

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

PRINTED: 04/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2015
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NAME OF PROVIDER OR SUPPLIER HARRISON SENIOR LIVING OF GEORGETOWN, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W. NORTH STREET GEORGETOWN, DE 19947
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F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from March 25, 2015 through April 2, 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 119. The stage two survey sample was thirty-six(36). Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; RD - Registered Dietitian; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; UM - Unit Manager; SW - Social Worker; MD-Medical Doctor; FSD - Food Service Director; MDS - Minimum Data Set-standardized assessment forms used in nursing homes; POS - Physician Order Sheet; MAR - Medication Administration Record; F - Fahrenheit; Continence - control of bladder and bowel function; Incontinence - loss of control of bladder &/or bowel function; Frequently Incontinent -7 or more episodes of incontinence, but at least 1 episode of continent voiding in a 7 day look back period.	F 000	Disclaimer Preparation and/or execution of the plan correction does not constitute an admission or agreement by the provider or the providers employees as to the truth of the allegations in the statement of deficiencies. The plan of correction is offered in mandatory compliance with the provisions of state and federal law. The corrective actions are implemented as remedial measures pursuant to law.	
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and	F 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Carlene Paulitte* TITLE *Administrator* (X6) DATE *5-4-15*

Deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined that the findings 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 159	<p>Continued From page 1</p> <p>account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of</p>	F 159	<p>F159</p> <ol style="list-style-type: none"> 1. Resident funds have been made available on weekends. 2. All residents have the potential to be affected by facility falling to ensure that their funds are available on weekends and/or days that business office is closed. 3. A lock box will be placed on unit at close of business on days prior to business office being closed. A print out of resident's available funds will be placed in lockbox. The nurse supervisor will have the key to access money and list of funds if they are needed on days that the business office is closed. Nurses will be educated on new policy for access to resident's funds on days when business office is closed. (Attachment A) 	

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F 159

Continued From page 2
the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:

Based on review of facility documentation and interview it was determined that the facility failed to ensure residents had access to their personal funds on weekends. Findings include:

Review of the facility's policy for Resident Funds documented that funds could be accessed Monday through Friday 8:30 AM until 5:30 PM.

Interview on 4/01/15 at 11:42 AM with E1, (NHA) revealed that the facility's policy for Resident Funds only addresses residents' access to money during business hours Monday through Friday. She stated that if there is a weekend outing planned staff would have the resident get their money out on Friday. E1 confirmed there was no practice in place for residents to have access to their funds on the weekend but that she would begin implementation of a system for residents to obtain their funds on weekends.

These findings were reviewed and confirmed with E1, and E2 (DON) on 4/2/15 at approximately 12:40 PM.

F 241
SS=E

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

F 159

4. Business office will ensure that all residents that wish to have access to funds when business office is closed were successful at obtaining their funds. If a resident was not able to get funds on a weekend or day when business office was closed a resident concern form will be completed and an investigation will be done.

May 8, 2015

F 241

F241

1. Unable to correct on day of observation for the residents that were observed, R192, R182, R88, R185, R193, R194, R171, R14, R101, R19, R47 and R97.

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F 241	<p>Continued From page 3 full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to serve beverages in a manner that enhanced dignity for 12 (R192, R182, R88, R185, R193, R194, R171, R14, R101, R19, R43, and R97) out of approximately 12 observed residents. Findings include:</p> <p>During lunch observation on 3/25/15, starting at 11:32 AM on the rehabilitation unit, the following residents received cartons of milk with no straws or cups - R192, R182, R88, R185, R193, R194 and R171.</p> <p>During lunch observation on 3/25/15 starting at 12:15 PM on the Kent unit the following residents received cartons of milk with no straws or cups - R14, R101, R19, R43, and R97.</p> <p>An interview on 4/1/15 at 2:45 PM with E9 RD revealed that residents should have cups on the tray in which to pour the milk. After further investigation RD revealed that it was the facility's practice not to put cups on the meal trays but for the staff to offer a plastic disposable cups available on the unit. E9 stated that the facility used to have amber colored cups in the kitchen and she was not sure why they were no longer used on the meal trays.</p> <p>These findings were reviewed and confirmed with E1 (NHA), and E2 (DON) on 4/2/15 at approximately 12:40 PM.</p>	F 241	<ol style="list-style-type: none"> 2. All residents have the potential for their dignity to be affected if beverages are served without utilizing cups. 3. Cups have been ordered and obtained and will be placed on trays to be utilized for beverages at mealtimes. Nurses and c.n.a.s will be educated on the need to utilize the cups and not serve milk in cartons to maintain resident dignity. 4. An audit will be completed daily for 2 weeks, weekly x 4 and then monthly x3 by DON or designee at resident meal times to ensure that cups are utilized for beverages. If it is noted that success is not 100% the audits will continue and will not go to the next step until success is 100% (Attachment B) 	May 8, 2015

