

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

LYC Residents Protection
FEB 18 2010
Director's Office

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 Revised Report following IDR held on 2/3/2010. The following changes were made to the report F166 and F329 were deleted, F221 examples deleted S/S change, F309 S/S change, F278 added. An unannounced QIS survey was conducted at the facility from October 5, 2009 through October 12, 2009. The deficiencies contained in this survey are based on observations, interviews and review of residents' clinical records and review of other facility documentation as indicated. The survey sample included four (4) admission and forty (40) census residents in Stage I. The Stage II sample included twenty-three (23) residents.	F 000	THE PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF THE DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISION OF FEDERAL AND STATE LAW. FOR THE PURPOSE OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 7305 OF THE STATE OPERATIONS MANUAL.	
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on detailed investigation in the Care Area, Physical Restraints, for ten (10) out of 23 residents with significant care concerns, it was determined that the facility used physical restraints without an assessment and not required to treat a medical symptom indicating staff convenience for two (2) of the ten (10) residents with Physical Restraint Care Area concerns. One resident (R53) was restrained in a Merry Walker (an ambulation device for a resident who was wheelchair mobile but required one person assistance) and used a lap buddy (lap cushion) when in the wheelchair. Another	F 221	F221 -Resident #53 – An order was obtained on October 9, 2009 for a therapy evaluation for use of a merry walker (MW). On October 12, 2009 a therapy evaluation to assess safety in MW was conducted. The resident has a DX of Alzheimer's Dementia with delusions. As a result of the therapy evaluation, there was recommendation that the resident should sit in a high back chair when lethargic and when more alert and mobile, Resident #53	11/16/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 2/15/10
---	------------------------	----------------------

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 221	<p>Continued From page 1</p> <p>resident (R17) was restrained in a Merry Walker (MW) for ambulation. The facility failed to ensure that these residents were free from restraints that were not required to treat a medical symptom. Findings include:</p> <p>During an interview with the administrator (E1) on 10/7/09 at approximately 10:30 AM, the surveyor was informed that the facility does not employ any physical restraint for any resident.</p> <p>Following the above interview, the survey team was provided a facility policy titled "Freedom from restraint." Review of this policy lacked evidence that the facility had a system that identified, assessed and care planned for restraints.</p>	F 221	<p>should be in a MW. Resident has a medical symptom of an acute need to ambulate and she unable to safely walk (no sense of boundary). A physician order was obtained on October 12, 2009.</p> <p>Resident #17 – Was assessed on May 13, 2009 due to a decline in functional mobility (medical symptom). On June 12, 2009 an order was received to continue therapy for training to ambulate in a merry walker. An order was obtained on October 8, 2009 for therapy re-evaluation for safe use of a merry walker. The Resident has DX of psychosis with behavioral disturbances. This resident has the adamant desire to ambulate (medical symptom) with no perception of pace. There is no recommendation for discontinued or decreased use of the merry walker. The resident appears to be safe ambulating in the merry walker. A physician order for the use of the merry walker was obtained on November 6, 2009.</p> <p>An Audit was completed by October 12, 2009 by the Director of Nursing Services (DNS) designee to identify other residents utilizing merry walkers or lap buddies needed a reassessment to determine use of the device. The audit revealed that two other residents were using such devices. Physician orders are present for those individuals</p>	
	<p>1. R53 was originally admitted to the facility on 1/21/04 with diagnoses including Alzheimer's disease, urinary incontinence, depression, hypertension, and aggression. Review of the two most recent significant change Minimum Data Set (MDS) assessments dated 9/20/09 and 6/28/09 respectively indicated that R53 was severely impaired for decision making-decision, required total assistance of staff for transfer, and required extensive assistance from staff for walking. In addition R53 experienced a fall within the past 30 days and past 31-180 days, and did not have a physical restraint.</p> <p>R53 was observed on 10/12/09 from approximately 9:10 AM to 10:30 AM in the MW and with a clip alarm attached to the resident's shirt. During this time, the resident did not ambulate independently and was transported by staff from one location of the unit to another in the MW. At approximately 10:15 AM, the surveyor</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 221

Continued From page 2
requested R53 to open the front gate of the MW, however, the resident was unable to open the gate.

Review of the October 2009 physician's order sheet (POS) indicated an order for a lap buddy may be used when up in chair, however, there was no order for the use of the MW for R53.

