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

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

STATE SURVEY REPORT

NAME OF FACILITY: WillowBrooke Court at Country House **DATE SURVEY COMPLETED:** February 26, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Complaint Survey was conducted at this facility from February 20, 2025 through February 26, 2025. The deficiencies contained in this report are based on interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was thirty-one (31) residents. The survey sample totaled six (6) residents. Abbreviations/definition used in this report are as follows: AIMS - Abnormal Involuntary Movement Scale/a rating scale to measure involuntary movements of the face, mouth, trunk, or limbs known as tardive dyskinesia that sometimes develops as a side effect of long-term treatment with antipsychotic medications; Alzheimer's disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Antipsychotic - class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions; Braden – scale used to determine risk for development of pressure ulcers; Cardiovascular – medications used to treat diseases associated with the heart or blood vessels; Cognitive deficit - mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; COPD – chronic obstructive pulmonary disease/chronic inflammatory lung disease that causes obstructed airflow from the lungs.		

Provider's Signature Jennifer Guanciale Title NHA Date 3/20/2025

NAME OF FACILITY: WillowBrooke Court at Country House **DATE SURVEY COMPLETED:** February 26, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Symptoms include breathing difficulty, cough, sputum production and wheezing; Diabetes - disease where sugar levels are too high; DON - Director of Nursing; ED - Executive Director; EMR - electronic medical record; LPN – Licensed Practical Nurse; MAR - Medication Administration Record/list of daily medications to be administered; MDS - Minimum Data Set/standardized assessment forms used in nursing homes; Ml – Milliliters/metric unit of liquid volume, 5 ml equals 1 teaspoon; Mg – Milligram/metric unit of weight, 1 mg equals 0.0035 ounce; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; NHA - Nursing Home Administrator; NP – Nurse Practitioner; OT – Occupational Therapy/treatment that helps a resident overcome physical, emotional and social challenges; Omnicell - An automated medication dispensing system; POA – Power of attorney; Psychosis - loss of contact/touch with reality; Psychiatric - relating to mental illness or its treatment;		
3201 **3201.1.0** **3201.1.2**	**Regulations for Skilled and Intermediate Care Nursing Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for**		

Provider's Signature Jenny Greenacre Title NHA Date 3/20/2025

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	skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed February 26, 2025: F623 and F684.		
S/S = D	**F658** **§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—** **(i)Meet professional standards of quality.** **This requirement was not met as evidenced by:** Based on interview and record review, it was determined that for one (SR6) out of three residents reviewed for falls, the facility failed to meet professional standards of the Delaware Board of Nursing Scope of Practice by having LPNs complete SR6's admission assessments. Findings include: Delaware State Board of Nursing – "RN, LPN... Duties 2024... Admission Assessments* - RN... *=Once a care plan is established, the LPN may do assessments...". Cross refer to F689, F690 Review of SR6's clinical record revealed: 11/1/24 – SR6 was admitted to the facility.	A. SR6 no longer resides at WillowBrooke Court at Country House. B. Residents that are newly admitted to WillowBrooke Court at Country House have the potential to be impacted by this identified area of concern. An audit was completed for new admissions for the past 14 days by the DON and ADON, no concerns were identified. C. A Root cause analysis was completed for the identified area of concern. It was determined that the facility failed to identify that Licensed Practical Nurses would not complete initial assessments on newly admitted residents as defined in a recent update 4/10/2024 of Delaware State Board of Nursing. The DON/Designee will educate the Professional licensed nursing staff on the	04/24/2025 03/20/2025

Provider's Signature Jenny Greenwart Title NHA Date 3/20/2025

NAME OF FACILITY: WillowBrooke Court at Country House **DATE SURVEY COMPLETED:** February 26, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Review of SR6's initial admission assessments revealed the following: -E15 (LPN) completed the Braden, Wandering, Pain assessments on 11/1/24; -E16 (LPN) completed the fall risk, baseline care plan, side rail assessments on 11/2/24; and -E14 (LPN) completed the AIMS and bowel and bladder assessments on 11/2/24. The facility lacked evidence that a RN completed SR6's initial admission assessments. 2/26/25 11:45 AM – During an interview, E14 (LPN) confirmed that for newly admitted residents she has completed initial admission assessments, including but were not limited to, bowel and bladder and pain. 2/26/25 3:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E13 (ED) and a representative from the Ombudsman's office.	4/10/2024 update to the Delaware Board of Nursing regarding initial assessments being completed by RN's and then LPNs may complete subsequent assessments. D. The DON/ Designee will audit assessments of newly admitted residents to ensure primary assessments are being completed by the RN on duty. These audits will be conducted daily for 2 weeks, then weekly for 2 weeks, then monthly for 1 month until 100% compliance is obtained. Outcomes of these audits will be submitted to the Quarterly QAPI committee meeting for review and recommendation as indicated.	
S/S - D	**F684** **§ 483.25 Quality of care** **Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.** **This requirement was not met as evidenced by:** Based on record review, review of facility documents as indicated and interviews, it	A. SR7 no longer resides at WillowBrooke Court at Country House. B. Residents that are experiencing significant decline at end of life with acute breathing distress have the potential to be impacted by this identified area of concern. An initial audit was conducted by DON of residents who are approaching end of life within the last 30 days to ensure that no other residents were impacted by this area of concern.	04/24/2025

