

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

PRINTED: 02/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2015
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NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE COURT AT MANOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 MIDDLEFORD ROAD SEAFORD, DE 19973
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from January 20, 2015 through January 28, 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 55. The Stage 2 sample totaled 25 residents.</p> <p>Abbreviations used in this report are as follows:</p> <p>NHA - Nursing Home Administrator; DON- Director of Nursing; ADON- Assistant Director of Nursing; RN - Registered Nurse; LPN- Licensed Practical Nurse; CNA - Certified Nurse's Aide; MDS - Minimum Data Set-standardized assessment form used in nursing homes; RNAC - Registered Nurse Assessment Coordinator; F - Fahrenheit</p> <p>F 246 SS=D 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was</p>	F 000	<p>Disclaimer Statement: Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. This plan represents the facility's credible allegation of compliance as of 4/28/2015.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

[Signature] NHA 2/18/15

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.

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F 246	<p>Continued From page 1</p> <p>determined that for one (R89) out of 25 sampled residents the facility failed to ensure the resident's call bell and water cup were within reach. Findings included:</p> <p>1. The following observations of R89 were made throughout the survey:</p> <p>1/21/15 - At 10:27 AM the resident's water cup was observed to be on the bedside table out of reach of the resident.</p> <p>1/23/15 - At 10:03 AM R89's water cup was on the bedside table out of reach of the resident. - At 10:39 AM the cup remained in the same location.</p> <p>1/26/15 - At 10:02 AM the resident's call bell and water cup were out of reach of the resident. The water cup was on the Over the Bed (OBT) table that had been moved a few feet away from the bed. The call bell was looped behind the enabler bar near the head of the bed. The resident confirmed she could not reach either and verbalized that she was having some pain. The nurse documented in the clinical record that she administered pain medication at 10:09 AM. - At 2:51 PM the call bell and the water cup remained out of the resident's reach. - At 3:28 PM the call bell and the water cup remained out of the resident's reach.</p> <p>1/28/15 - 11:20 AM the resident was observed in bed. The resident's water cup was on the OBT that had been pushed a few feet away from the bed</p>	F 246	<p>F246</p> <p>A. Resident #89 is stable at this time. Resident continues to be Independent in her room and independent with bed mobility. Resident is able to access call bell and water cup at will.</p> <p>B. All active Residents will have random audits conducted to verify call bell and water cup placement. Audits will be conducted weekly x4 until 100% compliant. Audits will then become monthly. Attachment #1 and #2.</p> <p>C. Staff Educator/Designee will educate nursing staff and health center management on purposeful rounding. Education will include observation of call bell and water cup being within reach of all residents. Attachment #3</p> <p>D. The Director of Nursing and Nursing Home Administrator will meet weekly x4 with management team to discuss compliance of weekly audits. Monthly review will be discussed at QA meetings.</p>	4/28/2015

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F 246	Continued From page 2 out of reach of the resident. Interview with the resident during each observation confirmed that she could not reach her water cup and/or call bell. These findings were reviewed on 1/28/15 at 11:35 AM with E6, RN charge nurse.	F 246		
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. This REQUIREMENT is not met as evidenced by: Based on observations throughout the survey, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain an orderly and comfortable interior. Findings include: Observations during the tour of the facility on 1/20/15, and 1/21/15 [between the hours of 9:00 AM and 3:00 PM] revealed the following concerns: 1. Observation of room 15 on 1/20/15 at 1:39 PM revealed that an area on the wall behind the recliner had multiple scrapes in the wall, areas of missing paint, and what appears to be water damage near the heating vent. 2. Observation of room 3 on 1/21/15 at 9:39 AM revealed a small hole in the bathroom wall near the light switch.	F 253	F253 A. Work orders were placed and repairs completed February 3, 2015 for rooms; 15,3,25,40,41. B. All of the resident's doors and walls were audited and inspected. Identified repairs are to be completed on February 27, 2015. Findings and completion report will be submitted for compliance. C. Specific detailed inspection will be added to the weekly QA Preventive maintenance program. Attachment #4a and #4b D. Results of weekly maintenance program will be reported monthly to the administrator and QA committee meetings.	4/28/2015

