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 Cokesbury Viillage **DATE SURVEY COMPLETED:** July 29, 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 July 24, 2025, through July 29, 2025. The deficiencies contained in this report are based on observations, interviews and record review. The facility census on the first day of survey was 32. The sample totaled was thirteen (13) residents. Abbreviations/definitions used in this report are as follows: Anxiety Disorder – a mental health condition that is characterized by persistent excessive worry, fear, and nervousness; Cognitive impairment – a decline in a person's ability to think, learn, remember, use judgement, and make decisions; CNA – Certified Nurse's Aid; DelVAX Delaware Immunization Registry – State of Delaware online registry of the immunization status of persons vaccinated against vaccine preventable diseases; DON – Director of Nursing; ED – Executive Director; Gastroesophageal Reflux Disease - a chronic condition where stomach contents flow back up into the esophagus, causing irritation and inflammation; Influenza – a contagious respiratory infection caused by a virus that affects the nose, throat, and lungs; LPN – Licensed Practical Nurse; Pneumococcal – refers to streptococcus pneumoniae bacteria that can cause lung, bloodstream, brain and spinal cord infections;		

Provider's Signature K Perrone Title NHA Date 9-3-25 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

NAME OF FACILITY: WillowBrooke Court at Cokesbury Viillage **DATE SURVEY COMPLETED:** July 29, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	NHA – Nursing Home Administrator; NP – Nurse Practitioner; Orthopedic – relating to the branch of medicine dealing with the correction of deformities of bones or muscles.	E5's contracting agency was notified of TB testing and regulation by NHA.	
3201	**Regulations for Skilled and Intermediate Care Facilities**	E5 will receive a 2 step TST (or equivalent), with results reported back to NHA.	
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement was not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed July 29, 2025: F882, F883, F887 and F943. **Title 16** **Health and Safety**	All contractor records reviewed. 1 contractor was found to be out of compliance. Current TST results were requested from contracted agency. If these are not available, a 2 step TST (or equivalent) will be required. Results will be submitted to the NHA. Contractor health files will be maintained onsite and contain information regarding current TST status. These health files will be monitored by the IP nurse/designee. IP nurse/designee will audit contractor health files monthly for TB testing compliance, until 100% compliance is reached. Audits will then decrease to quarterly and be ongoing. Results of audits will be reported to the QAPI committee. The QAPI committee will recommend any changes to the audit cycles, based on audit results. Audits will not be discontinued until 100% compliance is consistently demonstrated.	All to be completed by 9/12/25
3201.5.0	**Personnel/Administrative**		
3201.5.5	**The facility shall have written personnel policies and procedures. Personnel records shall be kept current and available for each employee, and include the following:**		

Provider's Signature K Perrone Title NHA Date 9-3-25 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

NAME OF FACILITY: WillowBrooke Court at Cokesbury Viillage **DATE SURVEY COMPLETED:** July 29, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201.5.5.1	**Results of tuberculosis screening** This requirement was not met as evidenced by: Based on staff record review and interview, it was determined that for one (E5) out of ten employees reviewed, the facility failed to have on file the results of the tuberculin (TB) testing. 3/21/25 – E5 (NP) started to work at the facility. 7/28/25 11:30 AM- During the review of the staff training worksheet, E1 (NHA) stated that she did not have any documentation of E5's tuberculin testing. E1 stated that the facility did not keep a file on the consultant employees and relied on their companies to supply that information. She stated that she had reached out to the consultant's [medical practice] and requested that they send over the documentation of their TB testing. 7/29/25 10:45 AM – E1 supplied the surveyor with a printout dated 12/19/2005 at 2:06 PM from [hospital] that stated E5 had a negative purified protein derivative (PPD) (the tuberculin skin test to determine if a person has been exposed to the bacteria that causes tuberculosis) on 6/11/2004 and 4/28/2005. It should be noted that these PPD tested occurred 21 and 20 years prior to E5 starting to work at this facility and were obtained while she worked for another employer. 7/29/25 2:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2	E5's contracting agency was notified of requirements for dementia related training by NHA. E5 completed a dementia related training module on 8/18/25 and provided the NHA with a certificate of completion. All contractor education records reviewed. 1 contractor was found to be out of compliance. Completion of a dementia training was requested from the contracted agency. A certificate of completion will be submitted to the NHA. Course taken was from Medscape. See certificate provided as attachment. Contractor education files will be maintained onsite. Staff development coordinator/designee will monitor education files. Staff development coordinator/designee will audit contractor education files for dementia training monthly for compliance, until 100% compliance is reached. Audits will then decrease to quarterly and be ongoing.	All to be completed by 9/12/25 All to be completed by 9/12/25

