

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2009
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958
-------------------------------------------------------------------	---------------------------------------------------------------------------------

(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 annual and complaint visit was conducted at this facility from February 2, 2009 through February 9, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The census on the first day of the survey was one hundred sixty-two (162). The survey sample totaled twenty-five (25), twenty-two (22) active and three (3) closed records respectively. An additional six (6) sub-sampled residents were observation only.	F 000	Disclosure Statement Preparation and/or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225	Interviews and statements were obtained from involved staff who had a recollection of the incident. 2. The NHA will review all investigations to ensure thorough investigative procedures have been followed. The DON or designee will conduct a random audit of residents involved in investigations/incidents for the next 30 days to ensure that all investigations have been resolved and proper witness statements received. 3. All nursing staff will be inserviced regarding the law surrounding allegations of abuse, neglect, or mistreatment and to obtain statements from staff at the time the incident occurs. 4. The ADON will report to QI/ Compliance Committee all investigative reports and outcomes quarterly until substantial compliance is met. The quarterly data will include a report of completed investigations and verification that all necessary statements have been obtained.	2/4/09 4/29/09 4/29/09 ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mary F. Diabuff, RN, BC, NHA</i>	TITLE <i>Administrator</i>	(X6) DATE 3/9/09
------------------------------------------------------------------------------------------------------------------	-----------------------------------	-------------------------

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.

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 225	<p>Continued From page 1</p> <p>prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility failed to report an allegation of mistreatment and/or abuse for two (#23, #6) out of 25 sampled residents. The facility failed to report an allegation of mistreatment for Resident #23. The facility failed to thoroughly investigate Resident #6's allegation. Findings include:</p> <p>1. Cross refer F309 example #1.</p> <p>Review of the facility's documentation dated 12/30/08 revealed and confirmed that Nurse #5 failed to administer the Fleets enema according to the facility's policy titled "Fleets Enema" by administering the enema to Resident #23 while he was in the standing position, and was resistive and combative. Within ten minutes after the enema, large amount of frank red blood was noted in the toilet and Resident #23 was sent to the emergency room for an evaluation.</p> <p>Although the facility's records determined that Nurse #5 did not follow the facility's policy, the</p>	F 225			

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 225	Continued From page 2 facility failed to report the above allegation of mistreatment to the State agency. Findings reviewed with administration on 2/9/09. 2. Resident #6 had diagnoses which included bipolar, dementia, diabetes and congestive heart failure. Review of the resident's clinical record revealed a nurse's note dated 11/15/08 that stated "Resident was tearful... Speaking of 'being hurt' and 'mean person' attempted to redirect with good effect". An interview on 2/4/09 with the ADON revealed that the nurse who wrote the note did not write an incident report or report the allegation to management. The nurse alleged she did a body check for injury but failed to document her findings. The allegation of abuse or mistreatment was not immediately reported to the state agency or facility administrator and was not thoroughly investigated.	F 225	F241 1. Resident #SS 7 tray service has been changed to include them in the homestlye dining program. The staff member completing the dressing change on Resident # SS1 will receive 1:1 training to close the privacy curtain and door prior to initiating the dressing change to insure the residents dignity. Resident #SS2 has been checked daily to insure nasal discharge has been addressed. 2. All residents in the dayrooms for meals will be monitored by the Charge Nurse to insure that meals are served to each resident appropriately and at the same time to each individual table. Random audits by the Unit Manager will be conducted to insure residents are provided with privacy during dressing changes. Random observation by the Unit Manager to insure proper hygiene measures aare met. Attachment A	3/13/09	
F 241 SS=B	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to ensure care was delivered in a manner that enhanced residents' dignity. Findings include: 1. On 2/4/09 residents were observed eating lunch in the Lewes large dining room. Residents	F 241	3. All nursing staff will be inserviced regarding proper meal service in the dayrooms. All nursing staff will be inserviced regarding maintaining dignity and privacy of residents during dressing changes and of personal hygiene. 4. Random observation audits will be conducted by the Unit Manager to ensure resident dignity is maintained. Report of observations will be reptred to QI/ Compliance Committee until substantial compliance is achieved.	ongoing 3/13/09 4/21/09	

