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: April 26, 2022

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 beginning April 20, 2022, through April 26, 2022. The facility census on the entrance day of the survey was 31 (thirty-one). The survey sample totaled fifteen (15). The survey process included observations, interviews, review of resident clinical records, facility policies and procedures and other facility documents as indicated. **Abbreviations/definitions used in this report are as follows:** ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; CNO - Chief Nursing Officer; DON - Director of Nursing; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RD - Registered Dietitian; RN - Registered Nurse; UM - Unit Manager; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact, 8-12: Moderately impaired, 0-7: Severe impairment.		
3201 **3201.1.0**	**Regulations for Skilled and Intermediate Care Facilities** **Scope**		

Provider's Signature [signature] Title NHA Date 5/23/22

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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 is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed April 26, 2022: F943. **§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 resident's care plan.** **(F) Other appropriate staff or professionals in**	Preparations and/ or execution of this plan of correction does not constitute admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law. State tag 483.21 Comprehensive Care plans	

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	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. Based on interview and record review, it was determined for one (R215) out of 11 sampled residents, the facility failed to review and revise R215's care plan when the consistency of the liquid was changed from thin liquids to thickened liquids. Findings include: Review of R215's clinical record revealed: 12/21/21 – R215 was admitted to the facility and had a physician's order for regular diet with thin liquids. 3/4/22 - Nutrition Note by E5 (NSM) stated, R215's liquid consistency changed to mildly thick due to coughing. 3/4/22 – A physician's order was written to change liquid consistency from thin to mildly thickened. Review of the care plan for chewing/swallowing problems lacked the change in the consistency of the liquid to nectar thickened liquid. 4/21/22 1:15 PM – An interview with E3 (RN UM) confirmed that the facility failed to revise the above care plan to include nectar thick liquid. 4/25/22 3:20 PM - Findings were reviewed with E1 (NHA) and E2 (DON). 4/26/22 beginning at 3:15 PM – Findings were reviewed with E1 (NHA) and E3 (DON) during the Exit Conference. **§483.25(g) Assisted nutrition and hydration.**	A.On 4/21/2022 R215 Care plan was updated to reflect the change of thin liquids to mildly thick liquids. On 4/25/2022 R215 weight entered on 12/21/2021 was struck from the medical record. On 4/25/22 R215 orders were updated to include the Magic cup and health shake with supplemental documentation to indicate amount of supplement taken. B. Residents that have orders for changes in diet that require care plans to be updated, have the potential to be impacted by this identified area of concern. The facility will ensure that residents with changes to their diet will also have a care plan accurately reflecting those changes. Residents admitted to the facility on hospice services with an order to be weighted have the potential to be impacted by the identified area of concern. The facility will ensure that residents admitted to the facility on hospice services with an order to be weighed will have a weight that is accurately documented and/or inform the physician if the weight was obtained from previous record. A note will be entered into the resident's medical record reflecting what source the weight was obtained from with	4/21/2022 4/25/2022 4/25/2022 6/24/2022

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	(Includes nasogastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- **§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;** **§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;** **§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.** Based on observation, interview, record review, and review of facility policy, it was determined that for one (R215) out of one sampled resident for nutrition review the facility failed to have a system to ensure accuracy of admission weight, consultation with Registered Dietician and Attending Physician for weight loss, and monitoring of nutritional interventions for weight loss. Findings include: Review of the facility's Nutrition Services policy and procedure titled "Weight Gain/Loss", with an issue date of 1/09 stated, "...weights will be documented for all residents...for the purpose of assessing significant weight changes and weight trends. Procedure: A copy of the weight records will be forwarded by a member of the nursing staff to the appropriate culinary and nutrition professional each month (registered dietician RD), nutrition care coordinator (NCC), or nutrition services manager (NSM). The RD, NCC, or NSM will review monthly weighs and	the rationale why the resident was not able to be weighted upon admission. Residents admitted to the facility requiring nutritional assessments (NUT) to be completed upon admission, each time a resident is readmitted, quarterly, upon significant change in condition and as deemed necessary by the community or the RD have a potential to be impacted by the identified area of concern. The facility will ensure that residents will have an initial nutritional assessment completed within 7 days of admission. Re-assessments will be completed each time a resident is readmitted, quarterly, upon significant change in condition and as deemed necessary by the community or the RD. Residents that have been recommended to have a supplement require a physicians order for additional nutritional support have the potential to be impacted by the identified area of concern. The facility will ensure that residents with supplemental nutritional support have an order that allows licensed nursing staff to document the amount of the supplement taken. C. Root cause analysis was completed on the identified area of concern and it was determined that the RD (registereddietician)/designee omitted the liquid portion of the diet change in the residents care plan.	