Record review lacked evidence of an assessment as to the use of the MW including whether the facility assessed the resident's ability to open and close the gate of the MW. Also, there was no medical symptom for the use of the MW. For the lap buddy, there was no evidence of an assessment for the use and no medical symptom.

On 10/12/09, the physical therapist (P.T.), E14 reassessed R53 for gait dysfunction and functional activity. An interview with E14 on 10/12/09 at approximately 2:15 PM revealed that the recommendations following the reassessment was for R53 to be in a high back chair when the resident is lethargic and when the resident is alert and mobile, R53 should be in the MW.

Above findings reviewed with the Administrator (E1), Assistant Administrator (E2), and Director of Nursing (E3) on 10/12/09 at approximately 4:15 PM.

Subsequent interview with E14 on 10/15/09 at approximately 12:45 PM and review of the P.T. reassessment dated 10/12/09 revealed that the reassessment was completed secondary to R53's decrease in activity and increase in lethargy. During the assessment, R53 was lethargic and E14 did not observe the resident walking. E14 related that R53's state was likely due to the

F 221

By November 13, 2009 the licensed staff were in-serviced on the following system for monitoring these devices. If the nurse has assessed a resident for the need of a merry walker or lap buddy the following protocol must be initiated:

1. The DNS and/or nurse supervisors must be contacted prior to the placement of the device on a resident.
2. If, after collaboration with the nurse supervisor, it is determined that a device is needed, the nurse must:
 - a. Obtain a physician order for the use of the device.
 - b. Complete an assessment and document the reason for use and safety potential of the device.
 - c. Discuss use of the device with the resident as appropriate and obtain their consent if they are their own responsible party.
 - d. Contact family/legal representatives and obtain consent if the resident is not their own responsible party.

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

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 221	<p>Continued From page 3</p> <p>Ativan (a benzodiazepine, a medication for sedation. When used in the elderly or debilitated individuals, they are more susceptible to the sedative effects of this medication and consequently could increase the potential for accident hazards) which is administered to R53 routinely at 10 AM and 4 PM due to aggressive behaviors. Additionally, E14 observed the resident on two other occasions; on 10/9/09 and 10/13/09, however, the resident continued to appear lethargic, thus, R53 was not observed walking during this assessment period. E14 relayed during this conversation, that the therapist typically does not assess whether a resident can or cannot open and close the gate to the MW, thus, this request was not made by the therapist to R53. Lastly, E14 reported that it is her understanding that the resident's current state of lethargy has been ongoing for approximately two weeks per her conversation with the attending provider.</p> <p>Although R53 had periods of lethargy, as reported by E14 during the above interview, the facility continued to utilize the MW for staff convenience. Prior to the evaluation by the therapist there was no evidence of a coordinated plan to provide the most appropriate seating for a resident who had periods of lethargy.</p> <p>Based on above, the facility failed to have a system to identify that the MW and the lap buddy were physical restraints for R53 and used both devices, MW and lap buddy in the absence of a medical symptom and for staff convenience.</p> <p>2. R17 was admitted to the facility on 5/10/09 with diagnoses including dementia with psychosis, essential tremors, degenerative joint</p>	F 221	<p>e. Document the initiation of the use of the device on the 24hr report and Nurse's notes section of the chart.</p> <p>f. Add the use of the device to the care plan.</p> <p>3. On a quarterly basis, the RNAC or designee will complete a reassessment for continued use of the device.</p> <p>4. The assessment form will be submitted to the interdisciplinary team for their review of the continued use and/or reduction of such devices.</p> <p>The DNS and/or designee will complete a monthly random audit of 10% of the resident's medical records that utilize devices monthly for the next 90 days to verify that routine assessments for use and/or reduction of merry walkers and lap buddies have been completed.</p> <p>The DNS or designee will report the results of the audits to the Administrator or Asst Administrator monthly for the next 90 days to evaluate ongoing compliance. Administration will review audits and provide recommendations and direction as needed.</p>	

