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: Country Rest Home

DATE SURVEY COMPLETED: March 19, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility beginning March 17, 2015 and ending March 19, 2015. The facility census on the entrance day of the survey was 47 residents. The survey sample was composed of 12 residents. The survey process included observations, interviews and review of residents' clinical records, facility documents and facility policies and procedures. **Abbreviations used in this report are as follows:** NHA – Nursing Home Administrator; DON – Director of Nursing; RN – Registered Nurse; LPN – Licensed Practical Nurse; CNA – Certified Nurse's Aide; F – Fahrenheit, temperature scale; mg- milligrams, unit of mass.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**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**		

Provider's Signature Mark Yoder Jr Title Administrator Date 6/1/2015

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	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. **This requirement is not met as evidenced by:** **F225** **483.13(c)(1)(ii) Not employ individuals who have been--** **(A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or** **(B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and** **(iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities** **§483.13(c)(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).** **§483.13(c)(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.** **§483.13(c)(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification**		

Provider's Signature M. Yoder, Sr. Title Administrator Date 6/1/2015

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	agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Intent §483.13(c)(1)(ii) and (iii) Based on record review and interview it was determined that the facility failed to immediately report an allegation of abuse to the administrator of the facility and to the State agency for two (R12 and R1) out of 12 sampled residents. Findings include: The facility's policy for Incident/accident Reports documented that physical, sexual and emotional abuse must be reported to the state agency. 1. R12 was admitted on 12/12/14 from her home with diagnoses which included dementia (memory loss), stroke, failure to thrive and dysphagia (difficulty swallowing). The resident was receiving Hospice (end of life) services at home that were continued at the facility. The resident was admitted at the request of Hospice after Adult Protective Service became involved due to domestic issues in the home involving the spouse. Review of a Resident to Family Investigative Form dated 2/18/15 documented that the resident was at the nurses' station with her spouse visiting. He (spouse) was in a frustrated, irritable mood and holding her wrist shaking it, pulling her pad (chair) alarm and yelling at her. The facility did not report this allegation of abuse to the State agency until 3/5/15 at 3:28 PM as indicated by the date and time stamp on the electronic reporting system. An interview with the E1, NHA on 3/17/15 around 1:50 PM revealed that he was unaware of the incident until the day before the State investigator visited the facility. The State investigator visited the facility to start an investigation on 3/11/15.	**483.13** A new policy on allegations of abuse was written on 3/15/15. See attachment #1. All currently employed staff will receive a copy with their paystub on 6/4/15. This policy will be given to all new hires and will be added as a yearly facility in-service. The DON will monitor that all reports of alleged abused have been properly reported to the Administrator. The Administrative Assistant will monitor that all new hires have received a copy of the allegations of abuse policy and that all staff are in-serviced yearly on the facilities policy on allegations of abuse. The problem was an outdated computer with an old browser that was not compatible with the website used for submitting resident to resident abuse. The computer was replaced on 1/28/2015 when Administration became aware of the problem. Staff have been instructed to report any issues with computer submissions immediately to the Administrative Assistant. The Administrative Assistant will monitor that any problems regarding submissions to the state are corrected in a timely manner.	6/4/2015

