.

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

PRINTED: 03/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE COURT AT COKESBURY VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 726 LOVEVILLE ROAD HOCKESSIN, DE 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
F 241	<p>Continued From page 1</p> <p>feeding and/or assisting the residents while wearing disposable gloves. Findings include:</p> <p>On 2/19/15 from 12:00 PM through 12:45 PM, in the assisted dining room, the following observations were made:</p> <p>1. R48 was assisted during the midday meal by S1, who was wearing disposable gloves. The facility failed to ensure R48 was cared for in a dignified manner.</p> <p>2. R60 was assisted during the midday meal by S2, who was wearing disposable gloves. Additionally on 2/24/15 from 12:00 PM through 12:48 PM, S2 was again observed assisting R60 during the midday meal while wearing disposable gloves. The facility failed to ensure R60 was cared for in a dignified manner.</p> <p>3. R28 was assisted during the midday meal by S3, who was wearing disposable gloves. Additionally on 2/24/15 from 12:00 PM through 12:48 PM, S3 was again observed assisting R28 during the midday meal while wearing disposable gloves. The facility failed to ensure R28 was cared for in a dignified manner.</p> <p>On 2/25/15 at 8:30 AM in an interview, I1 (Nursing Student's Instructor), with regards to all the above examples, stated that the practice of the school was to have students wear gloves only when giving direct resident care. It was not the practice of the school to have the students use gloves while they are feeding the residents. I1 stated they were instructed by the facility to err on the side of caution and have the students wear gloves just in case they would be handling the food.</p>	F 241	<p>1. R48, R60 and R28 all need assistance with meals and sometimes are totally dependant. The nursing students were assisting them on a one to one basis.</p> <p>2. Wearing gloves in the dining room is not our common practice, unless food will be in direct contact with hands. The Del Tech instructors and students were informed of this survey finding, and they will take corrective action for their future orientations.</p> <p>3. The nurse managers will continue to supervise dining room during meals, to make sure proper procedures are followed, and at the same time to promote residents dignity. Random audit will be done weekly on all three meals. Attachment 1</p> <p>4. The audit result will be reported to monthly QI until 100% compliance is achieved.</p>	<p>2-26-15</p> <p>3-3-15</p> <p>3-20-15</p> <p>ongoing</p>

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

PRINTED: 03/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE COURT AT COKESBURY VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 726 LOVEVILLE ROAD HOCKESSIN, DE 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
F 280	Continued From page 3 by: Cross refer to F323 R1 was re-admitted to the facility from the hospital on 8/1/14 with a diagnosis of vascular dementia (progressive decline in memory, reasoning and remembering, caused by a blockage or reduction of blood flow to the brain). An Initial Evaluation by PT (Physical Therapy), dated 8/2/14 included the findings: impaired standing balance; able to walk 40 feet with a hemi-walker (light weight walking cane) with close supervision; all transfers with stand by assistance. This same evaluation indicated that the dementia was a barrier to R1's learning. PT's long term goal of treatment for R1 included "able to perform all transfers independently by discharge". R1 was assessed as a high risk for falls on 8/8/14 and quarterly, thereafter, with the same results. The re-admission MDS assessment, dated 8/8/14, indicated R1 needed extensive assistance of staff to transfer to and from various surfaces, such as the bed, chair, wheelchair, toilet and standing position. The facility initiated a care plan, dated 8/11/14, for the problem, "I am at risk for falls because I had a decline in my mental state and I am taking new medicines". The interventions were: "make sure my gait is assessed and my fall risk is assessed; Follow fall risk protocol: Blue label on chart, and falling star on door frame; Keep bed locked and in appropriate position; Keep my environment clean and hazard free; Please make sure I can	F 280	1. With frequent falls, R1 has not had any significant injuries. Her care plan for fall was updated after each fall, and was discussed at morning clinical meeting the next day after the fall. 2. All residents who are fall risk have care plans in place with personalized interventions. The RNAC will continue to update care plans as needed, and the team will continue with the current process to address and discuss additional options to decrease falls and prevent significant injuries. 3. Effectively managing falls is one of our QAPI projects. Updating care plans to reflect changes is one of the areas of focus. The interdisciplinary team will continue to review falls as they occur, any new interventions will be documented on the care plans. The RNAC will review all resident care plans at our weekly meetings. Care plan audit will be an ongoing process. 4. The result of the audit will be reported to our monthly and quarterly QI meeting.	2-26-15 ongoing ongoing ongoing

