DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Courtland Manor Inc.

DATE SURVEY COMPLETED: February 23, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from February 19, 2024 through February 23, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents, as indicated. The facility census the first day of survey was fifty-seven (57). The survey sample totaled twenty-seven (27) residents.	
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 the CMS 2567-L survey completed February 23, 2024: F656, F657, F676, F692, F693, F695, F791, F802, F812, and F814.	Cross Ref F656, F657, F676, F692, F693 F695, F791, F802, F812, F814

Provider's Signature Lisa Havelaw Title Administrator Date 3-22-2024

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 02/23/2024

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 February 19, 2024 through February 23, 2024. The facility census was 57 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from February 19, 2024 through February 23, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents, as indicated. The facility census on the first day of the survey was fifty-seven (57). The survey sample totaled twenty-seven (27) residents. Abbreviations/definitions used in this part are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; OT - Occupational Therapy; PT - Physical Therapy;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/22/2024

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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F 000	Continued From page 1 RN - Registered Nurse; RNAC - Resident Nurse Assessment Coordinator; SW - Social Worker; UM - Unit Manager. ADL- Activitites of daily living; BIMS (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS score ranges from 0 to 15 with 15 being the best: 0-7: Severe impairment (never/rarely made decisions) 8-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); Care Plan - outlines the plan of action that will be implemented during a patient's medical care; Cognition - mental process; thinking; c/o - complaints of; Chronic obstructive pulmonary disease (COPD)- is a chronic inflammatory lung disease that causes obstructed airflow from the lungs; Dementia - a severe state of cognitive impairment characterized by memory loss Depression - mental disorder with feelings of sadness or a mood disorder that causes persistent feeling of sadness andloss of interest that affects how you feel, think and behave; Enteral feeding tube or G-tube (GT) - tube used to feed resident directly into the stomach and/or to administer medications; Extenisve Assistance - means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance; Interdisciplinary Team (IDT) - a coordinated group of staff from several different fields who work together towards a common goal or project;	F 000		

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F 000	Continued From page 2 Limited Assistance - resident highly involved in activity and received physical help in guided maneuvering of limbs or other non-weight bearing assistance three or more times during the last 7 days; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; Nasal cannula - tube placed into nostrils to deliver oxygen; O2 - Oxygen; Passive Range of Motion (PROM) - extent to which a joint can be moved safely; RP - responsible party; Range of Motion (ROM) - extent to which a joint can be moved safely; s/s - signs/symptoms.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 - (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	F 656		4/9/24

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F 656	Continued From page 3 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of sixteen residents reviewed for care plans, the facility failed to develop and implement a comprehensive resident centered care plan for an identified care area. Findings include: Review of R1's clinical record revealed: 1/24/23 - R1 was admitted to the facility. 1/24/23 - A physician's order was written for R1 to	F 656	A. R1 was not negatively impacted by the deficient practice. Care plan updated for refusals to get out of bed. B. All residents with repeated refusals to get out of bed have the potential of being affected by this deficient practice. A facility wide audit completed to ensure that all residents with repeated refusals to get out of bed have a corresponding care plan. No other residents identified by this deficient practice.	

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F 656	Continued From page 4 use the hoyer lift with assist of two for transfers. A review of the January 2023 and February 2023 CNA task flow sheet revealed that CNA's were marking "not applicable" for transfers. 2/22/24 9:33 AM - An interview with E4 (RN) confirmed that R1 refuses to get out of bed. 2/22/24 10:35 AM - An interview with E12 (CNA) revealed that R1 refused to get out of bed regularly despite staff offering to get R1 out of bed. The facility lacked evidence of developing and implementing a person centered care plan related to R1's repeated refusals to get out of bed. 2/23/24 2:50 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F 656	C. Root Cause Analysis determined to be due to staff not comprehending the coding accurately when there is repeated refusals and care plan not being revised. ADON/Designee will in-service The C N A□s on the importance of understanding coding when a resident refuses to get out of bed. The MDS Coordinator and Licensed nursing staff will receive additional training education from the DON/ designee on the importance of ensuring comprehensive care plans are in place for repeated refusals to get out of bed. D. The Nursing Administration/Designee will randomly audit care plans for residents who refuse to get out of bed. Random audits will continue once weekly x 4 weeks then monthly audit x 3 until 100% compliance is achieved and sustained. Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee to review the process and revision will be made to maintain and sustained compliance.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		4/9/24