Provider's Signature Jennifer Greenwald Title NHA Date 3/20/2025

NAME OF FACILITY: WillowBrooke Court at Country House **DATE SURVEY COMPLETED:** February 26, 2025

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	was determined that for one (SR7) out of six sampled residents, the facility failed to ensure SR7 received end of life care according to professional standards of practices. Findings include: Cross refer to F726 Review of SR7's clinical record revealed: 4/18/22 - SR7 was admitted to the facility with multiple diagnoses including Alzheimer's disease, anxiety, diabetes, high blood pressure, and weakness. 2/22/24 - A review of SR7's care plan revealed that SR7 could do the following tasks independently or with one person assistance: -eating; -personal hygiene; -oral care; -toileting; -able to turn in bed. A review of electronic medical record (Emr) progress notes revealed that SR7 experienced physical and mental decline throughout the months of September, October, November and December 2024. 9/26/24 - SR7's quarterly MDS documented that she was totally dependent or needed maximum assistance with: -eating; -mouth care; - toileting; -bathing; -personal hygiene; -repositioning in bed. 12/12/24 7:30 AM - A visit assessment note was written by E12 (NP) that documented that SR7 was experiencing significant decline	C. Root cause analysis was completed for the identified area of concern. It was determined that there was a gap in practitioner order transcription which resulted in delayed medication administration and physician notification. A review of order transcription, physician notification, and non-pharmacological interventions will be conducted by the DON with the involved licensed staff member. The DON/Designee will educate the involved licensed staff member on the importance of transcribing orders for comfort mediations timely, contacting the appropriate entities timely to prevent a gap in medication administration, and examples of non-pharmacological interventions as well as review of order transcription. The DON/Designee will educate the licensed professional staff members on the importance of transcribing orders for comfort mediations timely, contacting the appropriate entities timely to prevent a gap in medication administration, and examples of non-pharmacological interventions as well as order transcription.	

Provider's Signature Jenny Greenward Title NHA Date 3/20/2025

NAME OF FACILITY: WillowBrooke Court at Country House **DATE SURVEY COMPLETED:** February 26, 2025

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	in her ability to take her medications and to eat. 12/23/24 8:00 AM - A visit assessment note was written by E12 that SR7 was experiencing acute breathing distress, as evidenced by her rapid (32) breaths per minute. E12 further documented that SR7's was nearing the end of life, and that after consultation with SR7's family, that SR's regular medications were discontinued, and that medications for SR7's comfort care would be ordered by E12. On 12/23/24 at 8:00 AM, SR7 was assessed by E12 because SR7 was experiencing breathing distress, as reported by SR's husband. E12 assessed that SR7 was breathing at a rate of 32 breaths per minute (normal rate of breathing is 12-20 breaths per minute). E12 ordered for SR7 to receive the medication Ativan 0.5mg by mouth, every four hours as needed for anxiety. 12/23/24 11:45 AM - A medication order was written by E10 for Ativan 0.5 mg (Lorazepam), give 1 tablet by mouth every four hours as needed for anxiety. According to the National Hospice and Palliative Care Organization 2020, palliative care (care given to improve the quality of life through managing the symptoms of a life-threatening disease) of dyspnea (difficulty breathing) includes lorazepam every four hours as needed for dyspnea related anxiety. A review of the December 2024 medications administration record (MAR) revealed that Ativan 0.5 mg (lorazepam) medication that was ordered to treat SR7's breathing distress was not given until 3:28 PM on 12/23/24, seven hours after E12 completed her assessment of SR7.	D. The DON/ Designee will audit residents experiencing significant decline at end of life who have new medication orders for comfort to ensure medications are transcribed and carried through timely. These audits will be conducted daily for 2 weeks, weekly for 2 weeks then monthly for 1 month until 100% compliance is obtained. Outcomes of these audits will be submitted to the Quarterly QAPI committee meeting for review and recommendation as indicated.	

