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

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

STATE SURVEY REPORT

NAME OF FACILITY: Willowbrooke Court Skilled Center At Manor House **DATE SURVEY COMPLETED: May 6, 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, Complaint and Emergency Preparedness Survey was conducted at this facility from April 29, 2025, through May 6, 2025. The deficiencies contained in this report are based on interviews, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was thirty-two (32). The survey sample totaled nineteen (19) residents. Abbreviations/definitions used in this report are as follows: ADON – Assistant Director of Nursing; CNA – Certified Nurse's Aide; DNR – Do Not Resuscitate; DON – Director of Nursing; ED – Executive Director; NHA – Nursing Home Administrator; RN – Registered Nurse.		
3201			
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby**		

Provider's Signature [signature] Title NHA Date 5/20/2025

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	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 May 6, 2025: cross refer: F626, F628, F638, F656 and F657. **F628 §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.** **This requirement was not met as evidenced by:** Based on interview and record review, it was determined that for four (R12, R15, R130 and R140) out of four residents reviewed for discharge, the facility failed to notify the LTC State Ombudsman. Findings include:	1. Social services coordinator immediately reached out to the ombudsman for template and communication about notification of discharges. 2. Discharges for the last 30 days have been reviewed and will be sent to the ombudsman for notification. 3. Education will be provided to the social services coordinator on the notice before transfer and notification of the ombudsman before transfers or discharges. 4. Social services coordinator or designee will conduct an audit weekly x 90 days or until 100% compliance for 3 months for proper completion of notice of transfer. Results will be reported in QAPI.	8/6/2025

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	A facility policy "Transfer and Discharge Rights" revision date March 2025 documented, procedure: 1. a. "A copy of the notice will also be sent to a representative of the Office of the State Long-Term Care Ombudsman." 1. Review of R12's clinical record revealed: 11/18/24 – R12 was admitted to the facility from an acute care hospital. 11/20/24 – A discharge care plan documented that R12 wishes were to return to her independent living apartment. 2/18/25 – R12 was discharged back to her independent living apartment. 2. Review of R15's clinical record revealed: 11/27/24 – R15 was admitted to the facility. 4/13/25 1:40 AM – A nursing progress note documented R15 was pronounced deceased by E7 (RN). R15's code status was DNR and was receiving hospice services. 3. Review of R130's clinical record revealed: 4/12/22 R130 was admitted to the facility. 10/24/24 8:02 AM – A nursing progress note documented R130 was pronounced deceased by E15 RN. R130's code status was DNR.		

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	4. Review of R140's clinical record revealed: 4/7/25 – R140 was admitted to the facility from acute care hospital. 4/12/25 11:48 PM – A nursing progress note documented R140 was pronounced deceased by E14 RN. R130's code status was DNR and was receiving hospice services. 5/1/25 12:12 PM – During an interview, E4 (SW) confirmed that the State Ombudsman was not notified of the discharge and deaths. E stated, "I didn't know I had to notify the ombudsman." 5/1/25 2:41 PM – During an interview, E1 (NHA) confirmed that the social worker was not notifying the State Ombudsman when residents were discharged. 5/6/25 2:00 PM – Findings discussed with E1, E2 (DON), E3 (ADON), and E5 (ED) at the exit conference. **Title 16 Health and Safety** **Chapter 11 Long-Term Care Facilities and Services** **Subchapter IX. Criminal Background Checks; Drug Testing-PPECC** **§ 1191. Mandatory drug screening.** **(a) An employer may not employ any applicant without first obtaining the results of that**	1.Human Resource/Recruitment Coordinator immediately reached out to the Wellness Office and corrected the Drug Screening Authorization form that was being used and pulled all incorrect Drug	8/6/2025