Provider's Signature [signature] Title NHA Date Revised 9-3-25

NAME OF FACILITY: WillowBrooke Court at Cokesbury Viillage **DATE SURVEY COMPLETED:** July 29, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	(DON), E3 (Regional Clinical Director) and E4 (Executive Director) during the Exit Conference.	Results of audits will be reported to the QAPI committee. The QAPI committee will recommend any changes to the audit cycles, based on audit results. Audits will not be discontinued until 100% compliance is consistently demonstrated.	
3201.5.6	**Dementia Training**		
3201.5.6.1	**Nursing facilities that provide direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs.**		
	This requirement was not met as evidenced by:		
	Based on record review and interview, it was determined that for one (E5) out of ten employees reviewed for dementia training, the facility failed to have documentation of the dementia training.	R7 and R12's immunizations have been entered into DelVAX by unit clerk.	
	3/21/25 – E5 (NP) started to work in the facility.	All active resident records were reviewed. All were compliant.	
	7/28/25 11:30 AM- During the review of the staff training worksheet, E1 (NHA) stated that she did not have any documentation of E5's dementia training. E1 stated that the facility did not keep a file on the consultant employees and relied on their companies to supply that information. She stated that she had reached out to the consultant's [medical practice] and requested that they send over the documentation of her dementia training.	System for entering immunizations into DelVAX was found to be ineffective. New system implemented for DelVAX vaccine entering. IP nurse will now provide a weekly vaccination report to unit clerk, which includes all newly administered resident vaccines for that week. Unit clerk will enter newly administered vaccines into the DelVAX system weekly, based on the report provided.	All to be completed by 9/12/25
	7/29/25 10:45 AM – During an interview, E1 stated that she had not received any documentation regarding E5's dementia training.	Both the IP nurse and unit clerk have been educated on the process by ADON.	

Provider's Signature [signature] Title NHA Date Revised 9-3-25

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 Cokesbury Viillage **DATE SURVEY COMPLETED:** July 29, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
Title 16 Health & Safety Delaware Administrative Code **4200 Health Promotion and Disease Prevention** **4202 Control of Communicable and Other Disease Conditions** **Control of Specific Contagious Diseases**	The facility failed to provide evidence of E5's annual dementia training. 7/29/25 2:00PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (Regional Clinical Director) and E4 (Executive Director) during the Exit Conference. **Vaccine Preventable Diseases** **"Physicians and other health care providers who give immunizations shall report information about the immunization and the person to whom it was given for addition to the immunization registry in a manner prescribed by the Division Director or designee."** **This requirement was not met by:** Based on record review, it was determined that for two (R7 and R12) out of six residents reviewed for immunizations, the facility failed to report administered immunizations to the DelVAX Delaware Immunization Registry. Findings include: 1. R7's clinical record revealed: 4/26/2024 – R7 was admitted to the facility with diagnoses including orthopedic aftercare and mild cognitive impairment. 10/11/24 – R7 was administered an influenza immunization. 7/29/25 11:30 AM – During an interview, E1(DON) accessed DelVAX and printed a current copy of R7's Patient Administrative Record. The current DelVAX record for R7 not document an influenza immunization administered on 10/11/24. 2. R12's clinical record revealed:	IP nurse/designee will audit each newly administered resident vaccination weekly for uploading to DelVAX status. Results of audits will be reported at weekly standard of care meetings and scheduled QAPI meetings. This will be monitored by the standard of care committee weekly, until 100% compliance is reached. Once 100% compliance is reached, auditing will decrease to monthly x 2 months, until 100% compliance is reached. Once this is achieved, the QAPI committee will determine and recommend additional auditing cycles if necessary. All audits will be reviewed by the QAPI committee in addition to the standard of care committee. Audits will not be discontinued until 100% compliance has been consistently demonstrated. Documentation of current influenza vaccination for E5 was submitted to NHA on 7/30/25. All contractor records reviewed. 1 contractor was found to be out of compliance. Documentation of current influenza vaccine was	

