



**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**

Page 1 of 11

NAME OF FACILITY: WillowBrooke Court at Cokesbury Village

DATE SURVEY COMPLETED: July 31, 2026

| SECTION | STATEMENT OF DEFICIENCIES<br>SPECIFIC DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ADMINISTRATOR'S PLAN FOR<br>CORRECTION OF DEFICIENCIES | COMPLETION<br>DATE |
|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------|
|         | <p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from July 27, 2026, through July 31, 2026. The deficiencies contained in this report are based on observation, interview and record review. The facility census on the first day of survey was (32) thirty-two. The survey sample totaled eleven (11) residents.</p> <p>Abbreviations/definitions used in this report are as follows:</p> <p>BIMS – (Brief Interview for Mental Status) – assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best.</p> <p>0-7: Severe impairment (never/rarely made decisions)</p> <p>08-12: Moderately impaired (decisions poor; cues/supervision required)</p> <p>13-15: Cognitively intact (decisions consistent/reasonable);</p> <p>cm – centimeter;</p> <p>CNA – Certified Nurse's Aide;</p> <p>DON – Director of Nursing;</p> <p>LPN – Licensed Practical Nurse;</p> <p>MD – Medical Director;</p> <p>mg – milligram;</p> <p>NHA – Nursing Home Administrator;</p> <p>NP – Nurse Practitioner;</p> <p>RCD – Regional Clinical Director;</p> <p>RN – Registered Nurse;</p> <p>Senile Degeneration of brain – an age-related brain tissues loss, memory decline and cognitive impairment;</p> <p>SR – State Resident;</p> <p>Steri-Strips - thin, sterile adhesive skin closures used to pull the edges of a minor cut or surgical incision together.</p> |                                                        |                    |

Provider's Signature [Signature]

Title NHA

Date Revised 8-21-26



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| SECTION                                 | STATEMENT OF DEFICIENCIES<br>SPECIFIC DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ADMINISTRATOR'S PLAN FOR<br>CORRECTION OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                  | COMPLETION<br>DATE |
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| 3201<br>3201.1.0<br>3201.1.2<br>S/S - D | <p><b>Title 16<br/>Health and<br/>Safety</b></p> <p><b>Regulations for Skilled and Intermediate Care<br/>Facilities</b></p> <p><b>Scope</b></p> <p>Nursing facilities shall be subject to all appli-<br/>cable local, state and federal code require-<br/>ments. The provisions of 42 CFR Ch. IV Part<br/>483, Subpart B, requirements for Long Term<br/>Care Facilities, and any amendments or mod-<br/>ifications thereto, are hereby adopted as the<br/>regulatory requirements for skilled and inter-<br/>mediate care nursing facilities in Delaware.<br/>Subpart B of Part 483 is hereby referred to,<br/>and made part of this Regulation, as if fully<br/>set out herein. All applicable code require-<br/>ments of the State Fire Prevention Commis-<br/>sion are hereby adopted and incorporated by<br/>reference.</p> <p>This requirement was not met as evidenced<br/>by:</p> <p>Cross Refer to the CMS 2567-L survey com-<br/>pleted 7/31/26: F713, F730, F865 and F943.</p> <p><b>F684</b><br/><b>§ 483.25 Quality of care</b><br/>Quality of care is a fundamental principle<br/>that applies to all treatment and care pro-<br/>vided to facility residents. Based on the com-<br/>prehensive assessment of a resident, the fa-<br/>cility must ensure that residents receive<br/>treatment and care in accordance with pro-<br/>fessional standards of practice, the compre-<br/>hensive person-centered care plan, and the<br/>residents' choices.</p> <p>Based on record review and interview, it was<br/>determined that for one (SR4) out of three res-<br/>idents reviewed for hospice, the facility failed</p> | <ol style="list-style-type: none"> <li>1. Skin tear healed at time<br/>of survey. Unable to cor-<br/>rect. New skin tear proto-<br/>col implemented on<br/>8/13/26 for all residents.<br/>Resident on Acts hospice<br/>services and treatment<br/>was being followed by<br/>their team.</li> <li>2. Audit of resident incident<br/>reports relating to skin<br/>tears performed for the<br/>past 60 days Completed<br/>8/19/26. Orders and noti-<br/>fications were reviewed</li> </ol> | 9/7/26             |

Provider's Signature

*S. Perrone*

Title

*NHA*

Date

*Revised 8-21-26*



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|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
|         | <p>to ensure that SR4 received adequate care and treatment that met professional standards when SR4 had a skin tear treatment applied without a physician's order. Findings include:</p> <p>Cross refer F713</p> <p>Review of SR4's record revealed:</p> <p>5/9/25 – SR4 was admitted to (P8, hospice services) for senile degeneration of brain.</p> <p>6/18/26 10:32 PM – A late entry nurse progress note entered by E8 (RN) documented an incident that occurred at 7:00 PM where SR4 scraped her left leg and had a skin tear to her left shin measuring approximately 3 cm x 6 cm. E8 further documented, "... Moderate bleeding, no skin loss. [SR4] alert with no c/o (complaint of) pain at this time. Pressure applied to control bleeding. Area cleansed with normal saline, steri-strips (sic) applied. Call placed to [P8, Hospice] - left voicemail ... unable to get through [P7, on-call telehealth provider] via phone, secure text sent to [P4, NP]."</p> <p>6/22/26 – Four days later, a hospice recertification note documented, "...Additional evidence of frailty and impaired tissue integrity includes a recent skin tear to the left leg with scattered ecchymosis. The wound flap remains well approximated with seven Steri – Strips intact and open to air..."</p> <p>7/30/26 11:05 AM – A review of SR4's Physician Order Summary lacked evidence of a standing physician's order for skin tear treatment. In addition, there was a lack of evidence that SR4 had a physician's order for treatment of SR4's skin tear on 6/18/26.</p> <p>7/30/26 1:06 PM – During a telephone interview, P10 (Hospice Administrator) stated, "...</p> | <p>against the PCC record for accuracy and completion of orders. There were no other incidents of deficient practice noted. Completed 8/19/26.</p> <p>3. A root cause analysis revealed that this facility failed to have a standard protocol/standing orders to address treatments with skin tears. Standing orders with a skin tear protocol, including application of steri strips has been developed and approved by the medical director. This order has been placed in current resident records and will be added with each new admission. Education provided to licensed nurses by DON and ADON on accuracy of incident reporting, obtaining treatment orders and documentation of orders. Completed 8/13/26.</p> <p>4. The ADON or designee (RN) will audit skin tears for treatment orders during weekly wound rounds. These audit results will be reported at</p> |                    |