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 241	Continued From page 3 were observed sitting at a table with residents who were eating or being fed without having a meal themselves. 2. On 2/4/09 at 11:15 AM Resident SS#7 was observed sitting by the window that looked into the Lewes small dining room. The residents in the dining area were eating lunch while this resident called out throughout the meal to eat and to have breakfast. The resident was served her lunch from a later meal cart that arrived at 11:50 AM. 3. During observation of a dressing change for Resident SS#1 to the buttocks area, the nurse failed to close the door to the room and only partially pulled the privacy curtain to obstruct the view from the roommate. 4. Resident SS#2 was observed to be sleeping in front of the Lewes unit nurse's station with head tilted forward and a five inch strand of nasal discharge dripping onto the resident's shirt. Ten minutes later, the surveyor returned to find the resident in the same condition. The surveyor stopped to obtain the resident's name from behind the wheelchair, concurrently a C.N.A. walked by, greeted the surveyor while passing and rendered no assistance to the resident. 5. Resident #18, a female resident who relied on staff for grooming and hygiene was observed with unwanted facial hair from 2/2/09 through 2/6/09. An additional observation on 2/6/09 at 12:15 PM revealed four additional dependent female residents (SS#3, SS #4, SS #5, and SS #6) with unwanted facial hair.	F 241			
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and	F 253	F253 1. All light sheilds in the physical therapy room and the sussex day room were cleaned and bug carcasses were removed. 2. All light sheilds in the entire facility have been cleaned and bug carcasses removed. 3. The maintenance staff will be inserviced to clean the light sheilds monthly and place them on a preventative maintenance program. 4. The Maintenance Director will perform monthly audits to ensure compliance of cleaning. The finidig will be reported to the QI/compliance Committee quarterly until substantial compliance is met.	2/4/09 2/5/09 4/29/09 ongoing	

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 253	Continued From page 4 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations in the physical therapy room and the day room of the Sussex unit, it was determined that the facility failed to provide housekeeping services necessary to maintain an orderly and comfortable interior. Findings include: 1. Ten out of twelve light shields in the physical therapy room contained many insect carcasses. 2. Four out of six light shields in the Sussex unit day room contained insect carcasses.	F 253			
F 309 SS=D	483.25 QUALITY OF CARE 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, for one resident (#23) during an enema administration and failed to ensure the plans of care were properly implemented with the appropriate	F 309	F309 1. Resident #23 was discharged on 1/2/09. Resident # 2's fluid restriction orders were clarified and the dietary department was notified properly utilizing the Dietary Communication Form on 2/7/09. Resident # 20 and # 9 currently have their safety devices in place per the physicians order. 2. The nurse for resident #23 was counceled and provided 1:1 training regarding the administration of a fleets enema. All residents with orders for fluid restriction will be audited to ensure proper notification was sent to the dietary department and their fluid restriction is being met. Attachment B All residents with orders for safety devices will be audited to insure all devices are available and in use appropriately. All CNA Resident Care Information Sheets will be audited to ensure accuracy of orders, Attachment C + D	2/7/09 1/28/09 4/29/09	

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958	
(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 309	<p>Continued From page 5</p> <p>interventions for three (3) residents (#2, #20, #9,) out of twenty-five (25) sampled residents. Findings include:</p> <p>Cross refer F225, example #1.</p> <p>1. Resident #23 was originally admitted to the facility on 11/6/08 with diagnoses including dementia, diabetes mellitus, status post left hip fracture repair, and was on coumadin for atrial fibrillation. The admission Minimum Data Set (MDS) assessment dated 11/13/08 indicated that the resident was moderately impaired for daily decision making and required cues and supervision. Additionally, the resident had behaviors including periods of altered perception or awareness of surroundings, restlessness, as well as mental function varying over the course of the day. The resident required extensive assistance of two plus staff for transfer and did not ambulate.</p> <p>A review of the nurse's note dated 12/22/08 timed 7:10 PM by Nurse #5 documented "This writer (Nurse #5) and CNA (certified nursing assistant) #1 attempted to give pt. (patient, Resident #23) Fleets enema. Pt. (Resident #23) resisting enema. No bleeding noted, flecks of soft stool expelled from the rectum in the toilet. Called to rm. (room) by CNA #2 and frank red blood from rectum. VS (vital signs) 96.9 % (pulse oximetry), 99 (temperature), 18 (respirations per minute), and 151/85 (blood pressure). Charge nurse notified and verbal telephone order obtained to send pt. (Resident #23) to ER (emergency room) via 911."</p> <p>A review of the hospital's emergency room records dated 12/22/08 revealed the following</p>	F 309	<p>3. All professional nurses will be inserviced on the proper procedure for administering a fleets enema. All professional nurses will be inserviced on the proper procedure for notifying the Dietary Department of a fluid restriction order. All nursing staff will be inserviced regarding placement of safety devices per physician order as to follow the proper plan of care.</p> <p>4. RN Unit Managers/designee will conduct a random audit to insure nurses are giving fleets enemas properly, that dietary is properly notified of fluid restriction orders and that the proper amounts of fluid are being sent from dietary, and safety devices are properly placed with appropriate documentation on the Resident Care Information Sheet. The results of the above audits will be reported to the QI/Compliance Committee until substantial compliance is met.</p>	4/29/09 ongoing