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F 256 SS=E	<p>483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS</p> <p>The facility must provide adequate and comfortable lighting levels in all areas.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, the environmental tour and interviews it was determined that the facility failed to provide adequate lighting levels in all areas. Findings include:</p> <p>During stage1 observations on 3/25/15 and/or 3/26/15 and during the environmental tour with E5 (Director of Housekeeping and Laundry) and E6 (Maintenance Director) on 4/1/15 from 2:45 PM to 3:50 PM the following observations were made:</p> <ol style="list-style-type: none"> 1. The pull cord to activate the over bed light in room K3W was too short and not accessible to the resident. 2. The pull cord to activate the over bed light in room K12W was too short and not accessible to the resident. 3. Room S7W lacked a light cord to activate the over bed light. 4. The over bed light in room S10D was non-functional and it lacked a pull cord. 5. The pull cord to activate the over bed light in room S34D was too short and not accessible to the resident. <p>Findings were confirmed with E5 and E6 during</p>	F 256	<p>F256</p> <ol style="list-style-type: none"> 1. The pull cords for resident in K3W, K12W, S34D were lengthened and are now accessible to the residents. A light cord was added to room S7W and the light in S10D was repaired and light cord was added. 2. All residents have the potential to be affected if there is improper lighting in their areas. 3. All resident's rooms have been checked and any rooms noted with pull cords that were incorrect length or lights that were not functioning properly were fixed and now all is functioning properly. All staff will be educated on the need to observe their environment when in residents rooms to ensure that pull cords are proper length and lights are functioning properly. If it is noted that they are not the correct length or they are not functioning properly staff will complete a repair requisition form (Attachment C) and turn it into maintenance. 	

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F 256 F 309 SS=D	<p>Continued From page 5 the environmental tour.</p> <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> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R163) out of 36 residents the facility failed to follow the plan of care for blood pressure medication administration. Findings include.</p> <p>1. R163 had a physician's order dated 2/10/15 for Norvasc, for high blood pressure, 5 milligrams (mg). Hold for systolic (force of blood creating pressure in the arteries) blood pressure (SBP) 120 or less or heart rate less than 50.</p> <p>Review of the March 2014 MAR revealed the following;</p> <p>3/9/15 8 AM BP 113/59 3/24/15 8 AM BP119/62</p> <p>The resident's Norvasc was administered on both of these days despite the readings below 120 SBP.</p> <p>On 3/31/15 at 1130 AM interview with E10 RN,</p>	F 256 F.309	<p>4. An audit will be completed daily for 2 weeks, weekly x 4 and then monthly x3 by House Keeping Director or designee to ensure that pull cords are correct length and lights are in working order. If it is noted that success is not 100% the audits will continue and will not go to the next step until success is 100% (Attachment D)</p> <p>F309</p> <ol style="list-style-type: none"> 1. Unable to correct for resident R163. 2. All residents that have medication parameters have the potential to be affected if plan of care is not followed for medication parameters. 3. All residents that have parameters will be audited for month of March to ensure that meds are being held per parameters. Nurses will be educated on meaning of parameters and importance of holding medications according to parameters. 	May 8, 2015