Provider's Signature Jennifer Grunwald Title NHA Date 3/20/2025

NAME OF FACILITY: WillowBrooke Court at Country House **DATE SURVEY COMPLETED:** February 26, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	2/25/25 1:45 PM - During an interview E6 (RN) stated that the facility has emergency supply of medications (Ekit Omnicell), in a locked and protected container in the facility, which is managed by the facility pharmacy, but that is accessible to facility nurses, according to pharmacy process requirements. 2/25/25 - A review of facility Ekit Omnicell documents revealed the following: - the pharmacy Ekit Omnicell procedure guide revealed that all controlled substance medications require a pharmacy approval prior to accessing and withdrawing the emergency supply of the medication. Ativan is a controlled substance medication. -the process to access emergency medications from the Ekit Omnicell: -the physician or NP must send the order to the pharmacy; - the nurse must complete the pharmacy request form for removal of the controlled substance medication and fax it to the pharmacy. In an emergency situation, the pharmacy can be called to obtain a verbal request authorization to remove an item from the Ekit Omnicell supply. -the Ekit Omnicell medication inventory list included Ativan 0.5 mg tablets. 2/25/25 9:30 AM - During an interview, E12 stated that she electronically sent the prescription to the pharmacy for SR7's Ativan 0.5 mg (lorazepam), give 1 tablet by mouth every four hours as needed for anxiety when she returned to her office.		

Provider's Signature Jenny Guenard Title NHA Date 3/20/2025

NAME OF FACILITY: WillowBrooke Court at Country House DATE SURVEY COMPLETED: February 26, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	2/26/25 9:19 AM - During an interview, P1 (Pharmacy Clinical Case Manager) stated that the pharmacy received the Ativan 0.5 mg (lorazepam), give 1 tablet by mouth every four hours as needed for anxiety prescription order from E12 at 8:49 AM on 12/23/24; P1stated that there was no documented Omnicell access request to the pharmacy on 12/23/24. 2/26/25 11:10 AM - During an interview, E10 (LPN) stated that SR's husband approached her several times throughout the day to ask when medication would be given to SR7. E10 replied that she would give SR7 the medication as soon as it arrived from the pharmacy. The Ativan medication to treat SR7's breathing distress was available to be given to SR7 at approximately 9:30 am on 12/23/24 from the Ekit Omnicell, yet it was not given to SR7 until 3:28 PM that afternoon. 2/26/25 3:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E13 (ED) and a representative from the Ombudsman's office.		
S/S = G PNC	**F689** **§483.25(d) Accidents.** **The facility must ensure that –** **§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and** **§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.** **This requirement was not met as evidenced by:**	A. Past Non-Compliance: Deficient practice previously identified and corrected as noted. PNC compliance date 02/19/2025	02/19/2025

Provider's Signature Jenny Greenwood Title NHA Date 3/20/2025

NAME OF FACILITY: WillowBrooke Court at Country House **DATE SURVEY COMPLETED:** February 26, 2025

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	Based on interview and record review, it was determined that for one (SR6) out of three residents reviewed for falls, the facility failed to ensure that SR6 was assessed accurately as a fall risk, care planned upon admission and received adequate supervision to prevent an accident. On 11/8/24, SR6 had an unwitnessed fall, sent emergently to the hospital and was diagnosed with a right hip fracture. As a result of the facility's failures, SR6 was harmed. Based on review of the facility's corrections after the incident and no further incidents have occurred, the finding was determined to be past non-compliance. Findings include: Cross refer to F658, F690 Review of SR6's clinical record revealed: 11/1/24 – SR6 was admitted to the facility temporarily as the resident's other facility in Pennsylvania had an infection control outbreak and no bed availability at the time of being discharged from the hospital for a change in mental status. SR6's diagnoses included, but was not limited to, psychosis, dementia, high blood pressure, diabetes, COPD (chronic obstructive pulmonary disease) and chronic kidney disease. 11/1/24 4:59 PM – A nurse's note by E15 (LPN) documented that SR6 had increasing confusion and that SR6 had a "recent hospitalization 4 months ago she fell and broke her sternum [breastbone]." 11/2/24 4:46 AM – The initial Fall Risk Evaluation, completed by E16 (LPN), documented that SR6 was a low fall risk based on the following: -Section A: Alert (oriented x 3)... -Section B: NO FALLS in past 3 months...		