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 309	<p>Continued From page 6</p> <p>laboratory results: 8:11 PM: Hemoglobin (Hgb.) 12.1g/dl low (normal range 13.2-16.9) Hematocrit (Hct.) 38.5 % low (normal range of 40.5-50.6)</p> <p>Subsequent Hgb. and Hct. approximately three hours later at 11:05 PM on 12/22/08 indicated a decrease of Hgb. to 11.8 and Hct. to 37.8. After monitoring in the emergency room, the resident returned to the nursing facility with the discharge diagnosis of gastrointestinal bleeding.</p> <p>A review of the Hgb. and Hct. on 12/25/08 revealed results 11.3 and 33.8 respectively.</p> <p>A written statement by Nurse #5 obtained from the facility indicated that CNA #1 placed the resident in bed at about 6:30 PM and the resident got up from the bed at 7 PM. Nurse #5 and CNA #1 found the resident attempting to toilet self and stating that he had to poop. Nurse #1 proceeded with lubricating the tip of the enema and inserting into the anus (lower opening of the digestive tract, through which feces pass). The resident began to try to sit and yelling "What are you doing to me?" Resident sat on the toilet and Fleets was completed with the tip showing brown feces only. No bleeding noted. At 7:10 PM, CNA #2 and Nurse #6 reported to Nurse #5 that there was blood in the toilet and a large amount of frank red blood was noted in the toilet and coming from the anus.</p> <p>A written statement by CNA #1 obtained from the facility documented that the CNA #1 assisted Resident #23 to stand so that the enema can be given in the bathroom. The statement further indicated that the resident became combative while she was giving him the enema and the resident started to bleed very heavy afterwards.</p>	F 309		

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958	
(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 309	<p>Continued From page 7</p> <p>A review of the facility's nursing policy and procedure on Fleets Enema indicated to assist resident to a left Sims position (body position in which the individual is on the left side with right knee flexed against abdomen and left knee slightly flexed) for the enema administration.</p> <p>A review of the facility's documentation dated 12/30/08 revealed and confirmed that the above policy and procedure on administration of Fleets enema was not followed when the enema was administered to Resident #23 while he was in a standing position.</p> <p>2. Resident #2 was originally admitted to the facility on 9/16/08 with diagnoses including atrial fibrillation, anemia, failed kidney transplant, end stage renal disease, and was on renal dialysis.</p> <p>A record review revealed a physician's order for fluid restriction of 1,500 cc (cubic centimeter) per day dated 2/3/09.</p> <p>A review of the facility's policy titled "Fluid Restriction" indicated that when fluid restriction is ordered, Nursing sends a Dietary Communication to the Dietary Department indicating the amount of fluid.</p> <p>Observations of breakfast and lunch trays on 2/5/09 lacked evidence that the resident was on a 1,500 cc per day fluid restriction.</p> <p>An interview with the staff of food service on 2/6/09 at 9 AM confirmed that the dietary department did not receive a Dietary Communication form regarding the above fluid restriction for Resident #2, thus, the fluid restriction as stated in the plan of care was not</p>	F 309		