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

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 221	<p>Continued From page 4</p> <p>disease, hypothyroidism, and anxiety. Most recent significant change MDS assessment dated 8/2/09 indicated that R17 was moderately impaired for decision making-decision poor; cues/supervision required. In addition, required limited assistance by staff for walking in the room and corridor, fell in the past 31-180 days, and did not have a physical restraint.</p> <p>Multiple observations of R17 during the survey from 10/5/09 through 10/9/09 revealed that the resident was in the MW with a clip alarm attached to the resident's clothing. On 10/8/09 at 2:30 PM, R17 was in the MW with the clip alarm and the assigned CNA, E8 verbally requested R17 to open the front gate of the MW, however, R17 was unable to open the gate. This request of opening the gate was made by the surveyor, in the presence of E8 at approximately 2:40 PM on this same date with the same response from R17.</p> <p>Record review lacked evidence of R17's assessment as to the use of the MW, a medical symptom, or a physician's order for the use.</p> <p>During an interview with the administrator, E1 on 10/7/09 at 10:30 AM, the surveyor requested a copy of an assessment for R17 since R17 was unable to open the front gate of the MW. E1 indicated that the facility does not have any physical restraint assessment for any resident.</p> <p>During an interview with the Assistant Administrator, E2 on 10/12/09 at approximately 3:45 PM, the surveyor again requested the facility's assessment as to the use of the MW for R17, however, no information was provided.</p> <p>Based on the above, the facility failed to have a</p>	F 221		

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

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 221	Continued From page 5 system to identify that the MW was a physical restraint for R17 and failed to document the medical symptoms that the MW was used to treat.	F 221		
F 278 SS=D	<p>483.20(g) - (j) RESIDENT ASSESSMENT</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for 5 (R53, R17,</p>	F 278	<p>F278</p> <p>1. We will code Merry Walkers as restraints on the MDS form as required by the <i>regulation</i>. These devices will be assessed for resident safety and appropriateness via the enclosed assessment form. The Merry Walker is used solely to allow a resident to ambulate independently as an enabler or rehab tool. Residents who do not wish to use the merry walker will not be provided one. Only one of the cited residents continues to use a merry walker as of this time.</p> <p>Resident #53 has not used the Merry walker since 1/14/2010.</p> <p>Resident #17 continues to use the merry walker as an ambulation enabler but is has been coded as a restraint on the MDS effective 2/15/2010 because she cannot exit the merry walker in the manner "required by regulation".</p> <p>#25 Resident #25 expired on October 28, 2009 so no corrective action is possible.</p>	2/15/10

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

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 278 Continued From page 6
R26, R44, R11) out 23 residents the facility failed to accurately assess a merry walker as a chair that prevents rising (restraint). Findings Include:

The Resident Assessment Instrument (RAI) Manual used to complete the Minimum Data Set Assessment (MDS) documents for Merry Walkers "If the resident's freedom of movement is restricted because the resident cannot open the front gate and exit the device (due to cognitive or physical limitations that prevents him or her from exiting the device), then the device should be coded as a restraint in Item P4 of the MDS." P4 is the section for Restraints.

1. Review of the two most recent significant change Minimum Data Set (MDS) assessments dated 9/20/09 and 6/28/09 respectively indicated that R53 was severely impaired for decision making, required total assistance of staff for transfer, and required extensive assistance from staff for walking. These assessments stated under devices and restraints not used, indicating that R53 did not use a Merry Walker. Additionally under Section V Resident Assessment Protocol Summary the section for restraints and care plan was blank. This indicated R53 had no restraints and was not care planned for restraints.

R53 was observed on 10/12/09 from approximately 9:10 AM to 10:30 AM in the MW and with a clip alarm attached to the resident's shirt. During this time, the resident did not ambulate independently and was transported by staff from one location of the unit to another in the MW. At approximately 10:15 AM, the surveyor requested R53 to open the front gate of the MW, however, the resident was unable to open the

F 278 Resident #44 has not used the merry walker per her own request since January 14, 2010.

Resident #11 is no longer able to ambulate due to extreme weakness and has not used the merry walker since January 14, 2010.

2. We have reviewed other residents' use of devices which: prevent rising or restrains the trunk/limb and which the resident cannot easily remove. Two Residents were identified who have "difficulty" performing self-release of their devices. The devices we "re-assessed" and coded per MDS 2.0 instructions.

3. The RNAC had been instructed to "code" devices as a trunk/limb/chair restraint regardless of whether the device increases the resident's functional mobility or ADL skills in accordance with the regulation.