Provider's Signature Jenni J- Quenwalt Title NHA Date 3/20/2025

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	-Section C: Ambulatory/Continent; -Section D: Vision Status adequate; -Section E: Balance problem while walking; -Section F: No noted drop in blood pressure between lying and standing; -Section G: Medications – Antipsychotics... Cardiovascular Medications... Other Medications that Cause Lethargy or Confusion: None of these medications taken currently or within last 7 days; -Section H: Predisposing diseases – Circulatory/heart... psychiatric/cognitive... pain... history of falls: None present. However, the initial Fall Risk Evaluation was not an accurate reflection of SR6. The evaluation inaccurately documented that SR6 was oriented x 3 (person/place/time), had no history of falls, continent of bowel and bladder, was not prescribed certain medications or had predisposing diseases. SR6 was prescribed Seroquel for psychosis, amlodipine and doxazosin for hypertension, gabapentin for pain, and melatonin for insomnia. 11/2/24 – SR6's baseline care plan did not include a risk for falls and prevention. 11/4/25 8:25 PM – A rehabilitation note documented, "OT (Occupational Therapy) evaluation complete, please see for details... Recommend Sup [Supervision] amb [ambulating]/transferring w/ (with) rollator for safety. Res [Resident] is a fall risk due to cog [cognitive] deficits/confusion." Despite having this recommendation from OT, the facility failed to care plan SR6 as a fall risk. 11/8/24 1:30 PM – The facility's incident report documented that SR6 was found on the floor lying on the right side in the resident's room with complaints of pain to the right		

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NAME OF FACILITY: WillowBrooke Court at Country House **DATE SURVEY COMPLETED:** February 26, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	hip. SR6 was sent emergently to hospital and diagnosed with a right hip fracture. SR6 did not return to the facility. On 11/11/24, Recreation staff were educated "on ensuring residents are supervised when exiting activities or that a staff member is made aware of residents needing to go back to their rooms." 11/15/24 – The facility's investigation determined the root cause of the 11/8/24 incident to be that after the activity ended, SR6 self-ambulated without her rollator back to the resident's room without supervision. The investigation found it was likely that SR6 ambulated possibly by wheelchair to her room without assistance and slipped on the markers that she dropped on the floor. The facility took the following actions: Facility initiated a Performance Improvement Plan on 11/27/24 for failure to develop and implement a baseline care plan for risk for falls and prevention for SR6. The facility conducted an audit of all newly admitted residents around the same admission timeframe of SR6 and identified similar concerns with two other residents. The facility conducted a second audit of all other residents, which revealed no issues. Education was provided to the staff regarding completion of baseline care plans in 48 hours. The facility's monitoring included audits of residents' baseline care plans and comprehensive care plans to ensure 100% compliance was met and the process implemented was effective and reviewed by the QAPI committee. The facility's corrections were verified by the Surveyor with the correction date of 12/10/24.		

Provider's Signature Jennifer Greenwood Title NHA Date 3/20/2025

NAME OF FACILITY: WillowBrooke Court at Country House **DATE SURVEY COMPLETED:** February 26, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	2/26/25 3:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E13 (ED) and a representative from the Ombudsman's office.		
S/S = D	**F690** **§483.25(e) Incontinence.** **§483.25(e)(1) The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.** **§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that—** **(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;** **(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and** **(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.** **§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of**	A. SR6 no longer resides at WillowBrooke Court at Country House. B. Newly admitted residents who are deemed incontinent of Bowel and Bladder at time of admission have the potential to be impacted by this identified area of concern. The DON/Designee will audit current residents residing at WillowBrooke Court at Country House to ensure that Bowel and Bladder assessments were completed and that residents identified as a candidate for prompted voiding or habit training/scheduled voiding programs have such programs in place. C. Root cause analysis was completed for the identified area of concern. It was identified that one resident admitted with bowel and bladder incontinence who was a candidate for prompted voiding or habit training/ scheduled voiding program did not have such program in place. The check and balance put in place of care plan review via the Minimal Data Set Coordinator did not occur as the resident discharged to the	04/24/2025

