

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2016
NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901	
(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 000	<p>INITIAL COMMENTS:</p> <p>An unannounced annual and complaint survey was conducted at this facility from January 28, 2016 through February 3, 2016. 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 the first day of the survey was 61. The Stage 2 sample totaled 25 residents.</p> <p>Abbreviations used in this report are as follows:</p> <p>NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; MDS - Minimum Data Set-standardized assessment form used in nursing homes; RNAC - Registered Nurse Assessment Coordinator; CC - Cubic Centimeter; ER - Emergency Room; F - Fahrenheit; Acetaminophen (Tylenol) - medication for pain or fever; BIMS (Brief Interview for Mental Status) - test to measure thinking ability (score 13-15 = intact; 8-12 = moderate impairment; 0-7 = severe impairment); Cognitive/Cognition - mental processes, thinking; Diabetes Mellitus - disease where blood sugar levels are too high; Dementia - severe state of cognitive impairment characterized by memory loss, poor judgement, disorientation and personality changes;</p>	F 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">FEB 17 2016</p> <p style="text-align: center;">COURTLAND MANOR, INC.</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *David A. Mills* TITLE: ADMINISTRATOR (X6) DATE: 3/22/16

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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Paul A. Myler

ADMINISTRATOR

3/18/16

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 Foley Catheter - urinary drainage device; Incontinence - loss of control or bladder and/or bowel.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	A. - This was an isolated incident caused by the mistake of a single employee. The deficient practice was corrected for R36 when nurse on next shift notified MD of condition change and orders were carried out at that point. B. - Other resident records have been reviewed to determine if any significant changes in condition has occurred and to ensure MD or NP were notified. No other residents have been affected. C. - DON/RNAC will re in-service staff on the need to immediately notify the physician of change in resident condition. This in-service will occur 1x to meet POC completion date and staff will be notified during audits as identified in Section D. D. - Since this was determined to be an isolated incident caused by a single employee's mistake the ADON, RNAC, or House Supervisor will continue to monitor, through audits of records, for significant condition changes of residents. In addition, the ADON, RNAC or House Supervisor will assure, again through audits, that the MD or NP have been notified and orders are carried out appropriately. Negative findings will be brought to DON's attention for immediate correction. These audits will be conducted randomly on 6 charts per month over a 3 month period in an attempt to achieve a 100% success rate. Findings over the 3 month evaluation period will be brought to QA for further discussion. Facility will continue this review until 100% success rate is achieved and then move to 3 charts being randomly reviewed monthly to ensure continued compliance.	02/29/2016

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F 157	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that for one (R36) out of 25 sampled residents it was determined that the physician was not consulted for a change of status in urinary function and implementation of an invasive procedure. Findings include:</p> <p>The following was reviewed in R36's clinical record:</p> <p>January 2016 - Physician's orders included changing the Foley catheter monthly but did not include reference to irrigation or flushing of the the catheter.</p> <p>1/27/16 11:00 PM - A nurse's note documented that the Foley catheter was flushed at 11:00 PM. There was no documentation as to why the Foley needed to be flushed. There was no evidence the physician was consulted before the procedure was conducted.</p> <p>2/1/16 3:45 PM - Interview with E8 (LPN) revealed that during her shift [3-11 PM on 1/27/16] the resident only had 300 cc of output in the urine bag which was not enough. The next time the bag was checked there was nothing in it and the bed was all wet. E10 (RN) the supervisor was there and said she would irrigate the catheter that something must be clogged up.</p> <p>2/2/16 6:20 AM - Interview with E9 (LPN) revealed that when she came to work Wednesday night (11:00 PM on 1/27/16) she received in report that the resident had some blood in the catheter but was unaware that the catheter had been flushed. E9 went on to state</p>	F 157		

