

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

PRINTED: 10/25/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/11/2011
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NAME OF PROVIDER OR SUPPLIER  COKESBURY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 726 LOVEVILLE ROAD HOCKESSIN, DE 19707
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F 000	INITIAL COMMENTS	F 000		
F 167 SS=C	<p>An unannounced annual survey was conducted at this facility from October 4, 2011 through October 11, 2011. 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 43. The Stage 2 sample totaled 26 residents.</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to display the survey report available for examination in a place readily accessible to residents and failed to post an appropriate notice of their availability. Findings include: On 10/6/11 at approximately 11:05 AM it was observed that the folder containing last years Survey report was inside a file holder posted on a recessed wall across the nursing station, on top of a tall garbage can. The note posted across the</p>	F 167	<p>Cokesbury Village continually strives to provide quality services to our residents through our Quality Improvement Program of evaluation, education and implementation. The following are our latest efforts to insure Quality of Care.</p> <p>1. The trash can was removed from the area, the file folder was lowered and the HIPAA information sign was relocated. The survey result is accessible to all residents including those in wheelchairs. The resident interviewed (R41) attended post survey meeting with DLTCRP last year, but he did not remember.</p>	10/6/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Robyn Crandall* EXECUTIVE DIRECTOR, NHA 11/10/11

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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NAME OF PROVIDER OR SUPPLIER  <b>COKESBURY VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>726 LOVEVILLE ROAD HOCKESSIN, DE 19707</b>	
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F 167	Continued From page 1 file holder stated "Privacy HIPAA Statement".  In an interview with R41 (Resident Council President) on 10/6/11, he stated that he did not know where the survey report was located. When the State surveyor showed R41 the location, he stated that he had seen that holder before but had ignored it because of it saying "Privacy HIPAA Statement." R41 was seated in a wheelchair and was unable to reach the survey report due to the tall trash can blocking access.	F 167	2. The annual survey result has been posted in the same area for many years. Cokesbury Village will continue the practice to communicate the survey information with residents and families through resident council meetings, care plan meetings, and address their concerns and questions.	On-going
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278	3. The survey findings were communicated with all nursing staff at monthly meetings.  4. The receptionist and other nursing staff will make sure that the survey information area is clear of any obstructions, and to make sure that it's accessible to residents and family at all times.	10/26/11  On-going

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F 278	<p>Continued From page 2 resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to ensure the accuracy of the Minimum Data Set (MDS) Assessment for three (R23, R19 and R39) out of 26 sampled residents. Findings include:</p> <p>1. Review of R23's medical record revealed that the Weekly Wound Assessment Form, a Physician's Progress Note and a nurses note all dated 8/23/11 stated that R23 had an unstageable pressure ulcer to the right foot second toe. As of the 10/4/11 Weekly Wound Assessment, R23 continued to have the unstageable pressure ulcer to the right foot second toe.</p> <p>Review of R23's MDS, dated 9/8/11 revealed that Section M (Skin Conditions) failed to code the unstageable pressure ulcer to the right foot second toe.</p> <p>Interview with E3 (Assistant Director of Nursing), on 10/11/11 confirmed that there were no pressure ulcers documented on the MDS dated 9/8/11. E3 stated that she must have missed the pressure ulcer and that she would do a correction to the MDS and transmit it.</p>	F 278	<p>1. R23's MDS was corrected immediately with the proper coding, transmitted and accepted. R19's MDS was modified with the proper coding, transmitted and accepted. R39's quarterly assessment was completed on 10/13/11 with ARD of 10/6/11. J1400 was correctly coded, transmitted on 10/14/11 and accepted.</p> <p>2. The MDS coordinator reviewed MDS for the past quarter, and determined that no other coding errors were identified under section M &amp; J.</p>	<p>10/11/11</p> <p>10/13/11</p> <p>10/31/11</p>



