STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085017	A. BUILDING _____ B. WING _____	06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COKESBURY VILLAGE	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
E 000	Initial Comments An unannounced annual survey was conducted at this facility from May 28, 2019 through June 3, 2019 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was 39. For the Emergency Preparedness survey, all contracts, operations plan, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual survey and emergency preparedness survey were conducted at this facility from May 28, 2019 through June 3, 2019. 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 39. The survey sample totaled eighteen (18) residents. Abbreviations/definitions in this report are as follows: B/L - Bilateral/both sides; CNA - Certified Nurse's Aide; ED - Executive Director; DON - Director of Nursing; MDS - Minimum Data Set (standardized assessment form used in nursing homes); NHA - Nursing Home Administrator; POA - Power of Attorney; RNAC - Registered Nurse Assessment Coordinator.	F 000		
F 585	Grievances	F 585		7/17/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/19/2019

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 585 SS=E	Continued From page 1 CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone	F 585		

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F 585	Continued From page 2	F 585		

number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not

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F 585	Continued From page 3 confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of facility documentation, the facility failed to establish a grievance policy that included components of the Federal requirement under §483.10(j)(4). Findings include: During a resident meeting with surveyors on 5/28/19 at approximately 11:00 AM, only one (1) out of seven (7) residents, who wished to remain anonymous, was aware of how to file a grievance. The copy of the facility's grievance policy and procedure was requested. The undated document provided was titled, "Grievance Report". It stated, "A grievance is any issue that is not resolved by an individual or department to the satisfaction of the resident or family/legal representative. According to the Centers of Medicare and Medicaid Services such grievances may include those with respect for care and treatment and the behavior of staff and other residents."	F 585	1. The residents who attended the meeting on 5/28/19 were reminded of the location where the grievance information was on 6/14/19. 2. The information on grievance reporting process was reviewed at the resident council meeting on 6/19/19, the meeting minutes is placed in the central area for other residents/family to review. 3. The Grievance office, phone number and email address was added to the posting on 6/20/19. A locked box will also be available for residents/family to drop off the grievance who choose to remain anonymous. The blank grievance report forms and a copy of the grievance policy are placed in a binder next to the drop off box for easy access. The administrator/designee will have the key and will check the box daily during the week. The administrator will keep the grievance log according to policy, and will	

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F 585	Continued From page 4 The facility's admission "Information Book," page 21 stated, "Grievance Policy/Complaint Resolution...Residents, family members and visitors may voice grievances/concerns and suggestions with respect to treatment, care and/or services. These grievances/suggestions may be made without any fear of recrimination or reprisal. The administrator or designee will make prompt efforts to resolve the grievances and evaluate the suggestions...Grievance forms are available at the nurses' station for the individual to document her/his grievance/suggestion. (If so instructed by the individual, a staff member may complete the form.) We request all grievances be brought to either the licensed nurse, director of nursing, social worker or administrator...An investigation and follow-up is completed on each grievance and is reviewed with the individual who filed the grievance ..." The facility failed to establish a grievance policy and procedure that included Federal requirements under §483.10(j)(4) as follows: "...Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her	F 585	follow up with grievances timely and effectively. The grievance information will be reviewed at resident council meeting monthly moving forward by the social service coordinator or the recreation director. 4. The administrator will report grievance and resolution at monthly and quarterly QAPI meetings.	

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F 585	Continued From page 5 grievance... (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; An observation of the first floor Healthcare Center on 5/28/19 at approximately 2:08 PM, lacked evidence of any postings in prominent locations throughout the facility containing information regarding the facility's grievance process, identifying who the Grievance Officer was, how to contact them, and how to file grievances anonymously. Findings were reviewed with E2 (DON) during an interview on 6/3/19 at approximately 9:50 AM. Findings were reviewed with E1 (NHA), E2 (DON and E5 (ED) during the exit conference on 6/3/19 at approximately 4:45 PM.	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility failed	F 641	1. The resident R14 continues on Hospice care, with most medications	6/20/19

