DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
Cambridge Building
263 Chapman Road Suite 200
Newark, DE 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Courtland Manor Inc. **DATE SURVEY COMPLETED:** September 26, 2022

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 September 20, 2022 through September 26, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 52. The survey sample totaled 24 residents.		
3201.0	**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 the following:** Cross refer to CMS 2567-L survey completed September 26, 2022: F679, F684, F695 and F812.	Cross Reference to the CMS 2567-L survey ending September 26, 2022: F679, F684, F695, F812	10/18/22

Provider's Signature ____ Title ADMINISTRATOR Date 10/18/22

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 09/26/2022

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 September 20, 2022 through September 26, 2022. The facility census was 52 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, 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 found.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from September 20, 2022 through September 26, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 52. The survey sample totaled 24 residents. Abbreviations/definitions used in this report are as follows: ADL - Activity of Daily Living; ADON - Assistant Director of Nursing; ANHA - Assistant Nursing Home Administrator; CNA - Certified Nurse's Aide; Cognitively impaired - mental decline including losing the ability to talk or write, resulting in the inability to live independently; DON - Director of Nursing; FSD - Food Service Director;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/18/2022

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 Geri-chair - a wheelchair type chair that reclines; Kardex - plan of care for individual residents; LPN - Licensed Practical Nurse; MDS (Minimum Data Set) - a standardized set of assessments completed in nursing homes; Nasal cannula - a tube placed into the nostrils to deliver oxygen; NHA - Nursing Home Administrator; Parkinsons's Disease - a progressive disorder of the nervous system that affects your movement or a disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement, and coordination; PRN - as needed; RN - Registered Nurse; Ted hose - elastic stockings that help to prevent blood clots and swelling in the legs.	F 000		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R23) out of three residents reviewed for activities, the facility failed to provide an ongoing program of activities designed to meet the resident needs in	F 679	A The survey team identified two issues in regards to one resident (R23): 1. The survey team cited that the facility failed to provide an ongoing program of activities designed to meet resident	10/18/22

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F 679	Continued From page 2 accordance with the comprehensive assessment and plan of care. In addition, the facility activity staff were unaware of where to locate the resident activity preferences. Findings include: An undated policy entitled Activity Care plan included: Long term (activity) goals should be appropriate to residents needs. Review of R23's clinical record revealed: 9/9/16 - R23 was admitted to the facility with Parkinson's Disease and dementia. 1/24/17 - A care plan for activities included "Resident Likes: Music (variety), Sing-a-longs, listening to music/CD's/VCR, videos, being read to, watching/listening to TV (documentaries, musicals, (train rides) and courtyard visits (weather permitting). Will engage in aspects of Tranquil Stimulation program that can be provided on an individual basis." 7/29/22 - A quarterly MDS assessment documented that R23 had severe cognitive impairment, was unable to speak and was dependent on staff for all care. 9/20/22 10:29 AM - During an observation, R23 was in the section C television room staring blankly at the ceiling. R23 was not engaged in meaningful or preferred activities. Although E18 (Activity Assistant) was in the television room, R23 was not engaged and was without staff interaction for approximately twenty minutes. 9/21/22 2:20 PM - During an observation, R23 was in bed staring aimlessly at the ceiling without meaningful activity. There was no music or	F 679	needs. This is deemed as an isolated incident for R23 as the facility does provide ongoing programming on a daily basis including one to one activities for residents. 2. The survey team cited that the facility activity staff were unaware of where to locate the resident activity preferences for R23. This is deemed as an isolated incident as only 1 activity staff member was asked and that activity staff member did not provide the correct answer. Activity preferences are reviewed in the morning and a book of preferences is located on each activity cart. B All other residents have the potential to be affected by the deficient practices listed, though no other residents were identified at this time. C All activity staff have been in-serviced, as a reminder, on both resident engagement and where activity preferences of the residents are located. No system changes are needed at this time as correction can be made through education. D Activity Director will conduct 3 audits per week of multiple staff members to make sure residents are remaining engaged in programs and to make sure activity preferences are on hand during programming. Once a success rate of 100% is achieved over a 4 week span audits will be concluded and checks will be done periodically to maintain compliance.	