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	applicant's mandatory drug screening. **(b) All applicants must submit to mandatory drug screening, as specified by regulations promulgated by the Department.** **(c) The Department shall promulgate regulations regarding the pre-employment screening of all applicants for use of all of the following illegal drugs:** **(1) Marijuana/cannabis.** **(2) Cocaine.** **(3) Opiates.** **(4) Phencyclidine ("PCP").** **(5) Amphetamines.** **(6) Any other illegal drug specified by the Department, under regulations promulgated under this section.** **(d) The employer must provide confirmation of the drug screen in the manner prescribed by the Department's regulations.** **This requirement was not met as evidenced by:** Based on interview and record review it was determined that for seven (E3, E6, E7, E8, E9, E10 and E11) out of ten (10) employees reviewed, the facility failed to complete the required pre-employment drug screening.	Screening Cups and ordered the correct Drug Screening Cups. 2. The new Hire File Check List has been updated to include Marijuana on the Drug Screen list and will verify that it has been completed by the results of the Drug Screen from the Wellness office. 3. Human Resources/Recruitment Coordinator will plan to retest the 7/10 pending review by legal counsel per our Regional HR. Education will be provided to the Wellness office and HRC on the proper completion of drug screening. 4. An audit will be completed on all drug screens performed in the Wellness office to verify compliance for 90 days or until 100% compliant, and report in QAPI.	

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	Findings include: 5/2/25 10:25 AM – A review of the facility's employee drug test results revealed that seven (7) employees out of ten (10) reviewed did not have marijuana/cannabis included in their pre-employment drug screen testing regimen: E6 (Housekeeper) – 10/18/24, date of the drug test with no evidence of a marijuana test completed. E7 (RN) – 10/18/24, date of the drug test with no evidence of a marijuana test completed. E8 (Lifeguard) – 11/1/24, date of the drug test with no evidence of a marijuana test completed. E9 (Prep Cook) – 1/17/25, date of the drug test with no evidence of a marijuana test completed. E3 (ADON) – 2/20/25, date of the drug test with no evidence of a marijuana test completed. E10 (CNA) – 3/14/25, date of the drug test with no evidence of a marijuana test completed. E11 (Busser) – 4/14/25, date of the drug test with no evidence of a marijuana test completed. 5/2/25 11:50 PM – During an interview with E1 (NHA), the findings were communicated and he confirmed the facility testing cup for the urine drug screen did not include the marijuana test. 5/5/25 10:45 AM – An interview with E1 (NHA)		

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	revealed that the wrong batch of urine drug testing cups were ordered. 5/6/25 2:00 PM - Findings discussed with E1, E2 (DON), E3 (ADON), and E5 (ED) at the exit conference.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085009	A. BUILDING _____ B. WING _____	C 05/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments 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 April 29, 2025 through May 6, 2025. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from April 29, 2025, through May 6, 2025. The deficiencies contained in this report are based on interviews, record review and a review of other facility documentation as indicated. The facility census on the first day of the survey was six (6). The survey sample totaled six (6) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; ED- Executive Director; EMR- electronic medical record; NHA- Nursing Home Administrator; Hypnotic - a sleep inducing medication; Insomnia - sleep disorder that is characterized by difficulty falling and/or staying asleep; Non-pharmacologicial - any intervention (therapy or technique) intended to improve health or well-being that does not involve the use of any drug or medicine;	F 000		

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

Electronically Signed | 05/20/2025

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 Ombudsman - an independent officer of the legislature who investigates complaints from the public against administrative action and, if finding the action unfair, recommends a remedy; Sedative - a drug taken for its calming or sleep-inducing effect.	F 000		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R8) out of six reviewed for Resident Assessments, the facility failed to assess R8 no less than once every three months. Findings include: Review of R8's clinical record revealed: 10/1/24 - R8 was admitted to the facility. 10/7/24 - An admission MDS was completed for R8. 12/27/24 - A significant change MDS was completed for R8. 3/26/25 - A quarterly MDS was noted to be in progress for R8. As of 5/5/25, it was not completed. 5/5/25 10:10 AM - An interview with E2 (DON) confirmed that the quarterly MDS was still in	F 638	1. R8's MDS was completed on 5/7/2025 2. A complete audit will be conducted for the timeliness of MDS completion and MDS ARDs set within 92 days from the previous ARD and administration and nursing will be notified of results for education. 3. Education will be provided to the RNAC on the process for setting ARDs and completing MDSs timely. 4. RNAC or designee will conduct weekly audits x4 weeks until 100% compliance is achieved, then bi-weekly x4 weeks until 100% compliance is achieved. Then monthly x3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will review the process, and revision will be made to maintain and sustain compliance.	6/13/25