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F 657	Continued From page 5 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for eight (R3, R7, R9, R10, R14, R27, R32 and R53) out of of sixteen (16) sampled residents, the facility failed to have input from all required interdisciplinary team (IDT) members at the residents' care plan meetings. In addition, R53's nutrition risk care plan was not revised. Findings included: 1. Review of R3's clinical record revealed: 5/25/05 - R3 was admitted to the facility. 2/21/24 - A review of quarterly care plan meetings for the following dates 1/12/23, 4/6/23, 6/29/23,	F 657	A. R 27,10,14,9,7,3,53,32 was not negatively impacted by the deficient practice. R 53 nutritional risk care plan revised. B. All residents scheduled for a care plan meeting have the potential of being affected by the deficient practice. The facility will incorporate input from CNA and physician at the resident's quarterly care plan meeting. Residents who are at nutritional risk will have their care plan reviewed and revised.	

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F 657 Continued From page 6

9/21/23 and 12/14/23 lacked evidence of input from the Physician and the CNA.

2. Review of R7's clinical record revealed:

8/25/22 - R7 was admitted to the facility.

2/22/24 - A review of quarterly care plan meetings for the following dates 3/6/23, 6/8/23, 8/31/23 and 1/4/24 lacked evidence of input from the Physician and CNA. A review of a quarterly care plan meeting on 11/22/23 lacked evidence of input from the Physician, dietary and the CNA.

3. Review of R9's clinical record revealed:

8/14/08 - R9 was admitted to the facility.

2/21/24 - A review of quarterly care plan meetings for the following dates 2/23/23, 7/20/23, 10/12/23 and 1/4/24 lacked evidence of input from the Physician and the CNA. A review of a quarterly care plan meeting on 4/27/23 lacked evidence of input from the Physician, activities and the CNA.

4. Review of R10's clinical record revealed:

6/17/16 - R10 was admitted to the facility.

2/21/24 - A review of quarterly care plan meetings for the following dates 1/23/23, 4/6/23, 6/29/23, 9/21/23 and 12/14/23 lacked evidence of input from the Physician and the CNA.

5. Review of R14's clinical record revealed:

8/14/15 - Resident was admitted to the facility.

2/22/24 - A review of quarterly care plan meetings

F 657

C. Root Cause Analysis was determined to be due to lack of understanding of the requirement for the CNA and physician to be involved in the care plan meeting.

DON/Designee will in-service IDT members on the importance of obtaining input from the IDT in resident care plan meetings.

D. Nursing Administration/designee will randomly audit care plan meeting sheets to ensure the IDT was involved in the meeting. Random audits will continue once weekly x 4 weeks then monthly audit x 3 until 100% compliance is achieved and sustained.
Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee to review the process and revision will be made to maintain sustained compliance.

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F 657	Continued From page 7	F 657		

Continued From page 7
for the following dates 2/23/23, 4/27/23, 7/10/23, 10/12/23 lacked evidence of input from the Physician and the CNA.

6. Review of R27's clinical record revealed:

8/6/20 - Resident was admitted to the facility.

2/22/24 - A review of quarterly care plan meetings for the following dates 3/30/23, 6/22/23 and 9/14/23 lacked evidence of input from the Physician and the CNA. A review of a quarterly care plan meeting on 11/22/23 lacked evidence of input from the Physician, dietary and the CNA.

7. Review of R32's clinical record revealed:

12/28/21 - Resident was admitted to the facility.

2/21/24 - A review of quarterly care plan meetings for the following dates 4/6/23, 6/29/23 and 9/21/23 lacked evidence of input from the Physician and the CNA. A review of a quarterly care plan meeting on 12/14/23 lacked evidence of input from the Physician, dietary and the CNA.

2/22/24 approximately 11:10 AM - When asked if E7 (CNA) attends care plan meetings, E7 responded, "No, should I?" E7 said she was a newer employee, however, so E7 didn't know if she was supposed to attend.