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	calculate significant change over 30 days, 90 days and 180 days. A copy of all significant weight losses and gains and trending weight losses and gains will be given to the care team for appropriate review and documentation. 2. The care team will review and document all significant weight changes/trends, with appropriate referrals to the RD, NCC, or NSM. The RD, NCC, or NSM will review all significant weight changes/trends and referrals and take actions as necessary including follow-up documentation.... 5. The community [facility] is responsible for obtaining correct weights on a regular basis, and for keeping accurate records..." Review of the facility's Nutrition Services policy and procedure titled "Significant Weight Loss Protocol", with a revision date of 8/12 stated, "...Policy: Persons in the position responsible for providing nutritional care to residents...will strive to ensure residents maintain a stable weight, identify factors contributing to unplanned weight loss, and intervene as appropriate to resolve the problem and to avoid further weight loss...Procedure: 1. Identify residents with significant/severe weight losses. a. Monitor monthly weights... b. Identify residents with significant/severe weight loss... d. Assess the weight loss, document accordingly including update care plan...g. Review the meal consumption record to estimate the average percentage of food/fluids intake for the past 2-4 weeks... i. Document estimated nutrition needs with the estimated actual intake from meal consumption record... k. Implement nutrition interventions based on individual case...Document the additional nutritional values the interventions will add to the diet, in terms of calories and proteins..." Review of R215's clinical record revealed: 12/21/21 – R215 was admitted to the facility	Root cause analysis was completed on the identified area of concern and it was determined that the licensed nurse was not able to obtain a weight upon admission due to residents combative behavior. The resident's weight was recorded from the most recent medical record from the discharging facility. The licensed nurse did not inform the physician of source of recorded weight and did not note the source in the resident's medical record. Root cause analysis was completed on the identified area of concern and it was determined that the resident did not have a NUT assessment completed at the time of the change in weight status. Root cause analysis was completed on the identified area of concern and it was determined that a resident with a recommendation for supplemental nutritional support did not have a physician's order that allowed licensed nurses to document the amount of supplement taken. The RD/ designee will in-service staff responsible for care plan updates on the policy related to care planning to ensure that diet order changes are updated and correct in the resident's care plan. The DON/ designee will in-service licensed nurses on the process of obtaining weights of hospice residents with orders for weights upon admission and the proper documentation/ notification required	