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F 638	Continued From page 2 progress and was overdue by 38 days. E2 stated that during the dates 3/26/25 to 4/21/25 no qualified staff was working that was able to complete the MDS. Additionally, E2 stated that the MDS would be completed by 5/7/25 as the MDS coordinator (E12) was back from leave and working on it. 5/6/25 2:00 PM - Findings discussed with E1, E2 (DON), E3 (ADON), and E5 (ED) at exit conference.	F 638		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		6/17/25

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F 656	Continued From page 3 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R8) out of five residents sampled for medication review, the facility failed to develop a comprehensive care plan for insomnia. Findings include: Review of R8's clinical record revealed: 10/1/24 - R8 was admitted to the facility including a diagnosis of insomnia. 10/1/24 - A physician's order was written for "melatonin oral tablet 10 mg: give one tablet by mouth every twenty four hours as needed for insomnia." January 2025 - The MAR documented that R8	F 656	1.The insomnia care plan was developed 1/16/2025. 2.A complete audit of all residents with a diagnosis of Insomnia and/or receiving a Sedative/Hypnotic will be reviewed for accuracy and timeliness. Nursing will be notified of results for education and process change. 3.Education will be provided to nursing staff and care coordinator on the process for adding care changes to the care plan and timeliness of the addition. 4.RNAC or designee will conduct weekly audits x4 weeks until 100% compliance is achieved, then bi-weekly x4 weeks until 100% compliance is achieved. Then monthly x3 months with a goal of 100%	

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F 656	Continued From page 4 received several doses of melatonin. 5/5/25 3:02 PM - An interview with E13 (RN) confirmed that she would attempt non-pharmacological interventions per the care plan. Additionally, E13 acknowledged that R8 did not have a care plan addressing insomnia during that timeframe. The facility lacked evidence of developing a care plan with goals and interventions related to insomnia. 5/6/25 2:00 PM - Findings discussed with E1, E2 (DON), E3 (ADON), and E5 (ED) at exit conference.	F 656	achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will review the process, and revision will be made to maintain and sustain compliance.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		6/17/25

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F 657	Continued From page 5 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for three (R5, R7, and R8) out of six sampled residents, the facility failed to have input from all required interdisciplinary team (IDT) members at the residents' care plan meetings. Findings include: 1. Review of R5's clinical record revealed: 5/18/23 - R5 was admitted to the facility. 9/4/24 - A quarterly MDS assessment was completed for R5. 9/16/24 - A care plan meeting note lacked evidence of CNA and physician input. 12/4/24 - A quarterly MDS assessment was completed for R5. 12/10/24 - A care plan meeting note lacked evidence of CNA and physician input. 3/4/25 - A quarterly MDS assessment was completed for R5. 3/10/25 - A care plan meeting note lacked evidence of CNA and physician input.	F 657	1.Care plan completion dates and required staffing attendance were reviewed but cannot be changed. 2.A complete audit of all residents care plan completion dates and required staff attendance will be reviewed for accuracy and nursing and the IDT will be notified of results for education and process changes. 3.Education will be provided to the MDS Nurse, nursing staff and Interdisciplinary Team (IDT) on the process for signing care plan completion timely and who is required by regulation to attend care conference. 4.RNAC or designee will conduct weekly audits x4 weeks until 100% compliance is achieved, then bi-weekly x4 weeks until 100% compliance is achieved. Then monthly x3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will review the process, and revision will be made to maintain and sustain compliance.	