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F 157	Continued From page 3 that a larger amount of blood was observed in the drainage collection bag at the end of her shift, the physician was notified at that time and an order was received to transfer the resident to the ER for evaluation. 2/03/16 10:53 AM - Interview with E2 (DON) confirmed that there should have been a physician's order to do an irrigation / flush of the Foley catheter. These findings were reviewed with E1 (NHA) and E2 on 2/3/16 at 2:30 PM.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information	F 164	A. - SS1 was not affected under this regulation due to the resident's personnel record not being violated. There was no break in privacy or confidentiality of records. The employee involved used poor judgment as it relates to a sensitive issue regarding SS1. Corrective action was taken by inservicing staff member, after deficient practice had occurred. B. - At the present time no other residents were affected by the deficient practice due to the fact that this was an isolated incident involving one resident, therefore we are unable to provide corrective action to address the deficient practice. C. - Activity staff will be in-serviced, by Activity Director, on proper procedure on asking when residents need assistance as well as sensitivity training to assure that corrective action is taken. In addition, a cow bell will be placed in the dining area for staff to use in the event assistance is needed and additional staff is not in close proximity.	02/29/2016

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F 164	<p>Continued From page 4</p> <p>contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to ensure personal privacy for 1 (SS1) out of 25 sampled residents when a staff member yelled in the hallway that a resident was "soaking wet" [indicating the resident was incontinent and needed to be changed]. Findings include:</p> <p>1/28/16 at 11:40 AM observation revealed While the surveyor and E14 (CNA) were at the D-wing nursing station, a female [determined later to be E13 from Activities] yelled from the dining room "I got one for you. (SS1's name) is soaking wet".</p> <p>11/28/16 at 11:45 AM observation revealed E13 yelled again from the dining room "[E14's first name], (SS1's name) is soaking wet".</p> <p>1/29/16 During an interview with E14, and E19 (RN) present, when asked what was the process for a staff member in the dining room informing the CNA at the nursing station that a resident needed incontinence care, E14 said the staff member should approach the CNA and tell them quietly. E14 said he got upset yesterday when E13 yelled that SS1 was "soaking wet".</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 2/3/16 at 2:30 PM.</p>	F 164	<p>D: - Activity Director will observe activity staff daily to assure compliance is maintained. After a 3 month evaluation period it will be determined if a 100% success rate has been achieved. Once 100% success rate is achieved Activity Director will observe activity staff 2x a week over a 3 month evaluation period on an ongoing basis. Findings will be reported at QA quarterly for review and discussion of maintained compliance and to see if necessary changes are needed.</p>		

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F 253 F 253 SS=B	Continued From page 5 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to provide housekeeping and maintenance services for 8 (308, 313, 317, 321, 327, 404, 410, and 418) out of 28 rooms. Findings include: Observations during Stage 1 (01/28/16 and 01/29/16 from 7:30 AM to 4:00 PM) and on an environmental tour on 02/02/16 from 11:48 AM to 12:03 PM and revealed the following: -Rm 308 - laminate broken off the left side of the sink counter -Rm 313 - laminate broken off the left side of the sink counter -Rm 317 - laminate peeling off of the sink counter -Rm 321 - laminate peeling off of the sink counter front and left side -Rm 327 - laminate peeling off of the sink counter front and left side -Rm 404 - towel bar mounted on the sink counter is loose -Rm 410 - rust stain on back left corner of the sink, separation of the caulk around the sink, and towel bar mounted on the sink counter is loose -Rm 418 - rust stain on back left corner of the sink, separation of the caulk around the sink, and the towel bar mounted on the sink counter is loose	F 253 F 253	A. - Survey team members identified 8 sinks areas that need attention in resident rooms. Facility's current procedure has rooms checked weekly for needed repairs. Identified areas are placed on rotation, based on materials needed, in order to complete needed repairs. Several sinks already have been replaced at this time. A majority of repairs to those 8 identified areas were completed prior to survey exit and additional repairs are scheduled. B. - Weekly maintenance log was reviewed with maintenance staff prior to survey exit and no additional areas needed repair. All identified areas have been repaired at this time. C. - Housekeeping communication log will be developed to communicate any additional concerns that arise prior to weekly checks being completed. Administration will do weekly walk throughs to be sure repairs are being completed. D. - Corrective action will be taken as needed, on an immediate basis, any negative findings by Administration will be reviewed with maintenance routinely as well as during QA quarterly for review and discussion of maintained compliance and to see if necessary changes are needed.	03/04/2016