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F 309	Continued From page 6 UM confirmed that R163's Norvasc was not held for SBP parameters on these two dates. These findings were reviewed and confirmed with E1 (NHA), and E2 (DON) on 4/2/15 at approximately 12:40 PM.	F 309	4. An audit will be completed daily for 2 weeks, weekly x 4 and then monthly x3 by DON or designee to ensure that medications are being held according to parameters. If it is noted that success is not 100% the audits will continue and will not go to the next step until success is 100% (Attachment E)	May 8, 2015
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R163) out of 36 sampled residents the facility failed to re-evaluate the resident's toileting plan when an assessment showed a decline from totally continent to frequently incontinent of urine. Findings include: The facility's policy for Incontinence Management documented that residents who are incontinent have the right to receive treatment and services to prevent incontinent episodes and restore as much urinary function as possible. R163's Bowel and Bladder Screener dated 11/26/14 documented the resident does not	F 315	F315 1. Resident E10's March toileting schedule was reviewed and E10 was noted to be now mostly continent. A new toileting assessment was completed at time of review. 2. All residents have the potential to be affected if their toileting is not re-evaluated when a decline in continence is noted.	

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F 315	<p>Continued From page 7</p> <p>always void without incontinence but does at least daily (void appropriately), is usually aware of the need to toilet and was a candidate for a scheduled toileting (timed voiding) program.</p> <p>The resident's admission MDS dated 12/2/14 documented the resident was continent of bladder during the 7 day assessment period.</p> <p>A care plan dated 12/2/14 documented that the resident was on a trial bowel and bladder toileting schedule.</p> <p>R163's Bowel and Bladder Screener dated 12/19/14 documented the resident does not always void without incontinence but does void at least daily, is usually aware of the need to toilet and was a candidate for scheduled toileting. In handwriting on the printed form the nurse wrote that on 12/19/14 the electronic medical record showed episodes of incontinence and a 5 day toileting trial was initiated. A note dated 12/31/14 documented that upon reviewing the 5 day toileting record, the resident was completely continent and a toileting program was initiated.</p> <p>The resident's toileting plan was to toilet at 6 AM, 11 AM, 2 PM, 7 PM, and 10 PM.</p> <p>The quarterly MDS dated 2/26/15 documented the resident was frequently incontinent of urine during the 7 day observation period. No further assessments were found in the clinical record.</p> <p>Interview on 3/30/15 at 2:44 PM with E10 RN and E3, RNAC revealed that when the quarterly MDS was conducted on 2/26/15 showing the decline in continence the nursing unit was not notified of the decline. This resulted in a new voiding</p>	F 315	<p>3. When MDS is completed RNAC will notify nursing unit of decline in any resident's continence pattern and nursing will initiated toileting program. Nurses and c.n.a.s will be educated on the updated toileting program. The toileting program is initiated for all new admissions and any resident with a change in medical condition or increase in incontinence, beginning with a 3 day incontinence form. If noted on this form that resident has incontinence with a pattern then the toileting program is initiated for this resident with specific times and is reviewed monthly for needed changes. If 3 day shows no pattern in incontinence episodes then the Weekly Incontinence record is done to determine specific times needed for toileting program. If resident is continent no toileting program is needed at that time. (Attachment F, G, H)</p>	

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F 315	Continued From page 8 assessment not being completed and the current toileting program not being re-evaluated. E10 reviewed the March toileting schedule and noted the resident was now mostly continent. A new toileting assessment was initiated. These findings were reviewed and confirmed with E1 (NHA), and E2 (DON) on 4/2/15 at approximately 12:40 PM.	F 315	4. An audit will be completed daily for 2 weeks, weekly x 4 and then monthly x3 by DON or designee to ensure residents noted with decrease in continence pattern have had their toileting program initiated and that it is being done correctly. If it is noted that success is not 100% the audits will continue and will not go to the next step until success is 100% (Attachment I)	May 8, 2015
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, the environmental tour and interviews, it was determined that the facility failed to provide an environment as free of accident hazards as possible. Findings include: 1. During stage 1 observations on 3/25/15 from 2:50 PM to 4:39 PM and during the environmental tour on 4/1/15 from 2:45 PM to 3:50 PM and 4:10 PM to 4:25 PM with E5 (Director of Housekeeping and Laundry) and E6 (Maintenance Director), the following resident rooms had water temperatures (temps) in the resident hand sinks that exceeded 110 degrees with potential to burn/scald residents:	F 323	1. Unable to correct temperatures the day of observation for rooms K27W, K29W, S2W, S4D, S10D. 2. All resident's safety has the potential to be affected if the water temperature in their room is not at the correct temperatures. 3. Plumbers have been contracted to come in and fix the mixing valve so that water will not be supplied to rooms greater than 110 degrees. Nurses and c.n.a.s will be educated on acceptable water temperatures and if water feels to be too warm or too cold than a repair requisition form will be completed for maintenance to check and fix if necessary. 4. An audit will be completed daily for 2 weeks, weekly x 4 and then monthly x3 by housekeeping director or designee on 5 different rooms on each unit to ensure proper water temperatures. If it is noted that success is not 100% the audits will continue and will not go to the next step until success is 100% (Attachment J)	