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F 679	Continued From page 3 television provided to R23. The room was silent. 9/22/22 8:57 AM - During an observation, R23 was in the right corner of the television room on the C unit reclined in a geri-chair, eyes open and staring up toward the ceiling. The television was on, but R23 was not turned the right way to be able to see it. 9/22/22 11:18 AM - R23 was observed in the corner of the television room, in a geri-chair with her mask up over her eyes. E18 (Activity Assistant) was sitting at a table in front of the television watching a game show with R36 and R48 and was not interacting with any other residents. R23 was in the back of the room at a table, turned towards the wall without meaningful interaction. 9/22/22 11:28 AM - Although E18 was still in the television room, R23 remained in the corner of the room without meaningful activity. R23 continued to have her mask up over her eyes. 9/22/22 11:34 AM - During an interview, E18 (Activity Assistant) revealed that she was not aware of a kardex or anything for the activity staff to have knowledge of the activity interests for each of the residents. E18 further revealed she finds out what the resident's activities and interests are by asking them (the residents) or from other staff. When asked by the Surveyor what if the resident could not tell you due to being non-verbal, E18 was unable to state where to find the information. E18 stated that activity staff do not have access to the resident care plans. When asked what activities R23 was interested in, E18 stated that she did not know, but she thought it might be music. E18 stated that the residents in	F 679		

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F 679	Continued From page 4 geri-chairs were usually asleep. E18 stated that she was not sure if E6 (Activity Director) could supply her with a list of resident interests, but she could ask E6. The Surveyor informed E18 that R23 had her mask up over her eyes and was not included in any activity. E18 looked at R23, continued to watch the game show, and engaged only with R36 and R48. 9/22/22 11:52 AM - E19 (CNA) entered the television room, was approximately five feet away from R23. E19 failed to identify that R23's mask was covering her eyes and the resident was not engaged in an activity. 9/22/22 12:17 PM - During an interview, E6 (Activity Director) confirmed the facility did not have a kardex with resident interests for the Activity Assistants, but they are discussed in morning meeting. E6 stated that she could provide Activity Aides with resident preferences for activities. The Surveyor informed E6 that R23 was observed for three days without any activity or stimulation. E6 stated the facility had a program for impaired residents that included massage, gentle touch, music etc. and the "Tranquil Program" would be starting up again tomorrow (9/23/22). E6 confirmed that R23 had not been receiving individualized activities, including the Tranquil Program related to COVID. 9/26/22 9:19 AM - During an observation, R23 was again at a back table in the television room alone and not engaged in any activity. Findings were reviewed with E1 (NHA), E2 (ANHA), and E3 (DON) during the exit conference on 9/26/22 beginning at approximately 12:30 PM.	F 679		

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R49) out of one resident reviewed for activities of daily living, the facility failed to apply R49's ted hose per the physician's order. Findings include: Review of R49's clinical record revealed: 1/6/20 - R49 was admitted to the facility with dementia. 1/6/20 - R49's care plan for self care deficit included to apply R49's ted hose in the morning and remove at night. 8/20/21 - A physicians order included: Apply ted hose (open toes): in AM (morning), off HS (at night). 9/9/22 - A quarterly MDS assessment documented that R49 was dependent on staff for activities of daily living. 9/20/22 10:17 AM, 9/22/22 9:32 AM and 9/23/22 9:58 AM - R49 was observed without his ted hose.	F 684	A The survey team identified a quality of care issue regarding R49 stating that the facility failed to apply ted hose to R49 per physician orders. When this was pointed out by the survey team it was immediately addressed by staff and compliance has been maintained. It was determined that this was an isolated incident only pertaining to R49 as staff was following the responsible parties wishes and not the doctors orders. B All other residents have the potential to be affected by the deficient practice listed though no other residents were identified at this time. C Nursing staff was in-serviced on the importance of making sure that tasks are signed off as completed once they are done properly as this was the case in regards to R49. Since the deficient practice only affected 1 resident and the practice was deficient because the staff was following the responsible parties request no system changes are needed at this time. Correction was made through education.	10/18/22