Provider's Signature _____ Title NHA Date Revised 9/3/25

NAME OF FACILITY: WillowBrooke Court at Cokesbury Viillage **DATE SURVEY COMPLETED:** July 29, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	1/2/23 – R12 was admitted to the facility with diagnoses including gastro-esophageal reflux disease and anxiety disorder. 1/28/25 – R12 was administered a pneumococcal immunization. 7/29/25 11:30 AM – During an interview, E1 accessed DelVAX and printed a current provided a copy of R12's Patient Administrative Record. The current DelVAX record for R12 did not document a pneumococcal immunization administered on 1/28/25. 7/29/25 2:00 AM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (Regional Clinical Director) and E4 (Executive Director) during the Exit Conference.	requested from the contracted agency. This is to be submitted to the NHA. Contractor health files will be maintained onsite and contain information regarding current influenza vaccination status. These health files will be monitored by the IP nurse/designee. IP nurse/designee will audit contractor health files monthly for influenza vaccine compliance, until 100% compliance is reached. Audits will then decrease to quarterly and be ongoing. Results of audits will be reported to the QAPI committee. The QAPI committee will recommend any changes to the audit cycles, based on audit results. Audits will not be discontinued until 100% compliance is consistently demonstrated.	
Title 16 **Health and Safety, Part II Regulatory Provisions Concerning Public Health** **Chapter 11 Long-Term Care Facilities and Services Subchapter IV, 1144 Influenza immunizations**	**(b) The facility shall keep on record a signed statement from each employee stating that the employee has been offered vaccination against influenza and has either accepted or declined such vaccination.** This requirement was not met by: Based on record review and interview, it was determined that for one (E5) out of ten sampled employees, the facility failed to provide documentation of employee signed statements of influenza vaccination acceptance or declination. Findings include: 7/25/25 2:00 PM – Request for documentation of influenza vaccination status for E5 (NP) was given to E1 (NHA). 7/29/25 11:15 AM – During an interview, E1 stated "I do not have any information regarding influenza vaccines for [E5]."		

Provider's Signature _____ Title NHA Date Revised 9-3-25

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 Cokesbury Viillage **DATE SURVEY COMPLETED:** July 29, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	7/29/25 2:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (Regional Clinical Director) and E4 (Executive Director) during the Exit Conference.		

Provider's Signature S Pierson Title NHA Date Revised 9-3-25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COKESBURY VILLAGE	726 LOVEVILLE ROAD , HOCKESSIN, Delaware, 19707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility from July 24, 2025 through July 29, 2025. The facility census was thirty-two (32) 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.	E0000		08/13/2025
F0000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from July 24, 2025 through July 29, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was five residents. The investigative sample totaled five residents. Abbreviations/definitions used in this report are as follows: Anemia – a deficiency in healthy red blood cells that are essential in carrying oxygen throughout the body; CNA - Certified Nurse's Aide; BIMS – (Brief Interview for Mental Status) – assessment of the resident's mental status and cognition. The total possible BIMS score ranges from 0 to 15. A score of 0-7 indicates severely impaired cognition, 8-12 indicates moderately impaired cognition, and 13-15 indicates intact cognition; DON - Director of Nursing; ED - Executive Director; Infection Preventionist (IP) – term used for person(s)	F0000		08/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COKESBURY VILLAGE	**726 LOVEVILLE ROAD , HOCKESSIN, Delaware, 19707**