4. MDS's will be reviewed by the ADON with emphasis on coding devices as restraints.

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

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 278

Continued From page 7 gate.

F 278

E14 (physical therapist) relayed during a conversation with the surveyor on 10/14/10, that the therapist typically does not assess whether a resident can or cannot open and close the gate to the MW, thus, this request was not made by the therapist to R53.

2. R17 Review of the most recent significant change Minimum Data Set (MDS) assessment dated 8/2/2009 stated that R17 was moderately impaired for decision making-decision poor; cues/supervision required. In addition, required limited assistance by staff for walking in the room and corridor, fell in the past 31-180 days. These assessments stated under devices and restraints not used, indicating that R17 did not use a Merry Walker. Additionally under Section V Resident Assessment Protocol Summary the section for restraints and care plan was blank. This indicated R17 had no restraints and was not care planned for restraints.

Multiple observations of R17 during the survey from 10/5/09 through 10/9/09 revealed that the resident was in the MW with a clip alarm attached to the resident's clothing. On 10/8/09 at 2:30 PM, R17 was in the MW with the clip alarm and the assigned CNA, E8 verbally requested R17 to open the front gate of the MW, however, R17 was unable to open the gate. This request of opening the gate was made by the surveyor, in the presence of E8 at approximately 2:40 PM on this same date with the same response from R17.

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

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 278

Continued From page 8

3. Review of the most recent significant change MDS assessment dated 8/2/09 indicated that R26 was moderately impaired for decision making-decision poor and cues/supervision required, was independent with locomotion in a wheelchair (W/C), and maintained position during sitting and trunk control. Additionally, fell in the past 30 days. These assessments stated under devices and restraints not used, indicating that R26 did not use a Merry Walker. Additionally under Section V Resident Assessment Protocol Summary the section for restraints and care plan was blank. This indicated R26 had no restraints and was not care planned for restraints.

On 10/5/09 at 10:55 AM, R26 was in the W/C with a lap buddy and the surveyor requested that R26 remove the lap buddy. R26 verbally indicated "I cannot." Subsequent observation on 10/7/09 at 11:10 AM noted R26 in the W/C with the lap buddy in the C-wing day room. The resident was asked by a staff nurse, E9 to remove the lap buddy on two occasions, however, the resident was unable to remove the cushion. Also, the surveyor requested the resident to remove the lap buddy, with the presence of E9 at approximately 11:25 AM and R26 replied "have your daddy do it."

4. R44 was coded on the Significant Change MDS dated 9/13/09 in section P4 under restraints, chair prevents rising was coded a zero. Additionally under Section V Resident Assessment Protocol Summary the section for restraints and care plan was blank. This indicated R44 had no restraints and was not care planned for restraints.

F 278

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

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 278	<p>Continued From page 9</p> <p>A nurses's note dated 9/18/09 indicted the resident was using a merry walker to ambulate. Observations during the survey 10/5 - 10/8/09 revealed the resident in the merry walker. There was no assessment of the merry walker determining if the resident could open the front gate and exit. The resident was not observed getting herself out of the merry walker independently.</p> <p>5. R11 had Significant Change MDS's dated 6/14/09 and 9/6/09 that stated in section P4 under restraints, chair prevents rising was coded a zero. Additionally under Section V. Resident Assessment Protocol Summary the section for restraints and care plan was blank. This indicated R11 had no restraints and was not care planned for restraints.</p> <p>Nurses notes during this period of time revealed that the resident was ambulating with the merry walker. On 10/12/09 the resident was observed ambulating in the merry walker. When interviewed by the surveyor on 10/12/09 the resident denied voluntary self-release of the merry walker and stated that the front gate of the merry walker was released by nursing staff.</p>	F 278		
F 279 SS=E	<p>483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial</p>	F 279	<p>F279 – Resident # 47's merry walker was discontinued on September 29, 2009 per resident's dislike and the Physical Therapy's discharge from therapy. The care plan was updated to</p>	11/16/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 279

Continued From page 10
needs that are identified in the comprehensive assessment.