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2009	
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 309	<p>Continued From page 8 implemented.</p> <p>3. Resident #20 was admitted to the facility on 12/09/08 with muscle weakness and deconditioning. A review of the physician's orders for February 2009 revealed Resident #20 was to have an alarm monitor on at all times, hipsters on at all times and landing strips on both sides of the bed. He was care planned accordingly. A fall risk assessment dated 12/09/08 placed Resident #20 at a high risk for falls with a score of 10 (high risk = 10 or higher). A further record review revealed the certified nursing assistant (CNA) communication information did not indicate any of the above safety approaches outlined on the sheet, although CNA Flow Sheets were documented that the service was being provided.</p> <p>Multiple observations were made on February 5, 6, and 9, 2009 and revealed Resident #20 did not have an alarm on, was not wearing hipsters and did not have landing strips (2) in his room. These findings were confirmed on 02/09/09 with both Nurse #2 and the Unit Manager of Sussex.</p> <p>4. Resident #9 had current physician's orders and care plan for hipsters (padded undergarment) and low bed with mats to reduce injury in the event of a fall.</p> <p>Resident #9 was found on 1/28/09 at 7:30 AM laying on the floor mat. Although the facility's investigation concluded that all ordered devices were in place, review of staff statements conflicted with this conclusion. Statements revealed that the resident was not wearing the hipsters when found on the floor. Staff also indicated the bed, although not in a high position, was not in the lowest position. The resident also had a bed alarm to alert staff that the resident</p>	F 309		

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958	
(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 309	Continued From page 9 was up that was not in place. These staff statements were corroborated by interview with the family member who found the resident on the floor. The resident sustained no injury from the alleged fall. The facility failed to ensure that all components of the plan of care were implemented when Resident #9 fell.	F 309		
F 312 SS=B	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews it was determined that the facility failed to carry out activities of daily living for those residents who were not able to maintain good grooming and personal hygiene. The facility failed to remove unwanted facial hair on several female residents who relied on staff for care. Findings include: Cross refer F241, example 5. Resident #18, a female resident who relied on staff for grooming and hygiene was observed with unwanted facial hair on her chin and sides of the mouth from 2/2/09 through 2/6/09. An additional observation on 2/6/09 at 12:15 PM revealed four additional dependent female residents (SS#3, SS #4, SS #5, and SS #6) with unwanted facial hair on their chin and sides of their mouth. Interviews with these residents and review of their records revealed that they relied on staff of the facility to	F 312	F312 1. Resident # 18, SS#3, SS#4, SS#5, and SS#6 have been groomed appropriately and chin hair has been removed. 2. All female residents will be observed for unwanted facial hair and groomed appropriately. 3. All nursing staff will be inserviced on providing proper grooming related to unwanted facial hair on female residents. 4. Random audits will be conducted monthly by RN Unit Managers/designee to insure female residents do not have unwanted facial hir. These audits will be conducted until significant compliance is achieved. These outcomes will be reported to the QI/ Compliance Committee for further recommendation. Attachment E	3/13/09 4/29/09 4/29/09 Ongoing

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958	
(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 312	Continued From page 10	F 312		
F 314 SS=D	remove the unwanted facial hair. 483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to implement interventions for the prevention of pressure sores for two (2) residents (#12, #3) and failed to provide appropriate wound care services to prevent infection for one resident (SS#1) out of twenty-five (25) sampled residents. Findings include: 1. Resident #12 was admitted to the facility on 01/13/03 with multiple diagnosis, a history of pressure ulcers and on Hospice since 01/07/08. A pressure risk assessment dated 12/02/08 placed Resident #12 at high risk with a score of 15 (14-29 + high risk). Hospice services began on 01/07/08. A review of the physician's order sheets dated February 2009, revealed an order to float heels while in bed and chair. Resident #12 was care planned accordingly. Certified Nursing Assistant (CNA) Flow Sheets indicated by documentation that the service was being provided. Multiple observations were made on February 2, 3 and 4, 2009 and revealed heels	F 314	F314 1. Resident #12 is deceased. Resident # 3's pressure area is healed. 2. All residents with a physicians order for heel elevation will be audited by the RN Unit Managers . The nurse performing the dressing change will receive 1:1 education regarding proper procedures for dressing changes and proper handwashing technique. Attachment F 3. All nursing staff will be inserviced regarding heel elevation as it pertains to wound prevention. All professional nurses will be inserviced regarding proper procedures for dressing changes and hand washing. 4. The RN/Unit Manager will conduct random audits of all residents with orders for heel elevation, dressing changes, and monitor the nurses handwashing technique monthly and report findings to the QI/ Compliance Committee quarterly for recommendations and until substantial compliance is met.	4/29/09 4/29/09 4/29/09 ongoing