Provider's Signature Jennifer Guennard Title NHA Date 3/20/2025

NAME OF FACILITY: WillowBrooke Court at Country House **DATE SURVEY COMPLETED:** February 26, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	bowel receives appropriate treatment and services to restore as much normal bowel function as possible. **This requirement was not met as evidenced by:** Based on interview and record review, it was determined that for one (SR6) out of three residents reviewed for falls, the facility failed to ensure that the resident received care and services for bowel and bladder incontinence. Findings include: Cross refer to F658, F689 The facility's policies and procedures for Bowel/Bladder Continence Program, last revised on November 2017, stated the following: "Policy: To strive to assess and evaluate residents' continent/incontinent status... Urinary Toileting Programs... 2. Prompted Voiding – For use with dependent or more cognitively impaired residents. Includes: a. Regular monitoring with encouragement to report continence status. b. Using a schedule and prompting the resident to toilet. c. Praise and positive feedback when the resident is continent and attempts to toilet... the resident will be placed on a toileting program that is dependent on staff involvement and assistance... These programs include: 1. PROMPTED VOIDING. PURPOSE: Maintain dignity and self respect. PROCEDURE: a. Prompt the resident to toilet according to his/her personal schedule. b. Praise and provide positive feedback when the resident is continent and attempts to toilet...". Review of SR6's clinical record revealed: 11/1/24 3:41 PM – A nurse's note documented that SR6 was admitted to the facility with confusion.	hospital on day 7 of stay and did not return to the facility. The DON/ Designee will educate MDS coordinator on the process of care plan review as it relates to Bowel and Bladder upon completion of the Baseline Care plan and completion of the Bowel and Bladder assessment and individualized prompted toileting schedule has been implemented when appropriate. D. The DON/ Designee will audit new admissions upon completion of Bowel and Bladder assessments to ensure those who are candidates for prompted voiding or habit training/ scheduled voiding program have such programs in place. These audits will be conducted daily for 2 weeks, weekly for 2 weeks and monthly for 1 month until 100% compliance is obtained. Outcomes of these audits will be submitted to the Quarterly QAPI committee meeting for review and recommendation as indicated.	

Provider's Signature Jennifer Quennoit Title NHA Date 3/20/2025

NAME OF FACILITY: WillowBrooke Court at Country House **DATE SURVEY COMPLETED:** February 26, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	11/2/24 11:43 AM – SR6's bowel and bladder assessment evaluation, completed by E16 (LPN), documented: Section A. Reason for assessment: new admission. Section B. History: (1) Symptoms: none of the above present; (2) Pattern of Incontinence: Both (including Night and Day); (3) Type of incontinence: Unknown; and (4) Usual Bowel Pattern: Daily. Section C. Disease/Injury/Medication that could predispose resident to incontinence: No. Section D. Relevant resident factors: (1) Physical Status: Ambulatory with assist; (1a) What assistive devices are being used: "Walker"; (2) Medical/Emotional Status: Confused; (3) Was resident incontinent prior to admission? Yes; (3a) Duration: Months. Section E. Evaluation: c. Candidate for prompted voiding or habit training/scheduled voiding program. 11/2/24 – E16 (LPN) initiated a care plan for SR6 to include ADL (Activities of daily living) self-care performance deficit with an approach toilet (resident) with supervision. SR6's care plan lacked evidence of an individualized prompted voiding/scheduled voiding program as indicated in SR6's bowel and bladder evaluation completed on the same day, 11/2/24. 11/2/24 2:33 PM – A progress note, by E14 (LPN), documented that SR6 was incontinent of bladder and continent of bowel.		

Provider's Signature Jennifer Greenwalt Title NHA Date 3/20/2025

NAME OF FACILITY: WillowBrooke Court at Country House **DATE SURVEY COMPLETED:** February 26, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	11/3/25 7:00 AM – A progress note documented "... alert to self, pleasantly confused... Has episodes of bladder incontinence. Can walk with rollator and supervision...". 11/3/24 2:41 PM – A progress note, by E14 (LPN), documented that SR6 was incontinent of bladder and continent of bowel. 11/4/25 8:00 AM – E12 (NP) evaluated SR6 and spoke to SR6's POA. The following was documented in E12's note: "Due (sic) cognitive deficits – resident is unable to provide reliable hx [history]. Hx was therefore obtained from... [POA]... reports that resident with recent 'significant rapid cognitive decline'...". 11/4/25 8:25 PM – A rehabilitation note documented, "OT (Occupational Therapy) evaluation complete, please see for details. Recommend a toileting schedule to assist w/ (with) incontinence mgt (management), toilet hygiene & [and] safety/fall prevention...". 11/8/24 2:30 PM – A progress note documented, "Resident had an unwitnessed fall at approx. 1:30 PM while attempting to use the bathroom unassisted...". Review of the November 2024 CNA Documentation Survey Report revealed that SR6 was not on an individualized prompted toileting program. 2/26/25 11:10 AM – During an interview, E3 (RNAC) was asked to explain the facility's process for a resident who was admitted incontinent. E3 stated that a bowel and bladder assessment will be completed and then it would be discussed with the IDT (interdisciplinary team) members to come up with a plan. E3 also stated that therapy will make		