(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 designated by the facility to be responsible for the facility infection prevention and control program; Influenza – a contagious respiratory infection caused by a virus that affects the nose, throat, and lungs; Intact cognition – able to make own decisions; LPN - Licensed Practical Nurse; MDS assessment – federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; NHA - Nursing Home Administrator; NP - Nurse Practitioner; Pneumococcal – refers to streptococcus pneumoniae bacteria that can cause lung, bloodstream, brain, and spinal cord infections; RN - Registered Nurse; Traumatic subarachnoid hemorrhage – bleeding into the area between the brain and surrounding membranes resulting from a head injury.	F0000		
F0882 SS = F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in	F0882	Credentialed Infection Prventionist returned to work on 7/30/25. Corporate credentialed Infection Preventionist nurse provided guidance and support of the infection prevention program during the absence. Two full-time RNs are now certified as Infection Preventionists through an accredited body. Both the ADON and DON have current certifications. NHA will audit credentialing annually for compliance, and ensure the credentials are active. Results of credentialing will be reported annually to QAPI committee. QAPI committee will determine when to discontinue auditing, based on audit results. Audits will not be discontinued until 100% compliance is consistently demonstrated.	09/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COKESBURY VILLAGE	726 LOVEVILLE ROAD , HOCKESSIN, Delaware, 19707

(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
F0882 SS = F	Continued from page 2 infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on interview, the facility failed to designate an onsite Infection Control Preventionist at the facility from 6/3/25 to 7/13/25. Findings include: 7/28/25 1:30 pm - During an interview, E2 (DON) stated "[E7] is working from home. I started on 7/14/25. I have a certification for Infection Prevention training." 7/28/25 1:50 pm – During an interview, E7 (ADON, Infection Preventionist) stated, "I have been working from home since 6/3/25. I will be back on 7/30/25." 7/29/25 11:35 am - During an interview, E2 stated, "I don't know that anyone was here between 6/3/25 and 7/13/25 that has an Infection Preventionist certification." 7/29/25 2:00 pm - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (Regional Clinical Director) and E4 (Executive Director) during the Exit Conference.	F0882		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F0883	R5 was discharged on 7/26/25. Unable to correct. Immunization history was documented and maintained for R5 in the EHR, in the immunization tab. All active resident records were reviewed for pneumococcal immunization status. All were compliant. Education to be provided by DON and ADON to licensed nurses regarding admission requirements for immunization review and need to offer immunizations when immunizations are not current, along with documentation of acceptance or declination when this occurs. (complete by 9/18/25). IP nurse/designee will audit each new admission for vaccination status. Results will be reported at weekly standard of care meetings and scheduled QAPI meetings. This will be monitored by the standard of care committee weekly, until 100% compliance is reached. Once 100% compliance is reached, auditing will decrease to monthly x 2 months, until 100% compliance is reached. If 100% compliance not achieved, the auditing will continue monthly until 100% compliance is achieved. Once this is achieved, the QAPI committee will determine and recommend additional auditing cycles if necessary. All audits will be reviewed by the QAPI committee in addition to the standard of care	09/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COKESBURY VILLAGE	726 LOVEVILLE ROAD , HOCKESSIN, Delaware, 19707

(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
F0883 SS = D	Continued from page 3 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R5) out of five residents reviewed for infection control, the facility failed to offer and document pneumococcal immunization. Findings include: The facility policy dated 2023 and titled, "COVID-19, Influenza, and Pneumococcal Education and Consent for Residents" included, "... Upon admission the licensed nurse will obtain consent from the resident or legal responsible party using the COVID-19, Influenza, or Pneumococcal Vaccine Consent Form... This form will then be stored in the residents' primary care electronic health record... An immunization history is documented	F0883	Continued from page 3 committee. Audits will not be discontinued until 100% compliance is consistently demonstrated for 2 consecutive months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COKESBURY VILLAGE	726 LOVEVILLE ROAD , HOCKESSIN, Delaware, 19707

