

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

PRINTED: 02/25/2016  
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  02/12/2016
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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 February 5,2016 through February 12,2016. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentatlon as indicated. The facillty census the first day of the survey was 52. The Stage 2 sample totaled 27 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; RNAC - Registered Nurse Assessment Coordinator; Aflb (Atrial Fibrillation) - Irregular heart rhythm that increases risk for blood clots; ICD-9 diagnosis code - numbers indicating a specific medical condition; ICD-10 diagnosis code - numbers indicating a specific medical condition (effective 10/1/15); MAR - Medication Administration Record; MDS (Minimum Data Set) - standardized assessment form used in nursing homes; PRN - as needed; Anticoagulant - blood thinner to prevent blood clots; Anxiety - unpleasant state of feeling worry, nervous or restless; Ativan - medication for anxiety; Chronic - illness that is of long duration or frequent recurrence; Constipation - difficulty passing bowel movement;</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 of prepared and/or executed soley because it is required by the provision of federal and state law. This plan represents the facility's credible allegation of compliance as of 5/12/2016</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE George Cleyes, NHA TITLE Executive Director (X6) DATE 3/22/16

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 000	Continued From page 1 Coumadin - blood thinner; Hyperlipidemia - high levels of fats (cholesterol, triglycerides) in the blood; Lipids - fats (cholesterol, triglycerides) in the blood; Morphine - medication for pain; Narcotic - type of pain medication; Rhinitis - stuffy, runny nose; Triglycerides - type of fat in the blood that can lead to heart disease when elevated; Zofran - medication for nausea/vomiting.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/ CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when	F 164		

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F 164	<p>Continued From page 2</p> <p>release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by</p> <p>Based on observation and interview with family members and staff it was determined that the facility failed to maintain personal privacy and confidentiality for 3 (F1, F2, and R9) out of 27 sampled residents by not speaking privately about resident conditions. Findings include:</p> <p>1. Interviews conducted during stage 1 of the survey revealed that 2 (two) out of 3 (three) family members wishing to remain anonymous answered "No" to the question "Does staff speak privately (without being overheard) about your relative's medical or behavioral condition?"</p> <p>- On 2/5/16 at 2:41 PM F1 [family member] stated privacy was not maintained when talking "at the nurses' station with other people around". [It was unclear at which nursing station the conversation occurred.]</p> <p>- On 2/8/16 at 8:27 AM F2 [family member] stated privacy was not maintained when "others are around the nurses' station when discussing".</p> <p>2. Random observation made between 11:40 AM - 12:05 PM on 2/9/16 at the Rehoboth nurses' station while the surveyor was reviewing clinical records. This nursing station was located next to the lounge area used by residents for activities, watching television and a waiting area prior to the dining room opening for lunch.</p> <p>- 11:40 AM - The lounge area was loud because an activities staff member was reading to the group with a raised voice in order to be heard</p>	F 164	<p>1. A) The community was informed that 2 out of 3 family members who wish to remain anonymous were interviewed concerning staff not speaking privately about relatives medical or behavioral condition.</p> <p>B) All residents family have the potential to experience lack of privacy during conversation with staff in open areas.</p> <p>C.) ADON/Staff Developer will educate all staff regarding privacy and confidentiality when addressing protected health information of our residents and/or family members. Special focus will be toward conversation in public areas. The staff education will include a review of the HIPPA Training. By completion date and as needed all staff will be in-serviced on the above content to include policy and procedure.</p>	5/12/16