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F 371 SS=F	Continued From page 4 <b>STORE/PREPARE/SERVE - SANITARY</b>  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 observations made in the dietary area and interviews, it was determined that the facility failed to prepare, serve, and distribute food under sanitary conditions. Findings include:  1. On 10/4/11 at 8:15 AM, the food-contact surface area of three (3) out of ten (10) frying pans stored on the clean and ready to use rack above the three-compartment sink were observed in disrepair. In an interview with E6 (Facility Dining Services Director) on 10/4/11, he confirmed the finding and removed the pans from the rack.  2. Observations on 10/4/11 of the kitchen steam table food pan ready-to-use storage rack revealed six (6) of six (6) steam table pans were dripping wet. The pans were observed stacked wet on the rack. In an interview with E6 (Facility Dining Services Director) on 10/4/11, he confirmed that the food pans were supposed to be air dried before stacking them and storing on the storage rack.	F 371	<ol style="list-style-type: none"> <li>Pans in disrepair were removed from service and replaced with new pans.</li> <li>The pans will be checked nightly by department personnel responsible for closing the kitchen.</li> <li>The inspection is added to the "Closing Checklist". Attachment #2</li> <li>Opening Manager to review compliance.</li> </ol> <ol style="list-style-type: none"> <li>Pans were removed from storage rack, run through the dish machine, and set on drying table to air dry.</li> <li>An in-service conducted by the Executive Chef &amp; Sous Chef will educate the Utility staff of the proper procedure of air drying pans.</li> <li>A change in the nighttime procedure so Utility Workers in the dish room air dry wet pans overnight. AM Utility will inspect and place dried pans on storage rack. This will be added to the "Closing Checklist".</li> </ol>	<p>10/4/11</p> <p>10/4/11</p> <p>10/4/11</p> <p>1/5/12</p> <p>10/4/11</p> <p>11/5/11</p> <p>10/4/11</p>

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F 371	Continued From page 5  3. On 10/4/11 at 8:35 AM, observations of the kitchen dishwasher operation revealed the following:  a. E6 tested the facility's dishwasher three (3) times with a test strip for the presence of chlorine sanitizing agent using a test strip. Each time, the sanitizer in the dishwasher was not detected on the test strips at concentrations required by regulations. E6 called their dishwasher vendor to check the presence of the chlorine sanitizer in the dishwasher. The vendor's data report review revealed that the sanitizing solution in the dishwasher was adequate. The vendor had to retrain all dietary staff in the proper procedure for testing the presence of chlorine sanitizing solution in the dishwasher with a test strip.  b. A dietary staff (E7) was placing dirty dishes at the entrance of the dishwasher, and this same staff was observed removing the clean dishes from the dishwasher without washing his hands. E7's fingers were observed touching the clean sanitized plates as he removed them from the exit area of the dishwasher. Interview with E6 on 10/4/11 confirmed these findings.  4. Observations of the male and female dietary staff bathroom doors in the kitchen with E8 (Assistant Dining Director) on 10/4/11 at 11:22 AM, revealed the doors were open. The doors remained open after continued attempts to close them tight as the doors were larger than the opening of the door frames. In an interview with E8 on 10/4/11, she stated that the door latching mechanism was not working properly and she would contact maintenance in order to place a	F 371	<p>4. Opening Manager to review compliance.</p> <p>1. Machine shut down until Ecolab representative was available.</p> <p>2. An in-service was conducted by Ecolab rep on proper was to use test strip. Attachment #5</p> <p>3. AM Utility staff are required to document sanitizer PPM's on approved log before running dishes through machine. Attachment # 6</p> <p>4. Opening Manager to review compliance. Log kept for 1 year.</p> <p>1. Doors need to be adjusted to fit the door jamb. Reviewed by maintenance staff for repair.</p> <p>2. Doors were shaved down to fit flush with the door jamb as an initial repair. New doors are to be ordered.</p> <p>3. Door checks are to be added to the Weekly Maintenance/Kitchen checklist Attachment # 7</p> <p>4. A weekly walk through the kitchen by Plant Operations</p>	<p>1/5/12</p> <p>10/4/11</p> <p>10/4/11</p> <p>10/4/11</p> <p>1/5/12</p> <p>10/5/11</p> <p>10/12/11</p> <p>11/4/11</p> <p>11/5/11</p>