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F 657	Continued From page 6 5/5/25 12:45 PM - An interview with E4 (SW) confirmed that a CNA is always invited to care plan meetings and if they are not able to attend she tries to include CNA input in the meeting. E4 was unable to provide evidence of CNA input in the aforementioned meeting dates. 5/5/25 1:00 PM - An interview with E1 (NHA) revealed that the physician visits should correlate with the care plan meetings and the meeting notes should reflect any concerns presented in the physician's progress notes. A review of the aforementioned care plan meetings and physician progress notes revealed that physician's visits did not occur prior to the care plan meeting. The care plan meeting notes lacked evidence that the physician provided input. 5/6/25 11:30 AM - During an interview, E1 confirmed that the physician's progress notes did not correlate with the care plan meeting notes. 2. Review of R7's clinical record revealed: 8/16/24 - R7 was admitted to the facility. 9/25/24 - A significant change MDS was completed for R7. 10/1/24 - A care plan meeting note lacked evidence of CNA and physician input. 11/25/24 - A significant change MDS was completed for R7. 12/3/24 - A care plan meeting note lacked evidence of CNA and physician input.	F 657		

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(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
F 657	Continued From page 7 2/19/25 - A quarterly MDS assessment was completed for R7. 2/25/25 - A care plan meeting note lacked evidence of CNA and physician input. 5/5/25 12:45 PM - An interview with E4 (SW) confirmed that a CNA is always invited to care plan meetings and if they are not able to attend she tries to include CNA input in the meeting. E4 was unable to provide evidence of CNA input in the aforementioned meeting dates. 5/5/25 1:00 PM - An interview with E1 (NHA) revealed that the physician visits should correlate with the care plan meetings and the meeting notes should reflect any concerns presented in the physician's progress notes. A review of the aforementioned care plan meetings and physician progress notes revealed that physician's visits did not occur prior to the care plan meeting. The care plan meeting notes lacked evidence that the physician provided input. 5/6/25 11:30 AM - During an interview, E1 confirmed that the physician's progress notes did not correlate with the care plan meeting notes. 3. Review of R8's clinical record revealed: 10/1/24 - R8 was admitted to the facility. 10/7/24 - An admission MDS was completed for R8. 10/15/24 - A care plan meeting note lacked evidence of CNA and physician input.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085009	A. BUILDING _____ B. WING _____	C 05/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 8 12/7/24 - A significant change MDS was completed for R8. 1/7/25 - A care plan meeting note lacked evidence of CNA and physician input. 3/26/25 - A quarterly MDS assessment was in progress for R8. 4/1/25 - A care plan meeting note lacked evidence of CNA and physician input. 5/5/25 12:45 PM - An interview with E4 (SW) confirmed that a CNA is always invited to care plan meetings and if they are not able to attend she tries to include CNA input in the meeting. E4 was unable to provide evidence of CNA input in the aforementioned meeting dates. 5/5/25 1:00 PM - An interview with E1 (NHA) revealed that the physician visits should correlate with the care plan meetings and the meeting notes should reflect any concerns presented in the physician's progress notes. A review of the aforementioned care plan meetings and physician progress notes revealed that physician's visits did not occur prior to the care plan meeting. The care plan meeting notes lacked evidence that the physician provided input. 5/6/25 11:30 AM - During an interview, E1 confirmed that the physician's progress notes did not correlate with the care plan meeting notes. 5/6/25 2:00 PM - Findings discussed with E1, E2 (DON), E3 (ADON), and E5 (ED) at exit conference.	F 657		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085009	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 5/6/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CENTER AT N	**1001 MIDDLEFORD ROAD SEAFORD, DE**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 628	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §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 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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 628	Continued From Page 1

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, 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(l).

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 628	Continued From Page 2

therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.

§483.21(c)(2) Discharge Summary
When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:
(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined that for one (R4) out of one resident reviewed for discharge the facility failed to notify the Ombudsman of the resident discharge to home. Findings include:

The facility policy for Transfer and Discharge last updated March 2025, documented "Transfer and Discharge Rights - The Social Services Director will send a copy of the notice to representative of the Office of the State Long-Term Care Ombudsman."

Review of R4's clinical record revealed:

1/20/25 - R4 was admitted to the facility.

3/11/2025 - R4 was discharged to independent living.

5/1/25 12:12 PM - During an interview, E4 (SW) confirmed the Ombudsman was not notified of R4's discharge.

5/1/25 2:41 PM - E1 (NHA) confirmed the findings.

5/6/25 2:00 PM - Findings discussed with E1, E2 (DON), E3 (ADON), and E5 (ED) at exit conference.