The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on detailed investigation, for seven (7) residents of 23 residents with significant care concerns, it was determined that the facility failed to develop a comprehensive care plan for identified resident care areas of restraints and psychoactive medications. Five residents (R44, R47, R53, R11 and R17) used a MW ambulation device, one resident (R26) used a lap buddy in the wheelchair, and the behaviors and interventions for one resident (R52) were not included in the comprehensive care plan. Findings include:

- R47 had a therapy plan to ambulate with a merry walker between 9/2/09 and 9/29/09. Between 9/23 and 9/29/09 the merrywalker was being used upon rising and until after lunch with the exception of meal time. There was no care plan initiated for this ambulation program with the merry walker and the potential of this device being a restraint for R47.
- Cross refer F221 example #1. Record review and observation of R53 as well as

F 279

address the discharge of the merry walker on September 29, 2009.

Resident # 53- Care plan was updated for the lap buddy for beauty shop day ONLY to keep her sitting up straight to get her hair done. The care plan for the use of the merry walker was updated on October 12, 2009. Resident #53 will be put in a high back chair when fatigued and be allowed to walk independently in her merry walker when agitated.

Resident # 26 – Expired. No corrective action to report.

Resident # 52 - Care plan for behavior symptoms of delusions was completed on October 8, 2009.

Resident #11 - Assessed by Physical Therapy and a care plan was started on August 27, 2009. The care plan was due to decreased functional mobility. The care plan was reassessed

On September 6, 2009 Physical Therapy reassessed the use of the merry walker. Use of merry walker was added to Resident #11 fall care plan on October 12, 2009.

Resident #44 - Merry walker was discontinued on October 9, 2009. The care plan does not address the use of a merry walker.

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

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 279

Continued From page 11
staff interview it was revealed that the facility employed use of a MW and a lap buddy as a physical restraint. Record review lacked evidence of a care plan for these devices and the potential of the device being a restraint.

3. Cross refer F221 example #2.
Record review and observation of R17 as well as staff interviews revealed that the facility employed use of a MW as a physical restraint. Record review lacked evidence of a care plan for this device and the potential of the device being a restraint.

4. Record review and observation of R26 as well as staff interviews revealed that the facility employed use of a lap buddy as a physical restraint. Record review lacked evidence of a care plan for this device and the potential of the device being a restraint.

5. Review of Resident 52's Nurse's Notes dated 9/11/09 stated the resident was admitted with a diagnosis of Alzheimers Dementia with Delusions. R52 was prescribed Ativan for anxiety, behaviors. The facility did not initiate a care plan for the behavior symptom of delusions for R52 and the corresponding interventions. Record review lacked evidence of a care plan for these behavior symptoms

6. The facility failed to initiate a care plan for R11's use of a MW.

Observations conducted on 10/12/09 revealed Resident #11 using a Merry Walker to ambulate

F 279

Resident #17 – Use of merry walker was reviewed (reassessed) by the physical therapist on October 9, 2009. It was noted to be an appropriate assistive device. We added use of merry walker as an approach to the potential for injury care plan after assessing the device as a safe device for the resident. Cross-reference F221.

All other resident charts were reviewed and other residents using such devices have been assessed and care planned.

Cross-reference F221 for precluding repeat deficient practice.
Cross-reference F221 for monitoring measures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 279 Continued From page 12 independently on the nursing unit

Review of the care plan revealed the sole reference to the Merry Walker used by Resident #11 was addressed by PT. Review of the care plan dated 9/10/09 and developed by PT revealed the problem "(Decreased) functional (ambulation)" with the goal of Resident #11 ambulating in the Merry Walker during the day.

The facility failed to develop a comprehensive care plan for a merry walker device that was being used daily for ambulation and could be a restraint and/or accident hazard for R11.

7. The facility failed to initiate a care plan for R44's use of a MW. Resident R44 was observed daily in the MW from 10/5 to 10/8/09. There was no care plan initiated for the purpose or use of this device. There was no indication that the facility had addressed this device and the potential for being a restraint and/or accident hazard for this resident.

F 279

F 280 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS

F 280

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.