Provider's Signature M. McMahon, Jr. Title Administrator Date 6/1/2015

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	2. Review of a facility incident report revealed a resident to resident abuse incident occurred on 12/9/14 involving R1.On 1/16/15 the incident was reported to the State Agency by the facility. During an interview on 3/19/15 at 3:10 PM with E2 DON, it was confirmed that the incident was reported several weeks after it occurred. E2 explained that attempts were made to submit the incident to the state agency but the facility's computer was in need of repair and was not submitting the incidents properly. These findings were reviewed with E1, E2, and E3, Administrative Assistant on 3/19/15 at 3 PM. **F226** **§483.13(c) Staff Treatment of Residents** **The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.** **§483.13(c)(1)(i) Staff Treatment of Residents** **(1) The facility must--** **(i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;** Based on review of facility documents and interviews it was determined that for one (R12) out of 12 sampled residents the facility failed to protect the resident after an allegation of spousal abuse and during the investigation. The facility failed to have adequate and complete policies and procedures that address the prohibition of abuse, neglect and mistreatment including; screening, training, prevention, identification, investigation, protection and reporting/response. Findings include: The facility's policy for Allegations of Abuse documented an objective; Residents will be treated with respect and dignity. This is their home, and they will be treated as such. Residents will have no fear for their safety.	**483.13** A new policy on allegations of abuse was written on 3/15/15 (see attachment #1). All currently employed staff will receive a copy with their paystub on 6/4/15. This policy will be given to all new hires and will be added as a yearly facility in-service. The DON will monitor that all reports of alleged abused have been properly reported to the Administrator. The Administrative Assistant will monitor that all new hires have received a copy of the allegations of abuse policy and that all staff are in-serviced yearly on the facilities policy on allegations of abuse.	6/4/2015

Provider's Signature M. Yoder, RA Title Administrator Date 6/1/2015

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	Under Procedure it was documented; all staff are required to report concerns of possible verbal or physical abuse of a resident. The abuse of the resident is to be reported and documented on an incident report and then given to the assistant administrator. The assistant administrator will investigate further and conduct interviews as deemed necessary. After investigation, management will report legitimate complaints and fax appropriate documentation to the Division of Long Term Care. An in-service will be held on resident rights yearly and more frequently, if needed. 1. Cross refer F225 Example #1 Review of a Resident to Family Investigative Form dated 2/18/15 documented that R12 was at the nurses' station with her spouse visiting. He (spouse) was in a frustrated, irritable mood and holding her wrist shaking it, pulling her pad (chair) alarm and yelling at her. Review of the investigative packet provided by the facility revealed that the administrative assistant (E3) was made aware on 2/18/15 and spoke with the spouse about his behavior and witness statements were collected. The State agency was not notified of the allegation of abuse until 3/5/15. The spouse was not removed from contact with the resident until an investigation was completed. The facility did not initiate any protective measures until 3/11/15 when a sign was placed inside the nurses' station that read "visitation with the husband is to be supervised in the lobby at all times! Any problems call (E1's name[NHA]) ASAP (as soon as possible). Any physical abuse call 911. On 3/11/15 the facility also initiated a care plan with the problem of; spouse with history of physical and verbal abuse to resident (R12) with approaches that included the visitation restrictions from the above sign.		

Provider's Signature W. Yoder, Jr. Title Administrator Date 6/1/2015

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	The facility failed to immediately protect R12 after an allegation of abuse was identified. 2. Review of the above Policy and Procedure documented in its entirety failed to include; screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences. An interview with E1, on 3/19/15 around 2:00 PM confirmed that the facility's policy needed to be revised to include the required elements. These findings were reviewed with E1, E2, DON and E3, on 3/19/15 at 3 PM. **F241** **§483.15(a) - Dignity** **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.** Based on observation it was determined that residents were not always treated in a dignified manner, for one (R6) resident out of 12 sampled residents. Findings include: The facility's policy for Dining and Food Service documented that residents at the same table will be served and assisted concurrently. 1a. On 3/17/15 around 9:30 AM R6 was observed sitting in the dayroom wearing a white terry cloth clothing protector dirty with debris. There was no meal being served and no food present. 1b. On 3/17/15 at 11:35 AM two residents (SS1 and SS2) were at a dining room table with their lunch. At 11:42 SS3 also sitting at the table received lunch. At 11:49 AM R6, who was also at	**F241** **483.15(a)** The policy for the dining room experience has been updated (see attachment #2). These deficiencies were reviewed with the staff the day of the incident and an in-service is scheduled for June 10th with all the staff on the wing that received the citation to review these deficiencies and the updated policy. The Administrative Assistant will monitor that residents are treated in a dignified manner during mealtime.	6/10/2015

