Protection

Residents

DHSS - DHCQ 261 Chapman Road Suite 200 Newark, DE 19702

STATE SURVEY REPORT Page 1

NAME OF FACILITY: Willowbrooke Court Skilled Center At Manor House DATE SURVEY COMPLETED: June 3, 2024

| SECTION                      | STATEMENT OF DEFICIENCIES Specific Deficiencies  | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
|------------------------------|--|---|-----------------|
| 3201<br>3201.1.0<br>3201.1.2 | An unannounced Annual and Complaint Survey was conducted at this facility from May 29, 2024 through June 3, 2024. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 37. The investigative sample totaled 12 residents.  Regulations for Skilled and Intermediate Care Facilities  Scope  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, 2024: cross refer: F658 and F757. |   |                 |

Provider's Signature

\_Title\_\_*UHA* 

Date 4/12/2024

PRINTED: 06/24/2024 FORM APPROVED OMB NO. 0938-0391

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MUL<br>A BUILD |     | LE CONSTRUCTION  S  |      | TE SURVEY<br>MPLETED       |
|--------------------------|---|---|---------------------|-----|---|------|----------------------------|
|                          |   | 085009  | B. WING             |     |   | 06   | C<br>/03/2024              |
|                          | PROVIDER OR SUPPLIER  | ILLED CENTER AT MANOR HOU   | JSE                 | 1   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1001 MIDDLEFORD ROAD<br>SEAFORD, DE 19973                    | 1 00 | 70012021                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG  |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5)<br>COMPLETION<br>DATE |
| E 000                    | Initial Comments  |   | ΕC                  | 000 |   |      |                            |
|                          | was conducted at the  | nnual and complaint survey<br>nis facility from May 29, 2024<br>24. The facility census was 37<br>ne survey.  |                     |     |   |      |                            |
| F 000                    | conducted by The I<br>the Office of Long-T<br>Protection at this fa<br>period. Based on ob  | edness survey was also Division of Health Care Quality, Ferm Care Residents Cility during the same time Diservations, interviews, and Diservations Preparedness Emergency Preparedness Entified                             | F 0                 | 100 |   |      |                            |
|                          | was conducted at the through June 3, 202 in this report are base interviews, review of facility documentation census on the first of  | nnual and Complaint Survey is facility from May 29, 2024 4. The deficiencies contained sed on observations, folinical records and other on as indicated. The facility lay of the survey was 37. The extotaled 12 residents. |                     |     |   |      |                            |
|                          | Abbreviations/definit as follows:   | tions used in this report are   |                     |     |   |      |                            |
|                          | ADON - Assistant D<br>CNA - Certified Nurs<br>DON - Director of Ni<br>ED- Executive Direc<br>EMR- electronic med<br>NHA- Nursing Home | e's Aide;<br>ursing;<br>tor;<br>dical record;   |                     |     |   |      |                            |
|                          | the coagulation (clot   | cation that works to prevent ting) of blood;  |                     |     |   |      |                            |
| ABORATORY                | DIRECTOR'S OR PROVIDE   | R/SUPPLIER REPRESENTATIVE'S SIGNA   | TURE                |     | TITLE   |      | (X6) DATE                  |

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.