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	with an admission weight of 181.2 pounds (#). (During an interview with E2 (DON) on 4/25/22 at approximately 11:10 AM, E2 (DON) confirmed during the survey, the facility identified, investigated and determined that the admission weight of 181.2# was incorrectly documented on 12/21/21). 12/22/21 – The admission Nutrition Assessment by E6 (RD) stated that R215 required staff assistance with eating and was eating well overall. In addition, he had peripheral edema of all his extremities. The plan was to monitor his nutritional status with goal for weights of 181# with plus or minus 3 (three)# thru next review. Recommendations was to continue current diet, weigh weekly for four (4) weeks then monthly, to assist R215 with meals, and to document % meal consumed. 12/26/21 – Nursing Progress Note documented that R215 refused to be weighed. 1/2/22 9:24 AM – R215's weight was 160.6 #. 1/2/22 10:54 AM – R215's weight was 160.6 #. 1/4/22 11:38 PM – R215's weight was 160.6 #. 1/5/22 - Nutrition Note by E5 (NSM) stated R215's diet was changed to puree diet due to R215 pocketing food in his mouth. 1/5/22 – A Care Plan was initiated which stated that R215 had trouble chewing/swallowing regular foods due to cognitive deficits and that he had an involuntary weight loss of 3.1% in 30 days [E5 (NSM) had calculated based on weight on 2/4/22 and 2/27/22 of 159.8# and 154.8# respectively] while receiving hospice services due to my overall medical decline. Interventions included for staff to assist with meals and feed R215 with patience, honor his food choices and preferences, provide health	if the resident's weight is not able to be obtained. The RD/ designee will in-service staff responsible for conducting NUT assessments on the policy as it relates to how often a NUT assessment should be conducted. The DON/ designee will in-service licensed nurses on the policy of nutritional supplement orders that will allow the nurse to document the amount of supplement taken. D. The RD/ Designee will audit orders of future diet changes to ensure care plans have been updated with the correct diet including liquid consistency. An initial audit will be conducted of residents currently residing in the facility to ensure diet orders are correctly reflected in the current care plan. These audits will be conducted initially and then weekly for 12 weeks or until substantial compliance (100% compliance for 3 consecutive weeks) is obtained to ensure compliance with residents who have had a diet change is updated in the residents care plan. The DON/ designee will audit notes from the Standards of Care (SOC) meeting for accuracy by comparing them to the weight summary report that indicates trigger weight loss or gain of residents for an unplanned significant weight loss/ gain of 5% in 30 days, 7.5% in 90 days, or 10% in 180 days. These resident's will be re-weighed to ensure accuracy of the	

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	shakes with my meals [updated on 3/30/22], and provide puree diet with mildly thick liquids. 1/6/22 – IDT Meeting Minutes stated, "...12/26/21 refused reweigh... Reweigh obtained 1/2/22 160.6. Questionable that 181.2 is correct. Edema noted upon admission of extremities. Decline anticipated on hospice upon admission. 1/5 diet changed...." Despite the facility documenting that they were questioning the accuracy of the admission weight of 181.2#, there was lack of evidence that the facility investigated the issue, including reassessing R215's nutritional status, consulting RD or attending physician. 1/9/22 – R215 weighed 156.6# (variance of 4# in 5 days). 1/9/22 – R215's weight of 156.9# (variance of 3.7# in 5 days). 1/11/22 – R215's weight of 159.1#. 1/16/22 – R215's weight of 162.1#. 2/4/22 – R215's weight of 159.8 #. 2/27/22 – R215's weight of 154.8#. Although there was a 5# variance between the 2/4/22 and 2/27/22 weight, there was lack of evidence of re-weigh to confirm the actual weight to determine if there was additional weight loss. 3/4/22 - Nutrition Note by E5 (NSM) stated, R215's liquid consistency changed to mildly thick due to coughing. Although a change in the consistency of liquid was completed on 3/4/22 as well as potential further weight loss, as evidence by the 5# variance from 2/4/22 and 2/27/22 weight, there	obtained documented weight. Documentation of these findings will be included in the residents medical record and the physician will be informed of the findings. Audits of the resident weights compared to the weight summary report will be conducted weekly for 12 weeks or until substantial compliance (100% compliance for 3 consecutive weeks) is obtained to ensure compliance with residents whose weight has triggered as a gain or loss according to policy. The RD/ designee will audit NUT assessments for completion against the weight summary report/ SOC meeting minutes to determine the need for a new assessment. These audits will be conducted weekly for 12 weeks or until substantial compliance (100% compliance for 3 consecutive weeks) is obtained to ensure compliance with NUT assessments on residents with a change in weight/ nutritional status requiring a new assessment to be conducted. The DON/ designee will audit recommendations of nutritional support supplements to ensure that there is a physician order coinciding with the recommendation and that the licensed nurse is able to document the amount of supplement taken. These audits will be conducted weekly for 12 weeks or until substantial compliance (100% compliance for 3 consecutive weeks) is obtained to ensure compliance with supplemental recommendations and physician orders.	