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F 253	Continued From page 6	F 253		
F 272 SS=D	<p>Findings were reviewed with E1 (NHA) on 02/03/16 at 11:10 AM.</p> <p>Findings were also reviewed with E1 and E2 (DON) on 02/03/16 at 2:30 PM.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum</p>	F 272	<p>A. - The correct coding was amended for resident 61 and the resident was not affected by the deficient practice. It was a documentation error.</p> <p>B. - Current MDS's are being reviewed for miscoding of oral/dental status. No other residents have been affected at this time by the miscoding.</p> <p>C. - This was an isolated incident and the RNAC has been re-educated by the DON, on the correct coding on dental status.</p> <p>D. - Dental coding is coded on a yearly or change of status MDS. The DON/ADON will check the MDS dental coding on a weekly basis as resident MDS's become due. This will be an ongoing process to maintain compliance.</p>	02/29/2016

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F 272	Continued From page 7 Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to conduct an accurate oral assessment in an initial comprehensive assessment for 1 (R61) out of 25 sampled residents. Findings include: R61's admission MDS (5/18/15) documented in the Oral Dental Status section that the resident had no natural teeth or tooth fragments. 1/28/16 observation and interview with R61 at 2:10 PM revealed R61 had 6-8 bottom front teeth and no other teeth. The resident stated she never had dentures and denied pain or problems with eating. 2/1/16 interview at 1:20 PM with E5 (RNAC) who confirmed the MDS error stating the resident refused to allow direct observation on admission and the resident denied having teeth. This finding was reviewed with E1 (NHA) and E2 (DON) on 2/3/16 at 2:30 PM.	F 272			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280	A 1. - R10 had their care plan updated the same day the surveyor brought it to our attention. The approach was being done it just was not documented on the care plan.	02/29/2016	

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F 280	<p>Continued From page 8</p> <p>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to revise the care plan for 2 (R10 and R35) out of 25 sampled residents to reflect current care needs. Findings include:</p> <p>Cross Refer F464 1. The following information was found in R10's clinical record:</p> <p>3/27/08 - R10 was admitted to the facility with multiple diagnoses including dementia and diabetes mellitus.</p> <p>1/15/16 Quarterly MDS stated resident had severe cognitive impairment with a BIMS score of</p>	F 280	<p>A 2. - R35 had their care plan updated the same day the surveyor brought it to our attention. The approach was being done it just was not documented on the care plan.</p> <p>B 1. - No other residents have been affected by this deficient practice. Care plans will be reviewed at care plan meetings to insure all approaches are being utilized and documented.</p> <p>B 2. - No other residents have been affected by this deficient practice. Care plans will be reviewed at care plan meetings to insure all approaches are being utilized and documented.</p> <p>C 1. - The RNAC was re-in serviced, by DON, on documenting any new approaches to the care plans.</p> <p>C 2. - The RNAC was re-in serviced, by DON, on documenting any new approaches to the care plans.</p> <p>D 1. - The DON/ADON will randomly check 4 care plans weekly for any new approaches needed. In addition, care plans will continue to be reviewed weekly during care conferences and any adjustments are made at that time as well. This is a current facility procedure that will continue on an ongoing basis.</p> <p>D 2. - The DON/ADON will randomly check 4 care plans weekly for any new approaches needed. In addition, care plans will continue to be reviewed weekly during care conferences and any adjustments are made at that time as well. This is a current facility procedure that will continue on an ongoing basis.</p>	

