



**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-6681

STATE SURVEY REPORT

Page 1 of 11

NAME OF FACILITY: Foulk Manor South

DATE SURVEY COMPLETED: April 15, 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>An unannounced annual and complaint survey was conducted at this facility beginning April 11, 2011 and ending April 15, 2011. The facility census on the entrance day of the survey was 43. The survey sample was composed of 7 residents. The survey process included observations, interviews and review of residents' clinical records, facility documents and facility policies and procedures.</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 is not met as evidenced by:</b></p> <p><b>§483.13(c)(1)(i) F224 Requirement:</b> <b>Staff Treatment of Residents</b></p> <p><b>The facility must develop and</b></p>	<p>Response to the sited deficiencies do not contribute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the statement of deficiency. The plan of correction is prepared solely as a manner of compliance with state laws.</p>

Provider's Signature *Brenda C. Collins-Mundy* Title Executive Director Date 6/23/11



**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: Foulk Manor South

DATE SURVEY COMPLETED: April 15, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p><b>implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</b></p> <p><b>(1) The facility must-</b></p> <p><b>(i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;</b></p> <p>Based on review of the clinical record, facility documents and staff interview it was determined that the facility failed to ensure that one resident (Resident #6) was free from substantiated neglect. Findings include:</p> <p>Clinical record review revealed a nurse's note dated 1/12/2011 and timed (2:00 PM) that stated "... (Resident #6) reported... that she no longer wanted E4 (staff CNA) to take care of her anymore. When E5 (staff member) asked what happened (Resident #6) responded that "a couple nights ago between Friday evening, (1/7/2011) and Sunday evening, (1/9/2011)", she asked E4 to remove her brace but E4 never did. (Resident #6) further stated "she put on call light (and) someone answered (but) no one ever came to room to assist her."</p> <p>Review of the incident report dated 1/12/2011 and timed 9:00 AM revealed "(Resident #6)... attempting to ask (E4) staff member to take brace off left lower leg when (E4) staff member cut her off abruptly stating "I know my job". Review of the facility investigation of this incident revealed that although E4 (staff CNA) denied Resident #6 asked for removal of her leg brace on Sunday, 1/9/2011, another staff member stated that she saw Resident #6 with "her leg brace on in the</p>	<p><b>3201.1.2</b></p> <p>(1) Resident #6 had no negative outcomes from findings. Resident #6 is no longer at the community.</p> <p>(2) Any resident that requires assist with care has the potential to be affected.</p> <p>(3) All licensed staff will be re-educated on timely reporting of abuse, neglect, mistreatment of residents and on the facility's investigative process for allegations of abuse.</p> <p>3b. All incidents of alleged abuse, mistreatment, and neglect will be thoroughly investigated and reported to DHSS as per state guidelines. Incidents will be reviewed in standup to ensure appropriate steps have been taken, with resident plan of care revised to reflect resolution.</p> <p>4. All incidents of alleged abuse, neglect, and mistreatment will be thoroughly reviewed by the DON/Designee within 24 hours of the time of the occurrence to assure compliance with reporting and that appropriate interventions have been implemented. Negative findings will be reported to the NHA with immediate corrective action as warranted.</p> <p style="text-align: right;">7/1/2011</p>



**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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

STATE SURVEY REPORT

Page 3 of 11

NAME OF FACILITY: Foulk Manor South

DATE SURVEY COMPLETED: April 15, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>morning (7-3 shift, 1/10/2011) when I came in." Further review of the incident investigation completed by the facility revealed that Resident #6 informed E7 (staff CNA) during the evening shift of (Monday), 1/10/2011 that she feared retribution if she reported E4. E7 (staff CNA) responded by directing Resident #6 to express her concerns on the "next day" to E3 (director of nursing). However the clinical record is absent any documented reporting of this incident of alleged abuse and alleged neglect to E3 (DON) and/or E1 (executive director) until 1/12/2011.</p> <p>In an interview conducted with E6 (staff nurse) on 4/15/2011 it was stated that Resident #6 slept the remainder of the 3-11 shift and all of the 11-7 shift on the actual date of the incident, Sunday, 1/9/2011, wearing her left brace and without any assistance from E4 to remove it. During the same interview conducted on 4/15/2011 it was also stated that the assignment for E4 who was on duty for both the 3-11 and 11-7 shifts, 1/8/2011 and 1/9/2011, included the care of Resident #6.</p> <p>As a result of the allegation of neglect reported 1/12/2011 E4 was removed from duty and terminated upon substantiation of neglect by the facility. These findings were reviewed with E1 (executive director) and E2 (regional RN) on 4/15/2011.</p> <p><b>§ 483.25(h) Accidents. F323</b></p> <p><b>The facility must ensure that –</b></p> <p><b>(1) The resident environment remains as free from accident hazards as is possible; and</b></p>	