F280 – This citation demonstrates that the regulation requires that physician orders and physician comments/recommendations be added to the comprehensive "nursing" care plan. These issues are normally present in Medications Administration Records and Treatment Administration Records (MAR's and TAR's). Since these were present for all "cited" issues we understand that the regulations required duplication for order/recommendations as "approaches" in the nursing care plan. Specific residents affected include:

12/20/09

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

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 13</p> <p>and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on detailed investigation, for two (R47 and R45) residents of 23 residents with significant care concerns, it was determined that the facility failed to update and revise care plans when approaches were changed or initiated. Findings include:</p> <p>1a. R47, after having a fall in the bathroom on 3/29/09, had a new physician's order dated 3/30/09 that stated "do not leave resident alone in bathroom". The approach was not added to the care plan or the nurse aide documentation record.</p> <p>1b. R47 had a physician's order dated 6/18/09 that included anti-depressant medication changes and indicated staff should monitor behavior (depression, pain, and neuropathic pain) for need to increase and notify nurse practitioner. It also stated to engage patient in activities during the daytime hours.</p> <p>These changes in care were not added to the care plan.</p> <p>2. R45 was seen by the dentist on 4/23/09, at the family's request, for loose fitting dentures. Due to the poor condition of the gum ridges, the dentist</p>	F 280	<p>Resident #47 – We have added "...do not leave resident alone in the bathroom" as an approach on the care plan. We have also added "... monitor behaviors of depression, pain or neuropathic pain, need to increase antidepressant and notify the nurse practitioner" on November 6, 2009.</p> <p>We will create a care plan for activities and specify "...engaged in patient activities during the daytime hours" as an order. We have also included it as a "must sign off on" versus an FYI physician order.</p>	
			<p>Resident 45 – Was being evaluated for new dentures by the consultant Dentist and was found to be a poor candidate for replacement dentures due to receding of his gums. The Dentist made a <i>note</i>, not an <i>order</i> recommending that dentures be reapplied as needed and extra denture adhesive be used (presumably to fill in where gums had receded). This <i>comment</i> was added as an <i>approach</i> on the care plan.</p> <p>Other resident charts will be reviewed to determine if other physician orders or comments need to be added to care plan .</p> <p>The care plan staff will be in-serviced to assure they are aware of this new regulatory requirement. The RNAC will review the care plans for compliance with the new regulation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	Continued From page 14 determined that new, lower dentures couldn't be fitted properly and that additional denture adhesive would need to be utilized to keep the denture in place while in use. Interviews with E5 and E13 verified the approach to lower denture adhesive application. The Activities of Daily Living (ADL) care plan was not updated to reflect the new intervention for care of this resident's dentures.	F 280		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on detailed investigation in the Care Area, Accidents, for nine (9) out of 23 residents with significant care concerns, the facility has been determined to have failed to recognize that the use of Merry Walker (MW) became an accident hazard for two (2) of the nine (9) residents with Accidents Care Area concerns. The facility failed to adequately supervise two residents (R17 and R11) to prevent accidents. Findings include: 1. R17 was admitted to the facility on 5/10/09 with diagnoses including dementia with psychosis, essential tremors, degenerative joint disease, hypothyroidism, and anxiety. Most recent significant change MDS assessment dated 8/2/09 indicated that R17 was moderately	F 323	F323 – While we continue to reject the position that the devices used by the patients cited contributed in anyway to the “accidents” claimed and that review of care plans “after each incident” is required by regulation we submit the following: Resident #17 – We had Physical Therapy reassess (at surveyor demand) the resident on October 9, 2009. Care plans were revised on October 8,, 2009 and staff is aware of the monitoring as closely s possible and keeping resident as close to the station as possible. Resident #11 – We have updated the care plan on November 6, 2009. (Even though the merry walker had no bearing on the incidents and actually prevented injury at least once). The DON/ADON will review the residents with incidents/injuries to identify “devices” that may have a potential to cause or contribute to an accident. The DON/ADON will monitor incident and accident reports for evidence of issues involving devices.	11/16/09