Provider's Signature

*S. Perrone*

Title

*NHA*

Date

*Revised 8-21-26*



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| S/S - D | <p>If a hospice resident has a skin tear, the facility nurse will call only to notify us. We do not write the order for the skin tear treatment as it was not related to [SR4's] hospice diagnosis of senile dementia of the brain. From our end, the facility provider, who is [SR4's] primary care provider, should have put the order for [SR4's] skin tear, not us in hospice."</p> <p>7/30/26 1:46 PM – In a telephone interview, E8 (RN) stated, "... I can't remember if a doctor's order was written for the Steri-Strip treatment that I applied on [SR4's] leg. I did what a prudent nurse would do to stop the bleeding but no, I did not write a telephone order nor heard back from any of the providers for treatment order after I called."</p> <p>7/30/26 3:30 PM – During a telephone interview, when asked about SR4 and the skin tear incident on 6/18/26, P1 (facility MD) stated "... I physically have not rounded on her, I am not familiar with her. I did not receive a phone call regarding SR4's skin tear and the Steri-Strip that the nurse applied on her shin."</p> <p>7/31/26 10:10 AM – In an interview, E4 (RN Supervisor) confirmed and stated, "... [SR4] did not have a standing physician's order for skin tears. [SR4] also did not have the physician's order for Steri-Strips on [SR4's] scrape skin injury on 6/18/26."</p> <p>7/31/26 11:00 AM – Findings were discussed and confirmed with E4 and E2 (DON).</p> <p><b>F713</b><br/><b>§483.30(d) Availability of physicians for emergency care</b> The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency.</p> | <p>the weekly Standards of Care meeting. The audit will be weekly x 4 weeks until 100% compliance is reached. The audits will then decrease to twice per month x 1 month, then once per month x 1 month until 100% compliance is reached. Audits will then be brought to the quarterly QAPI committee meeting for review, recommendation and action as needed.</p> <ol style="list-style-type: none"> <li>1. Physician order was not obtained as the wound was healed at the time of discovery. Unable to correct.</li> <li>2. Record review of active records for the time period of First Docs taking on-call was performed by DON. Audit revealed no other instance of lack of on-call response. Reviewed records during week of 6/15/26.</li> </ol> | 9/7/26             |

Provider's Signature

*[Signature]*

Title

*NHA*

Date

*Revised 8-21-26*



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|---------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
|         | <p>Based on interview and record review, it was determined that for one (SR4) out of three residents reviewed for hospice, the facility failed to ensure that a physician was available for emergency care when SR4 obtained a scrape skin injury to her leg with moderate bleeding on 6/18/26. Findings include:</p> <p>Cross refer F684<br/>Review of SR4's record revealed:</p> <p>6/18/26 10:32 PM – A late entry nurse progress note documented, "At about 1940 [7:40 PM] staff was assisting [SR4] from the small dining room to the table located in front of the unit clerk desk. [SR4] raised her leg and got a scraping to left leg from the table. Skin tear to left shin approximately 3x6 cm sustained. Moderate bleeding, no skin loss. [SR4] alert with no c/o (complaint of) pain at this time. Pressure applied to control bleeding. Area cleansed with normal saline, Steri-Strips applied. Call placed to [P8, Hospice] - left voicemail ... unable to get through [P7, on-call telehealth provider] via phone, secure text sent to [P4, NP]."</p> <p>7/28/26 2:00 PM – An observation of the nurse's station bulletin board revealed flyers with the following provider information, including contact telephone numbers and contact hours information:<br/>Flyer #1 - P7 – to start on 6/15/26 "... 24/7/365..." (24 hours/7 days a week/365 days).<br/>Flyer #2 - P6 – to start on 6/15/26 "on call health care team ... hours of services M (Monday) – F (Friday) 5pm to 6 am and weekends until Monday 6 am".</p> <p>7/30/26 12:28 PM – In a telephone interview, P4 (former facility NP) stated that she did not recall receiving text messages via phone or</p> | <p>3. Education provided by the DON and ADON to licensed nurses on immediate escalation process of critical quality related concerns. Additional education also provided on the new after hours on-call vendor, 3<sup>rd</sup> eye health, to licensed nurses by DON and ADON. DON and ADON immediately educated on Third Eye Health services. Additional education ongoing with completion date of 8/31/26.</p> <p>4. A root cause analysis revealed that the nurse did not follow an escalation process utilizing resources available internally after hours. A system change will be implemented to require the RN supervisor on each shift to complete a physician call log, including time of call and time of response. This log will be submitted directly to the DON (ADON in the absence of DON) after each shift. On the log there</p> |                    |