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

PRINTED: 03/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE COURT AT COKESBURY VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 726 LOVEVILLE ROAD HOCKESSIN, DE 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	
F 280	Continued From page 4 reach my call bell before leaving my room; monitor my vital signs per protocol; and follow recommendations from therapy". R1 had 7 unwitnessed falls between 8/14 through 2/15, resulting in injuries such as abrasions, skin tears, bruises and a hematoma (localized collection of blood outside the blood vessels, usually in liquid form within the tissue). Six of these falls occurred when R1 transferred independently between surfaces. One fall occurred when R1 moved a chair that was blocking her way. The quarterly MDS assessment, dated 1/15/15, stated R1 needed extensive assistance of staff during transfers and toilet use. Although the facility continued to review this care plan, the facility failed revise the care plan and failed to address the pattern of falls that occurred when R1 self transferred, and failed to identify appropriate preventative strategies in order to reduce the frequency of falls and to ensure safety during transfers. This finding was acknowledged by E1 (NHA) and E2 (DON) on 2/25/15 at approximately 4:00 PM	F 280			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	1. With frequent falls, R1 has not had significant injuries. Her care plan was updated after each fall and was discussed at morning clinical meeting the day after the fall. New Interventions from nursing and rehab were in place as indicated.	2-26-15	

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

PRINTED: 03/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 086017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE COURT AT COKESBURY VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 726 LOVEVILLE ROAD HOCKESSIN, DE 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
F 323	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of other facility documentation, it was determined that the facility failed to establish and implement a systemic approach to ensure one (R1) out of 27 Stage 2 sampled residents' safety to prevent falls with injuries and failed to ensure the environment remained as free of accident hazards as was possible. R1 had 7 unwitnessed falls between 8/14 through 2/15 resulting in injuries such as abrasions, skin tears, bruises and a hematoma (localized collection of blood outside the blood vessels, usually in liquid form within the tissue). Six of these falls occurred when R1 transferred independently between various surfaces. One fall occurred when R1 attempted to move a chair that was blocking her way. Findings include: R1 was admitted from the facility to the hospital on 7/24/14 due to erratic behavior and disorientation and was re-admitted to the facility on 8/1/14 with a diagnosis of vascular dementia (progressive decline in memory, reasoning and remembering, caused by a blockage or reduction of blood flow to the brain). An Initial Evaluation completed by PT (Physical Therapy) on 8/2/14 included the findings: impaired standing balance; able to walk 40' with a hemi-walker (light weight walking cane) with close supervision; all transfers with stand by assistance and Dementia was a barrier to learning. The PT's long term goal of treatment included "able to perform all transfers independently by discharge".	F 323	2. A review was conducted of current residents with fall risk. All interventions are in place and are listed on care plans for staff to follow. The team will continue to follow our policy and procedures for falls, always looking for new interventions with the goal to decrease occurrences and to prevent significant injuries from falls. 3. Our QAPI team will continue to look for further interventions as we work to balance safety and quality of life for our residents. Staff will continue to encourage the use of call bells and the elimination of safety hazards. For residents experiencing frequent falls the team will work to identify patterns as well as additional interventions. 4. Keeping track of falls is one of the QAPI projects, and is an ongoing process. The report will be shared at monthly and quarterly QI meetings.	3-2-15 ongoing ongoing