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

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 15</p> <p>impaired for decision making-decision poor and cues/supervision required. In addition, R17 required limited assistance by staff for walking in the room and corridor, fell in the past 31-180 days, and did not have a physical restraint</p> <p>Review of nurses notes and facility's incident reports revealed that R17 during 3 PM-11 PM shift on 9/14/09, 9/17/09, and 9/24/09, slid onto the floor from the MW and did not sustain any injury. In addition, nurse's note dated 9/26/09 timed 1:20 PM indicated that R17 attempted to climb out of MW several times and was placed in D-wing (secured unit) for close supervision.</p> <p>Review of care plan for potential of injury related to history of falls, change in mental status/psychosis implemented, and behavior of putting herself on the floor updated on 6/18/09 included approaches including move closer to nurses station, use of MW beginning on 6/12/09, and ambulate with staff twice a day. Care plan lacked evidence that the approaches were reviewed after each of the above incidents beginning on 9/14/09.</p> <p>An interview with the assigned CNA, E6 on 10/8/09 at approximately 6:45 PM revealed that the CNA was uncertain of any close monitoring required by the resident or the need for the resident to be close to the nurse's station.</p> <p>Review of the CNA's "ADL (Activities of Daily Living) Plan of Care" document lacked any intervention from the care plan for potential for injury such as having the resident closer to nurses station.</p> <p>Interview with the DON, E3 on 10/8/09 at</p>	F 323	<p>The DON will "report" quarterly to the QA meeting</p> <p>Cross-reference F221</p> <p>Post review of the POC, the State Survey Agency stated that the POC was unacceptable. Their question was "How will you prevent accidents from happening how assistive devices are used?"</p> <p>We categorically assert that <i>none</i> of the incidents cited were <i>caused</i> by assistive devices. The devices actually prevented injury for each resident involved and did not contribute to an injury. Assistive devices are used to prevent injury or enable a higher level of function (ambulation in particular). The residents cited were evaluated by a Physical Therapist both prior to and during the survey to identify the appropriate use of the device. Based on the question asked and citation there is no way to "prevent accidents from happening when assistive devices are used" because cause of an accident is "irrelevant" based on citation and even Physical Therapy evaluation and treatment is inadequate for "prevention".</p> <p>As such we understand that 42CFR part 483.25(L) prohibits the use of devices, as they are accident hazards.</p>	

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

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 16</p> <p>approximately 7 PM revealed that no other interventions were initiated after each of the incidents including reassessment to determine whether the MW was safe for R17.</p> <p>Subsequently, the above care plan's approaches were revised on 10/8/09 to attempt to keep R17 closer to nurses station in the evening and attempt to provide one on one supervision as much as possible as well as monitoring the resident as close as possible. In addition, reassessment by the physical therapist (P.T.) for the continued use of the MW was coordinated on 10/8/09.</p> <p>An interview with the P.T., E14 who completed the reassessment on 10/12/09 revealed recommendation for close monitoring and one on one as needed for R17's safety during the 3 PM-11 PM shift while resident in MW.</p> <p>2. R11 was admitted with diagnoses that included dementia, hypertension, congestive heart failure and depression. According to the MDS assessment completed 9/6/09 for a significant change, R11 had short-term and long-term memory problems and moderately impaired decision-making skills. Additionally R11 was totally dependent upon the assistance of one staff member for locomotion on and off the unit. R11 also required the extensive assistance of one staff member during locomotion in her room and the extensive assistance of two plus staff members were required when she ambulated in the corridor.</p> <p>Observations conducted 10/12/09 initially revealed R11 seated in a MW in the corridor of her assigned nursing unit then standing,</p>	F 323		

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

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2009
--	---	--	---

NAME OF PROVIDER OR SUPPLIER

COURTLAND MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE

**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 323	<p>Continued From page 17</p> <p>ambulating and guiding her MW without assistance toward the dayroom and her bedroom. In an interview at approximately 10:18 AM on 10/12/09 with R11 she stated that she did not open the gate to exit from the MW. Instead, she stated, nursing staff opened the gate of the MW for her. Additionally R11 denied ever opening the gate of the MW. During the same interview R11 stated she had fallen approximately three times while ambulating with the MW. R11 further stated that she had slipped off the seat cushion of the MW. Review of the clinical record, care plan and facility incident reports revealed R11 sustained falls while using the MW on 2/16/09 and 6/6/09 without injuries.</p> <p>According to the incident report dated 2/16/09 at 12:00 PM R11 was found suspended upon a strap located between the seat and front frame of the MW. In another incident report dated 6/6/09 and timed 12:00 PM staff observed that R11 landed on the floor when her "knees buckle under her" while in her MW.</p> <p>Review of the care plan also revealed that the facility failed to develop interventions specific to actual falls and the potential for falls while R11 ambulated in a MW. The facility failed to recognize that the MW had become an accident hazard for R11 and failed to develop new interventions after the falls.</p>	F 323		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085019	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 10/12/2009
NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 889 SOUTH LITTLE CREEK ROAD DOVER, DE		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 309	<p>483.25 QUALITY OF CARE</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and clinical record review, it was determined that the facility failed to follow the physician's orders for one (R44) resident out of 23 sampled residents.</p> <p>Findings include:</p> <p>During medication observation on 10/7/09 at 9:05 AM, staff nurse, E5 administered ASA (acetylsalicylic acid) 81 mg. (milligram) with water to R44 . Review of R44's October 2009 physician's order sheet revealed that the above medication was to be given with food.</p> <p>Interview with E5 on 10/7/09 at 10 AM revealed that the resident was administered above medication without food.</p> <p>Findings reviewed with the Director of Nursing (DON), E3 on 10/8/09 at 9:30 AM.</p>