2/22/24 approximately 11:50 AM - When asked if E8 (CNA) attends care plan meetings, E8 said she was unsure what this was. The Surveyor explained they are quarterly IDT meetings where the resident's care plan was discussed. E8 stated she was a newer employee and wasn't sure about whether she would attend.

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F 657	Continued From page 8 2/22/24 12:03 PM - When asked if CNAs attend care plan meetings or provide input, E9 (CNA) stated, "No we don't." 2/23/24 9:09 AM - During an interview, E6 (SW) and the Surveyors confirmed that the mandatory IDT consists of the treating provider, the nurse who cares for the resident, the CNA who cares for the resident, a dietary staff, and activities staff member. The Surveyors pointed out that although the care plan meetings are held consistently, in most meetings, neither the treating provider nor the CNA participated. 8. Review of R53's clinical record revealed: 4/3/23 - R53 was admitted to the facility. 2/22/24 - A review of quarterly care plan meetings for the following dates 4/4/23, 6/15/23, 9/7/23, 11/30/23 and 2/22/24 lacked evidence of input from the Physician and the CNA. 2/23/24 9:09 AM - During an interview, E6 (SW) confirmed that the mandatory IDT consists of the treating provider, the nurse who cares for the resident, the CNA who cares for the resident, a dietary staff, and activities staff member. E6 confirmed that the care plan meetings for R53 lacked the Physician and the CNA's input. 2/23/24 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive	F 676		4/9/24

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F 676	Continued From page 9 assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R53) out	F 676	A. R 53 was assessed by therapy and any assistance recommended was	

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F 676	Continued From page 10 of one resident reviewed for assistance with ADL's, the facility failed to provide cueing, prompting or assistance to R53 while she was eating her lunch. Findings include: Cross refer to F692 and F810 Review of R53's clinical record revealed the following: 4/3/23 - R53 was admitted to the facility with various diagnoses, including dementia. 4/10/23 (revised 11/27/23) - A care plan was developed for R53's nutritional problem related to general condition with interventions, including but not limited to "...assist resident as needed...encourage resident to eat...encourage resident to feed self 75% of meal...staff to finish feeding meal PRN (when necessary) if resident will allow...". 11/24/23 - R53's quarterly MDS assessment revealed that R53's cognition was severely impaired. In addition, R53 required setup and/or clean up assistance for eating and was noted with behavioral symptoms including throwing or smearing of food. 2/19/24 12:19 PM through 12:30 PM - During multiple dining observations in the facility's main dining room, R53 was seen seated at the table with a plate of pureed food served by E16 (Dietary Staff) in front of her. Unsupervised and unattended, R53 was observed picking up her spoon, but the spoon fell on the plate. R53 continued to do this and the spoon repeatedly dropped on the table. R53 was next observed scooping the pureed food on her plate and	F 676	provided. B. Any resident who needs assistance with eating has the potential of being affected by the deficient practice. All residents needing assistance with eating will be reviewed and referred to therapy as indicated. C. The root cause was determined to be lack of oversight and understanding by staff when a resident needs assistance with eating and the need for referral to therapy if an adaptive utensil for feeding is needed . Nursing staff will be provided additional education on notification of nurse management when a resident needs more assistance/supervision, and when to refer to therapy for adaptive utensil. D. Nursing Administration/designee will randomly audit residents to ensure residents needing assistance and assistive device with meal is in place. Random audits will continue once weekly x 4 weeks then monthly audit x 3 until 100% compliance is achieved and sustained. Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee to review the process and revision will be made to maintain sustained compliance.	

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F 676 Continued From page 11 F 676

ingesting it, licking her hands.

2/19/23 12:30 PM - FM1 (R53's family member) entered the dining room and walked towards R53. R53 remained unattended and unsupervised, and was actively scooping the pureed food on her plate and ingesting it. FM1 took a seat at R53's table and started telling R53 to use the spoon, as he guided her right hand to pick up the spoon. Successive observation revealed that R53 attempted to use the spoon to scoop her vanilla pudding from the cup, but the spoon dropped on the plate. R53 then attempted to drink the vanilla pudding from the cup.

2/19/23 12:33 PM - Facility staff, E12 (CNA) and E18 (CNA), were observed attending to R53 to clean and wipe her hands, but both CNAs left leaving FM1 to continue cueing R53 to use the spoon to scoop her pureed food.