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

PRINTED: 03/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 086017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2015	
NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE COURT AT COKESBURY VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 726 LOVEVILLE ROAD HOCKESSIN, DE 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
F 323	<p>Continued From page 6</p> <p>The admission MDS assessment, dated 8/8/14 and most recent quarterly MDS, dated 1/15/15, stated R1 was independent in daily decision making. Both of these MDS assessments also stated R1 needed extensive assistance from staff to transfer, that is, between surfaces to and from bed, chair, wheelchair, standing position and toilet use.</p> <p>R1 was assessed on 8/8/14 as a high risk for falls and quarterly thereafter, with the same results.</p> <p>The facility initiated a care plan dated 8/11/14 on the problem of R1's "risk for falls because...had a decline in ...mental state and...taking new medicines "(last revised on 2/1/15). This care plan's interventions included "Keep my environment clean and hazard free" and "follow recommendations from therapy".</p> <p>Additionally, the facility established the following care plans, dated 8/11/14, to address R1's problems related to:</p> <ol style="list-style-type: none"> 1. "...recently in the hospital and had a mental status change and need more help with caring for myself" (last revised on 2/6/15); 2. "...trouble making appropriate decisions related to new onset of dementia" (last revised on 2/6/15); <p>Review of R1's nurses' note record revealed the following sequence of events:</p> <p>1.8/7/14 at 8:30 PM-Resident was found sitting on the floor in her bathroom on wet buttock leaning against her wheelchair (w/c) on her back and next to the toilet...stated "I was attempting to transfer from toilet to w/c".</p>	F 323		

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

PRINTED: 03/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 086017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2015	
NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE COURT AT COKESBURY VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 726 LOVEVILLE ROAD HOCKESSIN, DE 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
F 323	<p>Continued From page 7</p> <p>8/8/14 - "...small bruising appearing lower back, new bruise found on L (left) elbow which resident states she bumped during fall."</p> <p>2. 9/17/14 at 3:00 AM - "Resident found on floor in BR (bathroom) floor... CNA heard loud noise and found resident. This nurse saw resident sitting on BR floor leaning on (r/right) elbow. 2 cm (centimeter) abrasion to upper back... Resident walking with new walker and stated R (right) knee give (sic) out and she fell...new small skin tear noted at site of R lower leg d/t (due to) fall."</p> <p>9/19/14 - "Resident expressed pain in R knee and increased weakness".</p> <p>3. 10/3/14 at 1:00 PM - "Resident had fall (sic) in room...Observed on L (left side)...Skin tear to L hand; Hematoma on L knee...Rollator (wheeled walker) was exchanged for RW (rolling walker)...received Tylenol at 4:00 PM for...moderate pain to L knee with + (positive) effect. L knee remain swollen and noted with fluid fill blister...dark purple bruise to R lower arm area".</p> <p>10/3/14 at 4:50 PM - "Instructed by PT to use RW with SBA (Stand by Assist) to and from bathroom for next couple days to monitor ability to ambulate".</p> <p>The left knee hematoma resulted in a large collection of fluid (blister). During an appointment with an Orthopedist (physician that deals with bones and associated muscles, joints, and ligaments), the blister was drained and diagnosed as a "hematoma effusion (excess fluids collected around or even within the joint) of left knee" and treated accordingly.</p>	F 323		

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

PRINTED: 03/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 086017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE COURT AT COKESBURY VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 726 LOVEVILLE ROAD HOCKESSIN, DE 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)	(X6) COMPLETION DATE
F 323	<p>Continued From page 8</p> <p>4. 10/18/14 at 4:00 PM- "Resident was noted on the floor by activities staff...noted Resident laying on the floor in her room on her back and buttock...noted bruise to left elbow...Resident stated 'I was walking from the bathroom with my walker to sit on the w/c, but I couldn't get into it easily. I lost my balance and fell'..noted the locked w/c...Resident bed and the walker next to Resident...".</p> <p>5. 12/19/14 at 10:14 AM - "Resident found on floor lying on back next to recliner. Indicated that she was in the middle of transfer from motorized w/c to recliner when she fell...no new injury."</p> <p>6. 1/8/15 at 11:30 PM - "CNA heard resident calling out for help. Upon entering resident room, resident was found lying on the floor beside the bed. Resident states 'I tripped over my walker.' Resident was ambulating with walker from bathroom to the recliner prior to fall. Abrasion noted to L elbow...denies hitting head."</p> <p>7. 2/1/15 at 5:10 PM - "Resident heard by this nurse calling out. Call bell also noted to be on. Resident found lying on the left side by bedside. Walker near bathroom doorway. Resident state, 'I am sorry I shouldn't have moved that chair and I won't do it again'. Resident stated she tried to move the chair before going to the bathroom. Lost balance and fell to the floor on the L side. Stated she reached for the call bell and put light on...small skin tear noted to L elbow".</p> <p>On 2/25/15 at approximately 8:00 AM, it was observed that R1's left knee hematoma was healed.</p>	F 323		