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	recommendations. The Surveyor asked E3 about SR6. E3 reviewed the bowel and bladder assessment that called for prompted toileting and then E3 looked at the CNA Tasks in SR6's clinical record. E3 confirmed that prompted toileting schedule did not come over to the CNA Tasks. Surveyor reviewed the 11/4/24 rehab note recommending a toileting schedule. E3 acknowledged the 11/4/24 rehab note and confirmed that a prompted toileting schedule was not done. 2/26/25 11:22 AM – During an interview, E17 (CNA) recalled that SR6 was confused, required assistance and incontinent. The facility failed to ensure that SR6, a newly admitted cognitively impaired resident who was incontinent of bladder and bowel, was placed on an individualized prompted toileting schedule to meet the resident's needs. 2/26/25 3:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E13 (ED) and a representative from the Ombudsman's office.		
S/S = D	**F726** **§483.35 Nursing Services** **The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.**	A. SR7 no longer resides at WillowBrooke Court at Country House. B. Residents that are experiencing significant decline at end of life with acute breathing distress have the potential to be impacted by this identified area of concern. The DON/designee will audit residents at the end of life with current orders for comfort medications prescribed for acute breathing distress to ensure that residents have	04/24/2025

Provider's Signature Jennifer Guenwald Title NHA Date 3/20/2025

NAME OF FACILITY: WillowBrooke Court at Country House DATE SURVEY COMPLETED: February 26, 2025

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	§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. **§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.** **§483.35(c) Proficiency of nurse aides.** **The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.** **This requirement was not met as evidenced by:** Based on record review, review of facility documents as indicated and interviews, it was determined that for one (SR7) out of the survey sample reviewed for competent nursing staff, the facility failed to ensure that SR7 received competent nursing care, according to professional standards of practice, on 12/23/24. Findings include: Cross refer F684 Review of SR7's clinical record revealed: 4/18/22 - SR7 was admitted to the facility with multiple diagnoses, including Alzheimer's disease, diabetes, high blood pressure, and anxiety.	access to comfort medications timely. C. Root cause analysis was completed for the identified area of concern. It was determined that the licensed staff was hired on 1/30/2024 and completed orientation on 2/14/2024 which included use of the Omni Cell. The identified area of concern during survey occurred on 12/23/2024. Leaving an 8-month gap between orientation and application of knowledge as it relates to pharmacy processes and pulling narcotics from the Omni Cell. A competency review as it relates to pharmacy processes and pulling narcotics from the Omnicell will be conducted on or about month 6 of new hire to ensure mastering of the process. The DON/ Designee will educate the involved staff member as it relates to the pharmacy processes and pulling narcotics from the Omnicell The DON/ Designee will educate licensed nursing staff on the pharmacy process and pulling narcotics from the Omni cell. D. The DON/ Designee will audit residents who are experiencing significant decline at end of life with acute breathing	

Provider's Signature Jennifer Greenwalt Title NHA Date 3/20/2025

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	A review of SR7's electronic medical (Emr) records documented that in 2024, SR7 experienced progressive physical and mental decline throughout the months of September, October, November and December. E12 (Nurse Practitioner) documented that SR7 was near the end of life in December 2024. On 12/23/24 at 8:00 AM, SR7 was assessed by E12 because SR7 was experiencing breathing distress, as reported by SR's husband. E12 assessed that SR7 was breathing at a rate of 32 breaths per minute (normal rate of breathing is 12-20 breaths per minute). E12 ordered for SR7 to receive the medication Ativan 0.5mg by mouth, every four hours as needed for anxiety. Anxiety related breathing distress can often be present at the end of life; according to the National Hospice and Palliative Care Organization 2020, breathing distress can be treated with Ativan (lorazepam). 2/25/25 9:30 AM - During an interview, E12 stated that she ordered for SR7 to receive Ativan (lorazepam) 0.5 mg every four hours as needed for anxiety, to relieve SR7's breathing distress. 2/25/25 1:45 PM - During an interview E6 (RN) stated that the facility has emergency supply of medications that can be accessed and given to residents until the medication is delivered from the pharmacy. The emergency medications are located in a locked container in the facility, which is managed by the facility pharmacy. The locked emergency medication container is accessible to facility nurses according to a pharmacy process. The process to access the medication Ativan (lorazepam) included contacting the pharmacy for an access to code in order to open the locked emergency box of medications.	distress to ensure that comfort medications are given timely following the pharmacy process for pulling narcotics from the Omni Cell. These audits will be conducted daily for 2 weeks, weekly for 2 weeks then monthly for 1 month until substantial 100% compliance is obtained. Outcomes of these audits will be submitted to the Quarterly QAPI committee meeting for review and recommendation as indicated.	

