DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Courtland Manor
February 21, 2023

DATE SURVEY COMPLETED:

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 3201.1.0 3201.1.2	**The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced Complaint Survey was conducted on February 20, 2023 through February 21, 2023. The deficiencies contained in this report are based on interviews, review of residents' clinical records and review of other facility documentation. The facility census the first day of the survey was 56. The survey sample size was six (6) residents. **Regulations for Skilled and Intermediate Care Facilities** **Scope** **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 21, 2023: F563 & F609.	Cross Reference to the CMS 2567-L Survey ending March 21, 2023: Tag 563, & F609	3/15/2023

Provider's Signature Sandra Schurman_____Title_Administrator_____
__Date _3/13/2023_____

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 02/21/2023

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 000	INITIAL COMMENTS An unannounced Complaint Survey was conducted on February 20, 2023 through February 21, 2023. The deficiencies contained in this report are based on interviews, review of residents' clinical records and review of other facility documentation. The facility census the first day of the survey was 56. The survey sample size was six (6) residents. Abbreviations/definitions used in this report are as follows: CNA - Certified Nursing Assistant; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RN - Registered Nurse.	F 000		
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that	F 563		3/13/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/13/2023

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 563	Continued From page 1 provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure residents rights to visitation were protected during a COVID-19 outbreak at the facility. Findings include: Review of QSO-20-39-NH memorandum for Nursing Home Visitation COVID-19, created 9/17/20 and revised 9/23/22, indicated, "Facilities must allow indoor visitation at all times and for all residents as permitted under the regulations. While previously acceptable facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits." The undated facility policy that addresses visiting hours indicated, "... visiting is permitted twenty four hours per day. Seven days a week at the residents pleasure... Due to COVID-19 pandemic, visitation hours are adjusted according to federal and state guidelines...". 2/7/23 - E1 (NHA) authorized email correspondence to residents and families that	F 563	A. The surveyor identified an issue that the facility failed to maintain the resident□s rights to receive/deny visitors. This deficient practice was immediately addressed as the resumption of full visitation email was sent out to all resident□s responsible parties. 2/20/23 B. Although all residents had the potential to be affected, no residents were noted to be impacted by the deficient practice C. The receptionists were in-serviced on the change in visitation status. No system changes are needed at this time as correction was made by NHA and the receptionist were made aware. D. The deficient practice was rescinded by the NHA, who does not plan on reimplementing the deficient practice. The success rate remains 100%.	

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F 563	Continued From page 2 indicated the following, "In order to help with stopping the spread inside and outside the building, I have made the decision to shut the building down to visitation... If someone must visit we are asking the visit be limited to just the responsible party of the resident and the visit last no more than 15 minutes once a day. Let me make it clear that I do not feel anyone from outside the building should be visiting residents at this time... any other visitor, who is not the responsible party, will be denied admission to the facility." 2/9/23 - An email with the subject line "Denied Visitors" was submitted directly to the State Agency. The email contained an attached copy of the 2/7/23 email the facility sent to residents and families detailed above. 2/20/23 2:40 PM - During an interview, R4 was asked whether resident visitations had been restricted and R4 responded, "They were [restricted], but not lately. People can come in now." 2/20/23 3:06 PM - During an interview, E1 (NHA) confirmed the facility restricted visitation in response to a COVID-19 outbreak. E1 then provided a copy of a drafted email to be sent to residents/responsible parties announcing the resumption of visitation effective the same date, 2/20/23. 2/21/23 1:54 PM - Findings were reviewed during the exit conference with E1, E2 (DON) and E3 (ADON).	F 563		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		3/15/23

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F 609	Continued From page 3 §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 other facility documentation, it was determined that for one (R1) out of one resident sampled for abuse, the facility failed to identify and immediately report within two hours an allegation of verbal abuse between staff and a resident. Findings include: The facility abuse policy, last updated September	F 609	A. The surveyor identified an issue with reporting alleged violations stating that the facility failed to identify and immediately report within the two hours of an allegation of verbal abuse between staff and a resident (R1). When this was pointed out by the surveyor, it was immediately addressed. The state investigator was	

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F 609	Continued From page 4 2017, indicated, "Any employee of a facility or anyone who provides services to a patient or resident of a facility on a regular or intermittent basis who has reasonable cause to believe that a patient or resident in a facility has been abused, mistreated, neglected or financially abused shall immediately report such abuse...". During an interview on 2/20/23 at 9:42 AM, E5 (CNA) confirmed that on 2/14/23 E5 observed E4 (CNA) telling R1, "What did I tell you about biting and hitting, do you want me to beat your ass?" E5 confirmed the observation was verbal abuse, but did not immediately report it. 2/20/23 1:05 PM - The facility submitted an incident to the State Agency regarding the allegation of staff to resident abuse of R1. 2/21/23 1:54 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON). 2/23/23 11:42 AM - Review of facility documentation of abuse training revealed that E5 (CNA) received abuse training and education on 4/4/22.	F 609	already in the building currently and was being giving all information of the facility investigation in real time. The allegation was electronically reported to the state after the facility investigated the allegation. After many interviews, it was determined that this was an isolated incident on timely reporting. B. All other residents have the potential to be affected by the deficient practice listed, through no other residents were identified at this time. C. All staff were given retraining on abuse to include timely reporting of all allegations of abuse to allow for immediate required reporting. No system changes are needed at this time as immediate reporting is already part of the facility abuse training and it determined that (E5) did not follow the facility abuse policies on timely reporting. Correction was made through education. D. Nursing Administrative staff will conduct audits of 3 staff members per week on reciting the proper time frame for reporting alleged abuse until a success rate of 100% is achieved over a 4-week span when audits will be concluded but checks will be done periodically to maintain compliance. Required Abuse training will continue.	