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F 253	Continued From page 3 3. Observation of room 25 on 1/21/15 at 10:54 AM revealed damage from wheelchair traffic to the bathroom door. 4. Observation of room 40 on 1/21/15 at 11:21AM revealed scrapes to the bathroom door consistent with damage from wheelchair traffic, and disrepair of the trim/protective covering of the door. 5. Observation of room 41 on 1/21/15 at 11:47AM revealed wall damage behind the entrance door and removal of the finish covering the bathroom cabinet. Findings were reviewed with E1, NHA and E2 DON on 1/28/15 at 2:30 PM.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272	F272 A. Resident #93 had no negative outcome from unchecked box in MDS. Care and services were provided. Significant correction was completed by RNAC to reflect an indwelling foley catheter. Resident #89 had no negative outcome from unchecked box on MDS. Resident documented as having Hospice care and correction completed to reflect life expectancy of less than 6 months. B. All assessments completed by RNAC involving foley placement and Hospice care will be verified with Director of Nursing, prior to completion date. Attachment #5	

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F 272	Continued From page 4 Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to initially and periodically conduct a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for 2 (R89 and R93) out of 25 stage 2 sampled residents. Findings include: 1. R93 was readmitted to the facility from the hospital on 1/7/15. The hospital discharge summary, dated 1/7/15, stated that R93 was to follow up with a urologist (physician that specializes in disorders in the urinary tract) as an outpatient and to remove his foley catheter (a tubular, flexible instrument inserted and retained in the bladder by a balloon) if tolerated.	F 272	C. DON/Designee will provide education to RNAC consistent with reviewing assessments before completion utilizing Point Right System when applicable. Attachment #6 D. Monthly audits will be conducted on section "H", "J" and "O" of the MDS in order to monitor compliance. Audits will be conducted monthly x 3. Results will be reviewed and discussed at the QA meetings.	4/28/2015	

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F 272	Continued From page 5 Review of R93's admission MDS assessment, dated 1/14/15, was not checked to indicate that R93 had a urinary catheter (foley). A urology consult, dated 1/15/15, stated that R93's foley would be removed on 1/16/15 and re-evaluate. On 1/23/15 at 3:35 PM, E4 (RNAC) confirmed she should have coded R93 as having an indwelling urinary catheter on the admission MDS assessment dated 1/14/15. 2. R89 was admitted on 1/13/15 and admitted to Hospice (end of life) services on 1/16/15. Review of the admission MDS dated 1/20/15 documented that R89 was on Hospice but did not document that the resident had a life expectancy of less than six months. An interview on 1/27/15 around 10 AM with E4 confirmed that this MDS item was not correctly documented. These findings were reviewed with E1, NHA and E2, DON on 1/28/15 at 2:30 PM.	F 272		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve	F 274	F274 A. Resident #72 was admitted to Hospice services and was pronounced prior to completion of a significant change assessment. No negative outcome resulted as care and services were provided. B. All in house Residents who choose Hospice care will have a significant change assessment opened in the Data Base with Assessment Reference Data (ARD) clearly set.	

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F 274	<p>Continued From page 6</p> <p>itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that within 14 days after a determined significant change in the residents physical condition the facility failed to conduct an Interdisciplinary review for one (R72) out of 25 sampled residents Findings include:</p> <p>R72's Clinical record contained the following:</p> <p>9/25/14- An admission MDS assessment was completed for R72.</p> <p>9/29/14- A physician's orders was written to admit R72 to hospice.</p> <p>10/12/14-Death certificate documented R72 was pronounced at 10:28 PM.</p> <p>During an interview on 1/26/15 at 11:45 AM with E4 RNAC, it was confirmed that no significant change MDS assessment was conducted on R72. E4 stated that on "9/25/14 a comprehensive assessment was done, a significant change assessment was not done but should have been." E4 confirmed the ARD (assessment reference date) should have been scheduled during that two week window prior to R72's date of death.</p> <p>Findings were reviewed with E1, NHA and E2</p>	F 274	<p>C. RNAC/Designee will be educated to leave the significant assessment open in the data base and if the resident is pronounced before completion a narrative note will be written explaining why the assessment was not needed. Attachment #7</p> <p>D. DON/Designee will conduct monthly audits of in-house residents who elect Hospice care to monitor compliance with setting Assessment Reference Data. A written narrative note will be documented if assessment was not completed. Results will be discussed monthly at QA meetings. Monthly x3.</p>	4/28/2015	