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

PRINTED: 03/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2015	
NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE COURT AT COKESBURY VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 726 LOVEVILLE ROAD HOCKESSIN, DE 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
F 323	Continued From page 9 On 2/25/15 at approximately 8:50 AM, in an interview with E6 (CNA), she stated that R1 was on a daily Restorative Walker with supervision. In her room she walked independently and preferred it that way. However, when she turned around to sit, she was unable to determine the distance between the seat of the wheelchair, chair or toilet seat and missed aiming where to sit. The facility failed to address R1's pattern of falls and failed to implement appropriate preventative strategies to reduce her falls with injuries and ensure her safety during her transfers from one surface to another and during toilet use. This finding was discussed with E1 (NHA) and E2 (DON) on 2/25/15 at approximately 2:00 PM.	F 323		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to keep the compactor pad area free from debris. Findings include: Observation of the compactor pad area in the building's basement on 2/19/15 at 10:46 AM revealed debris on the pad. On 2/19/15 at 10:46 AM, E5 (DCS) confirmed the finding. E5 stated that the compactor was used	F 372	A. Compactor area was Immediately swept up and debris on the pad was discarded B. Culinary, Environmental and Plant Operations staff to be In-serviced relating to checking for and removal of debris in compactor area and on pad. Attachment 2 C. Grounds and Environmental staff will monitor the compactor and pad area after the waste hauler has removed trash to assure that any debris that falls out will be cleaned up. D. The area will be inspected on the weekly check sheet and reported In Q.I. meetings for compliance. Attachment 3	02/19/2015 02/19/2015 04/20/2015

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

PRINTED: 03/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE COURT AT COKESBURY VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 726 LOVEVILLE ROAD HOCKESSIN, DE 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	
F 372	Continued From page 10 by other areas of the building other than healthcare.	F 372			



**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

Page 1 of 7

NAME OF FACILITY: Willowbrooke Court at Cokesbury Village

DATE SURVEY COMPLETED: February 25, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from February 19, 2015 through February 25, 2015. 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 42. The Stage 2 survey sample size was 27.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <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 report date completed 2/25/15, F241, F280, F323 and F372.</p>	<p>Cokesbury Village continually strives to provide quality services to our residents through our Quality Assurance Performance Improvement Process. The following are our latest efforts to improve our community. preparation and/or execution of this plan of correction does not constitute admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law.</p> <p>F241</p> <p>1. R48, R60 and R28 all need assistance with meals and sometimes are totally dependent. The nursing students were assisting them on a one to one basis.</p>	<p>2-26-15</p>

Provider's Signature *Orsby Crowder* Title EXEC DIRECTOR, NHA Date 3/25/15



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

Page 2 of 7

NAME OF FACILITY: Willowbrooke Court at Cokesbury Village

DATE SURVEY COMPLETED: February 25, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

		<p>2. Wearing gloves in the dining room is not our common practice, unless food will be in direct contact with hands. The Del Tech instructors and students were informed of this survey finding, and they will take corrective action for their future orientations.</p> <p>3. The nurse managers will continue to supervise the dining room during meals, to make sure proper procedures are followed, and at the same time to promote residents' dignity. Random audit will be done weekly on all three meals.</p> <p>Attachment #1</p> <p>4. The audit result will be reported to monthly QI until 100% compliance is achieved.</p>	<p>3-3-15</p> <p>3-20-15</p> <p>ongoing</p>
--	--	---	---

Provider's Signature Robyn Crowdell Title EXEC DIRECTOR, NHA Date 3/25/15



**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

Page 3 of 7

NAME OF FACILITY: Willowbrooke Court at Cokesbury Village

DATE SURVEY COMPLETED: February 25, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