2/19/23 12:38 PM - In an interview, FM1 stated that (R53) has dementia and has difficulty using the spoon for scooping food. FM1 further stated that, "...The nursing staff should continue to supervise (R53) while she is eating because she is making a mess while scooping the food with her hands. This happened before one time when I visited her in the hall and they (nursing staff) left her alone eating in the TV room making a mess with her food and her hands. She is not eating well and losing weight." FM1 continued to state that, "(R53) has trouble using the regular spoon - with her dementia and increased weakness, she needs a wide handled spoon to make it easy for her to pick it up and scoop her food. I don't know how the nursing staff here can get it done for mother (R53). Someone has to look at her and see if she can use that kind of device."

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	085019	A. BUILDING ____ B. WING ____	C 02/23/2024

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F 676	Continued From page 12 2/19/23 12:55 PM - During an interview, E18 (CNA) stated that, "...Resident [R53] is needing assistance now with feeding. E18 (CNA) continued to state that she reports to the nurse if a resident needs a feeding device. E18 further confirmed that resident [R53] needed an assistive device for feeding and that she will let the nurse know. 2/20/24 3:30 PM - Findings were discussed with E1 (NHA) and E2 (DON). 2/23/24 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F 676		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when	F 692		4/9/24

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F 692	Continued From page 13 there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R53) out of two residents reviewed for nutrition, the facility failed to identify and assess a significant weight loss. Additionally the facility failed to increase a nutritional supplement as requested by the RD. Findings include: Cross Refer to F676 and F810 Review of R53's clinical record revealed: 4/3/23 - R53 was admitted to the facility. 4/7/23 - A physician's order was written for regular diet, pureed texture, thin consistency, with extra calories. 4/10/23 - A care plan was created for nutrition risk potential related to general condition with the following interventions: allow enough time to finish meals; assist resident as needed; encourage resident to feed self 75% of meal; evaluate ability to swallow, etc. 6/22/23 - A physician's order was written for two cal one time a day for supplement give four ounces. 11/30/23 - A quarterly MDS assessment revealed that R53 was a set up and/or clean up assistance with eating and the resident completes the task. 12/4/23 - A review of the weight and vitals in the EMR revealed that R53 weighed 85.2 pounds.	F 692	A. R3 was assessed by reweight and dietician notified. Dietary recommendation implemented. B. All residents with monthly weight/reweight will be reviewed. Residents with significant weight loss will be reviewed by dietitcian and dietary recommendations as applicable. C. The root cause was determined to be lack of oversight with regards to meal intakes and actual weight loss. The Dietician/Designee will be in-serviced by the Regional Dietician/Designee on poor intake monitoring and significant weight loss. Nursing staff will be in-serviced on weight process in collaboration with the Dietician. The root cause for the supplement not being carried out was determined to be due to oversight by the provider of the recommendation. Dietician/Designee will be in-serviced by the Regional Dietician on proper ordering process for recommendations. Licensed Nurse will be educated on reviewing of recommendations to providers and confirming recommendations in the EHR. D. Nursing administration/Designee will review recommendations from the	

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F 692	Continued From page 14 12/2023 - A review of meal intake for December 2023 revealed that R53 consumed an average of 75-100% and 14 meals were 25% or less or refused. 1/23/24 - A review of the weight and vitals in the EMR revealed that R53 weighed 76.0 pounds. This is a 10.8% or 9.2 pounds loss from 12/4/23. 1/2024 - A review of meal intake for January 2024 revealed that R53 consumed an average of 75-100% with 32 meals were 25% or less or refused. The facility lacked evidence of a reweigh for R53 to verify the weight loss. There was no evidence in the clinical record that the dietitian or the doctor were consulted about the significant weight loss. 2/18/24 3:09 PM - A progress note from E13 (dietition) revealed R53 had a weight loss of 9.2 pounds between December 2023 and January 2024. E13 recommended an increase of supplement to twice a day. This was twenty-six days after the initial weight loss. 2/23/24 - Review of the physician's orders revealed that the supplement was not increased based on the 2/18/24 request. 2/23/24 10:41 AM - During an interview, E13 confirmed that a request for an increase in R53's supplement was submitted and was unsure why the order was not put in yet. E13 stated that she will take care of it today. 2/23/24 11:00 AM - E13 provided documentation that the request for R53's increase in supplement	F 692	Dietician 3x a week until compliance is achieved. Following will be a monthly audit x 3 consecutive months until a 100% compliance is achieved. Results of all audits will be presented to the Quality assurance and Performance Improvement Committee to review the process and revision will be made to maintain sustained compliance.	