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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

STATE SURVEY REPORT

Page 4 of 11

NAME OF FACILITY: Fouk Manor South

DATE SURVEY COMPLETED: April 15, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p><b>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on review of the closed clinical record and staff interviews it was determined that the facility failed to ensure that one resident (Resident #2) out of seven sampled received adequate supervision to prevent potential and actual elopements from the facility. Findings include:</p> <p>Review of the clinical record revealed that Resident #2 was transferred from (a psychiatric facility) to the long term care facility on 10/26/2009 with diagnoses that included Alzheimer's disease, agitation and hypertension. An assessment form, "Data Collection Tool", completed on admission revealed that Resident #2 exhibited short-term and long-term memory impairment. Additionally a "Wandering/Elopement Risk Review Tool" completed on admission also revealed that Resident #2 scored "14" and was considered "at risk" for elopement. Further review of the clinical record revealed a nurse's note dated 10/30/2009 that stated CNA was making rounds and observed that "(Resident #2) was not found in his bed at (1:00 AM)...Nurse was called...when CNA realized there was an open window in the dayroom that lead to the outside (and) courtyard... (Resident #2) was found and brought back into the building...". The facility failed to provide adequate supervision for Resident #2 who was at risk for elopement.</p>	<p><b>483.25(h) Accidents F323</b></p> <p>(1) Resident #2 is no longer at the facility.</p> <p>(2) All residents identified at risk for elopement have the potential to be affected.</p> <p>At the time of incident in 2009, All Windows were checked and secured to assure that they do not slide no more than four (4) inches open. Any egress issues identified since then have been immediately corrected. All care plans for residents identified at risk for elopement have been reviewed to assure the interventions meets the resident's current care needs. No issues were identified.</p> <p>3. All license staff will be provided with an in-service on the care planning process with emphasis on the importance of revising the care plan to meet resident's current care needs. Weekly Environmental rounds will be conducted by the Maintenance Director to identify safety issues. Changes in the resident's care status will be reviewed in the daily nursing standup to assure compliance with any care plan revisions.</p>



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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

STATE SURVEY REPORT

Page 5 of 11

NAME OF FACILITY: Foulk Manor South

DATE SURVEY COMPLETED: April 15, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>Clinical record review also revealed the documentation of an additional five attempts by Resident #2 to elope from the facility between 10/31/2009 and 11/3/2009. Review of the care plan completed on admission, 10/26/2009, also revealed the development of goals and interventions to address wandering. However the facility failed to revise the care plan with measurable goals and specific interventions following an actual elopement committed by Resident #2 on 10/30/2009 and five attempted elopements from the facility committed by Resident #2 between 10/31/2009 and 11/3/2009.</p> <p>This finding was reviewed with E1 (executive director) and E2 (regional RN) on 4/15/2011.</p> <p><b>§483.75(e)(8) F497 Regular In-Service Education</b></p> <p><b>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must –</b></p> <p><b>(i) Be sufficient to ensure the containing competence of nurse aides, but must be no less than 12 hours per year.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on review of facility documentation and staff interview the facility failed to ensure that two sampled nursing assistants (E8 and E9) received the mandatory 12 hours of in-service training</p>	<p>4. All residents identified at risk for elopement will be reviewed monthly by the DON/Designee in the Safety Meeting to assure compliance with safety issues. Findings will be reported to the QA committee with corrective action as warrant.</p> <p style="text-align: right;">7/1/2011</p> <p><b>483.75 (e) (8) F497</b></p> <p>(1) E8 and E 9 have received their mandatory 12 hour of in-service training hours.</p> <p>(2) All nursing aides' records have been audited to ensure that staff has completed their mandatory 12 in-service hours. No issues were identified.</p> <p>(3) HR manager was educated that in-service hours must be completed from anniversary date to anniversary,</p> <p>(4) Quarterly audits to be completed by HR Manager/Designee to assure compliance and findings reported to the ED and QA committee with corrective action as warranted.</p> <p style="text-align: right;">07/01/2011</p>