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F 164	<p>Continued From page 3</p> <p>over the conversations occurring between 20 plus residents waiting for lunch and several visitors.</p> <p>- 11:45 AM - At the other end of the nursing station the surveyor recognized E3's (DON) voice as she entered the nurses' station. With the surveyor's back facing facility staff at the other end of the nurses' station, the surveyor heard E5 (RN) state "for [R9's first and last name] the doctor gave orders for" a special mattress, morphine, ativan, zofran and stopped some other medications. E5 said that she told the physician we could do palliative care unless he [doctor] wanted to order hospice, but we [facility] can do everything that hospice can do here. The surveyor turned and saw that E5 was speaking to E3. E5 and E3 discussed the resident's weight, which was under 80 pounds, since R9's weight determined which mattress would be appropriate. It was when the surveyor heard R9's first and last name that prompted the surveyor to focus on the conversation at the other end of the nurses' station.</p> <p>- 12:00 PM - The lounge area was so full of residents and visitors that several residents needed to be moved in their wheelchairs so the meal cart could be pushed through the area from the kitchen to the Bethany (locked) unit. A visitor was seen walking through the dining room to bypass the congested lounge area when leaving the area.</p> <p>The conversation about R9 was loud enough to be heard over the talking among the numerous residents and family members waiting for the dining room doors to open.</p> <p>During an interview on 2/11/16 at 12:15 PM with E3, the surveyor informed E3 of the conversation about R9 and E3 stated this was not the first time</p>	F 164	<p>Systemic Monitoring will included audits as outlined in sections D. D.) Random interviews conducted by the social service coordinator and NHA will be conducted with random residents and family members to ensure their privacy and confidentiality are protected. These audits and interviews will be conducted twice a week x 4 weeks until 100% compliant and monthly thereafter x 3 months. Results will be reviewed and discussed at the monthly QA meeting.</p> <p>2) A. The community was informed of a conversation being overheard for R-9. No harm or negative outcome for R-9 was identified. The staff involved were immediately reminded of privacy and confidentiality of protected health information. Rehoboth nurses station was monitored by administrative staff for volume control and confidentiality of residents.</p> <p>B. All residents in WBC at Manor House have the potential to have health information disclosed due to open nurses station.</p>	5/12/16	

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F 164	Continued From page 4 she had heard that about E5. "She does have a loud voice".  These findings were reviewed with E2 (NHA) and E3 on 2/12/16 at 2:00 PM.	F 164	C. The ADON/Staff Developer will educate all staff regarding privacy and confidentiality when addressing protected health information of our residents and family members. A special focus will be towards conversation in public areas. Staff education will include review of HIPPA Training by completion date and as needed. This will be monitored by audits outlined in section D.	5/12/16	
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; 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	F 272	D. The activities director will observe the Rehoboth wing nurses station for residents privacy and confidentiality. The bi-weekly audits will be conducted x 4 weeks until 100% compliant and monthly thereafter x 3 months. Results will be reviewed and discussed at the monthly QA meeting.  A. R49 had no negative outcome from the omitted diagnosis on the annual MDS dated 12/26/15. Care and services were provided and a significant correction was completed by RNAC to reflect all active diagnosis.	5/12/16	

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F 272	Continued From page 5 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 ensure the accuracy of the comprehensive assessment for 1 (R49) out of 27 sampled residents by not including four diagnoses for which the resident was receiving medications. Findings include:  R49's current (February, 2016) and December, 2015 physician orders included: - medication given daily for allergies for chronic rhinitis. - bowel protocol including a PRN oral medication, suppository and enema. - pain medication daily for chronic pain [side effect of this drug is constipation]. - medication daily to prevent constipation. - blood thinner/anticoagulant due to heart valve replacement [latest dose change].  Review of MDS assessments stated: - 9/26/15 quarterly MDS assessment included many diagnoses including chronic pain, chronic rhinitis, long term anticoagulant use, and constipation. - 12/26/15 annual MDS assessment did not include the diagnoses of chronic rhinitis, chronic pain, long term anticoagulant use and constipation even though the resident received medications for each condition during the 7-day	F 272	B. WBC at Manor House recognizes that all residents have the potential to be affected. All comprehensive assessments completed by RNAC involving coding active diagnosis in section I, will be verified by DON prior to completion date.  C. ADON/Staff Developer will provided education to RNAC and back up staff member on active diagnosis consistent with recommendations from the RAI.  D. Audits of Section I of the comprehensive assessment will be conducted weekly x3 months by DON to ensure accuracy of the comprehensive assessment. Results will be reviewed and discussed at the monthly QA meeting.	5/12/16