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F 274 F 309 SS=D	<p>Continued From page 7 DON on 1/28/15 at 2:30 PM.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R60) out of 25 sampled residents, the facility failed to monitor and provide intervention according to the plan of care, for a resident with constipation. Findings include:</p> <p>The facility's policy for constipation states that a resident probably has constipation if he/she passes fewer than three stools a week and the stools are hard and dry.</p> <p>R60 had a diagnosis of constipation.</p> <p>The resident had physician's orders dated 10/24/14 for as needed medication for constipation including Milk of Magnesia (MOM) to be given if no bowel movement (BM) in 3 days.</p> <p>A care plan dated 11/19/14 for risk for constipation included the goal "I will have a BM every 3 days". Interventions included to have a nurse initiate the bowel protocol as needed and monitor effects.</p>	F 274 F 309	<p>F309</p> <p>A. Resident #60 is receiving a routine bowel regime and care plan goals have been revised to reflect her diagnosis of constipation.</p> <p>B. All active residents will have bowel movement record/report pulled every 24 hours on 11-7 shift. Report will generate all residents who have not had a bowel movement in 3 days. Bowel movement protocol will begin with 7-3 shift. Nursing supervisor will report during the clinical morning meeting, any resident listed on the bowel movement list. Attachment #8</p> <p>C. Medical Director has reviewed, revised and approved standing orders for bowel movement protocol. Attachment #9. All staff will be educated concerning bowl movement protocol and MD notification. Attachment #10</p> <p>D. Weekly audits will be conducted on a random basis. Audits will be x4 weeks until 100% compliant. Attachment #11. Results will be discussed at weekly plan of correction meeting. Continued success will be measured with random monthly</p>	

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F 309	Continued From page 8 Review of the electronic medical record for bowel movements documented R60 had no BMs from 12/24/14 through 12/28/14 for a total of 15 shifts or 5 days. There was no evidence that a nursing assessment for constipation was done or MOM was administered. The resident had current January 2015 physician's orders for two routine medications for constipation (Miralax and Colace). An interview on 1/28/15 about 12:30 PM with E6, RN, confirmed that there was no evidence of a nursing assessment or administration of MOM for constipation. This was reviewed with E1, NHA and E2, DON on 1/28/15 at 2:30 PM.	F 309	audits and reported at QA meetings monthly x3. Attachment #12 F371 A. Employee E7 was immediately educated of the observed deficient practice. B. All of culinary staff was educated on cross contamination ,glove usage and handwashing. Education was completed by Nutrition service manager. Attachment #13 C. The root cause has been determined that increased frequency of training in cross contamination, glove usage and handwashing will improve performance and compliance with food handling requirements and annually thereafter.	4/28/2015
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		