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	was lack of reassessment of R215's nutritional status. 3/9/22 – A Nutrition Note by E5 (NSM) stated, "Resident's wife concerned about his weight loss, current weight 154.8# (2/27/22) down from 159.4# (2/4/22). Started offering health shakes with meals, accepting 100%, providing an additional 660 cal/18 gms protein. Will monitor weights as ordered, resident continuing to receive Hospice services." Despite the fact the above 3/9/22 Nutrition Note documented weight loss, there was lack of evidence of consult with RD or his attending physician. In addition, there was lack of evidence of a physician's order for the health shake including when the intervention was implemented, how much was consumed/refused, and how much nutritional support would be provided by this intervention. 3/9/22 – 3/31/22 – Review of clinical record lacked evidence of how the facility was monitoring the new intervention health shake for each of the meals to address the continued weight loss. There was a lack of evidence of a monthly weight for March 2022. 4/1/22 – A Nutrition Assessment completed by E5 (NSM) stated that R215 continued on Hospice services and have experienced involuntary weight loss related to overall medical decline with a 14.4% weight loss in 90 days. R215's nutritional goals included to maintain skin integrity, remain free from sign/symptoms of dehydration and aspiration, remain comfortable with food and fluids. The recommendations was to continue puree diet with mildly thick liquids, honor food preferences, and continue with weighing the resident as ordered.	Outcomes of these audits will be submitted to the Quarterly QAPI committee meeting for review and recommendation as indicated.	

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	Although the facility questioned the accuracy of the admission weight previously, the facility failed to investigate and continue to utilize the admission weight and documented in the above Nutrition Assessment that R215 had a 14.4% weight loss in 90 days. In addition, there was lack of evidence of consulting RD for reassessment of the continued loss. 4/4/22 - 149.6# (variance of 5.2#). 4/6/22 - 150.7#. 4/6/22 – A Nutrition Note E5 (NSM) stated spoke with wife about continued weight loss. Question accuracy of admission wt of 181.2#. Started health shakes with all meals last month, will add Magic Cup to lunch and dinner as a continued intervention. Despite the fact the above 4/6/22 Nutrition Note documented continued weight loss, there was lack of evidence of consult with RD or his attending physician. In addition, there was lack of evidence of a physician's order for the Magic Cup including when the intervention was implemented, how much was consumed/refused, and how much nutritional support would be provided by this intervention. 4/1/22 – 4/20/22 – Review of clinical record lacked evidence of how the facility was monitoring the interventions of health shake and Magic Cup to address continued weight loss. 4/20/22 beginning at 12:50 PM – R215 observed being fed puree diet with nectar thickened liquids by E8 (CNA). In addition, the unopened container of health shake and Magic Cup were on the tray. 4/21/22 2:30 PM – An interview with E5 (NSM) confirmed that she questioned the accuracy of		

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	the admission weight, however, confirmed there was no action taken to address this issue and assumed it was an error. In addition, no further RD consultation had taken place and that the nutritional interventions were considered part of a "fortified food program" and would be included in the meal % consumed. E5 confirmed that no physician's orders were obtained for the two nutritional interventions and that it would be tracked as a meal percentage. E5 stated that if R215 did not consumed 100% of both the health shake and the Magic Cup during a meal, the meal % would be less, however, if the meal % was 100%, E5 would assume that R215 consumed 100% of health shake and 100% of the Magic Cup. E5 stated if R215 taken less 100% the health shake and/or the Magic Cup, the meal % would be less than 100%. 4/21/22 from approximately 2:45 PM to 3:20 PM – Interviews were conducted with E8 (CNA), E9 (CNA), E10 (CNA) and E11 (RN). All the interviewees confirmed that health shakes and Magic Cups consumed during meals would not be considered part of the meal %. E9 (CNA) stated that amount consumed would be documented as fluid intake. Based these staff interviews, it is inconsistent with E5's (NSM's) understanding of how the facility would ensure implementation and monitoring of nutritional interventions to address R215's weight loss. 4/22/22 1:40 PM – An interview with E6 (RD) confirmed that she was consulted and completed the initial nutritional assessment on 12/22/21. E4 stated she was not consulted subsequently. E4 stated that E5 (NSM) oftentimes considers nutritional supplements as part of a "fortified food program", however, E4 confirmed that there should have been physician's orders for the health shake and the Magic Cup and a method for monitoring the effectiveness of the interventions to address		