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F 272	Continued From page 6 look back period.  During an interview with E4 (RNAC) on 2/10/16 at 3:06 PM, E4 confirmed the missing diagnoses on the 12/26/15 annual MDS assessment and stated that the ICD-9 codes from the prior quarterly assessment did not carry over until after the ICD-10 codes were implemented in October, 2015.  These findings were reviewed with E2 (NHA) and E3 (DON) on 2/12/16 at 2:00 PM.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/ COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.	F 278	1) A. Two identified quarterly assessments for R49 did not include diagnosis. A significant correction was made by the RNAC to include missing diagnosis. No harm or negative outcome was identified for R49 and care and services were provided. B. All comprehensive assessments completed by the RNAC involving coding active diagnosis in section I, will be verified with DON prior to completion date. C. ADON/Staff Developer will provide education to RNAC and back-up staff member on active diagnosis consistent with recommendations from the RAI. D. Audits of Section I of the quarterly assessment will be conducted weekly X3 months to ensure accuracy of the quarterly assessment. Results will be reviewed and discussed at monthly QA meeting.	5/12/16

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F 278	Continued From page 7  Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by:  Based on record review and interview It was determined that the facility failed to ensure the accuracy of quarterly assessments for 2 (R49 and R13) out of 27 sampled residents by failing to include a diagnoses for which the resident was taking medication. Findings include:  1. R49's current physician orders included a 12/17/14 order for a drug to treat elevated lipids [triglycerides].  Review of R49's quarterly MDS assessments found: - 6/26/15 diagnosis of hyperlipidemia was not checked on the diagnosis section. - 9/26/15 diagnosis of hyperlipidemia was not checked on the diagnosis section.  1/13/16 blood test showed triglycerides were 285 [normal is under 150].  2/10/16 During an interview with E4 (RNAC) at 3:06 PM - When questioned why hyperlipidemia was not included on the two quarterly assessments, E5 stated that distinguishing between chronic conditions being treated versus active treatment was hard. E5 stated that the corporate MDS person told us "we don't have to list the diagnoses that are under control".  Two quarterly MDS assessments for R49 failed to include a diagnosis.	F 278	2) A. One identified quarterly assessment for R13 did not include a diagnosis. A significant correction was made by the RNAC to include missing diagnosis. No harm or negative outcome was identified for R49 and care and services were provided as appropriate. B. All comprehensive assessments completed by the RNAC involving coding active diagnosis in section I, will be verified with DON prior to completion date. C. ADON/Staff Developer will provide education to RNAC and back-up staff member on active diagnosis consistent with recommendations from the RAI. D. Audits of Section I of the quarterly assessment will be conducted weekly X3 months to ensure accuracy of the quarterly assessment. Results will be reviewed and discussed at monthly QA meeting.	5/12/16	

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F 278	Continued From page 8  2. Review of R13's MDS assessment found: - 8/25/15 annual MDS assessment included afib in the diagnosis section. - 11/25/15 quarterly MDS assessment did not include afib in the diagnosis section even though the resident was receiving, the medication coumadin, with frequent laboratory tests to determine the correct dosage for treatment of afib  During an interview on 2/12/16 at 1:00 PM with E 4 (RNAC), E4 confirmed the missing diagnosis on the quarterly MDS and stated it should have been included.  A diagnosis was missing for one of R13's quarterly MDS assessments.  These findings were reviewed with E2 (NHA) and E3 (DON) on 2/12/16 at 2:00 PM.	F 278		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	1) A. This pharmacy recommendation was received and reviewed timely with the resident. While the resident understands the effects from taking both medications at the same time, R-42 wishes to continue as originally ordered by physician. The physician is aware of resident's decision and residents care plan was revised to reflect preference. No harm or negative outcome was identified for R-42.	5/12/16