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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

STATE SURVEY REPORT

Page 6 of 11

NAME OF FACILITY: Foulk Manor South

DATE SURVEY COMPLETED: April 15, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201.5.0</p> <p>3201.5.5</p> <p>3201.5.5.5</p> <p>3201.6.0</p> <p>3201.6.3</p> <p>3201.6.3.7</p>	<p>per year. Findings include:</p> <p>1. E8 (nursing assistant) was hired 3/18/2008. Review of in-service records revealed a shortage of 1.5 hours of training.</p> <p>2. E9 (nursing assistant) was hired 4/12/2004. Review of in-service records revealed a shortage of 8 hours of training.</p> <p>An interview with E1 (Executive Director) confirmed these findings.</p> <p><b>Personnel/Administrative</b></p> <p><b>The facility shall have written personnel policies and procedures. Personnel records shall be kept current and available for each employee, and include the following:</b></p> <p><b>Result of Adult Abuse Registry check</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Review of personnel information on 4/3/2011 revealed that the adult abuse registry checks for two staff members (E10 and E11) out of eleven sampled were not available.</p> <p>An interview with E1 (Executive Director) confirmed these findings.</p> <p><b>Services to Residents</b></p> <p><b>Nursing Administration</b></p> <p><b>The assessment and care plan for each resident shall be reviewed/ revised as</b></p>	<p>(1) E10 and E11 are contracted staff and discussion with surveyor to have both E10 and E11 removed from sample. E10 and E11 both have adult abuse checks completed.</p> <p>(2) A review of all staff employee records for adult abuse checks were completed to assure compliance. No issues were identified. Contracted staff is to provide proof of adult abuse checks prior to contracting at facility. There are no current issues identified with contract staff.</p> <p>(3) HR has been educated that any new employee must complete the adult abuse registry check prior to employment at facility.</p> <p>(4) Quarterly audits to be completed on all employees to assure compliance. Findings will be reported to the ED with corrective action warranted.</p> <p>07/01/2011</p>



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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

STATE SURVEY REPORT

Page 7 of 11

NAME OF FACILITY: Foulk Manor South

DATE SURVEY COMPLETED: April 15, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p><b>needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least quarterly form the date of the last full assessment.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on clinical record review and staff interview it was determined that the facility failed to ensure that a care plan was appropriately reviewed and revised to meet the needs of one resident (Resident #7) out of seven sampled. Findings include:</p> <p>Clinical record review revealed that Resident #7 had diagnosis that included degenerative dementia, hyperlipidemia and ambulatory dysfunction. According to the facility quarterly "Data Collection Tool" dated 3/14/11 Resident #7 was alert but exhibited short-term memory and long-term memory problems and "severely impaired" decision-making skills. The above referenced form also indicated that Resident #7 had a "wound" of the right heel.</p> <p>Review of the clinical record revealed "eschar" on the right heel of Resident #7 during completion of a skin assessment on 3/11/11. A wound assessment performed on 4/1/11 at 11:00 AM revealed that the bed of the right heel wound was "black" and the wound was "unstageable". However the right heel wound was debrided and assessed as a Stage 2 pressure ulcer on 4/8/11.</p>	<p><b>3201.6.3.7</b></p> <ol style="list-style-type: none"> <li>(1) R#7 remains in the facility and the eschar was removed by the wound care specialist on 4/8/2011. Wound was healed on 5/6/2011. Care plan has been revised to reflect resident's current status with appropriate interventions.</li> <li>(2) All residents have the potential to be affected by this practice.</li> <li>(3) All license staff will be provided with an educational in-service on the care planning process with emphasis on the importance of revising the care plan to meet resident's current needs. Care plans will be reviewed in the daily clinical meeting whenever there is a reported change in any resident's condition or health status to ensure resident's care needs are met.</li> <li>(4) Weekly Random audits will be completed by the DON/Nurse Designee to ensure that care plans have been initiated or revised to reflect the resident's current needs x3 months then quarterly thereafter. Findings will be reported to the QA committee and corrective action as warranted.</li> </ol> <p style="text-align: right;">07/01/2011</p>