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	the weight loss. 4/25/22 9:45 AM – An interview with E4 (MD) revealed that R215 was admitted with peripheral edema and required diuresis. E4 stated that due to R215's health status, gradual weight loss was anticipated and that the admission weight was not correct. E4 stated a process to confirm the admission weight may be needed to prevent similar reoccurrence. 4/25/22 11:10 AM – The Surveyor was approached by E2 (DON) to discuss R215's weights. E2 stated that during the current survey, the facility investigated into the accuracy of R215's weight and that their investigation confirmed that the weight was incorrect and the weight was obtained from the facility that R215 was transferred from on 12/21/21. E2 provided a written and undated statement from E7 (LPN) who admitted the resident on 12/21/21. The statement documented, "...We attempted to get his weight on admission but he was combative...I ended up entering the weight that the nurse I got report from at [Name of the facility] gave me as his last weight so I could close his admission assessment...". E2 confirmed that the facility should have timely addressed the admission inaccurate weight prior to the investigation during the current survey. In response to this finding, E2 stated that she updated the facility's EMR which stated "[DON's Name] 04/25/22 11:02 [AM] Incorrect Documentation." E2 confirmed that the facility's policies and procedures did not include a specific weight variance which would prompt a re-weigh to confirm the weight loss or gain. 4/25/22 3:20 PM - Findings were reviewed with E1 (NHA) and E2 (DON). 4/26/22 beginning at 3:15 PM – Findings were		

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	reviewed with E1 (NHA) and E3 (DON) during 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
	085003	A. BUILDING _____ B. WING _____	C 04/26/2022

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

(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 An unannounced annual, complaint and emergency preparedness surveys were conducted at this facility from May 3, 2022 to May 12, 2022 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was 89. For the Emergency Preparedness survey, all contracts, operations plans, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual, and complaint survey was conducted at this facility from April 20, 2022 through April 26, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was five. The survey sample size was two. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; CNO - Chief Nursing Officer; DON - Director of Nursing; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RD - Registered Dietitian; RN - Registered Nurse;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/11/2022

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 UM - Unit Manager;	F 000		
F 943 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 interview and review of facility documentation as indicated, it was determined that the facility failed to ensure that the required training on abuse, neglect and exploitation was completed for one (E8) out of 12 randomly sampled staff members. Findings include: Review of E8's personnel records revealed: 12/21/21 - The first day of assignment at the facility for E8 (Enrichment Assistant). 4/26/22 at 12:50 PM - In an interview, E1 (NHA) confirmed that E8 did not receive his abuse, neglect and exploitation training.	F 943	A. E8 is no longer employed at Willowbrooke Court at Country House. Last Day worked was March 6, 2022. B. The NHA/Designee will audit active Newly Hired employees who have been hired since January 1, 2022, and are working on Willowbrooke Court at Country House, to ensure that these employees have received training on Abuse, Neglect, and Exploitation. If any employees are found to not be in compliance with this training requirement, they will complete the training and brought into compliance. C. A Root Cause analysis was completed	6/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WILLOWBROOKE COURT AT COUNTRY HOUSE	4830 KENNETT PIKE WILMINGTON, DE 19807

(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 943	Continued From page 2 Findings where reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 4/26/22 beginning at 3:15 PM.	F 943	on the identified area of concern and it was determined that the Recreation Coordinator will require additional in servicing on the requirement that new hires require training on Abuse, Neglect, and Exploitation. The NHA/Designee will in-service the Recreation Coordinator, Director of Nursing, Assistant Director of Nursing, Housekeeping Manager, Culinary Manager, and Plant Operations Manager that newly hired staff will complete Abuse, Neglect, and Exploitation training during New Hire Orientation. D. The NHA/Designee will conduct weekly audits of Newly Hired employees that have completed New Hire Orientation to ensure that the employee completed training in Abuse, Neglect, and Exploitation. This audit will be conducted once weekly until we reach success for 4 consecutive weeks, then twice a month until we reach success for 2 consecutive months, then once a month until we determine 100% compliance has been achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee meeting for review and recommendation as indicated.	