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F 514	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by</p> <p>Based on observation, record review and interview it was determined that the facility failed to ensure that 4 ( R42, R33, R13 and R45) out of 27 sampled residents clinical records were accurately documented. Findings include:</p> <p>1. 12/10/16 at 9:07 AM - During medication observation R42 was administered iron and calcium at the same time.</p> <p>Review of R42's clinical record found that an 11/30/15 pharmacy comment report was sent to nursing asking for clarification since the absorption of iron "may be decreased by as much as 60% when administered at the same time as calcium. Please consider changing time of administration of calcium to 12 noon to prevent this interaction.</p> <p>Review of R42's November, 2015 and current ( February, 2016) MARs found iron and calcium were both scheduled to be given at 9:00 AM and 9:00 PM</p> <p>On 2/11/16 between 10:00 AM - 11:00 AM the surveyor asked E3 (DON) for the facility's response about R42's iron / calcium pharmacy request.</p> <p>At 1:30 PM on 2/11/16 E3 provided the surveyor with a copy of the consultant pharmacy monthly report with handwriting showing that both medications were scheduled for 9:00 AM and 9:00 PM along with a handwritten notation dated 12/30/15 "no change per patient request". E3</p>	F 514	<p>B. Residents in WillowBrooke Court at Manor House who receive calcium and iron have the potential to be affected. The community pharmacy consultant will conduct a review of all active resident medication orders to ensure that no unaddressed contraindications exist. Nursing will review pharmacy recommendation report and care plan preferences as indicated.</p> <p>C. The community pharmacy consultant will conduct a monthly review of all active residents medications orders to ensure that no contradictions exist. Nursing will review pharmacy report and care plan preferences as indicated. ADON/Staff developer will educate all professional nurses on the importance of a thorough follow through on all pharmacy recommendations to include medication contraindications. Education will also include care planning resident preferences by completion date and as needed. This will be monitored by audits outlined in section D.</p> <p>D. A random audit of the pharmacists nursing recommendations pertaining to potential drug interactions will be conducted by ADON monthly x3 months. If drug interactions exist follow through will include resident preference and physician consultation. Results will be reviewed and discussed at monthly QA meeting.</p> <p>2) A. All three identified nutritional risk assessment forms for R33 were corrected to reflect accurate information. No harm or negative outcome was identified for R33.</p> <p>B. All residents who receive a nutritional risk assessment could possibly have inaccurate documentation related to dentures. NSM will review to ensure that the dental information on the nutritional risk assessment is accurate.</p> <p>C. Nutrition Service Manager will review to ensure that the dental information on the nutrition risk assessments is accurate. NSM will review and compare nutritional risk assessment with nurses</p>	5/12/16	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/12/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>WILLOWBROOKE COURT AT MANOR HOUSE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1001 MIDDLEFORD ROAD SEAFORD, DE 19973</b>	
(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 514	<p>Continued From page 10</p> <p>confirmed that this information was not recorded in the resident's chart.</p> <p>2. Review of R33's clinical record revealed three Nutrition Risk Assessment forms (1/1/14, 1/13/14 and 1/27/16) completed by E7 (RD) each with "Dentures / partial" checked under the oral status section while the "Missing teeth" option was not checked.</p> <p>On 2/8/16 around 2:00 PM E7 confirmed R33 did not have dentures or partials and that the resident had natural teeth, even though some were missing.</p> <p>On 2/10/16 around 10:00 AM E8 (RN) confirmed that the resident had missing teeth but no partials or dentures.</p> <p>On 2/11/16 at 1:45 PM E9 (CNA) confirmed that R33 had missing front upper teeth (which was observed by the surveyor that same morning at breakfast), but no dentures or partial plates.</p> <p>During an interview on 2/11/16 at 4:00 PM, E7 confirmed the denture/partial answer, on the three assessment forms, was not correct.</p> <p>Three Nutrition Risk Assessment forms were incorrect in stating that R33 had dentures/partial when the resident did not have them.</p> <p>3. Review of R13's clinical record revealed a Nursing Pain Status Report, a 3-page document, that was undated and lacking the signature of the nurse who completed the form.</p>	F 514	<p>assessment. ADON/Staff Developer will in-service NSM by completion date on accurate documentation.</p> <p>This will be monitored by audits outlined in section D.</p> <p>D. An audit of all charts will be conducted by Nutritional Service Manager (NSM) to ensure charts reflect accurate dental information. The NSM will audit new admission assessments monthly x3. These audits will be reviewed and discussed in the QA meeting.</p> <p>3) A. For R13, the nursing pain status reports were corrected to include signature and date when form was completed. No harm or negative outcome was identified for R13.</p> <p>B. All residents who require a nursing pain status report assessment have potential to have a unsigned document. DON reviewed all active charts to ensure that the pain status report was signed.</p> <p>C. Systemic change will include DON/Designee to perform an audit of all resident charts to ensure that the nursing pain status report form is dated and signed by nurse that completed the form. All new admission will be assessed by RN supervisor for signatures. Education will be provided by ADON to all nurses and medical records personnel by completion date to ensure all medical records meet professional standards and practices to verify that all documents are complete and accurate.</p> <p>D. Monthly audits x3 months will be completed by DON/Designee of the nursing pain status report to ensure all forms are dated and signed. These audits will be reviewed and discussed in the QA meeting.</p>	5/12/16

