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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 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 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.

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.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 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 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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 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. 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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/6/25 2:00 PM - Findings discussed with E1, E2 (DON), E3 (ADON), and E5 (ED) at exit conference.