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F 280	<p>Continued From page 9 7 out of 15.</p> <p>R10's care plan problem for behavioral symptoms (initiated 4/1/08, last reviewed 1/20/16) included taking food from other residents with approaches of close visual supervision, distraction, ensure all items in public areas are put away, psychiatric evaluation as needed. Care plan reassessment on 1/20/16 documented that R10 continued to take food from others.</p> <p>2/1/16 interview at 1:24 PM with E4 (ADON) who stated the reason R10 sits alone was that the resident eats other resident's food. E4 and E5 (RNAC) were informed the care plan did not address the need for the resident to sit alone.</p> <p>2/1/16 at 1:53 PM - E5 informed the surveyor that the DON would return the care plan to E5 when revisions were completed.</p> <p>2/1/16 at 2:30 PM care plan now included an approach for serving meals with other residents at separate seating.</p> <p>R10's care plan was not updated to include seating the resident away from others as he would eat their food until brought to the facility's attention by the surveyor.</p> <p>2. The following was reviewed for R35:</p> <p>1/28/16 from 11:40 AM - 12:40 PM and 1/29/16 from 11:30 AM - 12:30 PM meal observations found that the resident ate her puree diet with pudding thickened liquids with her left hand, using primarily the index finger.</p>	F 280			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 10</p> <p>R35's care plan problem for feeding within the nutrition problem (initiation 12/11/14, last reviewed 1/18/16) included that the resident had an adamant desire to feed herself with her fingers despite attempts to encourage her to use utensils.</p> <p>2/1/15 observation starting at 8:50 AM revealed R35 sitting in a merry walker in the dining / activity area. R35 was transferred to a geri chair used for lunch at 11:50 AM without being taken into her own room for incontinence care or handwashing. There was no observation of washing or wiping the resident's left hand.</p> <p>2/1/16 interview with E12 (LPN) at 1:20 PM with E5 (RNAC) present during the discussion and both were aware of the observation and the care plan lacking the provision of the resident's hand hygiene.</p> <p>2/2/16 at 10:40 AM - R35's care plan now included an approach to wash the resident's hands before and after meals.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 2/3/16 at 2:30 PM.</p>	F 280		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p>	F 309	<p>A. - This was an isolated incident caused by the mistake of a single employee. The deficient practice was corrected for R36 when physician was later consulted and orders were carried out at that time.</p> <p>B. - Other resident records have been reviewed to determine if any other procedures were completed without a physician's orders. No other residents have been affected.</p> <p>C. - Staff will be re-instructed, by DON and RNAC, on the need for physician or NP order before procedure is complete.</p>	02/29/2016

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F 309	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R36) out of 25 sampled residents the facility failed to provide the necessary care and services in accordance with the physician's plan of care. The facility failed to ensure that staff only performed a procedure with a physician's order. Findings include: The following was reviewed in R36's clinical record: January 2016 - Physician's orders included changing the Foley catheter monthly but did not include reference for irrigation or flushing of the catheter. 1/27/16 11:00 PM - A nurse's note documented that the Foley catheter was flushed at 11:00 PM. There was no documentation as to why the Foley needed to be flushed. There was no evidence the physician was consulted before the procedure was conducted. 1/28/16 6:50 AM - A nurse's note documented 300 cc of bloody urine in the drainage bag. 2/1/16 3:45 PM During an interview with E8 (LPN) it was revealed that during her shift [3--11, 1/27/16] the resident only had 300 cc of output in the urine bag which was not enough. The next time the bag was checked there was nothing in it and the bed was all wet. E10 (RN) the supervisor was there and said she would irrigate the catheter that something must be clogged up. 2/2/16 6:20 AM During an interview with E9 (LPN)	F 309	D. - ADON, RNAC or house supervisor will continue to monitor significant resident condition changes and to assure physician orders were reviewed. Any negative findings will be brought to DON's attention for immediate correction. Since this was determined to be an isolated incident facility will randomly review 3 charts weekly, for any procedure without doctors orders being completed, over the next 2 months. Once 100% success rate is achieved. We will randomly check 3 charts monthly. Flow sheet will be used to monitor success and reviewed by the DON weekly.		

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F 309	Continued From page 12 revealed that when she came to work Wednesday night [1/27/16] she received in report that the resident had some blood in the catheter but was unaware that the catheter had been flushed. She monitored R36 for urine flow. E9 stated in the morning there was more blood in the bag. This was reported to the supervisor who called the doctor. The resident was sent to the ER for evaluation. 2/03/16 10:53 AM During an interview with E2 (DON) she confirmed that there should have been a physician's order to do an irrigation / flush of the Foley catheter. It was also confirmed that the nurse who did the flush should have documented her assessment and the procedure. The facility failed to ensure the plan of care was followed when a nurse provided a treatment that was not ordered. These findings were reviewed with E1 (NHA) and E2 on 2/3/16 at 2:30 PM.	F 309		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on dining observation it was determined that the facility failed to provide food that was palatable and served at the proper temperature	F 364	A. - Surveyor took temperature of resident's plate 18 minutes after meal was completed. Since temperatures were taken after meal service, and not as resident was being fed, accuracy of meal temperatures could not be obtained. Therefore, we are unable to determine if R17 was affected and we are unable to provide corrective action, at this time, to address the deficient practice. B. - No other residents were affected by the deficient practice due to the fact that all residents were fed therefore we are unable to provide corrective action to address the deficient practice. C. - Residents that have to be fed will be served their meals in courses if meal is deemed appropriate. (i.e. soups/cereals will be served first before entree). This will assure that meals are provided at proper temperatures.	02/29/2016