Provider's Signature

*[Signature]*

Title

*NHA*

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*Revised 8-21-26*



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|         | <p>computer regarding SR4's skin tear on 6/18/26. P4 further stated, "I saw [SR4] that week because I covered [P2, facility NP] from 8:00 AM to 4:30 PM. After 4:30 PM, I don't take calls or read messages from staff either through phone or computer."</p> <p>7/30/26 1:46 PM – During a telephone interview, E8 (RN) confirmed that no providers she contacted that night returned her call.</p> <p>7/30/26 3:30 PM – During a telephone interview, P1 (facility MD) stated, "I am not taking calls after 5:00 PM because we have [P6, on-call telehealth provider], an affiliate with [P7, P1's Provider Group] who handles calls from 5:00 PM and off hours."</p> <p>7/31/26 10:00 AM - A follow up observation in the nurse's station revealed that the flyers with both P6 and P7's contact phone numbers and contact hours information were removed from the bulletin board.</p> <p>7/31/26 10:02 AM – During an interview, E4 (RN Supervisor) stated that E2 (DON) removed the posters because the contact hours needed updating. E4 further stated, "... [P6] did not start on 6/15/26 contrary to what was posted on the board...there were a lot of 'unknown'... [E2] will print a new one with the correct contact hours and she will post them back on the board. The new contact hours information would be, for [P1] and [P7], they come Monday – Friday from 6AM to 5PM. For [P6] they start taking calls from 5PM to 6AM daily on weekdays and also on the entire weekend from 5PM on Friday until 6AM Monday."</p> <p>7/31/26 11:00 AM – Findings were discussed and confirmed with E4 and E2 (DON).</p> | <p>will be instructions to call the DON or NHA immediately if response time exceeds 10 minutes. First Docs was also contacted and requested to do an investigation of their own. They found that their internal process of escalation regarding non-response from provider was not followed. Since the time of the event, Cokesbury Village has transitioned to a new after-hours on-call vendor, 3<sup>rd</sup> eye health. Nurses access live practitioners through an iPad video portal. Average response time is approximately 2 minutes. DON will audit response times daily 5 days per week for 2 weeks. Each audit will have at minimum a 24 hour look back. 3<sup>rd</sup> eye has an electronic dashboard in which response time data can be immediately accessed. Threshold for compliance is a response time of &lt; 5</p> |                    |

Provider's Signature

*[Signature]*

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| 3201.6.0                | Services to Resident                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | minutes. If compliance is reached, the audit will decrease to daily 3 times a week for 2 weeks. If compliance is reached, the audit will decrease to weekly on-going. The audit results will be presented weekly at the Standards of Care meeting and quarterly at the QAPI committee meeting. The QAPI committee will determine when audits can be discontinued.                                                                                     | 9/7/26             |
| 3201.6.8                | Medications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                    |
| 3201.6.8.1              | Medication Administration                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                    |
| 3012.6.8.1.1<br>S/S - D | <p>All medications (prescription or over-the-counter) shall be administered to residents in accordance with orders which are signed and dated by the ordering physician or prescriber. Each medication shall have a documented supporting diagnosis. Verbal or telephone orders shall be written by the nurse receiving the order and then signed by the ordering physician or prescriber within 10 days.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on observation, interview and record review, it was determined that for one (SR1) out of nine residents reviewed for medication administration, the facility failed to ensure that SR1's bedtime Tylenol medication was administered in accordance with the physician order. Findings include:</p> <p>Cross refer 6.8.1.6</p> <p>Review of SR1's record revealed:</p> <p>1/19/24 - SR1 was admitted to the facility.</p> <p>11/19/25 - SR1 had a routine physician's order for Tylenol (Acetaminophen) 325 mg two tablets by mouth at bedtime for mild pain.</p> <p>5/28/26 - SR1's annual MDS (Minimum Data Set) assessment revealed that SR1 had a BIMS score of 15 with an intact cognition and was independent with drinking and eating.</p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                    |
|                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <ol style="list-style-type: none"> <li>1. SR1's order updated on 8/19/26 to reflect resident may take 1 or 2 Tylenol tablets PRN for mild pain.</li> <li>2. Medication pass audits to be performed weekly on each shift by DON or designee to ensure adherence to the medication administration policy and standard. Ongoing starting week of 8/17/26.</li> <li>3. Licensed nurses will be educated on Medication Administration Policy by</li> </ol> |                    |

Provider's Signature

*Z Perrone*

Title

*NHA*

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|         | <p>7/27/26 – SR1's MAR (electronic Medication Administration Record) indicated that SR1 was administered her two tablets of Tylenol 325 mg by E8 (RN) on 7/27/26 at 'bedtime'.</p> <p>7/28/26 9:30 AM – During an observation in her room, SR1 was seen eating breakfast and a white tablet was inside a medicine cup on the overbed table. When asked about the white tablet, SR1 stated, "... That was my Tylenol from last night given to me by the nurse for my pain." SR1 further stated that she has an agreement with the facility that she can get her two Tylenol tablets from the nurse, but she will only take them one at a time whenever she wants to. SR1 also stated, "...I take one tablet for pain at night before bed, and then I take the second pill later in the evening if I cannot fall asleep. As you can see, the pill is still here, ... I will take the pill when I am ready and when I want to..."</p> <p>7/28/26 9:35 AM – In an interview, E5 (RN) stated that she noticed the white pill inside the medicine cup on SR1's overbed table. E5 further stated, "...I tried to take the pill away but [SR1] insisted that I leave the medication in the cup, on the overbed table. [SR1] said she would take it when she's ready."</p> <p>It was noted that SR1's physician order for two tablets of Tylenol 325 mg at bedtime was not administered as ordered when SR1 took only one tablet instead of taking two. SR1 held the other tablet for over eight hours.</p> <p>7/28/26 9:55 AM - In an follow up interview, E5 confirmed and stated, "...The nurse last night should have not left that Tylenol tablet on [SR1's] overbed table."</p> <p>7/31/26 10:20 PM – Finding was discussed and confirmed with E4 (RN Supervisor).</p> | <p>DON and ADON. Ongoing with anticipated completion date 8/31/26.</p> <p>4. A root cause analysis revealed that the nurse failed to follow established procedures and standards for medication administration. System change implemented that licensed nurses will receive policy review of Medication administration policy and a med pass audit prior to being released from orientation. This will be completed by the ADON or RN designee. This will be implemented by 8-31-26. Weekly medication pass audits on each shift by the DON or designee will be performed x 4 weeks. If 100% compliant, audits will be decreased to twice monthly on each shift. If 100% compliant, audits will decrease to once monthly on each shift. All results will be presented and reviewed at the weekly Standards of Care Meeting and the Quarterly QAPI meeting. The QAPI committee will</p> |                    |