		<p>F280</p> <ol style="list-style-type: none"> 1. With frequent falls, R1 has not had any significant injuries. Her care plan for fall was updated after each fall, and was discussed at morning clinical meeting the next day after the fall. 2. All residents who are fall risk have care plans in place with personalized interventions. The RNAC will continue to update care plans as needed, and the team will continue with the current process to address and discuss additional options to decrease falls and prevent significant injuries. 3. Effectively managing falls is one of our QAPI projects. Updating care plans to reflect changes is one of the areas of focus. The interdisciplinary team will continue to review falls as they occur, any new interventions will be documented on the care plans. The RNAC will review all resident care plans at our weekly meetings. Care plan audit will be an ongoing process. 4. The result of the audit will be reported to our monthly and quarterly QI meeting. 	<p>2-26-15</p> <p>ongoing</p> <p>ongoing</p> <p>ongoing</p>
--	--	--	---

Provider's Signature Debra Conrad Title EXEC DIRECTOR, NHA Date 3/25/15



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

Page 4 of 7

NAME OF FACILITY: Willowbrooke Court at Cokesbury Village

DATE SURVEY COMPLETED: February 25, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201.7.0</p> <p>3201.7.5</p>	<p>Plant, Equipment and Physical Environment</p> <p>Facilities shall comply with the Delaware Food Code.</p> <p>Based on observation during the survey, it was determined that the facility failed to comply with the following section of the Delaware Food Code.</p> <p>6-501.114 Maintaining Premises, Unnecessary Items and Litter.</p>	<p>F323</p> <p>1. With frequent falls, R1 has not had significant injuries. Her care plan was updated after each fall and was discussed at morning clinical meeting the day after the fall. New interventions from nursing and rehab was in place as indicated.</p> <p>2. A review was conducted of current residents with fall risk. All interventions are in place and are listed on care plans for staff to follow. The team will continue to follow our policy and procedures for falls, always looking for new interventions with the goal to decrease occurrences and to prevent significant injuries from falls.</p> <p>3. Our QAPI team will continue to look for further interventions as we work to balance safety and quality of life for our residents. Staff will continue to encourage use call bells and the elimination of safety hazards. For residents experiencing frequent falls the team will work to identify patterns as well as additional interventions.</p> <p>4. Keeping track of falls is one of the QAPI projects, and is an ongoing process. The report will be shared at monthly and quarterly QI</p>	<p>2-26-15</p> <p>3-2-15</p> <p>ongoing</p> <p>ongoing</p>

Provider's Signature Dobyn Crowder Title EXEC DIRECTOR, NNA Date 3/25/15



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

Page 5 of 7

NAME OF FACILITY: Willowbrooke Court at Cokesbury Village

DATE SURVEY COMPLETED: February 25, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>The premises shall be free of: (B) Litter.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed, 2/25/15, F372.</p>	<p>meetings.</p> <p>F372</p> <p>A. Compactor area was immediately swept up and debris on the pad was disposed of.</p> <p>B. Culinary, Environmental and Plant Operations staff to be in-serviced relating to checking for and removal of debris in compactor area and on pad.</p> <p>Attachment #2</p> <p>C. Grounds and Environmental staff will monitor the compactor and pad area after the waste hauler has removed trash to assure that any debris that falls out will be cleaned up.</p> <p>D. The area will be inspected on the weekly check sheet and reported in Q.I. meetings as to compliance.</p> <p>Attachment #3</p>	<p>02/19/2015</p> <p>03/20/2015</p> <p>02/19/2015</p> <p>04/20/2015</p>

Provider's Signature *Robyn Crandall* Title EXEC DIRECTOR, NHA Date 3/25/15



**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

Page 6 of 7

NAME OF FACILITY: Willowbrooke Court at Cokesbury Village

DATE SURVEY COMPLETED: February 25, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

--	--	--	--

Provider's Signature *Debra Crandall* Title DEZ DIRECTOR, NNA Date 3/25/15



**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

Page 7 of 7

NAME OF FACILITY: Willowbrooke Court at Cokesbury Village

DATE SURVEY COMPLETED: February 25, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

--	--	--	--

Provider's Signature Arbyrn Crandall Title EXEC DIRECTOR/NA Date 3/25/15