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	the same table, received his lunch. R6 had to watch other residents at the table eat for 14 minutes before receiving lunch. These findings were reviewed with E1 NHA, E2, DON and E3, Administrative Assistant on 3/19/15 at 3 PM. **F309** **§483.25 Quality of Care** **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.** Based on record review and interview it was determined that for one (R3) out of 12 sampled residents the facility failed to ensure that R3 received the necessary care and services to manage pain. Findings include: The pain management standards were approved by JCAHO (Joint Commission) in July 1999 and the same guidelines were approved by the American Geriatrics Society in April 2002 which includes: -appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. Review of the facility's policy for Pain Assessment stated that if a resident indicates they have pain, the nurse will use the assessment tools (Wong-Baker FACES/Pain scale for cognitively-impaired, non-verbal adults) to assess and document that pain. Attached to the policy was the Pan Scale for Cognitively Impaired, Non-verbal Adults and the Wong-Baker FACES Pain Rating Scale. Each of these scales assesses for pain by obtaining a	**F309** **483.25** An updated and more detailed policy for pain assessment was written (see attachment #3) that includes a pain scale for the cognitively impaired, non verbal adults. All nurses will be in-serviced individually on this policy by June 10th. This policy is also included as part of the new hire orientation for nurses. The DON will monitor that the policy is being used correctly and will in-service staff as needed.	6/10/2015

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	score of 0 to 5 with 0 being no pain. R3 had a care plan dated 12/16/14 for chronic pain – shoulder pain. Interventions included to give pain medication promptly, monitor for effectiveness and increase as needed. R3 had a physician's order dated 1/20/15 to have one or two Percocet (pain medication) three times a day as needed for moderate or severe pain respectively. Review of the Medication Administration Record (MAR) revealed that 8 doses were administered in January 2015. On the back of the MAR nursing staff documented the location of the pain and the word "effective". There was no scale being used to evaluate the intensity and relief of pain. An interview on 3/18/15 at 2:51 PM with E7, LPN revealed that R3 is unable to verbalize his pain so she uses the facial scale to look at his movements and expressions to determine pain. Although she stated facial scale she described the cognitively impaired non-verbal scale. An interview on 3/19/15 around 2 PM with E2, DON confirmed that a scale was not being used to assess the resident's pain. She also confirmed that the facility's policy did not address how the facility assessed alert and oriented residents' pain. These findings were reviewed with E1 NHA, E2, and E3, Administrative Assistant on 3/19/15 at 3 PM. **F323** **§483.25(h) Accidents.** **The facility must ensure that –** **(1) The resident environment remains as free from accident hazards as is possible; and** **(2) Each resident receives adequate supervision and assistance devices to prevent accidents.**		

Provider's Signature M. Woodruff Jr. Title Administrator Date 6/1/2015

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	Based on observation, interview and record review it was determined that the facility failed to ensure that the resident environment was free from accident hazards for one (R1) out of 12 sampled residents. The facility also failed to safely store oxygen canisters. Additionally an improperly positioned refrigerator and a floor with cracks in the linoleum posed an accident hazard to residents. Findings include: 1. 12/20/15- A care plan intervention was initiated by R1's family member for a lock to be placed on the inside of R1's room door to keep other residents out. The care plan documented that R1 was able to lock and unlock the door independently and knew to go through the shared bathroom as an alternative exit. During a room inspection and resident interview on 3/17/15 at 2:12 PM R1 was unable to independently unlock the lock placed on the door inside R1's room. R1 was able to state that it was possible to exit through the shared bathroom and out though the neighboring resident's room. When R1 attempted to turn on the bathroom light to exit her room the light would not come on, The light did turn on from the adjoining resident's room. The bathroom light switch in R1's room would not work if the light switch was up in the adjoining resident's room and vice versa; causing either resident to potentially have to enter the dark bathroom and go to the adjoining room and turn on the light. In front of the adjoining resident room door, a portable toilet (bed side commode, BSC) was blocking the door and R1 stated she was unable to move the BSC. Consequently the alternative exit for R1 was blocked by an accident hazard. Findings were reviewed with E1 (NHA) and E2 (DON) on 3/19/15 at 3:15 PM. 2. Observations during the tour of the facility on 3/17/2015 at 10:30 AM revealed that 3 oxygen tanks were being stored in the room closet of R7 without holders. One oxygen tank was sitting in a	**F323** **483.25(h)** 1.) The lock was removed from the resident's door during the time of survey. The facility will not use locks on the doors used by residents in the future. The Administrative Assistant will monitor that locks are only used on appropriate doors in the facility. The bathroom light switch was replaced at the time of survey and is working condition. Maintenance will monitor to ensure that lights are in working condition in the future.	3/19/2015 3/19/2015

