STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085019	A. BUILDING _____ B. WING _____	C 01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND MANOR	889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901

(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
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from January 7, 2019 through January 11, 2019. The facility census the first day of the survey was 54. The sample size totaled 35 residents. There were no emergency preparedness deficiencies identified based on observation and interviews.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from January 7, 2019 through January 11, 2019. 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 54. The sample size totaled 35 residents. Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MD-Medical Doctor; UM - Unit Manager; MDS - Minimum Data Set-standardized assessment forms used in nursing homes; NP - Nurse Practitioner; CNA - Certified Nurse's Aide; Definitions: Calcium Alginate - type of wound treatment; Cancer - disease characterized by rapid growth of cells in the body; Lesion - a damaged skin area such as a wound;	F 000		
F 609	Reporting of Alleged Violations	F 609		2/11/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/24/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085019	A. BUILDING _____ B. WING _____	C 01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND MANOR	889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901

(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 609 SS=D	Continued From page 1 CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation it was determined that the facility failed to identify and report an allegation of verbal abuse. Findings include: Abuse and Neglect Prevention policy dated August 2017 includes: .....If an employee is unsure of whether abuse is	F 609	A The Survey Team cited the facility for not reporting an allegation of verbal abuse which at the time, of the incident, the facility did not view the generalized social media post as an actual allegation. Upon further review, this non-reporting citation is deemed as an isolated event, which affected no individual within the facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085019	A. BUILDING _____ B. WING _____	C 01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND MANOR	889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901

(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 609	Continued From page 2 occurring or whether a given set of circumstances represents abuse.....he/she should report it to the management. As a general guide, subsequent to a report the following will occur: 1. The report will be evaluated and investigated 2. If abuse is evident ... c. Report will be forwarded to appropriate agency or agencies 7/21/18 - Date of social media posting which included the following: "They have combative residents but it is a different story when THE NURSING ASSISTANTS DECIDE To cuss back at them and tell them if you hit me you know I will hit you back." 1/10/19 11:21 AM - During an interview with E1 (NHA) and E2 (DON) it was confirmed that the facility gained knowledge of the social media posting which was printed out by the Administrator on 7/22/18 at 2:35 PM. After gaining knowledge of the posting, E1 and E2 stated that the scope of their investigation was based on a disgruntled employee and that a lawyer was contacted for possible slander. There was no evidence that the facility identified an allegation of verbal abuse, resulting in the failure to report the allegation to the state agency. These findings were reviewed during exit conference on 1/11/19 beginning at 2:00 PM with E1 (NHA), E2, E3 (Assistant Administrator) and E4 (ADON).	F 609	warranting no immediate corrective action at this time. B For this particular event, no residents were affected by the cited practice but ultimately all residents have the potential to be affected. Moving forward, as facility becomes aware of any social media posts, that can be construed as an allegation of abuse or mistreatment, a report will be generated according to facility procedure. C At the time of this cited deficiency, facility□s current policy and procedure of reporting an allegation of abuse was appropriate. It was determined that the facility was deficient in not viewing the social media post as an actual allegation. Facility will update current policy and procedure to include social media comments that can be construed as an allegation of abuse or mistreatment that they become aware of, to assure that reporting is done accurately. All individuals involved in reporting allegations of abuse will be educated on this update. D Facility□s Administrator will continue to monitor all reportable incidents to the Division on a continual basis. Administrator will cross-reference any known social media posts with its corresponding report. Facility will strive for 100% success rate and correct any deficient practices as appropriate.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 610		2/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085019	A. BUILDING _____ B. WING _____	C 01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND MANOR	889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901

(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 610	Continued From page 3 must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation it was determined that the facility failed to thoroughly investigate an allegation of verbal abuse. Findings include: Review of the facility investigation/documentation revealed: Abuse and Neglect Prevention policy dated August 2017 includes: .....If an employee is unsure of whether abuse is occurring or whether a given set of circumstances represents abuse.....he/she should report it to the management. As a general guide, subsequent to a report the following will occur: 1. The report will be evaluated and investigated. 7/21/18 - Date of social media posting which included the following: "They have combative residents but it is a different story when THE NURSING ASSISTANTS DECIDE To cuss back at them and	F 610	A The Survey Team cited the facility for not investigating an allegation of verbal abuse which at the time, of the incident, the facility did not view the generalized social media post as an actual allegation therefore facility completed an investigation into what happened on the day in question but not an actual allegation. This is deemed as an isolated event, which affected no individual within the facility warranting no immediate corrective action at this time. B For this particular event, no residents were affected by the cited practice but ultimately all residents have the potential to be affected. Moving forward, as facility becomes aware of any social media posts, that can be construed as abuse or mistreatment, an investigation into an allegation of abuse will be conducted with the information that is received from the comments.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085019	A. BUILDING _____ B. WING _____	C 01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND MANOR	889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901