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F 692	Continued From page 15 was given to the practitioner on 2/21/24 and no order noted. The order was entered into R53's electronic medical record after a phone call was placed to the practitioner. 2/23/24 - A review of the weight and vitals in the EMR revealed that R53 weighed 80 pounds. The facility failed to recognize R53's significant weight loss, which resulted in a delay of interventions to correct the weight loss. 2/23/24 2:50 PM - Finding was reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia,	F 693		4/9/24

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F 693	Continued From page 16 diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that for one (R34) out of one resident reviewed for enteral (tube used to feed resident directly into the stomach) feeding, the facility failed to ensure that R34, received the appropriate treatment to prevent potential complications of enteral feeding. Findings include: Review of R34's clinical record revealed: 8/6/23 - R34 was admitted to the facility with difficulty of swallowing. 11/17/23 - R34's comprehensive MDS assessment revealed that R34's cognition was severely impaired and was dependent on one staff member for assistance. R34 was receiving enteral feeding. 2/5/24 - R34 had a physician's order for Jevity 1.5 to run at 45 ml/hr (milliliters/hour) up at 10:30 AM and down at 6:30 PM. 2/19/24 9:46 AM - In an observation in R34's room, E14 (LPN) was observed setting R34's feeding pump flow rate at 45 ml/hr. 2/19/24 9:47 AM - E14 was observed infusing an unlabeled enteral bottle of approximately 400 ml of enteral feeding formula into R34's enteral tube. An unlabeled bottle with approximately 200 ml of enteral feeding formula was also found on R34's bedside table.	F 693	A. R34 had no negative effects ; E14 was educated on facility policy and procedures on correctly labeling enteral feeding formula. B. Current residents with enteral feeding orders have the potential to be affected. All current residents with enteral feeding orders have been reviewed to assure that feeding bag or bottle has resident name, name of feeding formula, flow rate and date/time new bag/bottle initiated. No other residents have been affected by the deficient practice. C. The root cause was determined to be due to staff not following the facility policy/procedure to ensure the enteral feeding were appropriately labeled. Nursing administration will provide nurses with additional education on how to correctly label enteral feeding formula. D. Nursing Administration/designee will review residents with enteral feedings to ensure that enteral feeding is labeled correctly. Random audits will continue once weekly x 4 weeks then monthly audit x 3 until 100% compliance is achieved and sustained. Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee to review the process and revision will be made to	

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F 693	Continued From page 17 2/19/24 9:48 AM - During an interv ew, E14 stated that she assumed it was the Jevity 1.5 feeding bottle that the previous shift used. E14 also confirmed that the enteral bottle infusing on R34's enteral tube was not labeled. E14 further stated that it's the facility's standard of practice to label the feeding bag or feeding bottle with the resident's name, name of the feeding formula, flow rate and the date and time that the new bottle or bag was initiated. 2/20/24 3:30 PM - Findings were discussed with E1 (NHA) and E2 (DON). 2/23/24 2:50 PM - Findings were reviewed with E1, E2 and E3 (ADON) during exit conference.	F 693	maintain sustained compliance.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for two (R1 and R17) out of two sampled residents for respiratory care, the facility failed to maintain oxygen as ordered. Findings include: 1. Review of R1's clinical record revealed:	F 695	A. R17,1 was not negatively impacted by the deficient practice. The oxygen tubing was immediately changed and date indicated. B. All residents using oxygen have the potential of being affected by this deficient practice. Residents receiving oxygen	4/9/24

