

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

PRINTED: 03/03/2015  
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  02/06/2015
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NAME OF PROVIDER OR SUPPLIER  COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901
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F 000	INITIAL COMMENTS  An unannounced annual and complaint survey was conducted at this facility from February 2, 2015 through February 6, 2015. 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 62. The Stage 2 sample totaled 25 residents.  Abbreviations used in this report are as follows:  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; F - Fahrenheit	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to promote dining in a manner that enhanced dignity for two (R6 and R43) out of 25	F 241	R 6 and R 43 will remain table mates considering both residents need assistance with feeding. They have been placed in closer proximity, at the table, to allow staff to assist both residents simultaneously.  Residents on D Wing were monitored to ensure that there is no future potential of residents being affected.  As stated above, R 6 and R 43 were placed in closer proximity at the table. Dietary and Nursing Staff will be in-serviced on how to continually monitor to assure that food is not sitting in front of a particular resident for a prolonged period of time.  The ADON or Dietary Manager will conduct random audits weekly for 1 month then 2 X a month over a 3 month period, to assure compliance. Negative findings will be brought to Administrator's attention and also reviewed during QA quarterly.	03/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature] TITLE: ADMINISTRATOR (X6) DATE: 3/5/15

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 241	Continued From page 1 stage 2 sampled residents. Findings include:  During the 1st dining observation in D wing (10 residents reside in this unit) on 2/2/15 from 12:07 PM to 12:46 PM:  1. R8 sat at a table with her food in front of her while her table mate R43 was fed. R8 was not assisted to eat for approximately 30 minutes until R43 was finished eating.  During the 2nd dining observation in D wing on 2/4/15 from 12:11 PM to 12:56 PM:  2. R43 sat at the table with her food in front of her while table mate R6 was fed. R43 was not assisted to eat for approximately 44 minutes until R6 was finished eating.  Findings were reviewed during the informal exit on 2/6/15 at approximately 4:45 PM with E1 (NHA), E2 (DON) and E3 (Assistant NHA).	F 241		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was	F 246	There is no direct regulation to length of pull cords that is dictated by CMS or the State of Delaware at this time. All pull cords in identified bathrooms have been given extensions.  All bathrooms have been evaluated so there is no potential for other residents to be affected at this time.  Bathroom call bell cords will be evaluated weekly by Maintenance Staff to assure that compliance is maintained.  Corrective action will be taken as needed, on an immediate basis, and negative findings of audits will be brought to the QA meeting quarterly for review.	03/15/15

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F 246	Continued From page 2 determined that the facility failed to ensure that multiple shared bathrooms had call bell pull cords that were accessible to residents. The pull cords in 5 out of approximately 10 bathrooms reviewed were short and were not accessible to residents, if they were on the floor. Findings include:  During stage 1 of the survey on 2/2/15 to 2/3/15 and during the environmental tour with E6 (Maintenance Supervisor) on 2/6/15 from 1:40 PM to approximately 2:25 PM the following bathrooms were observed with short call bell pull cords of approximately 2":  1. B202 and B204 (each bathroom can be shared with up to 4 residents); 2. B206 and B208; 3. B205 and B207; 4. B226 and B228; 5. D410 and D416.  Findings were confirmed during the environmental tour on 2/6/15 from 1:40 PM to 2:25 PM with E6. During the environmental tour, E6 had another maintenance worker start adding extensions onto the short pull cords.	F 246		
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS  The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was	F 257	The identified areas were observed and documented during extreme cold weather conditions. Building systems were checked by facility staff and corrections to building dampers were made. This in turn increased air flow allowing warmer weather to flow.  Again, the building systems were checked by facility staff and corrections were made as needed to increase air flow to limit the potential for other areas to be affected during extreme cold weather.  Maintenance Staff will complete weekly temperature audits throughout the building for compliance standards.  Audits will be reviewed with Administration if temperatures fell below or above specified range. All negative findings will be addressed on a continually basis.	03/15/15

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F 257	Continued From page 3 determined that the facility failed to maintain comfortable temperature levels on two of the three units. Findings included:  1. Observations on 2/5/15 at 1:01 PM in B wing the following temperatures were recorded; entrance to B wing - 67.6F outside room 202 - 69.5F inside room 202 - 70.0F  The area felt very cool to the surveyor.  2. Observation on 2/6/15 at 2:15 PM in C wing room 329 the temperature was 70.4F. This was confirmed with E8, maintenance supervisor.  These findings were reviewed with E1, NHA and E2, DON on 2/6/15 at 3:30 PM.	F 257		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  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.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being in accordance with facility standards of practice for one (R3) out of 25 sampled residents.	F 309	R3's pain will be assessed before and after wound care procedures according to facility policy. Nursing staff will be re-instructed on assessments for pain and the facility's procedure for completing the pain flow sheet.  As stated above, nursing staff will be re-instructed on assessments for pain and facility procedure for completing pain flow sheets. Pain flow sheets will be reviewed to determine compliance with facility procedures in order to assure the potential of the deficient practice is limited pertaining to other residents.  The facility's current procedure for pain flow sheets will be assessed for needed changes to simplify or clarify its use such as post pain rating documentation.  ADON and House Supervisor will review pain flow sheets to check for compliance on the completion of forms. Findings will be reported to DON and follow up will be addressed as needed.	03/15/15