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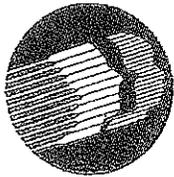
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F 371	Continued From page 6 work order. Interview with E8 on 10/4/11 confirmed this finding.	F 371			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	1. Linen and trash bins located on the Wilmington and New Castle back halls have been removed on 11/4/11. All dirty linen and trash will be kept in the ventilated soiled storage room. Portable soiled linen and trash bin containers will no longer being used in health center. New lidded storage containers were purchased on 11/3/11.  2. The halls will be evaluated for any foul odors daily. Anticipated delivery of new lidded storage containers is 11/15/11. Until delivery, soiled linen will be stored in the ventilated storage room and trash is brought to the main Health Center Soiled Utility room for disposal away from all resident rooms.	11/4/11  11/15/11	



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Division of Long Term Care  
Residents Protection

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

STATE SURVEY REPORT

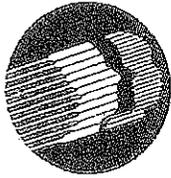
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NAME OF FACILITY: Cokesbury Village

DATE SURVEY COMPLETED: October 11, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<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 survey was conducted at this facility from October 4, 2011 through October 11, 2011. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 44. The survey sample totaled twenty six (26).</p> <p><b>Skilled and Intermediate Care Nursing Facilities</b></p> <p><b>Scope</b></p> <p><b>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.</b></p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Cross refer to the CMS 2567-L survey report date completed 10/11/11, F167,</p>	<p>Cokesbury Village continually strives to provide quality services to our residents through our Quality Improvement Program of evaluation, education and implementation. The following are our latest efforts to insure Quality of Care.</p> <p>1. The trash can was removed from the area, the file folder was lowered and the HIPAA information sign was relocated. The survey result is accessible to all residents including those in wheelchairs. The resident interviewed (R41) attended post survey meeting with DLTCRP last year, but he did not remember.</p> <p>2. The annual survey result has been posted in the same area for many years. Cokesbury Village will continue the practice to communicate the survey information with residents and families through resident council meetings, care plan meetings, and address their concerns and questions.</p> <p>3. The survey findings were communicated with all nursing staff at monthly meetings.</p> <p>10/6/11</p> <p>On-going</p> <p>10/26/11</p>

Provider's Signature Robyn Crandall Title EXECUTIVE DIRECTOR, NHA Date 11/10/11



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3201.7.5	<p>F278, F371 and F441.</p> <p><b>Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.</b></p> <p>Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 2-301.14, 4-202.11, 4-903.11 of the State of Delaware Food Code. Findings include:</p> <p><b>This requirement was not met as evidenced by:</b></p> <p><b>2-301.14 When to Wash.</b></p> <p><b>Food employees shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single-use articles and:</b></p> <p><b>(E) After handling soiled equipment or utensils;</b></p> <p><b>(F) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks;</b></p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Cross refer to the CMS 2567-L survey report date completed 10/11/11, F371, Example 3b.</p> <p><b>4-201.11 Equipment and Utensils.</b></p> <p><b>Equipment and utensils shall be designed and constructed to be durable and to retain their characteristic</b></p>	<p>4. The receptionist and other nursing staff will make sure that the survey information area is clear of any obstructions, and to make sure that it's accessible to residents and family at all times.</p> <p>1. R23's MDS was corrected immediately with the proper coding, transmitted and accepted. R19's MDS was modified with the proper coding, transmitted and accepted. R39's quarterly assessment was completed on 10/13/11 with ARD of 10/6/11. J1400 was correctly coded, transmitted on 10/14/11 and accepted.</p> <p>2. The MDS coordinator reviewed MDS for the past quarter, and determined that no other coding errors were identified under section M &amp; J.</p> <p>3. The MDS coordinator will continue to do assessments according to RAI Manuel, to gather information through resident interviews, chart reviews and interdisciplinary meetings. Any residents with pressure ulcers, falls and on hospice care will be coded accordingly. An audit tool has been established to check coding accuracy.</p> <p>(see Attachment #1)</p>

