

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

PRINTED: 07/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/22/2015
NAME OF PROVIDER OR SUPPLIER NEWARK MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 254 WEST MAIN STREET NEWARK, DE 19711		
(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 complaint survey was conducted at this facility starting and ending on June 22, 2015 after the facility experienced a malfunction of air conditioning.</p> <p>No federal deficiency was cited during this survey.</p>	F 000			

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

TITLE

(X6) DATE

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.



**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: Newark Manor Nursing Home

DATE SURVEY COMPLETED: June 22, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.9.8</p> <p>3201.9.8.9</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced complaint survey was conducted at this facility starting and ending on June 22, 2015. The deficiency contained in this report is based on review of facility documentation and interviews.</p> <p>Abbreviation used in this report are as follows:</p> <p>NHA - Nursing Home Administrator.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Reportable incidents are as follows:</p> <p>Reportable incidents are as follows: Utility Interruption lasting more than eight hours in one or more major service including electricity, water supply, plumbing, heating or air conditioning, fire alarm, sprinkler system or telephones.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on review of documentation and interview it was determined that the facility failed to immediately report to the state agency central air conditioning malfunctions that affected multiple residents on the second floor. Findings include:</p>	<p>1. Any reportable utility outage, including electricity, water supply, plumbing, heating, air conditioning, fire alarm, sprinkler system, or telephone lasting longer than eight hours will be reported to the Division of Long Term Care immediately.</p> <p>2. Maintenance will monitor all utilities as they are being used to determine proper function.</p> <p>3. New policy (Attachment) instituted to reflect the regulation to report utility outages.</p>	<p>July 8, 2015</p>

Provider's Signature  Title Administrator Date 7-13-15



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	<p>E1 (NHA) was interviewed on 6/22/15 at approximately 1:15 PM. E1 stated that the facility had been having problems with the central air conditioning system affecting one out of six zones in the facility for "a few weeks." The affected zone impacted multiple residents on the second floor. E1 stated the air conditioning system was aging and was having difficulty providing sufficient cooling.</p> <p>Review of state incident report documents revealed that the facility failed to immediately report the air conditioning issues to the state.</p> <p>Findings were reviewed with E1 on 6/22/15.</p>		

Provider's Signature _____ Title _____ Date _____