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F 309	<p>Continued From page 4</p> <p>On multiple occasions the facility failed to consistently monitor R3's pain levels post [after] pain medication administration. Additionally the facility failed to ensure assessment was completed for pain prior to doing a treatment to an affected area. Findings include:</p> <p>The Facility's Pain Management Policy documented:</p> <ul style="list-style-type: none"> <li>-Pain assessments are done when a routine order is received to assess effectiveness of new medications and when an as needed (PRN) medication is used daily for three consecutive days.</li> <li>-(PRN) Pain Medication Flow Sheets (Instructions on the sheet direct the user to enter the pain rating after an intervention) will be used to monitor each dose administered.</li> <li>-Regular ordered pain medications will be monitored using the flow sheets for the first 72 hours, then the physician will be notified of the resident's response. If effective the flow sheet will be discontinued.</li> <li>-A care plan should be initiated when pain is observed on assessment. It should be addressed as a separate problem, listed as pain actual, potential or relief.</li> </ul> <p>R3's clinical record revealed the following:</p> <p>5/16/14- A care plan for generalized discomfort was initiated. Interventions included, monitor effectiveness of pain medication and notify doctor if pain regime is not effective.</p>	F 309		

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F 309	<p>Continued From page 5</p> <p>10/8/14- A pain assessment rated R3's pain as 6/10, moderate, on the pain scale.</p> <p>11/5/14, 11/23/14, and 12/31/14- A pain assessment rated R3's pain 8/10, severe, on the pain scale.</p> <p>11/5/14- A physician's order was written for Tylenol (a mild pain reliever) for pain, and Tramadol (a stronger pain medication).</p> <p>11/20/14- A Podiatry (foot doctor) progress note documented R3 as having a "pressure area which is painful at (the) heel."</p> <p>11/21/14- A physician's progress note documented "discomfort with examination of (the) foot, cries out with repositioning."</p> <p>11/25/14- A physician's order was written adding Percocet (a very strong pain medication which requires a prescription).</p> <p>1/18/15- A significant change MDS assessment, rated R3's pain as occurring occasionally and rated as a 7/10 which is moderate on the pain scale.</p> <p>1/20/15- A physician's order was written clarifying Tylenol for mild pain, Tramadol for moderate pain, Percocet for severe pain.</p> <p>October 2014- Pain Management Flow Sheet, does not reflect evidence that R3 was assessed for pain using the appropriate pain scale post administration of pain medications on 10/9/2014, 10/10/2014, and 10/11/2014.</p>	F 309			

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F 309	<p>Continued From page 6</p> <p>November 2014-Pain Management Flow Sheet, does not reflect evidence that R3 was assessed for pain using the appropriate pain scale post administration of pain medications on 11/16/2014, 11/27/2014 and 11/30/2014.</p> <p>January 2015- Pain Management Flow Sheet, does not reflect evidence that R3 was assessed for pain using the appropriate pain scale post administration of pain medications on 1/22/15, 1/24/2015, 1/25/2015, 1/26/2015, 1/27/2015, and 1/29/2015.</p> <p>During an interview on 2/2/2015 at 3:19 PM R3 acknowledged having discomfort now or having had discomfort such as pain, heaviness, burning, or hurting with no relief; and stated "my foot hurts, it has a pressure ulcer (an open sore from pressure on an area of skin)".</p> <p>During a dressing change observation on 2/4/15 at 10:50 AM to R3's wound on the left foot, done by E12 RN, R3 complained of pain when medication was applied to the wound, and when the left leg was repositioned, E12 reported the last pain assessment was at the beginning of the shift when Tramadol was administered and there was no assessment of pain prior to the dressing change or during the dressing change observation. E12 confirmed during the observation that R3 is assessed for pain during dressing changes "sometimes" not every time. E12 then at the end of the dressing change observation, and following R3's verbalization of pain, assessed R3's pain level in the left foot. R3 reported pain at a 10/10 and E12 then left the room to retrieve pain medication.</p> <p>2/4/15- A physician's order was written for</p>	F 309		