Provider's Signature Jennifer Greenwalt Title NHA Date 3/20/2025

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	2/25/25 - The following facility documents were reviewed: -The list of the emergency medications stored in the facility's emergency box of medications; Ativan (lorazepam) 0.5 mg tablets is included in the list of emergency medications available. -The facility's nursing orientation checklist revealed that the emergency box of medications is reviewed at the time of nursing orientation to the facility. 2/26/25 9:19 AM - During an interview, P1 (Pharmacy Clinical Case Manager) stated that the pharmacy received the Ativan 0.5 mg (lorazepam) electronic prescription order from E12 at 8:49 AM on 12/23/24. P1 further stated that there was no emergency medication access request from the facility to the pharmacy on 12/23/24. On 12/23/24, from approximately 9:30 AM onward, the facility had an emergency supply of Ativan (lorazepam) 0.5 mg tablets available for nursing staff to access and to administer to SR7 to relieve her breathing distress, The process to access the emergency medication supply was not initiated by nursing staff caring for SR7 on 12/23/24. The December 2024 medications administration record (MAR) revealed that Ativan 0.5 mg (lorazepam) as needed every four hours for anxiety was first given to SR7 at 3:28 PM on 12/23/24, seven hours after E12 documented that SR7's was experiencing breathing distress. 2/26/25 3:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E13 (ED) and a representative from the Ombudsman's office.		

Provider's Signature Jennifer Greenwalt Title NHA Date 3/20/2025

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

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

STATE SURVEY REPORT

NAME OF FACILITY: WillowBrooke Court at Country House **DATE SURVEY COMPLETED:** February 26, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3225.12.0 **3225.12.1.3**	**Services** **Food service complies with the Delaware Food Code** **Delaware Food Code** **6-2 DESIGN, CONSTRUCTION, AND INSTALLATION** **6-202 Functionality** **6-202.15 Outer Openings, Protected** . **(A) Except as specified in (B), (C), and (E) and under (D) of this section, outer openings of a FOOD ESTABLISHMENT shall be protected against the entry of insects and rodents by:** **(1) Filling or closing holes and other gaps along floors, walls, and ceilings;** **(2) Closed, tight-fitting windows; and** **(3) Solid, self-closing, tight-fitting doors.** **This requirement was not met as evidenced by:** Based on the observation, interview and record review, the facility failed to provide a safe working environment for food service staff and a vermin proof environment for food storage and preparation. Findings include: 2/21/25 9:46 AM – During the kitchen tour with E8 (Director of Culinary), the surveyor found a gap under the double door of the storage room in the back of the kitchen, which opens to the outside where multiple garbage bins were located. The door gap was large enough that a rodent or insect could crawl through. The finding was confirmed with the E8.	A. The Gap under the double door of the storage room in the back of the kitchen has been repaired. B. The NHA/Designee will audit the past three months of pest control report to identify if there were any recommended repairs. Any recommended repairs that have not been addressed by the Plant Operations team will be remedied. C. A Root cause analysis was conducted, and it was determined that the new Director of Property Management had failed to review the Pest Control Logs to determine if there were recommendations for repairs needed. The Director of Property Management will review all new Pest Control Reports and ensure that any identified needed repairs are completed. The NHA/Designee will educate the Director of Property Management on the process of reviewing the Pest Control reports and ensuring appropriate remedies to needed repairs identified in the report. D. The NHA/Designee will audit Pest Control report to determine if any repairs were identified in the report and ensure that repairs are completed by the Plant Operations team. These audits will	04/04/2025 03/03/2025

Provider's Signature Jennifer Greenwalt Title NHA Date 3/20/2025

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	2/21/25 2:00 PM - A document review of the pest control service provider report revealed that on 9/21/23, the pest control provider first reported that the kitchen double door gap needed to be repaired. Weekly pest control service reports from 12/26/24 thru 2/20/25 continued to mention the need for the repair to the door gap. 2/26/25 3:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E13 (ED) and a representative from the Ombudsman's office.	be conducted weekly x4 weeks, then monthly 1 month until 100% compliance is achieved. Outcomes of these audits will be submitted to Quarterly QAPI Committee for review and recommendations as indicated.	

Provider's Signature Jennifer Greenwald Title NHA Date 3/20/2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085003	A. BUILDING _____ B. WING _____	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COUNTRY HOUSE	4830 KENNETT PIKE WILMINGTON, DE 19807

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from February 20, 2025 through February 26, 2025. The facility census was thirty-one (31) on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from February 20, 2025 through February 26, 2025. The deficiencies contained in this report are based on interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was thirty-one. The survey sample was six. Findings include: Abbreviations/definition used in this report are as follows: 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; DON - Director of Nursing; Diabetes - disease where sugar levels are too	F 000		

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

Electronically Signed | 03/20/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 high; ED - Executive Director; EMR - electronic medical record; MAR - Medication Administration Record/list of daily medications to be administered; NHA - Nursing Home Administrator; RNAC - Registered Nurse Assessment Coordinator.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of	F 623		4/24/25