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F 371	<p>Continued From page 9</p> <p>Based on observation and interview it was determined that the facility failed to serve food under sanitary conditions. Findings include:</p> <p>1. During an observation of lunch service on 1/26/15 between 11:55 AM and 12:13 PM the following was observed;</p> <p>E7 food service worker donned gloves to plate food for lunch. She then touched the reach-in refrigerator handle to open the door contaminating her gloved hands. She removed a tray of pre-made sandwiches, set out 4 plates and used her contaminated, gloved hands to put lettuce, tomato and pickle on the plates. E7 then opened the refrigerator again and removed a slice of white bread and rolled slices of ham with her gloved hands to put on a plate. E7 also used her gloved hands to push pieces of quiche off of a spatula onto the plate. This practice of touching food with her gloved hands that were contaminated by the fridge and other objects in the kitchen continued through the plating of the entire lunch meal. E7 touched no less than 16 sandwiches and multiple pieces of lettuce, tomato, pickles and ham slices with her unchanged gloved hands. E7 opened the refrigerator with the same contaminated gloved hands that she was using to serve food at least 11 times while plating lunch.</p> <p>This was reviewed with E8, Food Service Director on 1/27/15 around 12 PM. He confirmed that E7 should not handle food with contaminated gloved hands and that utensils should be used for plating.</p> <p>2. During the kitchen inspection on 1/27/15 around 12 PM with the surveyor and E7, the</p>	F 371	<p>Nutrition Manager/Designee will provide education of safe food handling at each staff meeting to prevent reoccurrence.</p> <p>D. Nutrition Manager/Designee will conduct audits 1 x a week x 4 weeks until 100% compliance. One more follow up evaluation will take place a month later to ensure a successful outcome.</p> <p>Attachment # 14 Example #2</p> <p>A. Culinary staff on site was reminded immediately that stacking of wet items is not permitted according to food code. Each item needs to air dry independently.</p> <p>B. Culinary staff will be educated on proper drying procedures. Chef manager will be responsible for this training. Attachment #15</p> <p>C. Culinary Director/Designee will conduct random audits to ensure that the staff is following the proper drying procedures. 1x a week x 4 weeks</p> <p>D. Culinary Director/Designee will conduct audits within the department. Storage of drying items protocol will be evaluated. This will be done biweekly for 2 months, and then monthly until 100% success rate is achieved.</p> <p>Attachment #16</p>	

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F 371	Continued From page 10 Public Health inspector, the following was observed; -Some clean metal steam table trays were stacked and stored wet on a shelf across from the three compartment sink. -The dishwasher's equipment gauge during high temperature final rinse registered 175-176 degrees F not the required 180 degrees F. The testing thermometer during the final rinse measured 159 degrees F at the food contact surface, not the required 160 degrees F. -Hand wash sink temperature measured 70-75degrees F which was below the required 100 degrees F. -An additional hand wash sink was not operational. A second observation on 1/27/15 around 2:30 PM revealed that the dishwasher water had been adjusted and was registering at or above the required temperatures. This was reviewed with E1, NHA and E2, DON on 1/28/15 at 2:30 PM.	F 371	(2) A. The Maintenance staff was notified immediately and able to correct the issues with the rinse temperature. B. In tandem with the maintenance department; Director of culinary, Chef/Manager and Director of Maintenance will monitor and log rinse temperature and pressure daily. Any abnormalities will be reported to Maintenance for repair. C. Root cause was a loose fixture on a pressure valve. Preventive maintenance(PM) log will be put in place. D. Director of Culinary/ Designee will monitor daily to ensure compliance with water temperature. (2) A. Maintenance was notified immediately regarding equipment malfunctioning parts were ordered for a mixing valve on the sink that would not reach required 100 degrees F temperature. Nonfunctional sink was repaired and registered above 110F on same day of inspection. B. In tandem with the maintenance department; Director of Culinary, Chef/Manager and Director of Maintenance will monitor and log hand sink temperature daily. Any anomalies will be reported to maintenance departments for repairs. C. Root cause was a faulty mixing valve on each sink. D. Director of Culinary/Designee will monitor the hand wash sink temperature on a daily basis x 4 weeks. The PM log information will be required and discussed at QA meetings x 3 months. Attachment #17 and Attachment #18	4/28/2015	4/28/2015



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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STATE SURVEY REPORT

Page 1 of 2

NAME OF FACILITY: WillowBrooke Court at Manor House Nursing Home

DATE SURVEY COMPLETED: January 28, 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 January 20, 2015 through January 28, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 55 The survey sample totaled 25 residents</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>3201</p> <p>Regulations for Skilled and Intermediate Nursing Facilities</p> <p>3201.1.2</p> <p>Cross refer to the CMS2567-L survey report dated 1/28/2015. F246, F253, F272, F274, F309 and F371.</p>	<p>4/28/2015</p>

Provider's Signature *Miriam J. Z...* Title N. H. A Date 2/18/15



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	<p>This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey exit date 01/28/2015 citations are F246, F253, F272, F274, F309 and F371.</p>		
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Provider's Signature  Title NHA Date 2/18/15