Provider's Signature M. Lyden SC Title Administrator Date 6/1/2015

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	holder outside of the closet of R7. The oxygen tanks remained in the closet of R7 on 3/18/2015 and 3/19/2015. 3. The following observations were made on 3/19/2015 at approximately 10:00 AM, on the Rose Garden hall next to the medication cart in the hallway, a small dorm size black refrigerator was positioned on top of a small filing cabinet. The filing cabinet being narrower than the refrigerator did not fully support the refrigerator and because the refrigerator was light enough to tip over it is a potential hazard. 4. On 3/19/2015, at 10:00AM, an area on the floor in room 115, near the bed of R5 had cracks in the linoleum tiles that posed an accident hazard to a resident. These findings were reviewed with E1, E2, and E3, Administrative Assistant on 3/19/15 at 3 PM. **F364** **§483.35(d) Food** **Each resident receives and the facility provides:** **(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;** **(2) Food that is palatable, attractive, and at the proper temperature;** Based on observation and interview it was determined that the facility failed to serve food that was palatable. Findings include: During lunch observation on 3/17/15 the meal cart arrived on the unit at 11:35 AM. At 12:06 PM, 31 minutes later, the second to last resident SS4 was served his pureed meal. The facility reheated the meal of the last resident to be served that day at 12:18 PM. On 3/19/15 at test tray of a pureed diet was requested. The tray was tested at 12:07 PM, 31 minutes after it arrived on the unit. The green beans were 101.2 degrees F, potatoes 114	2.) The oxygen tanks stored in the resident's room without holders had been delivered by the hospice provider's contract with Community DME. They have been notified in writing that the facility will no longer accept deliver of portable tanks from an outside source (see attachment #5). The facility provides their own portable tanks if the need arises and they are properly stored in carriers or carts in a designated area of the facility. Staff have been instructed not to accept delivery of portable tanks and if the facility portable tanks are being used that they are properly contained in a cart. A sign has also been placed in the oxygen area as a reminder. The DON and Administrative Assistant will monitor that all portable tanks are properly stored and contained during use in the future. 3.) A stand was built the week of 3/23/15 that fits over top of the filing cabinet and was wider than the refrigerator. This stand was secured to the wall to prevent it from moving. The Administrative Assistant will monitor that any new equipment is properly positioned and secured in the future. 4.) Maintenance is in the process of replacing the tiles in Rm #115 and will have the project completed by 6/30/2015. A temporary fix was done to prevent any accidents. Maintenance will monitor that the floors are kept in good condition and replace or repair as needed.	3/20/2015 3/31/2015 6/30/2015

Provider's Signature Michelle Vanderlee Title Administrator Date 6/1/2015

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	degrees F, and shrimp 104.6 degrees F. All the food tastes were cool and unpalatable. These findings were reviewed with E1, NHA E2, DON and E3, Administrative Assistant on 3/19/15 at 3 PM. **F431** **§483.60(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--** **(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and** **(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.** **§483.60(d) Labeling of Drugs and Biologicals** **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.** **(e) Storage of Drugs and Biologicals** **(1) 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.** **(2) 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 quantity stored is minimal and a missing dose can be readily detected.** Based on observation and staff interview it was determined that the facility failed to ensure that expired medications were removed from the medication carts on both units of the facility.	**F364** **483.35(d)** The policy for the dining room experience has been updated (see attachment #2) to address the issue of serving food at the proper temperature. These deficiencies were reviewed with the staff the day of the incident and an in-service is scheduled for June 10th with all the staff on the wing that received the citation to review these deficiencies and the updated policy. The DON and Administrative Assistant will monitor that the food is properly heated when serving the residents.	6/10/2015