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F 641	Continued From page 6 to ensure that the MDS assessment accurately reflected the resident's status for one (R14) out of 18 residents sampled. Findings include: Review of R14's clinical record revealed the following: 2/7/19 10:29 PM - A nurse's progress note stated the POA agreed to having R14's anticoagulant (blood thinning medication) discontinued. The anticoagulant was discontinued by the Nurse Practitioner. 3/28/19 - The significant change MDS assessment erroneously coded that R14 received an anticoagulant for the seven (7) days of the assessment review time period. 5/31/19 11:15 AM - In an interview with E4 (RNAC), the erroneous coding of anticoagulant use was confirmed. Shortly after the interview, E4 informed the surveyor that a modified MDS was submitted. 6/3/19 10:31 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E5 (ED). Findings were reviewed with E1 (NHA), E2 (DON and E5 (ED) during the exit conference on 6/3/19 at approximately 4:45 PM.	F 641	discontinued. MDS correction was completed to specify that he is not on anticoagulant, and was submitted on 5/31/19. 2. The MDS coordinator has completed 10 random MDS audits, focusing on medication section to ensure full compliance with this requirement. 3. A root cause analysis revealed that when doing the significant change MDS, the MDS coordinator was focusing more on the physical decline of the resident, and failed to check that the medication orders are current. Moving forward, the MDS coordinator with double check all sections on MDS, to assure accuracy prior to submission. She will also conduct random MDS audit monthly X three month or until 100% accuracy rate is achieved. 4. The audit report will be discussed at monthly and quarterly QAPI meetings. The interdisciplinary team will follow up with concerns timely.	
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		6/30/19

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F 684	Continued From page 7 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (R13) out of one (1) resident reviewed for the care area of vision and hearing. The facility failed to offer and/or apply R13's hearing aides on multiple occasions for approximately nine (9) months. Findings include: Review of R13's clinical record revealed the following: 7/5/18 - R13 was admitted to the facility. 7/12/18 - The admission MDS assessment stated R13 had minimal difficulty hearing - difficulty in some environments (such as- when person speaks softly or setting is noisy). 7/12/18 - A care plan for a communication problem related to hearing loss was created. Interventions included: "Collect my hearing aids at bedtime, and place in charger. Replace them each morning as I may misplace or lose them; Ensure that my hearing aids are in place." 7/22/18 12:10 PM - A nurse's progress note stated, "...Staff located bilateral hearing aides...'he/she doesn't wear very often' and	F 684	1. The resident R13 has not been wearing hearing aides for a while, and she doesn't seem to have communication issues in relate to hearing. After the hearing aides were located in her room on 5/31/19, she stated that she hears better without them. The left hearing aide doesn't fit well, and she refused to wear them. On 6/4/19, the order "to offer her hearing aides in the morning and to collect in the evening" was discontinued. Her family/POA was contacted regarding the left hearing aide adjustment, her plan of care will be updated as soon as appropriate. 2. An audit was completed by nursing to include all residents with orders of hearing aides. The focus is on the residents who are not able to manage and depend on staff for assistance. Currently all orders are updated with daily documentation in place. 3. Upon root cause analysis, it was identified that the order was entered incorrectly in PCC. The order requires nursing documentation, but the order was entered as no documentation necessary. The resulted in no documentation to show offering and resident refusing. The deficiency will be communicated to all nurses at monthly nursing staff meeting on 6/27/19. Moving forward, any hearing aide orders entered into PCC will be	

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F 684	Continued From page 8 declined to wear them at this time...". 8/2/18 - R13's Personal Property Inventory notes "B/L hearing aides + charger 8/18/19." 8/8/19 - A physician's order stated, "Hearing Aides (HA)-bilateral, in charger in med (medication) room insert in am(morning), remove at HS (hour of sleep) and place in charger two times a day *Document when declines HA's." 10/11/18 and 1/3/19 -Quarterly MDS assessments stated R13 had minimal difficulty hearing. 3/28/19 - A quarterly MDS assessment stated R13 had minimal difficulty hearing and was moderately impaired for daily decisions making (decisions poor; cues/supervision required). 5/28/19 2:48 PM - During an interview R13 stated the he/she had hearing aides, but is unsure if they were lost here in the facility or before he/she came. 8/1/19 through 5/30/19 - Review of CNA documentation reports, medication and treatment administration records, and nursing progress notes lacked any documented evidence that R13 was offered his/her hearing aides. Additionally, there was no documented evidence that R13 was refusing placement of the hearing aides. 5/30/19 1:21 PM - During an interview, E6 (Charge Nurse) stated that R13 used to not like wearing the hearing aides. E6 stated that he/she would look for them. 5/30/19 3:00 PM - E6 (Charge Nurse) stated that	F 684	double checked by the second nurse, to make sure it's entered correctly. the third nurse doing 24 hour chart check will confirm the order entry to assure accuracy. The ADON will keep a log of noncompliance when it occurs and will follow up with intervention as appropriate. 4. The interdisciplinary team will discuss new orders every morning by reviewing 24 hour report on PCC. Any discrepancies will be addressed timely. The ADON will report the log in monthly QAPI.	