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F 364	<p>Continued From page 13</p> <p>for 1 randomly observed resident's [R17] food. Findings include:</p> <p>During the breakfast dining observation in the main dining room on 1/28/16 from 7:30 AM to 8:07 AM the following was observed:</p> <p>At 7:35 AM E6 CNA was observed feeding R17 a plate of puree breakfast, that included, hot cereal which appeared cold as evidenced by a firm congealed appearance and creamed chipped beef which appeared to have formed a firm gelatinous exterior from cooling.</p> <p>At 7:45 AM E7 CNA relieved E6 from feeding R17's breakfast and E7 began feeding R17. At 7:47 AM, E7 was asked how long R17 had been eating and E7 stated "since about 7:00 AM", E6 was standing at the same table recording meal percentages and confirmed that she had been feeding R17 since 7:00 AM.</p> <p>At 8:05 AM when dietary staff removed R17's plate, immediately after R17 was finished being fed the temperatures were the following; hot cereal 78.7 F, creamed chipped beef 74.0 F.</p> <p>On 2/3/16 a test tray was done using pureed breakfast foods similar to what would be served to R17. Initially the puree breakfast served was measured at the following temperatures; sausage 123.1 F, hot cereal 151.2 F, french toast 140.1 F. After 47 minutes, the same duration which R17 was fed her puree breakfast during the first observation, the sausage was 75.8 F, hot cereal 93.6 and the french toast was 84.4 F, the sausage was forming a congealed layer, all were cool too taste, and unpalatable.</p>	F 364	<p>D. - Dietary management will note feeding times and temperatures before and after meals on 3 random residents daily over a 2 month evaluation period. When 100% success rate is achieved feeding times and temperatures before and after meals will be taken on 3 random residents weekly. This will continue ongoing to maintain compliance. Flow sheet will be reviewed at QA quarterly for review and discussion of maintained compliance, and to see if necessary changes are needed.</p>	

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F 364	Continued From page 14 The facility failed to provide R17's food during the breakfast dining observations that was palatable and served at the proper temperature.	F 364			
F 431 SS=D	This finding was reviewed with E1 (NHA) and E2 (DON) on 2/3/16 at 2:30 PM. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	A 1. - The expired medication in question had been removed from the cart the same day the surveyor found it. The inhaler was unmarked/unlabeled because the nurse had pulled the label in order to dispose of the inhaler. There was no intention to use medication any further. A 2. - The 2 day outdated acetaminophen was removed from the medication cart immediately after being found. No residents were affected due to the fact the medication was not given. B 1. - All medication carts were inspected for further expired inhalers and none were found. B 2. - All medication carts were inspected for further expired acetaminophen and none were found. C 1. - The ADON and House Supervisor will in-service nurses on proper disposal of out dated medications. C 2. - The ADON and House Supervisor will in-service nurses on proper disposal of out dated medications. D 1. - The ADON will check medication carts daily for any out of date medication utilizing a In house flow sheet tool. Negative findings will be reported to DON immediately. Audits will be reviewed monthly to determine if 100% success rate was achieved. This will be a continue, ongoing process. D 2. - The ADON will check medication carts daily for any out of date medication utilizing a In house flow sheet tool. Negative findings will be reported to DON immediately. Audits will be reviewed monthly to determine if 100% success rate was achieved. This will be a continue, ongoing process.	02/29/2016	

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F 431	Continued From page 15 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure 2 out of 3 medication carts were free of expired and/or unlabeled medications. Findings include: 1. An observation was made on 02/02/16 at 10:00 AM of an unlabeled inhaler of Ventolin HFA in the B-wing medication cart. An interview with E18 on 02/02/16 at 11:30 AM confirmed this finding. E18 disposed of the inhaler at the time of the interview. 2. An observation was made on 02/02/16 at 10:20 AM of a bottle of 500 mg caplets of Acetaminophen with an expiration date of 1/16. This finding was reviewed with E4 (ADON) on 02/03/16 at 2:30 PM. Findings were reviewed with E1 (NHA) and E2 (DON) on 02/03/16 at 2:30 PM.	F 431		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 463	A 1. - Repairs to Room 407 were made immediately. Call lights continue to be part of the facilities weekly maintenance check. A 2. - Repairs to Room 410 were made immediately. Call lights continue to be part of the facilities weekly maintenance check. B 1. - When the findings were reported to the facility the maintenance staff did and audit on all rooms and bathrooms no other rooms were affected.	02/29/2016