(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 610	Continued From page 4 tell them if you hit me you know I will hit you back." 1/10/19 11:21 AM - During an interview with E1 (NHA) and E2 (DON) it was confirmed that the facility gained knowledge of the social media posting which was printed out by E2 on 7/22/18 at 2:35 PM. After gaining knowledge of the posting, E1 and E2 stated that the scope of their investigation was based on a disgruntled employee. During the survey, review of numerous staff statements revealed that the facility based their investigation on the character/credibility of the former employee and not whether verbal abuse may have occurred. There was no evidence that the facility investigated an allegation of verbal abuse. These findings were reviewed during exit conference on 1/11/19 beginning at 2:00 PM with E1 (NHA), E2, E3 (Assistant Administrator) and E4 (ADON).	F 610	C At the time of this cited deficiency, facility□s current policy and procedure of investigating allegations of abuse was appropriate. It was determined that the facility was deficient in not viewing the generalized negative social media post as an actual allegation therefore the investigation that was completed was not sufficient. Facility will use current investigation procedures for abuse when it becomes aware of any social media posts that can be construed as abuse or mistreatment, which are deemed to be against company policy. All individuals involved in investigations will be educated to assure that investigations are carried out appropriately. D Facility will monitor to assure that investigations into social media posts that can be construed as abuse or mistreatment, which are deemed against company policy, are conducted as investigations of allegations of abuse. Nursing Admin team will review all investigations over a 3-month period until 100% success rate is achieved.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		1/14/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085019	A. BUILDING _____ B. WING _____	C 01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND MANOR	889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901

(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 656	Continued From page 5 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined that for one (R9) out of 20 sampled residents reviewed for investigation, the facility failed to develop a comprehensive person-centered care plan. Findings include: The following were reviewed in R9's clinical record:	F 656	A The survey team identified an issue regarding R9 stating that a comprehensive person-centered care plan was not developed in relation to an open cancer lesion. Facility created an open cancer lesion care plan and tailored it specifically for the Dx of R9 to satisfy the deficient practice. B All other residents have been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085019	A. BUILDING _____ B. WING _____	C 01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND MANOR	889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901

(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 656	Continued From page 6 6/9/16 - R9 was admitted to facility. 10/19/16 (Revised 5/2/18) - An active Care Plan identifying potential for injuries related to: bruising, skin tears and thin tissue like skin. 7/20/18 - Quarterly MDS assessment documented skin cancer (face) as an active diagnosis. 10/1/18 - Significant Change MDS assessment documented open lesion other than ulcers, rashes, cut (e.g. cancer lesion). Bandaged cancer lesion on right face was observed on the following dates: 1/8/19 - 8:20AM 1/8/19 - 8:43 AM 1/9/19 - 8:34 AM 1/9/19 - 8:38 AM 1/9/19 - 10:00 AM 1/9/19 - 11:00 AM 1/9/19 - 11:29 AM 1/11/19 - 10:40 AM 1/11/19 - 10:52 AM Surveyor interviewed E5 (UM) who stated that "R9 had a slow growing skin cancer on right side of face that was initially removed. Lesion is growing back but is growing fast this time. As per daughter, resident refused to have surgery again. We clean and put calcium alginate with cover. It's very difficult to secure the dressing because the lesion is growing big and it's very close to her right eye. Lesion doesn't usually bleed but there are times when it oozes with drainage and when R9 picks on it at night." 1/11/19 - 1:30 PM Review of medical records lacked evidence that the open cancer lesion on	F 656	assessed and reviewed for open cancer lesions and no other residents were noted to be affected by the deficient practice. C As stated above, an open cancer lesion care plan will be used moving forward. Those individuals responsible for creating care plans were educated on using this new care plan and this will be reviewed quarterly during care plan meetings and as needed. D Nursing Administrative staff will monitor residents with Dx of cancer lesions and implement open cancer lesion care plan as needed. Care plans will be monitored over a 3-month period until a 100% success rate is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085019	A. BUILDING _____ B. WING _____	C 01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND MANOR	889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901

(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 656	Continued From page 7 R9's right side of face was care planned. 1/11/19 - 3:00 PM E2 (DON) confirmed that "There is no care plan identifying the open cancer lesion." The facility failed to develop a care plan addressing R9's skin cancer to right side of face. These findings were reviewed during exit conference on 1/11/19 beginning at 2:00 PM with E1 (NHA), E2, E3 (Assistant Administrator) and E4 (ADON).	F 656		

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: Courtland Manor Inc.

DATE SURVEY COMPLETED: January 11, 2019

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 from January 7, 2019 through January 11, 2019. The facility census the first day of the survey was 54. The sample size totaled 35 residents. There were no emergency preparedness deficiencies identified based on observation and interviews.		
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 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:** Cross refer to CMS 2567-L survey completed January 11, 2019: F609, F610, and F656.	Cross Reference to the CMS 2567-L survey ending 1/11/19: F609, F610, F656	2/11/19

Provider's Signature Maria A Mylo Title ADMINISTRATOR Date 2/11/19