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F 695	Continued From page 18 1/24/23 - R1 was admitted to the facility with a diagnosis of chronic obstructive pulmonary disease (COPD). 1/24/23 - A physician's order was written for continuous oxygen at 1.5 L/min (Liters per minute) via nasal cannula. 2/20/24 10:33 AM - An observation of R1's oxygen tubing revealed R1 was receiving oxygen via nasal cannula and the tubing had no date or label. 2/21/24 11:49 AM - An observation of R1's oxygen tubing revealed R1 was receiving oxygen via nasal cannula and the tubing had no date or label. 2/22/24 9:39 AM - An observation of R1's oxygen tubing revealed R1 was receiving oxygen via nasal cannula and the tubing had no date or label. 2/22/24 10:31 AM - During an interview, E4 (RN) revealed that R1 did not have an order for tubing change weekly and confirmed no date on current oxygen tubing. 2. Review of R17's clinical record revealed: 1/4/18 - R17 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (COPD), shortness of breath and wheezing. 6/11/21 - A physician's order was written for oxygen 2 L (Liters) via nasal cannula as needed for complaint of shortness of breath. May titrate up to 3 L. Check oxygen saturation every four	F 695	therapy were reviewed. No other residents were affected by this deficient practice. C. Root Cause Analysis determined staff lacked understanding of the importance of ensuring oxygen tubing was labeled and dated weekly as per facility protocol. An audit of all residents' using oxygen was completed to ensure orders are in place to change, date tubing weekly. Nurses provided additional education regarding the need to ensure orders and MAR reflects the need to change, date the tubing weekly. D. Nursing Administration/designee will audit residents who use oxygen to ensure that the tubing is changed weekly and dated. Random audits will continue once weekly x 4 weeks then monthly audit x 3 until 100% compliance is achieved and sustained. Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee to review the process and revision will be made to maintain sustained compliance.	

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F 695	Continued From page 19 hours for forty-eight hours to maintain oxygen saturation 92% or greater. 9/30/22 - A physician's order was written when oxygen in use, change nasal cannula tubing weekly and as needed every night shift every Monday. The facility lacked evidence of oxygen tubing change from 6/11/21 to 9/30/22. 2/22/24 9:35 AM - An observation of R17 using oxygen connected to a concentrator and no label noted on tubing. 2/23/24 8:42 AM - An observation of R17 using oxygen connected to a concentrator and no label noted on tubing. 2/23/24 9:50 AM - During an interview, E5 (RN) confirmed the tubing was not labeled or dated. E5 confirmed that the MAR was signed off but the tubing did not have a label. 2/23/24 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F 695		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an	F 791		4/9/24

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F 791	Continued From page 20 outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for two (R3 and R57) out of three sampled residents for dental services, the facility failed to assist the residents	F 791	A. R 57,3 were offered dental services and appointment scheduled. B. All residents have the potential to be	

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F 791	Continued From page 21 in obtaining routine dental services. Findings include: 1. 5/25/05 - R3 was admitted to the facility. 1/16/24 - A progress note revealed that "Resident's molar fell out this shift. No bleeding noted. No c/o (complaint of) or s/s (signs or symptoms) of pain or discomfort." 1/17/24 - A progress note revealed "Communication with Family Note test: RP (responsible party)... of molar that fell out on its own on 1/16/24. Still no pain or bleeding noted." 2/19/24 9:59 AM - During an interview, R3 said that his teeth are "decaying". R3 said that several have fallen out. 2/20/24 - A progress note revealed "Resident's RP called with the date and time for resident's dental appointment. This Thursday on 2/22/24 at 8:00 AM with (name and address of dental office). This information was related (sic) to the Unit RN for transportation scheduling." 2/20/24 3:27 PM - A progress note revealed "SW called resident's RP back and informed her per Nursing that in the attempt to schedule resident's transportation for the dentist this Thursday, transportation needs advanced notice of 72 hours. The RP stated she would call and try to reschedule the appointment for next week." 2/21/24 10:27 AM - An Orders administration note revealed "Reschedule dentist appointment one time only for 2 Days. Per RP she was rescheduling appt, (appointment) will follow up with RP today."	F 791	affected by this deficient practice. A facility wide audit was completed to ensure that residents were offered annual dental consultation if desired and any resident with dental issues have been referred to a dentist per responsible party consent. C. The Root Cause Analysis determined Communication of resident need for dental services further compromised by responsible party involvement in scheduling appointment for dental services/transport process and lack of staff understanding related to required and timely dental consultation. The policy/procedure has been up dated to reflect offering annual or as needed dental evaluation. Social Services/Designee will ensure a tracking is in place to ensure all residents are offered annual dental services. D. Nursing Administration/designee will audit residents to assure that annual dental consults have been provided and those with concerns about dental or oral concerns are addressed. Random audits will continue once weekly x 4 weeks then monthly audit x 3 until 100% compliance is achieved and sustained. Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee to review the process and revision will be made to maintain sustained compliance.	