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F 463	<p>Continued From page 16</p> <p>Based on observation and interview it was determined that the facility failed to maintain bathroom emergency call bells for 2 (Room 407 and Room 410) out of 28 rooms reviewed were functional. Findings include:</p> <p>1. 1/28/16 at 10:26 AM observation of Room 407's bathroom emergency call bell, when activated by the surveyor, lit up on the device in the bathroom, however the red blinking light in the hallway did not illuminate. The activated bathroom call bell would not alert staff to an emergency.</p> <p>1/28/16 at 10:30 AM Interview with E11 (Maintenance) was informed about the non-functional bathroom emergency call bell.</p> <p>1/28/16 at 11:00 AM Interview with E12 (Maintenance) who informed the surveyor the call bell was working and asked if the surveyor wanted to observe. When E12 asked E11 (who was in the bathroom replacing the call bell onto the wall) to activate it, no lights illuminated in the hallway. After an adjustment of wiring, the call bell was fully functional.</p> <p>2. 1/28/16 at 10:17 AM observation of Room 410's bathroom emergency call bell, when activated by the surveyor, lit up on the device in the bathroom, however the red blinking light in the hallway did not illuminate. The activated bathroom call bell would not alert staff to an emergency.</p> <p>1/28/16 at 10: 24 AM observation of E11 was repairing something in another room in the unit and was informed about R35's non-functional bathroom emergency call bell.</p>	F 463	<p>B 2. - When the findings were reported to the facility the maintenance staff did and audit on all rooms and bathrooms no other rooms were affected.</p> <p>C 1. - Weekly maintenance log was reviewed with maintenance staff prior to survey exit and current facility procedure was deemed to be appropriate. Random audits will be completed weekly on 6 areas by Administration for additional checks on call bells. This will be an ongoing process.</p> <p>C 2. - Weekly maintenance log was reviewed with maintenance staff prior to survey exit and current facility procedure was deemed to be appropriate. Random audits will be completed weekly on 6 areas by Administration for additional checks on call bells. This will be an ongoing process.</p> <p>D 1. - Maintenance staff was in-serviced, by Administration, on the importance of keeping call bells in working order for "staff" on D wing in case of emergencies. Corrective action will be taken as needed, on an immediate basis. Negative findings will be reviewed with Administration routinely as well as QA quarterly for review & discussion of maintained compliance and to see if necessary changes are needed.</p> <p>D 2. - Maintenance staff was in-serviced, by Administration, on the importance of keeping call bells in working order for "staff" on D wing in case of emergencies. Corrective action will be taken as needed, on an immediate basis. Negative findings will be reviewed with Administration routinely as well as QA quarterly for review & discussion of maintained compliance and to see if necessary changes are needed.</p>	

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F 463	Continued From page 17 1/28/16 at 10:35 AM observation of E11 who changed the hallway light bulb(s) and the bathroom call bell was fully functional afterward. The facility failed to ensure bathroom emergency call bells were functional in two resident bathrooms. These findings were reviewed with E1 (NHA) and E2 (DON) on 2/3/16 at 2:30 PM.	F 463			



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Courtland Manor

DATE SURVEY COMPLETED: February 3, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual and complaint survey was conducted at this facility from January 28, 2016 through February 3, 2016. 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 the first day of the survey was 61. The Stage 2 sample totaled 25 residents.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>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.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed February 3, 2016 2016 F.157, F164, F253, F272, F280, F309, F364, F431 and F463</p>	<p>Cross refer to the CMS 2567-L survey ending 2/03/2016 F157, F164, F253, F272, F280, F309, F364, F431, and F463</p>	<p>02/29/2016</p>
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Provider's Signature

Title

ADMINISTRATOR

Date

2/26/16