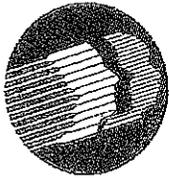
On-going

10/11/11

10/13/11

10/31/11

On-going



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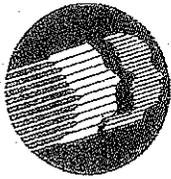
STATE SURVEY REPORT

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DATE SURVEY COMPLETED: October 11, 2011

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	<p>qualities under normal use conditions.</p> <p><b>4-101.11 Characteristics.</b></p> <p>Materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be:</p> <p>(A) Safe;</p> <p>(D) Finished to have a smooth, easily cleanable surface; and</p> <p>(E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition.</p> <p><b>4-202.11 Food-Contact Surfaces.</b></p> <p>(A) Multiuse food-contact surfaces shall be:</p> <p>(1) Smooth;</p> <p>(2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections;</p> <p>(3) Free of sharp internal angles, corners, and crevices;</p> <p>(4) Finished to have smooth welds and joints;</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 10/11/11, F371, Example 1.</p> <p><b>4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.</b></p> <p>(B) Clean equipment and utensils shall be stored as specified under ¶ (A) of this section and shall be stored:</p>	<p>4. The audit will be conducted monthly for three monthly or until 100% accuracy is achieved. The result will be reported to monthly and quarterly QI. 1/5/12</p> <p>1. Pans in disrepair were removed from service and replaced with new pans. 10/4/11</p> <p>2. The pans will be checked nightly by department personnel responsible for closing the kitchen. 10/4/11</p> <p>3. The inspection is added to the "Closing Checklist". Attachment #2. 10/4/11</p> <p>4. Opening Manager to review compliance. 1/5/12</p> <p>1. Pans were removed from storage rack, run through the dish machine, and set on drying table to air dry. 10/4/11</p> <p>2. An in-service conducted by the Executive Chef &amp; Sous Chef will educate the Utility staff of the proper procedure of air drying pans. 11/5/11</p> <p>3. A change in the nighttime procedure so Utility Workers in the dish room air dry wet pans overnight. AM Utility will inspect and place dried pans on storage rack. This will be added to the "Closing Checklist". 10/4/11</p>



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
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STATE SURVEY REPORT

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NAME OF FACILITY: Cokesbury Village

DATE SURVEY COMPLETED: October 11, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	
	<p>(1) In a self-draining position that allows air drying; and (2) Covered or inverted.</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 10/11/11, F371, Example 2.</p> <p><b>4-302.14 Sanitizing Solutions, Testing Devices.</b></p> <p>A test kit or other device that accurately measures the concentration in MG/L of sanitizing solutions shall be provided.</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 10/11/11, F371, Example 3a.</p> <p><b>6-202.14 Toilet Rooms, Enclosed.</b></p> <p>Except where a toilet room is located outside a food establishment and does not open directly into the food establishment such as a toilet room that is provided by the management of a shopping mall, a toilet room located on the premises shall be completely enclosed and provided with a tight fitting and self-closing door.</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 10/11/11, F371, Example 4.</p>	<p>4 . Opening Manager to review compliance. 1/5/12</p> <p>1 . Machine shut down until Ecolab representative was available. 10/4/11</p> <p>2 . An in-service was conducted by Ecolab rep on proper was to use test strip. Attachment #5 10/4/11</p> <p>3 . AM Utility staff are required to document sanitizer PPM's on approved log before running dishes through machine. Attachment # 6 10/4/11</p> <p>4 . Opening Manager to review compliance. Log kept for 1 year. 1/5/12</p> <p>1 Doors need to be adjusted to fit the door jamb. Reviewed by maintenance staff for repair. 10/5/11</p> <p>2 Doors were shaved down to fit flush with the door jamb as an initial repair. New doors are to be ordered. 10/12/11</p> <p>3 Door checks are to be added to the Weekly Maintenance/Kitchen checklist Attachment # 7 11/4/11</p> <p>4 A weekly walk through the kitchen by Plant Operations 11/5/11</p>	