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	Additionally the facility failed to ensure the temperature of a refrigerator containing medication was within the acceptable parameter and another refrigerator containing medications could not be secured with a lock. Findings include: 1. Observation on 3/19/15 at 11:00 AM of the Rose Garden medication cart and 11:30 AM of the East hall cart revealed the following medications and biologicals were expired; -One bottle of Cod liver Oil, a vitamin supplement, with an expiration date of 11/2013; - One blister pack of Zyrtec 10 milligrams (mg) a medicine for allergy symptoms, with an expiration date of 12/2013. -One bottle of Natural Beta Carotene, a vitamin supplement, with an expiration date of 3/2014; -One bottle of Tylenol, 500 mg, a medication for mild pain or fever, with an expiration date of 7/18/2014; -One blister pack of Guiafenesin 600mg, a medicine to help with coughing with an expiration date of 11/2014; -One bottle of Coenzyme Q10, a vitamin supplements 30 mg with an expiration date of 12/2014; - One bottle of Folic Acid open, with no date. -One blister pack of Tylenol 500mg with Diphenhydramine 25mg for mild pain and sleep, with an expiration date of 2/7/15; -Tylenol 1000mg (2-500mg tablets) packaged in a pharmacy bottle expired on 7/11/2014; -Tylenol PM packaged in a blister pack expired on 2/7/2015. An interview on 3/19/15 at 11:10 AM with E5 (LPN) confirmed the biologicals and medications on the Rose Hall cart were expired. An interview on 3/19/15 at 11:45 AM with E4 (RN) confirmed the medications on the East Hall cart were expired. 2. An observation on 3/19/2015 at approximately 9:30AM during a medication storage review	**F431** **483.60(b)** 1.) During our Quarterly QA meeting on 5/29/15 it was discussed with our pharmacy consultant that many expired mediations were being found. The pharmacy consultant agreed that she would begin to monitor all medications, not just the ones being delivered by Omnicare. This would include medications supplied by family members. The 11-7 nurse will also check at the beginning of each month for expired medications. The DON will monitor that expired medications have been removed from the cart in the future. 2.) A new policy was written for checking the refrigerator temps for medication storage (see attachment #4). The nurses are responsible to check the temperature twice a day as part of the narcotic count. New thermometers were ordered and will be replaced on a yearly basis or as needed to help ensure accuracy. The DON will monitor that the temperatures are being taken in the future.	5/29/2015 4/14/2015

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	revealed there was no log recording the temperature of the small refrigerator designated for medication in the main medication room. The temperature reading at that time was 49 degrees F (the temperature should be 41 degrees F or lower). 3. Observations made on 3/19/2015 at 10:30AM on the Rose Garden hall next to the medication cart in the hallway, a small dorm size black refrigerator contained flu vaccine and PPD (A Purified Protein Derivative used for skin testing for tuberculosis) solution. Inside was a locked box indicating insulin for emergency use, however the refrigerator itself was not locked and did not have a lock attached that could be secured. This was confirmed and reviewed with E1 (NHA). These findings were reviewed with E1, E2, DON and E3, Administrative Assistant on 3/19/15 at 3 PM.	3.) The refrigerator has a built in lock at the bottom of the frig but the key had been lost. A replacement key was ordered for the refrigerator and the staff have been instructed to keep locked at all times and to notify Administration if at any times they are unable to lock it. The DON will monitor that the refrigerator is locked on her rounds.	6/1/2015
3201.6.6	**Housekeeping and Laundry Services**		
3201.6.6.1	**The facility shall maintain a safe, clean and orderly environment, free from offensive odors, for the interior and exterior of the facility.** Based on observation and interview it was determined that the facility failed to maintain housekeeping and maintenance services to ensure a safe and clean environment. Findings include: 1. The following observations were made on 3/17/2015 at 9:30AM during a tour of the building; -The stainless steel water fountains in resident area and the sink in the nutrition room were coated with white sediment. -The sink outside of the laundry room was stained.	**3201.6.6.1** 1.) The sinks have been cleaned to remove the white sediment build up and stains. Housekeeping will monitor and clean on a regular basis to avoid the build up in the future.	6/1/2015