**Electronically Signed** 

06/13/2024

| PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  |           | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | 1 ` ′   | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED   |                            |
|--|-----------|--|--|---------|---|---|----------------------------|
| NAME OF PROVIDER OR SUPPLIER  WILLOWBROOKE COURT SKILLED CENTER AT MANOR HOUSE  STREET ADDRESS, CITY, STATE, ZIP CODE  1001 MIDDLEFORD ROAD  SEAFORD, DE 19973  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  STREET ADDRESS, CITY, STATE, ZIP CODE  1001 MIDDLEFORD ROAD  SEAFORD, DE 19973  (X5) (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CONSTRUCTION SHOULD BE CONSTRUCTIO |           |  | 085009   | B. WING |   |   |                            |
| WILLOWBROOKE COURT SKILLED CENTER AT MANOR HOUSE  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (X5) COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X6) COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | NAME OF F | PROVIDER OR SUPPLIER   |  | S       | TREET ADDRESS, CITY, STATE, ZIP CODE  |   |                            |
| PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  | WILLOW    | BROOKE COURT SK  | ILLED CENTER AT MANOR HOU  | ISF     | SEAFORD, DE 19973   |   |                            |
| F 000 Continued From page 1 F 000  | PREFIX    | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL   | PREFIX  | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE  | BE  | (X5)<br>COMPLETION<br>DATE |
| Atrial Fibrillation - irregular and often rapid heart rate that commonly causes poor blood flow to the body OR irregular heart rhythm.   | F 000     | Atrial Fibrillation - ir rate that commonly body OR irregular h  | regular and often rapid heart causes poor blood flow to the neart rhythm.  | F 000   |   |   | 2442/24                    |
| F 658 Services Provided Meet Professional Standards Services Provided Meet Professional Standards F 658 Seruces Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)  §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must.  (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for three (R1, R7, and R114) out of twelve residents reviewed for care plans, the facility failed to meet professional standards of the Delaware Board of Nursing Scope of Practice by having LPNs complete admission assessments and admission or progress notes. Findings include:  Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2023 Admission Assessments *- RN "= Once a care plan is established, the LPN may do assessments".  1. Review of R1's clinical record revealed: 5/1/24 - A review of R1's admission assessments functional abilities assessment, functional abilities assessment were completed by E4 (LPN).  6/13/24 12:10 PM - An interview with E4 confirmed  F 658  6/13/2  1. The admission assessments for R1, R7 and R114 were reviewed by the Director of Nursing on 6/7/2024. No changes were made. The 5-day MDS with ARD of 5/7/2024 for R1, 5/16/2024 for R7, 5/29/2024 for R1, 5/16/2024 for R7, 5/29/2024 for R1, 5/16/2024 for R7, 5/29/2024 for R1 of ursing on 0 f/7/2024. No changes were made. The 5-day MDS with ARD of 5/7/2024 for R1, 5/16/2024 for R7, 5/29/2024 for R1, 5/16/2024 for R7, 5/29/2024 for R1 of ursing on 0 f/7/2024. No changes were made. The 5-day MDS with ARD of 5/7/2024 for R1, 5/16/2024 for R7, 5/29/2024 for R1, 5/16/2024 for R7, 5/29/2024 for R1 of ursing on the supplies of ursing on days. No corrective action was needed. 3. The director of nursing and/or staff educator will complete education with nursing staff related to scope of practice for registered nurse and licensed practice for registered nurse and licensed practic             |           | Services Provided ICFR(s): 483.21(b)(3) Com The services provides outlined by the comust- (i) Meet professional This REQUIREMENT by: Based on record redetermined that for of twelve residents facility failed to meet the Delaware Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Findings include:  Delaware State Board by having LPNs con assessments and a Find | Meet Professional Standards 3)(i)  prehensive Care Plans ded or arranged by the facility, comprehensive care plan, all standards of quality. NT is not met as evidenced eview and interview, it was three (R1, R7, and R114) out reviewed for care plans, the et professional standards of d of Nursing Scope of Practice implete admission admission or progress notes.  and of Nursing - RN, LPN and 23 Admission Assessments a care plan is established, the sments".  Elinical record revealed:  mitted to the facility.  f R1's admission assessments well and bladder assessment, assessment, wandering risk, on assessment were .PN). | F 658   | R7 and R114 were reviewed by the Director of Nursing on 6/7/2024. N changes were made. The 5-day MI ARD of 5/7/2024 for R1, 5/16/2024 5/29/2024 for R114 were completed the RN care coordinator. No noted negative effects when reviewed by director of nursing.  2. The director of nursing reviewed admissions assessments complete licensed practical nurse in last 90 d No corrective action was needed.  3. The director of nursing and/or streducator will complete education we nursing staff related to scope of prafor registered nurse and licensed processed nurse related to admission assess For all new admissions, the DON/A will delegate the admission assess and initial admission progress note RNs. If an LPN completes any of the tasks, a RN will review, verify the accuracy and cosign for completion | o OS with for R7, d by days. aff with actice ments. ADON ments as to he | 6/13/24                    |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |                        | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|---|---|---|------------------------|-------------------------------|--|
|  |   | 085009  | B. WING                                 |   | C<br><b>06/03/2024</b> |                               |  |
| NAME OF I  | PROVIDER OR SUPPLIER  | a de la companya de   |   | STREET ADDRESS, CITY, STATE, ZIP CODE   | 1 00/                  | 03/2024                       |  |
| WILLOW   | BROOKE COURT SK   | ILLED CENTER AT MANOR HOL   | JSE                                     | 1001 MIDDLEFORD ROAD<br>SEAFORD, DE 19973   |                        |                               |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                     | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)                           | _D BE                  | (X5)<br>COMPLETION<br>DATE    |  |
| F 658  | that the nurse assig<br>resident is responsi<br>assessments and p | ge 2 ned to a new admission ble to complete the admission rogress note. E4 confirmed dmission assessments to be | F 65                                    | complete a weekly audit of admis<br>assessments x 3 months or until<br>compliance is obtained, or no lon<br>deemed appropriate by the | 100%                   |                               |  |
|  | completed. E4 confi<br>admission assessm                          | irmed she completed ents for R1 on 5/2/24.  |   | interdisciplinary team. The finding the audits will be documented, re and submitted to the QAPI comm                                  | viewed,<br>ittee for   |                               |  |
|  |   | Imitted to the facility.  |   | further review and any additional identified.   | action it              |                               |  |
|  | evaluation, functions   | led that the long term care<br>al abilities assessment, side<br>d Covid-19 admission                            |   |   |                        |                               |  |
|  |   | n interview with E4 confirmed ission assessments for R7 on  |   |   |                        |                               |  |
|  | 3. Review of R114's   | clinical record revealed:   |   |   |                        |                               |  |
|  |   | admitted to the facility.   |   |   |                        |                               |  |
|  | note, wandering risk evaluation, and the f                        | d that the admission progress assessment, long term care  |   |   |                        |                               |  |
|  |   | n interview with E4 confirmed ssion assessments for R114  |   |   |                        |                               |  |
|  |   | dings were reviewed with E1 I E3 (Corporate) during the   |   |   |                        |                               |  |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |               | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|---|--|---|---------------|-------------------------------|--|
|                          |   | 085009  | B. WING                                |   | l .           | C<br><b>03/2024</b>           |  |
| NAME OF I                | DOWNER OF CHERNIER  | 003003  |  | STREET ADDRESS, CITY, STATE, ZIP CODE   | 00/           | 03/2024                       |  |
|                          | PROVIDER OR SUPPLIER  | ILLED CENTER AT MANOR HOU   | ISE                                    | 1001 MIDDLEFORD ROAD SEAFORD, DE 19973  |               |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)   | BE            | (X5)<br>COMPLETION<br>DATE    |  |
| F 757<br>F 757           | Continued From particles of the consequences which reduced or discontinued or example. See the consequences which reduced or discontinue in paragraphs section. This REQUIREMEN by:  Based on record reduced or example of the consequence in paragraphs section. This REQUIREMEN by:  Based on record reduced or example is review facility failed to ensuadverse effects. Fin | ge 3 ree from Unnecessary Drugs 1)-(6) ssary Drugs-General. g regimen must be free from An unnecessary drug is any cessive dose (including apy); or xcessive duration; or out adequate monitoring; or out adequate indications for its e presence of adverse h indicate the dose should be nued; or combinations of the reasons is (d)(1) through (5) of this IT is not met as evidenced view and interview it was three (R1, R4, and R7) out of ved for medication review, the ure adequate monitoring of dings include: | F 757                                  | 1. Residents identified were immed assessed and no adverse side effewere noted. 2. Residents (R7 was discharged h time of correction) had orders adde medication administration record to | ome at        | 6/13/24                       |  |
|                          | <ol> <li>Review of R1's cl</li> <li>7/1/24 - R1 was adn</li> </ol>  | inical record revealed:   |  | monitor for adverse side effects for anticoagulants. The director of nurs completed facility wide audit of resign receiving anticoagulants for proper                                     | sing<br>dents |                               |  |
|                          |   | s order was written for 2.5 mg (anticoagulant) give   |  | to monitor for adverse side effects a documentation.  |               |                               |  |