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F 791	Continued From page 22 2/21/24 11:07 AM - During an interview, E10 (RN) stated that R3's dental complaints are new. R3 has not complained of pain to her. R3's (family member title) is his RP and she will make the dentist appointment. The facility does not have a dentist in house. The resident's RP makes the appointment and then transportation is arranged by nursing. 2/21/24 11:10 AM - A progress note revealed the following: "Spoke with resident RP. She is still working on getting resident dental appt rescheduled. She will contact us when she has made the appt." 2/23/24 9:09 AM - During an interview, E6 (SW) stated that the facility goes through the resident's representative, who schedules the dental appointment. There was no onsite dentist. The nurse will then schedule transportation. E6 believes a dental evaluation was offered yearly, but she was not sure where or if this was documented. E6 stated that most residents are able to tell staff if they want to see the dentist. 2/23/24 9:25 AM - During an interview, R3 stated that he has to go to "them" (staff) for a dental evaluation to be scheduled. R3 stated that no one asks him if he would like a dental visit. R3 said he told staff at that time that the tooth fell out that he would like to see a dentist. R3 said this has happened before. 2/23/24 11:12 AM - During an interview, E11 (RN) said that if resident had asked to see the dentist, it should have been documented in the medical record. E11 stated that R3 has had teeth fall out before. R3 was not complaining of pain and has	F 791		

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COURTLAND MANOR	**889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901**

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F 791	Continued From page 23 not had any problems eating. E11 said she will follow up with RP today about the appointment. E11 believes there was a delay in resident getting to the appointment due to transportation. 2/23/24 12:58 PM - During an interview, E11 (RN) stated that RP was supposed to have called in the morning about the appointment, but so far she hasn't. E11 said that usually RP calls later in the day, but if she doesn't hear from her, she will call herself. Surveyor and E11 discussed the need for a dental evaluation to be offered annually and then the facility can then document the resident's refusal or acceptance of the evaluation. 2. Review of R57's clinical record revealed: 1/8/24 - R57 was admitted to the facility. 1/9/24 - An admission MDS assessment was completed for R57 and indicated no broken or loose fitting dentures, no natural teeth or broken teeth and no mouth or facial pain. 2/19/24 9:43 AM - During an interview and observation revealed that R57 had several missing teeth and was waiting to see a dentist related to obtaining dentures. 2/23/24 9:17 AM - During an interview, E6 (SW) revealed that the facility requires the responsible party to make dental appointments. The facility will assist with transportation to appointments once the responsible party makes the appointment. E6 confirmed that R57 has not had a dental appointment or record that one has been offered. 2/23/24 2:50 PM - Findings were reviewed with	F 791		

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F 791	Continued From page 24 E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F 791		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on document review and interview, it was determined that the facility failed to provide a sufficient number of staff qualified to safely and effectively provide food and nutrition services. Findings include: 2/19/24 9:48 AM - Interview with E1 (NHA) revealed that only two members of the Kitchen staff were in possession of a current Food Protection Manager's certification from an accredited Food Safety program, and that neither of them were present in the kitchen during this	F 802	A. No resident harmed by lack of staff member with a current Food Protection Mangers Certification form an accredited Food Safety Program. The one expiration date of 2/29/24 updated with expiration date of 2/23/2029. B. All residents have the potential of being affected by this deficient practice and none noted to be affected through Food Committee or Resident Committee.	4/9/24