Provider's Signature

*[Signature]*

Title

*N/A*

Date

*8-21-26* *Revised*



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| SECTION                 | STATEMENT OF DEFICIENCIES<br>SPECIFIC DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ADMINISTRATOR'S PLAN FOR<br>CORRECTION OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | COMPLETION<br>DATE |
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| 3201.6.8.1.6<br>S/S - D | <p>7/31/26 1:34 PM – Finding was reviewed with E1 (NHA), E2 (DON) and E18 (RCD) during the exit conference.</p> <p>An individual resident may self-administer medications upon the written order of the physician, following determination by the interdisciplinary team that this practice is safe. The facility shall establish policies and procedures pertaining to the security of self-administered medication.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on observation, interview and record review, it was determined that for one (SR1) out of nine residents reviewed for medication administration, the facility failed to ensure that SR1 had a written physician's order to self-administer medication. Findings include:</p> <p>Cross refer 6.8.1.1</p> <p>Review of SR1's record revealed:</p> <p>7/21/26 – SR1's care plan indicated her order for Tylenol "650 mg as needed for generalized pain and headaches. I prefer to take 325 mg and hold onto the second pill for later". SR1's intervention indicated that she has been approved to take just one 325 mg tablet when administered and to hold the second tablet for about an hour later.</p> <p>7/28/26 9:30 AM – An observation of SR1 eating breakfast in her room revealed a white tablet in the medication cup beside SR1's food tray on top of the overbed table. When asked what that tablet was for, SR1 stated, "...That was my Tylenol from last night given to me by the nurse for my pain...I have a contract with the facility that I can take the second pill</p> | <p>determine that audits can be discontinued.</p> <ol style="list-style-type: none"><li>1. SR1 was assessed for medication self-administration on 8/19/26 and was found not to be competent with self-administration, therefore, no order for self-administration was obtained.</li><li>2. Medication pass audits to be performed weekly on each shift by DON or designee to ensure adherence to the self administration of medication policy. Ongoing starting week of 8/17/26.</li><li>3. Licensed nurses will be educated on the Self Administration of Medication policy by the DON and ADON. Ongoing with anticipated completion date 8/31/26.</li><li>4. A root cause analysis revealed that the nurse failed to follow established policies on self-administration of medication. System change implemented to include Medication Administration Policy Review and a</li></ol> | 9/7/26             |

Provider's Signature [Signature]

Title NHA

Date 8-21-26

*Revised*



**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**

Page 10 of 11

**NAME OF FACILITY:** WillowBrooke Court at Cokesbury Village

**DATE SURVEY COMPLETED:** July 31, 2026

| SECTION    | STATEMENT OF DEFICIENCIES<br>SPECIFIC DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ADMINISTRATOR'S PLAN FOR<br>CORRECTION OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | COMPLETION<br>DATE |
|------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
|            | <p>whenever I feel like it. I will take the pill when I am ready and when I want to..."</p> <p>7/28/26 10:00 AM – Review of SR1's physician's order summary lacked evidence that SR1 had a physician's order to self-administer medication.</p> <p>7/28/26 2:46 PM – In an interview, E5 (RN) stated that the nurse or NP must assesses the resident's ability to self-administer own (sic) medications. "[SR1] is not competent, well she has to be assessed first if she can self-administer her meds."</p> <p>7/28/26 2:55 PM – During an interview, E4 (RN Supervisor) stated that usually P2, (facility NP), would see the resident, assess for the ability to self-administer medications and would write a physician's order that states "may self-administer medication". E4 further stated, "For [SR1], she was not assessed for her ability to self-medicate. [SR1] does not have a physician's order to self-administer meds."</p> <p>7/31/26 1:34 PM – Finding was reviewed with E1 (NHA), E2 (DON) and E18 (RCD) during the exit conference.</p> | <p>med pass audit before the completion of orientation for licensed nurses. This will be completed by the ADON or RN designee. Weekly medication pass audits on each shift by the DON or RN designee will be performed x 4 weeks. If 100% compliant, audits will be decreased to twice monthly on each shift. If 100% compliant, audits will decrease to once monthly on each shift. All results will be presented and reviewed at the weekly Standards of Care Meeting and the Quarterly QAPI meeting. The QAPI committee will determine that audits can be discontinued.</p> |                    |
| 3201.9.0   | <b>Records and Reports</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |
| 3201.1.9.5 | <b>Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident's representative or family, attending</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <ol style="list-style-type: none"><li>1. Notification provided to the facility physician regarding the skin incident for SR4 completed on 7/29/26, Facility Medical Director notified.</li><li>2. DON will review incident reports for the past 60 days with the medical director to determine if</li></ol>                                                                                                                                                                                                                                                                    | 9/7/26             |
| S/S - D    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |

Provider's Signature

*X Peruse*

Title

*NHA*

Date

*8-21-26 Reused*



**DELAWARE HEALTH  
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**STATE SURVEY REPORT**

Page 11 of 11

NAME OF FACILITY: WillowBrooke Court at Cokesbury Village

DATE SURVEY COMPLETED: July 31, 2026

| SECTION | STATEMENT OF DEFICIENCIES<br>SPECIFIC DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ADMINISTRATOR'S PLAN FOR<br>CORRECTION OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | COMPLETION<br>DATE |
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|         | <p>physician and licensing or law enforcement authorities, when appropriate.</p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Based on record review and interview, it was determined that for one (SR4) of three residents reviewed for incident reporting, the facility failed to ensure adequate documentation of follow-up action, specifically documentation of physician notification related to SR4's incident. Findings include:</p> <p>Review of SR4's record revealed:</p> <p>6/18/26 7:40 PM – A facility incident report documented that SR4 had a skin tear to left shin measuring approximately 3cm x 6cm with moderate bleeding. The report further documented that P1 (facility MD) was notified on 6/18/26 at 7:55 PM.</p> <p>7/30/26 3:30 PM – During a telephone interview, P1 stated, "... I physically have not rounded on her, I am not familiar with her. I did not receive a phone call regarding [SR4's] skin tear and the Steri-Strip that the nurse applied on her shin."</p> <p>7/31/26 11:00 AM – Finding was discussed and confirmed with E4 and E2 (DON). The facility failed to ensure SR4's incident report was accurate.</p> <p>7/31/26 1:34 PM – Finding was reviewed with E1 (NHA), E2 and E18 (RCD) during the exit conference.</p> | <p>proper physician notification was done. To be completed by 8/20/26.</p> <p>3. Licensed nurses will be educated on Incident Reporting Policy by DON and ADON. Ongoing with anticipated completion date 8/31/26. A system change will be implemented by 8/31/26 to include a mock incident reporting exercise to be completed by newly hired licensed nurses during their orientation period. The mock incident report will be administered and evaluated by the ADON or RN designee.</p> <p>4. A root cause analysis revealed that the nurse did not follow established procedures for physician notification with incident reporting. Although a call was put out to the doctor, actual notification needed to be made before this could be documented on the incident report. The DON will audit incident reports for accuracy of physician notification and verify notification</p> |                    |

Provider's Signature

*K. Perrone*

Title

*NHA*

Date

*Revised.  
8-21-26*



**DELAWARE HEALTH  
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**STATE SURVEY REPORT**

Page 12 of 11

NAME OF FACILITY: WillowBrooke Court at Cokesbury Village

DATE SURVEY COMPLETED: July 31, 2026

| SECTION | STATEMENT OF DEFICIENCIES<br>SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR<br>CORRECTION OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                        | COMPLETION<br>DATE |
|---------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
|         |                                                    | tion with the medical director weekly x 4 weeks. If notifications are compliant, Audit twice monthly x one month. If notifications remain compliant, then audit once monthly x one month. All results will be presented and reviewed at the weekly Standards of Care Meeting and the Quarterly QAPI meeting. The QAPI committee will determine if audits can be discontinued. |                    |

Provider's Signature

*[Handwritten Signature]*

Title

*N/A*

Date

*8-21-26 Revised*

|                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                         |  |                                                                                                 |                                                                                                                          |                                                     |                            |
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| <b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>085017</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                        |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br><b>07/31/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WILLOWBROOKE COURT AT COKESBURY VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                         |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>726 LOVEVILLE ROAD , HOCKESSIN, Delaware, 19707</b> |                                                                                                                          |                                                     |                            |
| (X4) ID<br>PREFIX<br>TAG                                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                         |  | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                     | (X5)<br>COMPLETION<br>DATE |
| E0000                                                                              | Initial Comments<br><br>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 July 27, 2026 through July 31, 2026. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                         |  | E0000                                                                                           |                                                                                                                          |                                                     | 08/19/2026                 |
| F0000                                                                              | <b>INITIAL COMMENTS</b><br><br>An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from July 27, 2026, through July 31, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census on the first day of the survey was two (2) residents. The investigative sample totaled four (4) residents.<br><br>Abbreviations/definitions used in this report are as follows:<br><br>CNA – Certified Nursing Assistant;<br><br>DON – Director of Nursing;<br><br>LPN - Licensed Practical Nurse;<br><br>NHA - Nursing Home Administrator;<br><br>NP – Nurse Practitioner;<br><br>RCD - Regional Clinical Director;<br><br>RN – Registered Nurse;<br><br>Anemia – low level of hemoglobin, the red blood cell chemical that carries oxygen to body tissues or a condition in which you don't have enough healthy red blood cells to carry adequate oxygen to your tissues which may make you feel tired and weak;<br><br>Atrial Fibrillation - irregular and often rapid heart rate that commonly causes poor blood flow to the body OR irregular heart rhythm; |                                                                         |  | F0000                                                                                           |                                                                                                                          |                                                     | 08/19/2026                 |

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.