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

The above isolated deficiencies pose no actual harm to the residents



**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

LTC Residents Protection

STATE SURVEY REPORT

Page 1 of 4

FEB 18 2010

NAME OF FACILITY: Courtland Manor

DATE SURVEY COMPLETED: October 12, 2009

DATE REPORT COMPLETED: October 12, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>Revised Report following IDR held on 2/3/2010. The following changes were made to the report F166 and F329 were deleted, F221 examples deleted S/S change, F309 S/S change, F278 added.</p> <p>The State report incorporates by reference and also cites the findings specified in the Federal report.</p> <p>An unannounced QIS survey was conducted at the facility from October 5, 2009 through October 12, 2009. The deficiencies contained in this survey are based on observations, interviews and review of residents' clinical records and review of other facility documentation as indicated. The survey sample included in Stage I four (4) admission and forty (40) census residents. The Stage II sample included twenty-three (23) residents.</p> <p>Regulations for Skilled and Intermediate Care Nursing Facilities</p> <p>Services to Residents</p> <p>General Services</p>	<p>The preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required under State Regulation. We submit/allege that we are in compliance within the "reasonable man standard" for the alleged violations and that plan of correction is our allegation of compliance.</p> <p>Cross-reference the Federal Survey Response F309 and F323</p>
3201		
3201.6.0		
3201.6.1		



**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

DATE SURVEY COMPLETED: October 12, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.1.1	<p>The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.</p> <p>This requirement is not met as evidenced by:</p>	Cross-reference the Federal Survey Response F221
	<p>Cross refer to the CMS 2567-L survey report date completed 10/12/09, F309 and F323.</p>	Cross-reference the Federal Survey Response F221
3201.6.5.8.1	<p>The resident's comprehensive assessment shall document the medical symptom(s) potentially requiring the use of restraints.</p>	Cross-reference the Federal Survey Response F221
3201.6.5.8.2	<p>The facility shall follow a comprehensive, systematic process of evaluation and care planning to ameliorate medical and psychosocial indicators prior to restraint use.</p>	Cross-reference the Federal Survey Response F221
3201.6.5.8.3	<p>The resident's care plan shall document the facility's use of interventions, such as modifying the resident's environment to increase safety, and use of assistive devices to enhance monitoring in order to avoid the use of restraints.</p>	Cross-reference the Federal Survey Response F221



**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

DATE SURVEY COMPLETED: October 12, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.5.8.4	Should such interventions and assistive devices fail to provide for the resident's safety, a physician's written order permitting the use of restraints shall be required and shall specify the type of restraint ordered.	Cross-reference the Federal Survey Response F221
3201.6.5.8.5	The facility shall be accountable for the safe and effective implementation of the physician's order permitting the use of restraints.	Cross-reference the Federal Survey Response F221
3201.6.5.8.6	When the use of restraints has been implemented, the facility shall initiate a systematic process, on an ongoing basis, documented in the care plan, in an effort to employ the least restrictive restraint. These requirements are not met as evidenced by:	Cross-reference the Federal Survey Response F221
16 Del. C., Chapter 11, Subchapter	Cross refer to the CMS 2567-L survey report date completed 10/12/09, F221. Patient's Rights (7) Every patient and resident shall be free from chemical and physical restraints imposed for purposes of discipline and convenience, and	Cross-reference the Federal Survey Response F221



**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

DATE SURVEY COMPLETED: October 12, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
II, §1121	<p>not necessary to treat the patient's medical condition.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 10/12/09, F221.</p>	