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

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F 514	<p>Continued From page 11</p> <p>Interview on 2/11/16 at 4:00 PM E5 (RN) confirmed the missing date and nurse's signature . E5 stated she would show the document to E 3 who was not available at that time.</p> <p>R13's nursing pain status report was undated and lacking the nurse's signature who completed the form.</p> <p>4. Review of R45's clinical record revealed a 12/5/15 Health History form that had E11's (LPN) name who completed the form also written on the line where the resident's name should be recorded. R45's name was no where on the form</p> <p>On 2/8/16 at 4:00 PM E10 (Unit Secretary) and E 2 (NHA) confirmed that the nurse's name appeared where the resident's name should have been and that the resident's name was no where on the form.</p> <p>R45's health history form lacked the resident's identification.</p> <p>These findings were reviewed with E2 and E3 on 2/12/16 at 2:00 PM.</p>	F 514	<p>4.) A. R45 had the Health History Form corrected to include the resident's name. No harm or negative outcome was identified for R45.</p> <p>B. All residents who require a health history form have the potential to have affected by the same deficient practice.</p> <p>C. The systemic change will include DON/ Designee to perform review all residents charts to ensure that the health history forms are dated and signed by nurse that completed the form. All new admissions will be assessed by RN supervisor for accuracy of resident name. Education will be provided by the ADON to all nurses and medical records personnel by completion date. This will include all medical records meet professional standards and practices to ensure that all documents are complete and accurate. This will be monitored by audits outlined in section D.</p> <p>D. A monthly audit x3 months will be completed by DON/Designee of the health history form to ensure that residents name is written on proper line. These audits will be reviewed and discussed in the QA meeting.</p>	5/12/16



**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 Manor House**

**DATE SURVEY COMPLETED: February 12, 2016**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p><b>3201</b></p> <p><b>3201.1.0</b></p> <p><b>3201.1.2</b></p>	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced annual survey was conducted at this facility from February 5, 2016 through February 12, 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 52. The Stage 2 sample totaled 27 residents.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>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.</b></p> <p><b>This requirement is not met as evidenced by:</b> Cross Refer to the CMS 2567-L survey completed February 12, 2016 -F164, F272, F278 and F514</p>	<p>3201.1.2 Cross reference to CMS 2567-L survey report dated 2/12/16, F 164, F 272, F 278 and F 514.</p>	<p>5/12/16</p>

Provider's Signature \_\_\_\_\_ Title Exec. Director Date 3/2/16