|                                                                       |  |       |           |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE |  | TITLE | (X6) DATE |
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| <b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>085017</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X3) DATE SURVEY COMPLETED<br><br><b>07/31/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WILLOWBROOKE COURT AT COKESBURY VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>726 LOVEVILLE ROAD , HOCKESSIN, Delaware, 19707</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                                |
| F0000                                                                              | Continued from page 1<br><br>Benign Prostatic Hypertrophy/hyperplasia – (BPH) enlarged prostate;<br><br>Deep Vein Thrombosis - (DVT) occurs when a blood clot forms in one or more of the deep veins in the body;<br><br>Hypertension – high blood pressure;<br><br>Pneumonia – lung inflammation caused by bacterial or viral infection;<br><br>Sepsis – potentially deadly medical condition characterized by a whole-body inflammatory state; symptoms include fever, difficulty breathing low blood pressure, fast heart rate, and mental confusion;<br><br>Straight Catheter - a thin, flexible tube that is inserted into the bladder to drain urine and then immediately removed;<br><br>Urinary retention - an inability to completely empty the bladder.                                                                                                                                                                                                                                               | F0000                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 08/19/2026                                          |
| F0730<br>SS = E                                                                    | Nurse Aide Perform Review – 12Hr/Year In- service<br><br>CFR(s): §483.35(d)(7)<br><br>§483.35(d)(7) Regular in-service education.<br><br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and review of facility documentation, it was determined that the facility failed to ensure that a performance review was completed at least every twelve months for five (E6, E10, E11, E12 and E13) out of five sampled employees. Findings include:<br><br>7/29/26 9:24 AM– Review of the staff most recent performance evaluations revealed:<br><br>1. E6 (CNA) had a hire date of 8/22/23. Record review revealed E6's 90-day performance review dated 12/21/23.<br><br>2. E10 (CNA) had a hire date of 9/20/23. Record | F0730                                                                   | Evaluations to be completed and presented by ADON and DON for E6, E10, E11, E12 and E13 by 8/31/26.<br><br>CNA evaluations were audited by ADON and DON. There were 17 out of compliance. Outstanding evaluations will be completed and presented by the ADON and DON no later than 9/11/26.<br><br>Education to be provided by NHA to DON and ADON on F 730 requirement of annual performance evaluations. Will be completed by 8/24/26.<br><br>A root cause analysis revealed that changes in nursing leadership over the past year caused a lapse in timely completion of annual CNA evaluations. CNA evaluation schedule will be accessed and audited monthly by ADON or designee(DON or HR Director) for all evaluations coming due the next month. During times of nursing leadership transition, NHA will designate HR Director to assist with the monitoring of evaluation due dates and completion in the absence of a DON and ADON. Completion rates will be reported to QAPI through the Standards of Care Committee meeting on the first meeting of the month. Results will also be reported at the quarterly QAPI meeting. If audits are 100% compliant x3 months, audits can be decreased to every other | 09/07/2026                                          |

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                     |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WILLOWBROOKE COURT AT COKEBURY VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>726 LOVEVILLE ROAD , HOCKESSIN, Delaware, 19707</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                     |
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| F0730<br>SS = E                                                                   | Continued from page 2<br>review revealed E10's 90-day performance review dated 12/23/23.<br><br>3. E11 (CNA) had a hire date of 7/27/22. Record review revealed E11's undated performance review.<br><br>4. E12 (CNA) had a hire date of 5/27/16. Record review revealed E12's undated and unsigned performance review.<br><br>5. E13 (CNA) had a hire date of 9/28/23. Record review revealed E13's annual performance review dated 1/26/24.<br><br>The facility lacked evidence of a performance review completed at least every twelve months for E6, E10, E11, E12 and E13.<br><br>7/31/26 10:30 AM – Findings were discussed and confirmed by E1 (NHA).<br><br>7/31/26 1:34 PM – Findings were reviewed with E1, E2 (DON) and E18 (RCD) during the exit conference.                                                                                                                                                                                                                                                                                                  | F0730                                                                   | Continued from page 2<br>month x3 months. If 100% compliant then monthly audits can be discontinued. Audit results will continue to be reported to the quarterly at the quarterly QAPI committee. This will be ongoing until the QAPI committee determines that they can be discontinued.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 09/07/2026                                          |
| F0865<br>SS = E                                                                   | QAPI Prgm/Plan, Disclosure/Good Faith Atmpt<br><br>CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)<br><br>§483.75(a) Quality assurance and performance improvement (QAPI) program.<br><br>Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:<br><br>§483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;<br><br>§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; | F0865                                                                   | The issue of lack of on-call response was not properly escalated to the DON and ADON. Unable to correct.<br><br>Record review of active records for the time period of First Docs taking on-call was performed by DON. Audit revealed no other instances of lack of on-call response. Completed on 8/18/26 (reviewed week of 6/15/26).<br><br>A root cause analysis revealed that direct care staff were unclear about how to escalate concerns through to the QAPI Committee team. A "QAPI Concerns" locked mailbox was placed outside of the DONs office for all team members to place concerns that are quality related. The mailbox will be monitored by the DON or QAPI committee designee. Concerns will be addressed by the QAPI Committee. Team members will be educated by the DON and ADON on the QAPI mailbox purpose and use. Currently, QAPI modules are not part of the new hire training, but are required as an annual training. New team members will be assigned a QAPI training on hire and sign off an acknowledgment that they have been educated on the function and purpose of the QAPI mailbox. In addition, education provided by the DON and ADON to licensed nurses on immediate escalation process of critical quality related concerns. Education will be completed by 8/31/26. | 09/07/2026                                          |

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| <b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>085017</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                            |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/31/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WILLOWBROOKE COURT AT COKESBURY VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>726 LOVEVILLE ROAD , HOCKESSIN, Delaware, 19707</b> |  |                                                     |  |
| (X4) ID<br>PREFIX<br>TAG                                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X5)<br>COMPLETION<br>DATE                                                                          |  |                                                     |  |
| F0865<br>SS = E                                                                    | <p>Continued from page 3</p> <p>§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and</p> <p>§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.</p> <p>§483.75(b) Program design and scope.</p> <p>A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:</p> <p>§483.75(b)(1) Address all systems of care and management practices;</p> <p>§483.75(b)(2) Include clinical care, quality of life, and resident choice;</p> <p>§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.</p> <p>§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.</p> <p>§483.75(f) Governance and leadership.</p> <p>The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:</p> <p>§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.</p> <p>§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;</p> | F0865                                                                   | <p>Continued from page 3</p> <p>QAPI concerns submitted will be presented weekly at the Standards of Care Meeting for action. The Standards of Care meeting is a weekly focused QAPI meeting. Full QAPI meetings are quarterly. If immediate action is necessary, that action will take place immediately by the DON or designee QAPI committee team member ( NHA, social worker, ADON, RN, CNA, or Life Enrichment Coordinator). This will be audited by DON weekly x 2 weeks for completion. If 100% compliant audits will decrease to twice monthly x 1 month. If 100% compliant, the audits will decrease to monthly x 1 month. If 100% compliant, DON will ask for approval of the QAPI committee to discontinue the audits. The QAPI committee will monitor follow-up of all concerns brought forth to the committee ongoing.</p> | 09/07/2026                                                                                          |  |                                                     |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WILLOWBROOKE COURT AT COKESBURY VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>726 LOVEVILLE ROAD , HOCKESSIN, Delaware, 19707</b>                      |                                                     |                            |
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| F0865<br>SS = E                                                                    | <p>Continued from page 4</p> <p>§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;</p> <p>§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.</p> <p>§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and</p> <p>§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.</p> <p>§483.75(h) Disclosure of information.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>§483.75(i) Sanctions.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review it was determined that the facility failed to identify and correct a system failure when an on-call physician was not available for emergency care and did not respond after repeated communication attempts by staff. Findings include:</p> <p>Cross refer F713</p> <p>7/31/26 1:10 PM – During a QAPI interview, E1 (NHA) confirmed that the facility failed to identify and correct staff's inability to communicate with and receive a response from an on-call provider for R5's medical emergency requiring hospitalization on 6/26/26. The Surveyor asked E1 if the facility was aware of communication problems between the staff and on-call providers. E1 stated, "Neither I nor E2 (DON) was aware of this issue."</p> | F0865                                                                      |                                                                                                                          |                                                     | 09/07/2026                 |