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F 323	<p>Continued From page 9</p> <p>A. K27W- 113 degrees Fahrenheit (F) on 3/25/15, 116.1F on 4/1/15 at 3 PM, 111F on 4/1/15 at 4:20 PM by E6;</p> <p>B. K29W- 112F on 3/25/15, 116.1F on 4/1/15 at 3:05 PM, 116.1F on 4/1/15 at 4:25 PM by the surveyor and 113F by E6;</p> <p>C. S2W- 114F on 3/25/15, 108F (acceptable) on 4/2/15 at 9:20 AM;</p> <p>D. S4D- 113F on 3/25/15, 111.4F on 4/1/15 at 3:56 PM;</p> <p>E. S10D- 113.2F on 3/25/15, 109.1F (acceptable) on 4/1/15 at 3:17 PM.</p> <p>During stage 1 of the survey temperatures were taken on 3/25/15 using a surveyors digital thermometer. Temperatures were rechecked on 4/1/15 during the environmental tour using the same thermometer.</p> <p>On 4/1/15 at 4:05 PM, E5 and E6 approached the surveyor and advised they rechecked some of the room temperatures using E6's thermometer and they got lower temperatures than those found during the environmental tour. The surveyor used her own digital thermometer (not the one used in stage 1 and during the environmental tour) and rechecked rooms K27W and K29W2 as requested. Although different surveyor thermometers were used on 4/1/15 at 3:05 PM and on 4/1/15 at 4:20 PM, the water temperature for both rooms was 116.1F each time. Included above are the temperatures taken by E6 simultaneously with the surveyor.</p> <p>The facility thermometer readings did not match, however, and water temps varied with several degree differences during different checks.</p> <p>Findings were confirmed with E5 and E6 during</p>	F 323		May 8, 2015
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2015
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NAME OF PROVIDER OR SUPPLIER HARRISON SENIOR LIVING OF GEORGETOWN, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W. NORTH STREET GEORGETOWN, DE 19947
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(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
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F 323	<p>Continued From page 10 the environmental tour on 4/1/15.</p> <p>Findings were reviewed with E1(NHA) on 4/2/15 at approximately 10:00 AM. E1 stated that the same boiler was used for the kitchen (excluding dishwasher) and all resident rooms. She stated that E6 did an "adjustment" on the water temp after the kitchen tour was completed on 3/30/15 (water temps were low) which resulted in the higher resident hand sink temps on 4/1/15.</p> <p>2. During stage 1 and the environmental tour it was noted that S7W lacked a cover over the electrical outlet on the wall above her bed. This presented an accident hazard.</p> <p>Findings were confirmed with E5 and E6 during the environmental tour on 4/1/15 at approximately 3:40 PM. When asked if E6 performed routine maintenance checks in the facility, he stated "no" and stated that either nursing or housekeeping are to fill out a requisition when they find something that maintenance needs to attend to.</p> <p>3. During stage 1 and the environmental tour one large and one small bottle of Witch Hazel was observed on the floor by the bedside cabinet of K29D. While the residents in that room were cognitively intact and able to make reasonable decisions, there were numerous other residents who could wander into the room and accidentally ingest the Witch Hazel if they were unable to make reasonable decisions and lacked safety awareness.</p> <p>E5 removed the chemicals during the environmental tour and placed them out of view.</p> <p>4. During stage 1 and the environmental tour the</p>	F 323	<p>F323</p> <ol style="list-style-type: none"> 1. A cover was placed on the electrical outlet in room S7W. 2. All resident's safety has the potential to be affected if there are not covers on electrical outlets and/or if they are not in good condition. 