**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-8661

STATE SURVEY REPORT

Page 8 of 11

NAME OF FACILITY: Foulk Manor South

DATE SURVEY COMPLETED: April 15, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201.6.6</p> <p>3201.6.6.1</p>	<p>The care plan, documented as last reviewed on 2/17/11, revealed the identified problem, "Wound: Right heel", was developed on 3/14/11 three days after eschar of Resident #7's right heel was initially observed on 3/11/11. Additionally the facility failed to develop specific goals and interventions that addressed an actual pressure ulcer of the right heel sustained by Resident #7.</p> <p>This finding was reviewed with E1 (executive director) and E2 (regional RN) on 4/15/2011.</p> <p><b>Housekeeping and Laundry Services</b></p> <p>The facility shall maintain a safe, clean, and orderly environment, free from offensive odors, for the interior and exterior of the facility.</p> <p><b>This requirement is not met as evidenced by:</b></p> <ol style="list-style-type: none"> <li>1. Observations on 4/11/2011 at 12:30 PM of the restroom next to the Brandywine Wing nursing station revealed a hole in the bathroom wall. The hole may have resulted from contact with the door handle.</li> <li>2. Observations on 4/11/2011 at 12:45 PM of the Chesapeake Wing Bath revealed that the wiring of the wall heating unit was exposed and on the floor. M2 (Maintenance Worker) stated that the heating unit may have come in contact with a wheelchair.</li> <li>3. Observations on 4/12/2011 at 2:50 PM of resident room #171 revealed an odor. E1 (Executive Director) stated that the resident in B bed needed to be changed. Additionally, the fall cushion was in</li> </ol>	<p>3201.6.6.1</p> <ol style="list-style-type: none"> <li>(1) The hole in the bathroom wall at the Brandywine wing was repaired on 4/11/2011. Wiring of the wall heating unit which was exposed was repaired on 4/11/2011 The resident in room on 171-B at the time of the odor was detected care was immediately changed. Once soiled material was removed the order immediately disappeared. Fall cushion in room 171 was removed and disposed of. A new fall cushion was placed in room 171 on 4/12/2011.</li> <li>(2) All residents have the potential to be affected by this practice.</li> <li>(3) Daily rounds by the maintenance director or designee to identify any problems. Maintenance log was placed at each nurse's station for staff to report maintenance concerns. Staff will be provided education on use of the maintenance log.</li> <li>(4) Environmental rounds to be completed weekly x 2months then monthly by the Maintenance Director/Designee. Findings to be reported to the NHA and will be reviewed in the monthly QA meeting with corrective action as warranted.</li> </ol> <p>07/01/2011</p>



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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