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| F0865<br>SS = E                                                             | Continued from page 5<br><br>7/31/26 1:15 PM – Findings were confirmed with E1.<br><br>7/31/26 1:34 PM – Findings were reviewed with E1, E2, and E18 (RCD) during the exit conference.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | F0865                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 09/07/2026                                   |
| F0713<br>SS = D                                                             | Physician for Emergency Care Available 24 hrs<br><br>CFR(s): 483.30(d)<br><br>§483.30(d) Availability of physicians for emergency care<br><br>The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and interview, it was determined that for one (R5) out of three residents reviewed for hospitalization, the facility failed to ensure the provision of physician services 24 hours a day in case of emergency. Facility staff were unable to reach the on-call provider for approximately two hours for R5, who was unable to void and complained of abdominal pain on 6/26/26. Findings include:<br><br>Review of R5's clinical record revealed:<br><br>6/17/26 – R5 was admitted to the facility with diagnoses including pneumonia, sepsis, anemia, and benign prostatic hyperplasia with lower urinary tract symptoms.<br><br>6/26/26 7:45 PM – A progress note entered by P1 (MD) indicated, "[E5] has multiple complex comorbidities to include HTN [hypertension], A fib [atrial fibrillation] placing the patient at high risk for readmission without proper care. The patient will require frequent clinical evaluations, neglecting regular monitoring and management may result in symptom exacerbation and re hospitalization".<br><br>6/26/26 10:47 PM – A progress note entered by E8 (RN) indicated, "...[R5] complaining of difficulty voiding, scant amount of urine voided in urinal. Call place[sic] to on call provider, no call back received. Abdominal discomfort, abdomen distended...Resident request to be sentto[sic] ER r/t [related to] urinary retention...This writer tried calling [P7, on-call provider service] at 21:49 [9:49 PM] and 22:43 [10:43 PM]; staff at [P7] unable to get hold of the doctor. Bladder scan done – 591ml [milliliters]. Awaiting call back at this time". | F0713                                                            | R5 was sent to the ER for evaluation at the time of the event.<br><br>Record review of all active records for the time period of First Docs taking on-call was performed by DON. Audit revealed no other instance of lack of on-call response. Completed 8/18/26 (reviewed week of 7/15/26)<br><br>Education provided by the DON and ADON to licensed nurses on immediate escalation process of critical quality related concerns. Additional education also provided on the new after hours on-call vendor, 3rd eye health, to licensed nurses by DON and ADON. Immediately educated on Third Eye Health services, while survey was in progress. Additional education ongoing with anticipated completion date of 8/31/26. The updated on-call contact and phone numbers were posted on the bulletin board in the nursing office. (Immediately)<br><br>A root cause analysis revealed that the nurse did not follow an escalation process utilizing resources available to her internally after hours. First Docs was also contacted and requested to do an investigation of their own. They found that their internal process of escalation regarding non-response from provider was not followed. Since the time of the event, Cokesbury Village has transitioned to a new after-hours on-call vendor, 3rd eye health. Nurses access live practitioners through an iPad video portal. Average response time is approximately 2 minutes. DON will audit response times daily 5 days a week for 2 weeks through the 3rd eye electronic dashboard that shows response times for any entered date. Minimum of the past 24 hours will be reviewed with each audit. Threshold for compliance is a response time of < 5 minutes. If compliance is reached, the audit will decrease to daily 3 times a week for 2 weeks. If compliance is reached, the audit will decrease to weekly ongoing. The audit results will be presented weekly at the Standards of Care meeting and quarterly at the QAPI committee meeting. The QAPI committee will determine when audits can be discontinued. | 09/07/2026                                   |