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F 309	Continued From page 7 Percocet daily prior to wound care dressing.  2/6/15- R3's care plan was updated to include the following interventions, assesses what precedes pain, assess pain prior to treatment, medicate for pain thirty minutes prior to treatment.  These findings were reviewed with E1, NHA and E2, DON on 2/6/15 at 3:30 PM.	F 309		
F 364 SS=E	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 observations it was determined that the facility failed to provide food that was palatable and served at the proper temperature. Findings include:  During the 1st dining observation in the D wing on 2/2/15 from 12:07 PM to 12:45 PM the following were observed:  1. Although all foods were plated (on plates and ready to be eaten), as of 12:31 PM there were 3 residents (R6, R39 and R58) that had not been fed yet. The plates were cold to touch and uncovered. There was no microwave oven in view.  2. Staff began feeding R6 at 12:39 PM; R6's food	F 384	Dietary staff will check with nursing staff to assure that all residents are ready to be fed before plating meals and all meals will be plated on the unit. In addition, temperatures will be taken as food is served.  Upon observation no further residents were affected. Utilization of the corrective action will assure compliance.  In-Service will be conducted with Dietary Staff on plating and serving of food to assure compliance.  Dietary Manager will observe meal service on D Wing weekly for 1 month then 2 X a month to reinforce practices are in place. Negative findings will be reported to Administration and audits will be brought to QA for review quarterly.	03/15/15

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F 364	Continued From page 8 set uncovered in front of her for at least 30 minutes prior to the resident being fed.  3. At 12:45 PM, staff awakened R39 in the dining room and she then began feeding herself food that had been plated approximately 45 minutes earlier.  During the 2nd dining observation in the D wing on 2/4/15 from 12:11 PM to 12:56 PM the following were observed:  4. From 12:11 to 12:12 PM, 2 pureed diets were plated. At 12:56 PM, staff began feeding R43 (the 2nd resident that was served a pureed diet). R43's plated food sat in front of her for 44 minutes uncovered prior to her being fed and R43's food was not reheated prior to her being fed.  5. A test tray was done using the same foods served to R43- the plated food was obtained immediately after the 2 pureed diets were plated and the food was tasted and temperatures obtained at 12:56 PM when staff began feeding R43. The chicken and gravy were 87.3 degrees F, rice and gravy were 99.9 F and the beets were served chilled. The chicken/gravy and rice/gravy were cold and the rice was congealed; they were unpalatable.  Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Assistant NHA) during the informal exit on 2/6/15 at approximately 4:50 PM.  The facility failed to provide food during the lunch dining observations that was palatable and served at the proper temperature.	F 364			

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F 371 F 371 SS=E	Continued From page 9 483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to serve food under sanitary conditions during a dining observation in the D wing. Findings include:  During the 1st dining observation in D wing on 2/2/15 from 12:07 PM to 12:45 PM the following observations were made:  1. E10 (Dietary Aide) used her gloved hands and touched non-food contact surfaces multiple times (serving utensils, plates, etc.) while plating food for lunch and at 12:07 PM she picked up a roll with her contaminated glove. At 12:08 PM E11 (Registered Dietitian) came into the dining area and spoke to E10. At 12:09 PM E10 stated, "I'm waiting for tongs. I'm not supposed to use my gloved hands to pick up rolls."  2. An ice cream scoop, that was used to plate cubed and pureed chicken, fell into the serving container and was laying directly onto the chicken. E10 had previously handled the end	F 371 F 371	Dietary Staff will be in-serviced on proper food handling and infection control to assure that corrective action is taken.  Upon observation no further residents were affected. Utilization of the corrective action will assure compliance.  In-services conducted on proper food handling and infection control during dining service will be conducted.  Dietary Manager will observe dining staff on D Wing 2 x a month to reinforce accuracy of proper food handling and infection control procedures. Negative findings will be corrected immediately and brought QA for quarterly review.	03/15/15

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F 371	Continued From page 10 portion of the ice cream scoop so it was contaminated. E10 picked up the contaminated ice cream scoop with her gloved hand and continued to serve chicken using the same scoop. The chicken was not replaced.  Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Assistant NHA) during the Informal exit on 2/6/15 at approximately 4:55 PM.	F 371			
			Responses to the cited deficiencies do not constitute an admission or agreement by the community of the truth of the facts alleged or conclusion set forth in the statement of deficiency. The Plan of Correction is prepared solely as a matter of compliance with State Law.		



**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

Page 1 of 2

NAME OF FACILITY: Courtland Manor

DATE SURVEY COMPLETED: February 6, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced annual and complaint survey was conducted at this facility from February 2, 2015 through February 6, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 62. The stage 2 sample totaled 25 residents</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></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>		

Provider's Signature *[Signature]* Title ADMINISTRATOR Date 3/9/15



**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

Page 2 of 2

NAME OF FACILITY: Courtland Manor

DATE SURVEY COMPLETED: February 6, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey ending 02/06/2015 F241, F246, F257, F309, F364 and F371.</p>	<p>Cross refer to the CMS 2567-L survey ending 2/06/2015 F241, F246, F257, F309, F364 and F371</p>	<p>3/15/15</p>

Provider's Signature *[Signature]* Title ADMINISTRATOR Date 3/9/15