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F 684	Continued From page 9 R13's hearing aides were found in the back of the resident's drawer and were currently being charged. The facility failed to ensure that physician's orders and the care plan were implemented for R13. There was no evidence that the facility was offering the hearing aides daily or that the resident was refusing their placement from 8/1/18 through 5/30/19. 6/3/19 10:31 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E5 ED). Findings were reviewed with E1 (NHA), E2 (DON and E5 (ED) during the exit conference on 6/3/19 at approximately 4:45 PM.	F 684		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		6/30/19

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F 812	Continued From page 10 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure that food was stored and prepared in a sanitary manner. Findings include: The initial kitchen tour on 5/28/19 from 8:00 AM - 9:00 AM revealed the following: - A broom was resting on top of the hand washing sink basin near the dish washing area; - A bag of tater tots was opened and uncovered in the walk-in freezer; - The kitchen fume hood was greasy. Findings were confirmed with E3 (food service director) on 5/28/19 at approximately 9:00 AM. Findings were reviewed with E1 (NHA), E2 (DON and E5 (ED) during the exit conference on 6/3/19 at approximately 4:45 PM.	F 812	1. The broom resting on top of hand sink was immediately removed. The bag of tater tots was immediately discarded. The kitchen fume hood was cleaned and free of grease 5/29/19. 2. All other hand-washing sinks were immediately inspected to ensure that they were clean and sanitized. The walk-in freezer was inspected to ensure that all items were wrapped and covered properly. The kitchen fume hood was put on a four week routine cleaning schedule. 3. The culinary service director or designee will in-service all staff on cleanliness of handwashing sinks and property storage of all brooms; the in-service will also include property storage of all items in walk-in freezer, as well as the fume hood 4 week cleaning schedule. 4. A weekly audit will be completed utilizing the Culinary Sanitation Compliance Audit Form. If substantial compliance is achieved, monitoring will take place randomly. The culinary service director or designee will monitor the audit process, and will share the report to the interdisciplinary team at monthly QAPI meeting.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: WillowBrooke Court at Cokesbury **DATE SURVEY COMPLETED: June 3, 2019**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES		ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report.			
	An unannounced Annual and Emergency Preparedness survey was conducted at this facility from May 28, 2019 through June 3, 2019. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 39. The survey sample totaled 18 residents.	F000		
3201	**Regulations for Skilled and Intermediate Care Facilities**	F585	1. The residents who attended the meeting on 5/28/19 were reminded of the location where the grievance information was on 6/14/19. 2. The information on grievance reporting process was reviewed at the resident council meeting on 6/19/19, the meeting minutes is placed in the central area for other residents/family to review. 3. The Grievance office, phone number and email address was added to the posting on 6/20/19. A locked box will also be available for residents/family to drop off the grievance who choose to remain anonymous. The blank grievance report forms and a copy of the grievance policy are placed in a binder next to the drop off box for easy access. The administrator/designee will have the key and will check the box daily during the week. The administrator will keep the grievance log according to policy, and will follow up with grievances timely and effectively. The grievance information will be reviewed at resident council meeting monthly moving forward by the social service coordinator or the recreation director. 4. The administrator will report grievance and resolution at monthly and quarterly QAPI meetings.	7/17/19
3201.1.0	**Scope**			
3201.1.2	**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.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed June 3, 2019: F585, F641, F684, and F812.			

Provider's Signature Robyn Crawford Title ED/NHA Date 6/26/19

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: WillowBrooke Court at Cokesbury **DATE SURVEY COMPLETED: June 3, 2019**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES		ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Emergency Preparedness survey was conducted at this facility from May 28, 2019 through June 3, 2019. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 39. The survey sample totaled 18 residents.	F641	1. The resident R14 continues on Hospice care, with most medications discontinued. MDS correction was completed to specify that he is not on anticoagulant, and was submitted on 5/31/19. 2. The MDS coordinator has completed 10 random MDS audits, focusing on medication section to ensure full compliance with this requirement. 3. A root cause analysis revealed that	6/20/19
3201	**Regulations for Skilled and Intermediate Care Facilities**	F641	when doing the significant change MDS, the MDS coordinator was focusing more on the physical decline of the resident, and failed to check that the medication orders are current. Moving forward, the MDS coordinator with double check all sections on MDS, to assure accuracy prior to submission. She will also conduct random MDS audit monthly X three month or until 100% accuracy rate is achieved. 4. The audit report will be discussed at monthly and quarterly QAPI meetings. The interdisciplinary team will follow up with concerns timely.	
3201.1.0	**Scope**			
3201.1.2	**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.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed June 3, 2019: F585, F641, F684, and F812.			

Provider's Signature Robyn Crandall Title ED/NHA Date 6/26/19

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3201	**Regulations for Skilled and Intermediate Care Facilities**			
3201.1.0	**Scope**			
3201.1.2	**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.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed June 3, 2019: F585, F641, F684, and F812.			

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3201	**Regulations for Skilled and Intermediate Care Facilities**			
3201.1.0	**Scope**			
3201.1.2	**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.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed June 3, 2019: F585, F641, F684, and F812.			

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