3. An audit of all the rooms has been completed by maintenance to ensure that all electrical outlets have covers. All staff will be educated on the need to observe their environment when in resident's rooms to ensure that all electrical outlets have covers that are in good condition with no cracks or needed repairs. A repair requisition will be completed if there are any noted to be in need of repair. 4. An audit will be completed daily for 2 weeks, weekly x 4 and then monthly x3 by housekeeping director or designee on all rooms to ensure that all electrical outlets have covers that are in good condition with no cracks or needed repairs. If it is noted that success is not 100% the audits will continue and will not go to the next step until success is 100% (Attachment K) <p>F323</p> <ol style="list-style-type: none"> 1. Witch Hazel was removed from room K29D. 2. All residents have the potential to be affected especially those that are unable to make reasonable decisions and lack safety awareness. 3. An audit of all resident's rooms was completed to ensure that no other resident rooms had unsafe chemicals in their rooms. Nursing staff will be educated on the importance of why chemicals such as witch hazel should not be left in resident rooms and that if chemicals as such are noted in room to remove them and lock them in proper place for safety and explain to resident why. 	May 8, 2015
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F 323	Continued From page 11 following rooms had accessible bolts on both sides of their toilets that were uncovered and were accident hazards: A. S2W B. S12D C. S34D Findings were confirmed with E5 and E6 during the environmental tour.	F 323	4. An audit will be completed daily for 2 weeks, weekly x 4 and then monthly x3 by DON or designee on all rooms to ensure that there are no unsafe chemicals left in resident rooms. If it is noted that success is not 100% the audits will continue and will not go to the next step until success is 100% (Attachment L)	May 8, 2015
F 371 SS=F	483.35(i) 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 follow proper sanitation and food handling practices to prevent the outbreak of food borne illness. Findings include: A kitchen tour was completed on 3/30/15 from 2:45 PM to 3:40 PM with a surveyor, a Public Health Inspector, E7 (Corporate Director of Dining and Environmental Services), and E8 (Director of Dining Services). Findings include:	F 371	1. Covers have been placed on accessible bolts on toilets in room S2W, S12D, and S34D. 2. All resident safety has the potential to be affected by uncovered bolts around toilets. 3. An audit of all resident bathrooms was completed to ensure that all bolts had the proper coverage. All staff will be educated on the need to observe their environment when in resident's bathrooms to ensure that all toilets have no exposed bolts and if it is noted that they do to complete a repair requisition form for maintenance to repair. 4. An audit will be completed daily for 2 weeks, weekly x 4 and then monthly x3 by housekeeping director or designee on all rooms to ensure that there are no exposed bolts on toilets. If it is noted that success is not 100% the audits will continue and will not go to the next step until success is 100% (Attachment K)	
			F371	
			1. The 3 wet stainless steel pans were pulled off of ready to use rack and dried properly. 2. All residents have the potential to be affected if the above resulted in a food borne illness. 3. Pans are being properly stacked separately to ensure proper drying before placing on ready to use rack. Dietary staff will be educated on how to properly stack pans to ensure that they are dried correctly and then placed on ready to use rack; wet pans are not to be placed on ready to use rack. 4. An audit will be completed daily for 2 weeks, weekly x 4 and then monthly x3 by dietary director or designee of ready to use rack to	