(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
F0883 SS = D	Continued from page 4 and maintained for each resident in the electronic health record in the immunization section." 7/8/25 – R5 was admitted to the facility with diagnoses including traumatic subarachnoid hemorrhage and anemia. 7/21/25 – A comprehensive MDS assessment documented R5 had a BIMS score of 14, indicating intact cognition. 7/29/25 11:40 am - During an interview, E2 (DON) stated "We don't have any vaccine documentation for [R5]." 7/29/25 2:00 pm - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (Regional Clinical Director) and E4 (Executive Director) during the Exit Conference.	F0883		
F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and	F0887	R5 was discharged on 7/26/25. Unable to correct. Immunization history was documented and maintained for R5 in the EHR, in the immunization tab. All active resident records were reviewed for COVID-19 immunization status. Two were out of compliance. NP reviewed and declined ordering the COVID booster at this time. NP recommends waiting for the 25/26 booster to be available. Education provided to licensed nurses by DON and ADON regarding admission requirements for immunization review and need to offer immunizations when immunizations are not current, along with documentation of acceptance or declination when this occurs. IP nurse/designee will audit each new admission for vaccination status. Results will be reported at weekly standard of care meetings and scheduled QAPI meetings. This will be monitored by the standard of care committee weekly, until 100% compliance is reached. Once 100% compliance is reached, auditing will decrease to monthly x 2 months, until 100% compliance is reached. If 100% compliance is not achieved, the auditing will continue monthly until 100% compliance is achieved. Once this is achieved, the QAPI committee will determine and recommend additional auditing cycles if necessary. All audits will be reviewed by the QAPI committee in addition to the standard of care committee. Audits will not be discontinued until 100% compliance has been consistently demonstrated for 2 consecutive months.	09/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COKESBURY VILLAGE	726 LOVEVILLE ROAD , HOCKESSIN, Delaware, 19707

(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
F0887 SS = D	Continued from page 5 (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, one (R5) out of five residents reviewed for infection control, the facility failed to offer and document COVID-19 immunization. Findings include: The facility policy dated 2023 and titled, "COVID-19, Influenza, and Pneumococcal Education and Consent for Residents" included, "... Upon admission, the licensed nurse will obtain consent from the resident, or legal responsible party, using the COVID-19, Influenza, or Pneumococcal Vaccine Consent Form... This form will then be stored in the residents' primary care electronic health record... An immunization history is documented and maintained for each resident in the electronic health record in the immunization section." 7/8/25 – R5 was admitted to the facility with diagnoses including traumatic subarachnoid hemorrhage and anemia. 7/21/25 – A comprehensive MDS assessment documented R5 had a BIMS score of 14, indicating intact cognition.	F0887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COKESBURY VILLAGE	726 LOVEVILLE ROAD , HOCKESSIN, Delaware, 19707

(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
F0887 SS = D	Continued from page 6 7/29/25 11:40 am - During an interview, E2 (DON) stated "We don't have any vaccine documentation for [R5]." 7/29/25 2:00 pm - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (Regional Clinical Director) and E4 (Executive Director) during the Exit Conference.	F0887		
F0943 SS = D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. 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- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for two (E5 and E6) out of ten employees reviewed for training, the facility failed to have records of abuse, neglect and exploitation training for the contracted employees. Findings include: 7/28/25 11:30 AM- During the review of the staff training worksheet, E1 (NHA) stated that she did not have any documentation of E5 (NP) and E6 (MD)'s abuse, neglect and exploitation training. E1 stated that the facility did not keep a file on the consultant employees and relied on their companies to supply that information. She stated that she had reached out to each consultant's [medical practice] and requested that they send over the documentation of his abuse/neglect/exploitation training.	F0943	Abuse training has been completed for E6. Training will be completed by E5. Contract agencies have been notified of this requirement and informed of need to complete an adult abuse training module. All contractors' files were audited for documentation of abuse training. One additional contractor was missing this requirement. Contractor's employer was notified of this requirement and need to complete an abuse training education module. Staff development coordinator/designee will audit contractor education files for completion of abuse education initially weekly, until 100% compliance is reached. Files will then be audited quarterly for continued compliance. Results will be brought to QAPI meetings for review. QAPI committee will determine when to discontinue auditing, based on audit results. Audits will not be discontinued until 100% compliance has been consistently demonstrated.	09/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COKESBURY VILLAGE	726 LOVEVILLE ROAD , HOCKESSIN, Delaware, 19707

(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
F0943 SS = D	Continued from page 7 7/29/25 10:45 AM – During an interview, E1 stated that she had not received any documentation regarding E5 or E6's training for abuse, neglect and exploitation. 7/29/25 2:00PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (Regional Clinical Director) and E4 (Executive Director) during the Exit Conference.	F0943		