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| F0713<br>SS = D                                                                    | <p>Continued from page 6</p> <p>6/26/26 11:20 PM – A progress note authored by E8 indicated, "Another call placed to [P7] at 2310 [11:10 PM] still unable to get connected to provider. Resident requested to be sent to ER [emergency room], facility nurse on call made aware".</p> <p>6/26/26 11:48 PM - A progress note authored by E8 indicated, "Ambulance request done. [R5] sent to [hospital], [FM 2, family member of R5] notified and in agreement..."</p> <p>R5 was emergently transferred to the hospital approximately 2 hours after staff first tried to contact P7 and did not receive a response.</p> <p>6/26/26 11:40 PM – In a facility document entitled, "Order Audit Report", P1 electronically documented, "straight cath [catheter] for bladder residual &gt; [over] 350cc [cubic centimeters] every shift for urine retention".</p> <p>7/1/26 3:51 PM – A "Social Services Note" entered in R5's clinical record documented that R5 was admitted to the hospital with a DVT (deep vein thrombosis).</p> <p>7/30/26 2:00 PM - During a telephone interview E8 stated, "[R5] hadn't voided much the whole shift, his abdomen was distended and [R5] was very uncomfortable. There had been an order to straight cath, but for some reason it was discontinued...With this new system we're having difficulty getting hold of a doctor. With [P7] I always have difficulty...I tried multiple times to reach a provider and never got a response from them. [R5] was getting so upset and said if I didn't send him to the ER, he would call 911 himself. I tried to reach the [P2, NP] because that's what we do when we can't reach the on-call service...I felt bad because I knew [P2] was on vacation...[P2] didn't answer anyway. Later I noticed an order entered by [P1] to straight cath, but [R5] was already on the way to the ER...[P1] never actually spoke to me about [R5], [P1] just put the order in".</p> <p>7/30/26 3:00 PM – During an interview, E4 (RN Supervisor) stated, "I'll be honest, the whole roll out of this new service was a mess. I'm supposed to educate the nurses, but how do I do that if even I don't know how it's supposed to work. We call [P2] during the day and [P2] always answers, even when we call at other times, so we've come to rely on [P2]". The Surveyor then pointed to a flyer that stated, "To reach a [P7] provider 24/7/365...[telephone number]...our provider [P1] or [P11, NP for P7] will be notified immediately..." and</p> |                                                                         |  | F0713                                                                                           |                                                                                                                          |                                                     | 09/07/2026                 |

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| F0713<br>SS = D                                                             | Continued from page 7<br>asked if the information was accurate. E4 replied, "Yes, that's confusing because now it's [P6, on-call Telehealth provider]".<br><br>7/30/26 3:30 PM - During a telephone interview, P1 stated, "We have an on-call service. I can't recall exactly when it went into effect. If they call me, I always answer, but I do not take calls after five [5:00 PM]. We have [P6] for that, a nurse practitioner". P1 also stated that he could not recall the specifics of R5's incident on 6/26/26.<br><br>7/30/26 4:15 PM – Findings were reviewed with E1 (NHA) and E2 (DON).<br><br>7/31/26 10:30 AM – During a telephone interview, FM 2 stated, "That night we weren't there, me or my sister, but the nurse did call us...my father doesn't complain. He's soft-spoken. But that night he was really upset that the urinary problem couldn't be managed there, especially because he knows how to catheterize himself, but I guess there wasn't an order...turns out it was good that he went to the hospital because there was a lot going on, more than we realized. They found a clot in his jugular vein".<br><br>7/31/26 1:34 PM - Findings were reviewed with E1, E2, and E18 (RCD) during the exit conference. | F0713                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 09/07/2026                                   |
| F0943<br>SS = D                                                             | Abuse, Neglect, and Exploitation Training<br><br>CFR(s): 483.95(c)(1)-(3)<br><br>§483.95(c) Abuse, neglect, and exploitation.<br><br>In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-<br><br>§483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.<br><br>§483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property<br><br>§483.95(c)(3) Dementia management and resident abuse prevention.<br><br>This REQUIREMENT is NOT MET as evidenced by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | F0943                                                            | E16 has completed his abuse, neglect and exploitation training. Completed 8/12/26 through web based learning system Relias module.<br><br>An audit was performed for abuse training of culinary team members assigned to the skilled nursing area. Those who need abuse, neglect and exploitation training will be completed by 8/31/26 through web based Relias learning module. Team members outside of culinary department were audited and were compliant.<br><br>Education will be provided to the culinary managers regarding the requirements of F 865 in regards to abuse, neglect and exploitation training by Acts regional director culinary and nutrition services. This will be completed by 8/24/26.<br><br>A root cause analysis revealed that there was no system in place to audit completion of this Relias learning module, specific to the culinary department. Administrative staff consisting of managers/department heads who can verify Relias | 09/07/2026                                   |

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>085017</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X3) DATE SURVEY COMPLETED<br><br><b>07/31/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WILLOWBROOKE COURT AT COKESBURY VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>726 LOVEVILLE ROAD , HOCKESSIN, Delaware, 19707</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                     |                            |
| (X4) ID<br>PREFIX<br>TAG                                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |  | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                     | (X5)<br>COMPLETION<br>DATE |
| F0943<br>SS = D                                                                    | <p>Continued from page 8</p> <p>Based on record review and interview, it was determined that for one (E16) out of seven sampled employees reviewed for training, the facility failed to have evidence of abuse, neglect, exploitation and dementia training. Findings include:</p> <p>The facility was provided a list of seven names selected randomly and instructed to provide documentation of in-service training for abuse, neglect, exploitation and dementia training for new and existing staff. E16 (Line Cook) had a hire date of 5/26/26. E16's record review lacked evidence of abuse and dementia training. 7/31/26 12:20 PM - Finding was discussed and confirmed with E1 (NHA). 7/31/26 1:34 PM - Finding was reviewed with E1, E2 (DON) and E18 (RCD) during the exit conference.</p> |                                                                            |  | F0943                                                                                               | <p>Continued from page 8</p> <p>training courses will continue to oversee that new facility team members have their required abuse, neglect and exploitation training completed prior to reporting to their assigned employment duties. Each manager/department head oversees their own areas of responsibility. The dietary managers will audit completion of training upon orientation, before the team member reports to their assigned duties. It will also be audited annually in June for completion. The module is scheduled to be completed in the 2nd quarter of each year. Those who do not complete the required training will be removed from the schedule and not be permitted to work until it is completed. Audits will be performed by running a course specific Relias report. All audit results will be reported to the QAPI committee for compliance by the Nutrition Service Manager. Audits will be reported weekly, ongoing, at the Standards of Care Meeting for all new hires. Annual trainings will be reported, ongoing, at the second quarter QAPI committee meeting of the year.</p> |                                                     | 09/07/2026                 |