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F 802	Continued From page 25 day's morning and mid-day meal preparation. A staff person with a current Food Protection Manager's certification from an accredited Food Safety program must be on duty during every meal service. 2/19/24 12:25 PM - Document review revealed that one (1) of the two (2) Food Protection Manager certificates had an expiration date of 2/19/24. 2/19/24 2:43 PM - Findings were confirmed with E1 (NHA).	F 802	C. Root Cause analysis determined that when staff vacancy occurs the number of employees with ServSafe certification declined. A weekly dietary staffing report to include new hires with ServSafe Certification will be forwarded to the administrator for review. On 2/19/2024 the Administrator provided dietary staff with additional education that ServSafe Certification. D: The administrator/designee will audit employee ServSafe Certification. Random audits will continue once weekly x 4 weeks then monthly audit x 3 until 100% compliance is achieved and sustained. Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee to review the process and revision will be made to maintain sustained compliance.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		4/9/24

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F 812 Continued From page 26
from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined that the facility failed to ensure food was stored, prepared and served in a manner that prevents foodborne illness to the residents.
Findings include:

2/19/24 8:57 AM - During the initial tour of the kitchen, the walk-in refrigerator contained the following undated items: turkey lunchmeat, individual serving size pies, which had no protective covering, green peas, and baked potatoes. Containers of thickened juice, regular juice, and gravy were noted with expired "use by" dates.

2/19/24 10:39 AM - During a tour of the kitchen, there was some sugar and coffee grounds spilled on the floor below one of the prep tables.

2/19/24 11:48 AM - A block of butter was left uncovered on a prep-table for more than three (3) hours allowing possible contamination from dust, debris, and other contaminants.

2/19/24 1:23 PM - During a review of the food temperature logs, the facility kitchen records had no food temperatures recorded for twenty-four (24) meals out of two-hundred seventy-six (276) meals sampled. Temperatures of cooked foods and cold ready to eat foods were not being consistently recorded prior to being served. Fish, meat, and poultry must be heated to an

F 812

A. No residents affected by the deficient practice.
The walk-in Refrigerator undated items-turkey lunch meat, individual serving size pies with no protective covering, green peas, and baked potatoes, containers of thickened juice, regular juice and gravy were discarded immediately. All items dated with use by dates. The sugar and coffee grounds spilled on the floor below a prep table was cleaned up immediately. The block of butter discarded immediately.
The food temperatures taken and recorded prior to meal service.

B. All residents have the potential of being affected by this deficient practice.

C. The root cause was determined to be due to staff not following policy/procedure to properly store, prepare, distribute and serve. All dietary staff received additional education on 3/19/2024 by Administrator on ensuring food is stored, prepared and served in a manner that prevents foodborne illness to the residents.

D. The Dietary Manager/designee will audit how food is stored, prepared, distributed, and served. Random audits will continue once weekly x 4 weeks then

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F 812	Continued From page 27 appropriate specific temperature depending on the type of food and the method used to prepare it. Vegetables must be heated to one hundred thirty-five (135) degrees Fahrenheit (F), and cold ready to eat foods must be held below forty-one (41) degrees (F) to maintain food safety. 2/19/24 2:43 PM - Findings were confirmed with E1 (NHA).	F 812	monthly audit x 3 until 100% compliance is achieved and sustained. Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee to review the process and revision will be made to maintain sustained compliance.	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure garbage and refuse were disposed of properly to prevent pest invasion. Findings include: 2/19/24 9:34 AM - During the initial tour of the kitchen, two large garbage cans were not in use, but were uncovered. 2/19/24 11:57 AM - Subsequent tours of the kitchen revealed the two garbage cans remained uncovered throughout the day. 2/19/24 2:43 PM - Findings were confirmed with E1 (NHA).	F 814	A. No residents identified as being affected by the deficient practice. The 2 large garbage cans are covered when not in use. B. All residents have the potential to be affected by the deficient practice. Lids attached to each garbage can for ease of covering. The Dietary Manager/designee will complete observation rounds daily to ensure the garbage cans are covered when not in use. C. Root Cause Analysis determined to be due to staff not following protocols for preventing pest invasion by covering the garbage cans when not in use. All dietary staff received additional education on 2/19/2024 for covering garbage cans when not in use to prevent pest invasion. The Dietary Manager/designee will complete observation rounds daily to	4/9/24

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F 814	Continued From page 28	F 814	ensure the garbage cans are covered when not in use. D. The Dietary Manger/designee will be audit for having garbage cans covered when not in use. Random audits will continue once weekly x 4 weeks then monthly audit x 3 until 100% compliance is achieved and sustained. Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee to review the process and revision will be made to maintain sustained compliance.	