STATE SURVEY REPORT

Page 9 of 11

NAME OF FACILITY: Foult Manor South

DATE SURVEY COMPLETED: April 15, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201.6.9</p> <p>3201.6.9.2</p> <p>3201.6.9.2.4</p>	<p>disrepair. Finally, the bathroom ceiling exhaust was not functioning.</p> <p><b>Communicable Diseases</b></p> <p><b>Specific Requirements for Tuberculosis</b></p> <p><b>Minimum requirements for pre-employment and annual tuberculosis (TB) testing are those currently recommended by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on a review of personnel records on 4/13/2011, the facility failed to maintain a current annual tuberculin (TB) test result for one of ten sampled employees (E12). The date of hire of E12 was 11/2/2009.</p>	<p><b>3201.6.9.2.4</b></p> <p>(1) E12 is no longer employed at the facility.</p> <p>(2) All employee health records to be audited to assure staff have received appropriate tuberculin (TB) testing annually as per the regulations. Issues identified will be immediately corrected.</p> <p>(3) HR manager was re-educated on proper documentation that must be completed prior to new hire employment and employees annually. A tickler file will be implemented on all employees to assure compliance.</p>
<p>3201.7.0</p> <p>3201.7.3.1.3</p>	<p><b>Plant, Equipment and Physical Environment</b></p> <p><b>Hot water accessible to residents shall not exceed 110° F.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Observations on 4/12/2011 revealed the following:</p> <p>At 2:50 PM, the washbasin hot water temperature in resident room #171 was 119.7° F.</p> <p>At 3:00 PM, the washbasin hot water temperature in resident room #174 was 116.4° F.</p>	<p>(4) Quarterly audits to be completed on all employees by the HR Manager to assure compliance with annual employee testing. Findings will be reported to the ED with corrective action warranted.</p> <p style="text-align: right;">07/01/2011</p>



**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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

STATE SURVEY REPORT

Page 10 of 11

NAME OF FACILITY: Foulk Manor South

DATE SURVEY COMPLETED: April 15, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.7.3.4	<p>The facility shall be equipped with a resident call system which meets the current standards of the Guidelines for Design and Construction of Health Care Facilities. An intermediate care facility serving only developmentally disabled residents shall be except from this regulation.</p> <p><b>This requirement is not met as evidenced by:</b></p> <p>1. Observations on 4/11/2011 at 12:25 PM of the Brandywine Wing Tub Room revealed that the call alarm by the toilet was not functioning. M1 (Director of Environmental Services) stated that the issue may be due to moisture in the unit.</p>	<p><b>3201.7.3.1.3</b></p> <p>(1) Hot water temp was adjusted through mixing valve on 04/12/2011.</p> <p>(2) All residents have the potential to be affected.</p> <p>(3) Daily water temps maintained and documented by maintenance director or designee not to exceed 110°F and not to go below 105°F.</p> <p>(4) Random audits monthly and corrective action warranted. Findings to be reported to the QA committee.</p>
3201.7.4	<p><b>Physical Environment Requirements</b></p>	
3201.7.5	<p><b>Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on observations during the tour of the dining room on 4/12/2011, it was determined that the facility failed to comply with sections: 4-203.12 and 4-601.11 (C) of the State of Delaware Food Code.</p> <p><b>4-203.12 Temperature Measuring Devices, Ambient Air and Water.</b></p> <p><b>(B) Ambient air and water temperatures measuring devices that are scaled only in Fahrenheit shall be accurate to ±3°F in the intended range of use.</b></p>	<p>07/01/2011</p> <p><b>3201.7.3.4</b></p> <p>(1) Call alarm was repaired on 4/12/2011.</p> <p>(2) All residents have the potential of being affected by this practice.</p> <p>(3) Weekly call bell checks to be completed by the maintenance director or designee for proper functioning.</p>



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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

STATE SURVEY REPORT

Page 11 of 11

NAME OF FACILITY: Foulk Manor South

DATE SURVEY COMPLETED: April 15, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>1. Observations on 4/12/2011 at 10:30 AM of the dining room refrigerator revealed that a temperature measuring device in the freezer compartment was not available.</p> <p><b>4-601.11 (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</b></p> <p>1. Observations on 4/12/2011 at 10:30 AM of the dining room refrigerator revealed food spills in the refrigerator and freezer compartments.</p>	<p>(4) Findings will be reported to QA committee with corrective action.</p> <p><b>3201.7.5</b></p> <p>(1) On 4/12/2011 the temperature measuring in the freezer was replaced with a new device.</p> <p>On 4/12/2011 the refrigerator was cleaned which revealed food spills.</p> <p>(2) Staff was reeducated on ensuring that the refrigerators remain clean of spills and the thermometer must always be in the refrigerator.</p> <p>(3) Random audits to be completed monthly time two. Findings to be reported to the</p> <p>(4) ED and corrective action as warranted.</p> <p>07/01/2011</p>