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F 623	Continued From page 2 this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402,	F 623		

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F 623	Continued From page 3 codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R3) out of one resident reviewed for hospitalization, the facility failed to send a copy of a hospital transfer notice to the Office of the State Long-Term Care Ombudsman. Findings include: Review of R3's clinical record revealed: 1/10/25 - R3 was admitted to the facility with multiple diagnoses, including the aftereffects from	F 623	A.R3 notice of transfer was provided to resident and sent to state LTC ombudsman. Monthly log for submission was amended and sent to Ombudsman. B.Residents that have been transferred or discharged from Country House to an acute setting or home have the potential to be impacted by this identified area of concern. The facility will ensure that residents who have been transferred or	

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F 623	Continued From page 4 a fall, heart disease, chronic pain, diabetes and anemia. 1/15/25 - R3 experienced severe stomach pain with diarrhea, and the R3 was sent to the hospital for an evaluation, and was admitted to the hospital. 2/25/25 1:15 PM - During an interview, E1 (NHA) stated that the facility failed to send a copy of the hospital transfer notice the State Long-Term Care Ombudsman for the R3's 1/15/25 hospitalization. 2/26/25 3:30 PM - Findings were reviewed during the exit conference with E1, E2 (DON), E13 (ED) and a representative from the Ombudsman's office.	F 623	discharged from Country House to an acute setting or home will receive the notice of transfer with monthly submission provided to Ombudsman office. An audit was completed on residents who were transferred/discharged for the past 14 days by the social service coordinator, no issues identified. C.Root cause analysis was conducted for the identified area of concern, and it was determined that newly hired social service coordinator was unaware of the process for notice/discharge. NHA/designee will educate social service coordinator on the policy and procedure related to the distribution and submission process for transfer and dishcharge notification. D.NHA/designee will audit the notice of transfer/discharge to ensure that residents who have been transferred or discharged from WillowBrooke Court at Country House to an acute setting or home have received the notice, and that the monthly submission was provided to the Ombudsman□s office. These audits will be conducted weekly x4 weeks and monthly for 1 month until 100% compliance is achieved. Outcomes of these audits will be submitted to quarterly QAPI committee for review and recommendations as indicated.	

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F 684	Continued From page 5	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R1) out of five residents reviewed for unnecessary medications, the facility failed to ensure that R1's physician order for weekly blood pressure (BP) monitoring on Mondays was completed. Findings include: Review of R1's clinical record revealed: 5/22/24 - R1 had a physician's order for blood pressure every week on Mondays for diagnosis of high blood pressure. According to the monthly electronic MARs, R1 was receiving the following medications for a diagnosis of high blood pressure from December 1, 2024 through February 18, 2025: - Cardizem daily; - Hydrochlorothiazide daily; and - Atenolol twice a day. Review of the R1's clinical record for the weekly blood pressures revealed that 10 out of 12 scheduled opportunities, R1's blood pressure was not checked per the physician's order.	F 684	F684 A. R1 Physician order has been corrected to reflect blood pressure monitoring on Mondays with blood pressure documentation in place on electronic medication administration record. B.Residents that have orders for medications with blood pressure parameters have the potential to be impacted. The DON/designee will audit current residents with such orders to ensure the order entry is appropriate to trigger blood pressure documentation with parameter clearly stated on EMAR. C.Root cause analysis was completed on the identified area of concern, it was determined that the physician used closed brackets when creating the new order and the nurse failed to change the closed brackets to open brackets that would allow the order to appear on the EMAR when confirming order.	4/24/25

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F 684	Continued From page 6 2/25/25 11:30 AM - During a combined interview with E2 (DON) and E3 (RNAC/Supervisor), finding was reviewed and acknowledged. No further information was provided to the Surveyor. 2/26/25 3:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2, E13 (ED) and a representative from the Ombudsman's office.	F 684	The DON/ designee will educate the physician on order entry as it pertains to open and closed brackets. The DON/ designee will educate the licensed professional staff on order entry as it pertains to open and closed brackets. The DON/ designee will educate the licensed professional staff on ensuring that orders needing to appear on the EMAR have open brackets. D.The DON/ designee will audit orders awaiting confirmation by checking to ensure that orders requiring open brackets have them in place with supplementary documentation so that the order will appear on the EMAR. These audits will be conducted daily for 2 weeks then weekly for 2 weeks, monthly for 1 month until 100% compliance is obtained. Outcomes of these audits will be submitted to the Quarterly QAPI committee meeting for review and recommendation as indicated.	