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NAME OF PROVIDER OR SUPPLIER HARRISON SENIOR LIVING OF GEORGETOWN, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W. NORTH STREET GEORGETOWN, DE 19947
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F 371 Continued From page 12

1. There were 3 wet stainless steel insert pans stored in the ready to use rack. They were not stored under sanitary conditions.
2. The handwashing sink in the dish-washing room was partially blocked by a dish cart making it not easily accessible to staff.
3. Additionally, the handwashing sink in the dish-washing room lacked signage.
4. A 3-step process is used to manually wash, rinse, and sanitize the dishes correctly. The first step is thorough washing of dishes using hot water and detergent after food particles have been scraped. The facility failed to maintain the temperature of the wash solution in the 3 compartment sink to at least 110 Fahrenheit (F) or the minimum temperature specified on the manufacturer's label instructions. The wash solution temped at 101F.

E7 stated during an interview on 3/30/15 at approximately 3 PM (during environmental tour) that the water to the 3 compartment sink has to be below 110F so as not to be a burn risk to residents.

During an interview on 3/30/15 at approximately 4 PM, E8 stated she did not think there were any manufacturer's instructions stating that lower temperature ranges were acceptable.

During an interview on 3/31/15 at 9:20 AM, E8 stated that because water in the kitchen uses the same boiler that goes to the residents, the facility was looking into boosters to increase the water temperature to the kitchen (would not affect residents).

F 371 ensure that all pans that are placed on rack are in ready to use condition. If it is noted that success is not 100% the audits will continue and will not go to the next step until success is 100% (Attachment M)

May 8, 2015

F371

1. A sign was placed on day of observation at sink designating it to be a hand washing sink. Cart was removed from in front of sink at time of observation.
2. All residents have the potential to be affected by this if the above resulted in a food borne illness.
3. Staff continues to ensure that carts or other objects are not placed in front of hand washing sink so that sink is easily accessible. Dietary staff will be educated on need for signage above hand washing sinks designating them as hand washing sinks and the importance of not placing objects in front of the sink making it not easily accessible by staff.
4. An audit will be completed daily for 2 weeks, weekly x 4 and then monthly x3 by dietary director or designee to ensure that sink is not blocked by any objects. If it is noted that success is not 100% the audits will continue and will not go to the next step until success is 100% (Attachment N)

F371

1. Due to the water supply that goes to kitchen sinks being on the same boiler as the water that goes to resident rooms where water cannot be above 110 degrees a temporary fix is being done and hot water is being added to the wash solution sink to ensure water is above 110 degrees and stays above 110 degrees for duration of wash.
2. All residents have the potential to be affected by this if the above resulted in a food borne illness.
3. A plumber has been contracted to re-pipe water supply to kitchen so that a hotter water supply

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F 371	<p>Continued From page 13</p> <p>5. For the third step of the process, the facility failed to maintain the temperature of the sanitizing solution in the 3 compartment sink to at least 75F. The sanitizing solution temped 70F.</p> <p>These findings were reviewed and confirmed with E1 (NHA), and E2 (DON) on 4/2/15 at approximately 12:40 PM.</p>	F 371	<p>can be piped into kitchen. A log is being completed with all washes to ensure that water is at proper temperature for wash solution. All dietary staff will be educated on need to maintain water is wash solution above 110 degrees and to document accordingly on log. (Attachment O)</p> <p>4. An audit will be completed daily for 2 weeks, weekly x 4 and then monthly x3 by dietary director or designee to ensure that water is being maintained above 110 degrees for wash solution. If it is noted that success is not 100% the audits will continue and will not go to the next step until success is 100% (Attachment P)</p> <p>F371</p> <ol style="list-style-type: none"> The sanitizing solution used in our facility states that water has to be between 65-75 degrees for solution to be activated correctly. Test strips are used to check water and solution to ensure that solution is properly activated. At time of observation water was 70 degrees and our strip showed solution was properly activated. Hot water was added to raise temp to 75 degrees however cannot be raised over that or our test strip will indicate that solution has been deactivated. All residents have the potential to be affected by this if the above resulted in a food borne illness. Water will be maintained at 75 degrees however cannot be maintained over that and strips will be used to ensure that sanitizing solution is activated properly. A log will be maintained on water temperature and results of test strip with each wash. All dietary staff will be educated on need to maintain water temp at 75 degrees but not above and that must use strips to ensure that solution is activated properly and deactivated by improper water temperature. (Attachment O, Q) An audit will be completed daily for 2 weeks, weekly x 4 and then monthly x3 by dietary director or designee to ensure proper water temperature and results of test strip are showing proper activation. If it is noted that success is not 100% the audits will continue and will not go to the next step until success is 100% (Attachment R) 	May 8, 2015



**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: Harrlson House Senior Living of Georgetown

DATE SURVEY COMPLETED: April 2, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>201</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 survey was conducted at this facility from March 25, 2015 through April 2, 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 119. The stage two survey sample totaled thirty-six (36).</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>Cross reference to CMS 2567-L plan of correction submitted for tags F309, F315, F159, F241, F256, F323, and F371.</p>	

Provider's Signature Carlene Poutitte Title Administrator Date 5-4-15



**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

NAME OF FACILITY: Harrison House Senior Living of Georgetown

DATE SURVEY COMPLETED: April 2, 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 date completed April 2, 2015 F159, F241, F256, F309, F315, F323, and F371.</p>		

Provider's Signature _____ Title _____ Date _____