| AND PLAN               | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MI            | LTIPLE CONSTRUCTION  | OMB NO   | D. 0938-03                    |  |
|------------------------|---|---|--------------------|--|--|-------------------------------|--|
|                        |   | IDENTIFICATION NUMBER:  | A. BUILI           | DING   | (X3) DA  | (X3) DATE SURVEY<br>COMPLETED |  |
| NAME OF                | DDOV/DED OF COLUMN  | 085009  | B. WING            |  | 12000  | С                             |  |
|                        | PROVIDER OR SUPPLIER  |   | l.                 | STREET ADDRESS, CITY, STATE, ZIP (   | 06   | /03/2024                      |  |
| WILLOV                 | VBROOKE COURT SK  | ILLED CENTER AT MANOR HO  | USE                | 1001 MIDDLEFORD ROAD   | 300 <u>L</u>   |                               |  |
| (X4) ID                |   | TEMENT OF DEFICIENCIES  |                    | SEAFORD, DE 19973  |  |                               |  |
| PRÉFIX<br>TAG          | (CACH DEFICIENCY  | MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)  | I SHOULD BE  | (X5)<br>COMPLETIC<br>DATE     |  |
| F 757                  | Continued From page   | ne 4  | <u> </u>           |  |  |                               |  |
|                        | one tablet by mouth two times a day for atrial fibrillation.  5/2/24 - A care plan revealed that R1 was on anticoagulant therapy related to atrial fibrillation (heart condition) and interventions included but not limited to "administer my anticoagulant medications as ordered by my physician. Monitor me (R1) for side effects and effectiveness every shift."  5/31/24 - A review of R1's medical record revealed no evidence of monitoring for side effects related to anti-coagulant use.  6/3/24 10:55 AM - An interview with E1 (NHA) |   | F 7                | 3. The director of nursing ar educator will complete educing clinical nursing staff related an order to monitor for side education as to monitoring freffects. An order templet will by resident health services I clarify specific side effects to anticoagulant orders. The side monitoring will be documented along with the medication or 4. The director of nursing or complete a weekly audit of refreceiving anticoagulants x 3 auntil 100% compliance is obtained to the composition of the complete of the composition of the complete of the complete of the complete of the complete of the composition of the complete of the comp | ation with to obtaining effects, and or those side be created T team, to monitor with de effect ed on MAR designee will esidents months or |                               |  |
| 5<br>5<br>a<br>a<br>"r | 2. Review of R4's clini<br>5/18/23 - R4 was adm<br>5/19/23 - A care plan r<br>inticoagulant for atrial<br>nd interventions inclumonitor me (R4) and o   | itted to the facility.  evealed that R4 was on an fibrillation (heart condition) ded but not limited to |                    | interdisciplinary team. The find the audits will be documented and submitted to the monthly committee for further review and additional action if identified.  | dings from<br>I, reviewed,<br>OAPI   |                               |  |
| 7/<br>EI<br>ta<br>fib  | /14/23 - A physician's  | order was written for oral tablet 5mg give one for paroxysmal atrial on).                               |                    |  |  |                               |  |