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	2. Observation on 3/18/15 at 10:30 AM in room 121 revealed the following; -Scuff marks and chipped paint on the chair rail next to bed B. -Dark stain around the toilet shared with room 119. -A toilet bolt cover was missing exposing the bolt and washer that was rusted. 3. During initial tour on 3/17/15 at 9:40 AM in room 105 bathroom on the right side wall was a dried brown smear. The stain remained visible on 3/18/15 at 2 PM and 3/19/15 at 1:05 PM. These findings were reviewed with E1, NHA, E2, DON and E3, Administrative Assistant on 3/19/15 at 3 PM.	2.) The scuff marks and chipped paint on the chair rail have been repaired and the toilet seat has been replaced. Maintenance is in the process of replacing the floor in the bathroom and will have it completed on 6/1/15. Maintenance will monitor that repairs to rooms are done on a regular basis. 3.) The stain as been removed and cleaned. Housekeeping was alerted of the concern and the Administrative Assistant will monitor that bathrooms are cleaned and sanitized appropriately in the future.	
3201.7.3.1	**Water Supply and Sewage Disposal**		
3201.7.3.1.3	**Hot water accessible to residents shall not exceed 110 degrees F.** **This requirement is not met as evidenced by:** Based on observation and interview it was determined that the facility failed to maintain water temperatures at 110 degrees F or below. Findings include: The following temperatures were detected; - On 3/17/15 during initial tour at 9:00AM the hot water was assessed and the temperature 128 degrees F. This was brought to the attention of the E1, NHA. -On 3/17/15 at 9:40 AM the water temperature in room 105 was 115 degrees F. - On 3/17/15 at 2:45 PM the water temperature in the hand sink outside the laundry area was 117.7	**3201.7.3.1.3** Elvin Schrock Plumbing was out the week of 3/23/15 and serviced the hot water heaters. They replaced some of the elements and thermostats. The temperatures have been taken weekly by maintenance and have been within the acceptable range. Maintenance will continue to monitor the temperatures on a weekly basis and report to Administration for immediate action if it is found that the temperatures are not in compliance.	3/31/2015

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	degrees F. - On 3/17/15 at 2:50 PM the water temperature in the bathroom shared by rooms 119 and 121 was 117 degrees F. During an interview with E1, NHA on 3/17/15 at 3:30 PM he was made aware of the elevated temperatures and stated he would have them turned down and checked. -On 3/18/15 at 11 AM the bathroom shared by rooms 119 and 121 was 120 degrees F. The bathroom shared by 115 and 117 was 119 degrees F. On 3/18/15 E1 was again alerted to the elevated water temperatures. On 3/19/15 the water temperatures were within normal limits. These findings were reviewed with E1, E2, DON and E3, Administrative Assistant on 3/19/15 at 3 PM.		
3201.7.5	**Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Code.** **This requirement is not met as evidence by:** Based on observation and interview it was determined that the facility failed to comply with the 2014 Delaware Food Code. Findings include. Tour of the kitchen on 3/17/15 between 2:30 PM and 4:00 PM revealed the following violations of the Food Code: **3-202.15 Package Integrity** **Food packages shall be in good condition and protect the integrity of the contents so that food is not exposed to adulteration or potential contaminants.** - A dented can of food was observed on the shelf adjacent to the walk-in freezer. Note – corrected	**3201.7.5** **3-202.15** An area has been established to store any damaged, spoiled or recalled products until they can be disposed of or returned. A sign has been placed notifying staff of the proper procedure for these products. The dietary manager will monitor that the kitchen remains compliant with this regulation.	5/30/2015

