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

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Willowbrooke Crt Skilled Ctr at Manor House **DATE SURVEY COMPLETED:** June 5, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from June 2, 2026, through June 5, 2026. The deficiencies contained in this report are based on interviews, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was thirty-seven (37). The survey sample totaled sixteen (16) residents. Abbreviations/definitions used in this report are as follows: ADON – Assistant Director of Nursing; CNA – Certified Nurse's Aide; DON – Director of Nursing; LPN – Licensed Practical Nurse; NHA – Nursing Home Administrator.		
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**	*Cross reference POC for CMS 2567 survey completed June 5, 2026. F-Tag :F812*	*07/03/2026*

Provider's Signature Lori C. Bergamini Title Executive Director LNHA/RN Date 6/16/2026

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	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 was not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed June 5, 2026: F812.		
S/S- D	**F609** **§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.**	**Past non-compliance**	**11/11/2025**

Provider's Signature Kris C. Rineyamer Title Executive Director LNHA/RN Date 6/16/2026

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	Based on interview, record review and a review of other facility documentation, it was determined that for one (R20) out of two residents sampled for abuse, the facility failed to report to the State Agency (SA) within the required 8 hours. Based on a review of the facility's evidence to correct the non-compliance and the facility's substantial compliance at the time of the current survey, the deficiency was determined to be past non-compliance as of 11/11/25. Findings include: Review of R20's clinical record revealed: 9/4/25 – R20 was admitted to the facility. 11/8/25 6:55 AM – A nursing progress note documented that R20 reported to staff that a man came into her room and tried to rape her. The note further documented that the allegation would be given to the next shift in report. 11/10/25 6:10 PM – An incident report, from the facility, was submitted to the SA and documented an allegation of sexual abuse. The report documented that R20 reported an allegation of sexual abuse to staff. 6/4/26 1:12 PM – During an interview, E4 (LPN) stated the expectation is to report an allegation of		

Provider's Signature Kim C. Benjamin Title Executive Director LNHA / RN Date 6/16/2026

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	abuse to management immediately, and if it's on a weekend, to call the manager on duty. 6/4/26 1:29 PM – During an interview, E3 (ADON) stated the allegation of abuse was not reported to management immediately. E3 stated that management found that the allegation was documented in a progress note and that staff were expected to notify management so the investigation could be initiated. The facility did not submit the report to the SA within the two-hour timeframe. The allegation of sexual abuse was reported by the facility approximately 59 hours and 15 minutes later. Based on the review of the facility's investigation, documented response, completion of training via electronic and in-person communication, resident interviews and evaluation, and implementation of nurse discipline resulting in termination, it was determined that the facility met the requirement for past non-compliance as of 11/11/25. 6/5/26 12:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.		

Provider's Signature Lori C. Benjamin Title Executive Director LNHA/RN Date 6/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085009	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CENTER AT MANOR HOUSE	**1001 MIDDLEFORD ROAD , SEAFORD, Delaware, 19973**

(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
E0000	Initial Comments In accordance with 42 CFR 483.73, an Emergency Preparedness survey was conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility from June 2, 2026 through June 5, 2026. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		06/11/2026
F0000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from June 2, 2026, through June 5, 2026. The deficiencies contained in this report are based on interviews, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was nine (9). The survey sample totaled eight (8) residents. Abbreviations/definitions used in this report are as follows: ADON – Assistant Director of Nursing; CNA – Certified Nurse's Aide; DOC/N - Director of Culinary/Nutrition; DON – Director of Nursing; LPN – Licensed Practical Nurse; NHA – Nursing Home Administrator; RN – Registered Nurse.	F0000		06/11/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F0812	Corrective action for the specific deficient practice On June 5th, 2026, the wall adjacent to the food preparation table and ice machine was thoroughly clean and sanitized the ice machine filters were removed cleaned and reinstalled according to manufacturer's recommendation the Director of Culinary and Nutritional Services verified completion	07/20/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085009	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2026

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F0812 SS = F	Continued from page 1 §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 standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined that the facility failed to ensure food was stored, prepared, and served in a manner that prevents food borne illness to the residents. 6/3/26 10:22 AM – During a tour of the kitchen, a heavy build up of dust clumps was present on the wall adjacent to a food prep table and the ice machine. The air filters of the ice machine were covered in a thick layer of dust. 6/3/26 10:24 AM - Findings were reviewd with E5 (DOC/N) during the kitchen tour. 6/5/26 12:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0812	Continued from page 1 of the cleaning and sanitation process. 2. Identification of other residents who could be affected All residents residing in Willowbrooke Court had the potential to be affected. However, at the time of the inspection the ice machine reference is not utilized for Willowbrooke Court residents. Additionally, at the time of the inspection the food prep area had not been utilized for the day. Once it was discovered it was immediately cleaned and a comprehensive inspection of the kitchen food storage and food preparation areas were conducted by the Director of Culinary Nutritional Services. if any areas were identified as requiring cleaning it was immediately addressed however, no additional concerns were identified that posed a risk to the resident's food safety. 3. Systemic changes implemented to prevent reoccurrence The facility has revised its Culinary Department Sanitation and Preventative Maintenance program to include the following: Daily inspections of food preparation areas kitchen walls and equipment surfaces to ensure cleanliness and compliance with sanitation standards. Monthly inspections and cleaning of ice machines and related components in accordance to manufacturer recommendations. Documentation of the inspections and if applicable any corrective action will be noted in an audit and these audits will be kept within the culinary department Re-education of culinary staff regarding food service sanitation standards infection prevention practices and environmental cleanliness requirements will be completed by the DCNS who is ServeSafe and HACCP certified as an instructor and Proctor. Ongoing supervisory oversight by the Director of	07/20/2026

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F0812 SS = F		F0812	Continued from page 2 Culinary Nutritional Services to ensure compliance with facility policies regulatory requirements and food service standards 4. Monitoring to ensure continued compliance The Director of Culinary Nutritional Services or designee will conduct daily sanitation audits of the kitchen food prep areas equipment services and ice machines upon achieving and maintaining 100 percent compliance audits will progress too weekly for four weeks and then monthly for two months failure to mean 100% compliance at any audit level will result in continuation of the current audit frequency until compliance is achieved. Audit results will be reviewed by the administrator and discussed during the facility's quality assurance and performance improvement (QAPI) meetings monthly for three months any identified concerns will be corrected immediately, and additional staff education will be provided as identified.	07/20/2026