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F 684	Continued From page 6 9/26/22 9:59 AM - During an interview, E16 (RN) confirmed that the order for R49's ted hose was still in place, still in the care plan, and were being signed off for the month of September when they were not being applied. Findings were reviewed with E1 (NHA), E2 (ANHA) and E3 (DON) during the exit conference on 9/26/22, beginning at approximately 12:30 PM.	F 684	D Nursing Administrative Staff will conduct audits of 3 residents per week for compliance of ted hose use per MD orders until a success rate of 100% is achieved over 4 weeks.	
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 and interview, it was determined that for one (R38) out of one resident reviewed for oxygen therapy, the facility failed to provide respiratory care per professional standards. Findings include: An undated facility policy entitled "Oxygen Administration Of Via Concentrator" included: "Oxygen cannula and tubing are to be changed every week and PRN if cannula becomes contaminated. Date is to be indicated on piece of tape affixed to cannula and tubing." 9/20/22 9:39 AM - During an observation, R38's	F 695	A The survey team identified an issue with providing respiratory care per professional standards in regards to R38□s oxygen cannula, tubing and humidifier not being labeled with a date. This deficient practice was immediately addressed once pointed out by the survey team. It was determined that this was an isolated incident only pertaining to R38. B All other residents have the potential to be affected by the deficient practice listed though no other residents were identified at this time. C Licensed staff was in-serviced on	10/18/22

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

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F 695	Continued From page 7 oxygen nasal cannula, tubing and the humidifier bottle were not labeled with a date of when they were last changed. 9/20/22 2:07 PM - During an interview, E17 (LPN) confirmed R38's oxygen equipment was not labeled with a date and E17 was unaware of when they were last changed. Findings were reviewed with E1 (NHA), E2 (ANHA) and E3 (DON) during the exit conference on 9/26/22, beginning at approximately 12:30 PM.	F 695	making sure all items are dated, timed and initialed when opened including oxygen supplies. No system changes are needed at this time as correction can be made through education. D Nursing Administration Staff will conduct 1 audit per week to make sure all oxygen items are dated correctly. Once a success rate of 100% is achieved over a 4 week span, audits will be concluded and checks will be done periodically to maintain 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 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 of the facility kitchen and interview of staff, it was determined that the	F 812	A The survey team identified an issue that the facility failed to maintain	10/18/22

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F 812	Continued From page 8 facility failed to maintain consistent food temperature (temp[s]) logs. Findings include: 9/21/22 11:20 AM - Review of the facility food temperature logs revealed a total of thirty-four (34) meals served between July 1, 2022 and September 21, 2022 with no fooc temps recorded. During an interview on 9/21/22 at 1:13 PM, E7 (FSD) confirmed temps were not taken at every meal, E7 explained the missed temps were due to staffing challenges. During an interview on 9/21/22 at 2:04 PM, E1(NHA) confirmed the findings. Findings were reviewed with E1, E2 (ANHA) and E3 (DON) during the exit conference on 9/26/22, beginning at approximately 12:30 PM.	F 812	consistent food temperature logs. This deficient practice was immediately addressed as all Dietary Staff was in-serviced. No residents were impacted by the deficient practice. B No residents were impacted by the deficient practice though there is a potential for all residents to be impacted. C Dietary Staff was in-serviced on annotation of temperature logs and safe temperatures for food service. No system changes are needed at this time as correction can be made through education. D Food Service Director will conduct regular checks of all temperature logs. Audits will be conducted 3 times a week. Once a success rate of 100% is achieved over a 4 week span, audits will be concluded but regular checks will be continued to maintain compliance.	