Provider's Signature _____ Title Administrator Date 6/1/2015

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	on site can was removed from shelf. **3-302.12 Food Storage Containers, Identified with Common Name of Food** **Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food of food ingredients that are removed from their original packages for use in food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food.** – Observed unlabeled container of condiments on shelf adjacent to walk-in freezer. **3-501.16(A) (2) Time/Temperature Control for Safety Food, Hot and Cold Holding** **At 5C (41F) or less** - The air temperature of the two door reach-in refrigerator in the kitchen was 55 degrees F. The temperature of applesauce in the refrigerator was 52 degrees F. It was recommended that all temperature control sensitive foods be relocated. Any food in the refrigerator for six hours or more should be discarded. - On 3/18/2015 at 10:00AM the refrigerator in the nutrition room had a temperature reading of 47 degrees F. This is a small dorm size refrigerator with a small open freezer. Temperature taken on 3/19/2015 at 8:45AM revealed a measurement of 46 degrees F. There was no log indicating that the temperature was being monitored. - On 3/19/2015 at 9AM the reach-in refrigerator directly in the kitchen had a temperature of 56 degrees F. -On 3/19/15 at 10:28 AM the reach-in refrigerator was 44 degrees F on the facility's thermometer. At 10:41 it was 57.2 degrees F on the State thermometer. A container of yogurt was 55.6 degrees F.	**3-302.12** The food service employees have been informed that food removed from their original packages need to be dated and labeled and a note placed in the dietary communication book. The dietary manager will monitor on her rounds that this regulation remains in compliance and will also in-service staff if deficiencies are noted. **3-501.16(A)** A new larger refrigerator was purchased on 3/19/15 for the nutrition room. The dietary staff are responsible to check the temperature daily and record on the log provided. The dietary manager is responsible to monitor that the temperatures are being recorded and the temperature remains within the acceptable range and to replace the thermometers yearly or as needed.	6/1/2015 3/19/15

Provider's Signature Mark Yoder Jr. Title Administrator Date 6/1/2015

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	An interview on 3/19/15 at 10:43 AM with E6, dietary aide revealed that the facility was waiting on parts and confirmed that the facility had not discarded any food from the refrigerator. An interview on 3/19/15 at 2 PM with E1, NHA and E3, Administrative Assistant, revealed that the facility was cleaning out the reach-refrigerator and moving food to another refrigerator until the reach0in could be fixed or replaced. E1 stated that the temperature reading from their thermometer had been 40 – 41 degrees F so they had not reacted sooner to removing the food. They believe the thermometer in the unit may not have been working properly. E1 also revealed that refrigerator in the nutrition room had been defrosted, the temperature turned down and they would monitor the temperature.	The food was discarded from the reach in refrigerator on 3/19/15 and was no longer being used. A new reach in refrigerator/freezer combo was purchased on 3/23/15 to replace the old one. A new thermometer was purchased for refrigerator and freezer. Dietary staff will continue to take daily temperature readings and record on log provided. The dietary manager will monitor that the temps are being recorded and are within acceptable temperatures. Thermometers will be replaced yearly or as needed.	3/31/15
	6-301.14 Hand Washing Signage **A sign or poster that notifies food employees to wash their hands shall be provided at all handwashing sinks used by food employees and shall be clearly visible to food employees.** – There was no sign posted at the hand washing sink notifying employees to wash hands.	**6-301.14** A sign has been posted at the handwashing sink in the kitchen notifying food employees to wash their hands. The dietary manager will monitor that the sign remains in place to ensure compliance.	3/19/2015
	6-404.11 Segregation and Location **Products that are held by the permit holder for credit, redemption or return to the distributor such, such as damaged, spoiled, or recalled products, shall be segregated and held in designated areas that are separated from food equipment, utensils, linens, and single-service and single use articles.** – The facility had no designated area to store damaged, spoiled or recalled products. These findings were reviewed with E1 NHA, E2, DON and E3, Administrative Assistant on 3/19/15 at 3 PM	**6-404.11** An area has been established to store any damaged, spoiled or recalled products until they can be disposed of or returned. A sign has been placed notifying staff of the proper procedure for these products. The dietary manager will monitor that the kitchen remains compliant with this regulation.	5/30/2015

Provider's Signature VMC Yoder JR Title Administrator Date 6/1/2015