PRINTED: 06/24/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |   | TIPLE CONSTRUCTION | (X3) DA   | MPLETED C  |                    |
|---|---|---|--------------------|---|--|--------------------|
| AND FLAN OF   | 085009  |   | B. WING            |   |  | 6/03/2024          |
|   | ROVIDER OR SUPPLIER                                   | (ILLED CENTER AT MANOR HO   |                    | STREET ADDRESS, CIT<br>1001 MIDDLEFORD F<br>SEAFORD, DE 199 | ROAD   |                    |
| WILLOW  |   |   | ID                 | 2001/1050   | DIS BLAN OF CORRECTION   | (X5)<br>COMPLETION |
| (X4) ID<br>PREFIX<br>TAG  | CARL DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | PREF<br>TAG        | ODOCC DEEED   | RECTIVE ACTION SHOULD BE<br>RENCED TO THE APPROPRIATE<br>DEFICIENCY) | DATE               |
| F 757   | confirmed that fac                                    | age 5 - An interview with E1 (NHA) ility did not have monitoring in 1's use of anticoagulants.  | F                  | 757   |  |                    |
|   |   | clinical record revealed:   |                    |   |  |                    |
|   | 5/12/24 - A care panticoagulant the and interventions | admitted to the facility.  Idan revealed that R7 was on rapy related to clot prevention included but not limited to and document/report any of my anticoagulant therapy | ***                |   |  |                    |
|   | written Lovenox i                                     | M - A physician's order was<br>njection (anticoagulant) prefilled<br>Bmg/ 0.3mL: inject one dose<br>every evening shift for prevention                                  |                    |   |  |                    |
|   | revealed no evid                                      | w of R7's medical record<br>ence of monitoring for side<br>anti-coagulant use.  |                    |   |  |                    |
|   | confirmed that fa                                     | l - An interview with E1 (NHA)<br>acility did not have monitoring ir<br>R7's use of anticoagulants.   | 1                  |   |  |                    |
|   | 6/3/24 2:00 PM (NHA), E2 (ED), exit conference.       | <ul> <li>Findings were reviewed with E<br/>and E3 (Corporate) during the</li> </ul>   | Ξ1                 |   |  |                    |
|   |   |   |                    |   |  |                    |