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 314	Continued From page 11 were not being floated. This finding was confirmed with the Henlopen Unit Manager on 02/04/09. 2. Resident #3 was admitted to the facility on 09/02/06 with multiple diagnosis and had a history of pressure ulcers. A pressure risk assessment dated 07/14/08 placed Resident #3 at a moderate risk with a score of 12 (8-13 = moderate risk). A review of the physician's order sheet dated February 2009, revealed an order to float heels when in bed. Resident #3 was care planned accordingly. CNA Flow Sheets indicated by documentation that the service was being provided. Multiple observations were made on February 2, 3 and 4, 2009 and revealed heels were not being floated. This was finding was confirmed with the Henlopen Unit Manager on 02/04/09. 3. On 2/6/09 at 10:47 AM a treatment to a pressure sore to Resident #SS1's sacral area was observed. Nurse #3 was not seen washing her hands before approaching the resident. The nurse donned gloves and then used her gloved hands to crank the head of the bed down. The nurse used this same pair of gloves with no additional handwashing and removed the resident's old dressing. Nurse #3 then changed gloves and pulled the light cord with her newly gloved hands before proceeding with the dressing change. The nurse risked contamination of the wound when touching the crank and the light cord without washing hands afterward.	F 314			
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a	F 315			

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 315	<p>Continued From page 12</p> <p>resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to provide the appropriate care and services to prevent infection for one resident (#12) out of twenty-five (25) sampled residents. Findings include:</p> <p>Resident #12 was historical for pressure ulcers and had a Foley catheter in place to promote wound healing. According to the clinical record, Resident #12 was placed on contact isolation for Methicillin-resistant Staphylococcus Aureus (MRSA - a bacterium difficult to treat) of the urine. Multiple observations were made of Resident #12 from February 2, 3 and 4, 2009 with the Foley drainage bag and tubing laying on the floor at the bedside. On 02/03/09 at 2:15 PM, while the catheter was still in place and attached to the resident, the bag and tubing were observed in the trash can by the bedside.</p> <p>A review of facility nursing policy for catheter care to prevent infection of the resident's urinary tract reflected that catheter tubing and bag should be kept off the floor.</p> <p>An interview with the Unit Manager on the</p>	F 315	<p>F315</p> <ol style="list-style-type: none"> 1. Resident #12 is deceased. 2. All residents with a physicians order for a foley catheter will be audited to insure proper placement of the bag and tubing. Attachment G 3. All nursing staff will be inserviced on the proper placement of a foley catheter and tubing. 4. . The RN/Unit Manager will conduct an audit of all residents with foley catheters monthly and report findings to the QI/ Compliance Committee quarterly for recommendations. 	<p>4/29/09</p> <p>4/29/09</p> <p>ongoing</p>	

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 315	Continued From page 13 Henlopen Wing on 02/04/09 at 1:40 PM confirmed these findings.	F 315			
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 observation it was determined that the facility failed to maintain an environment free from accidents. Two staff members were observed transporting oxygen tanks unsecured. Findings include: 1. On 2/6/09 at 10 AM, staff nurse was observed carrying an unsecured oxygen tank to a resident. 2. On 2/9/09 at 10:05 AM, staff of the rehabilitation department was observed in the hallway with a resident who was using the oxygen via nasal cannula while ambulating with a walker. The staff member placed the oxygen tank over his shoulder and followed the resident who was ambulating.	F 323	F323 1. The oxygen tanks in the facility have been secured appropriately. 2. The nurse and the therapist observed will be inserviced on properly securing oxygen tanks. 3. All nurses and therapy staff will be inserviced on proper transportation of oxygen tanks. 4. The Rehabilitation Director and RN Unit Managers will conduct random audits to insure proper transportation of oxygen tanks. Findings will be reported to the Safety Committee monthly.	2/9/09 4/29/09 4/29/09	
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329			

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958	
(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 329	<p>Continued From page 14</p> <p>adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review it was determined that the facility failed to monitor two (2) residents (#15, #3) out of twenty-five (25) sampled residents for the side effects of a antipsychotic medication. Findings include:</p> <p>1. Resident #15 was admitted to the facility on 01/30/08 with BiPolar disorder and presenile dementia. A review of Resident #15's physician's order sheet from admission, revealed an order for Zyprexa, an antipsychotic drug. In addition, an order for an AIMS test every 6 months (Jan/July) was reviewed. Record review revealed the AIMS (Abnormal Involuntary Movement Scale) was not performed until 02/14/08 and then again on 11/11/08. Prior to administering the drug Zyprexa, an AIMS (neurological screening assessment)</p>	F 329	<p>F329</p> <p>1. Resident #15's AIMES test was completed on 11/11/08 and is due to be completed again on 5/11/09. Resident #3's AIMES test was completed on 1/1/09 and is due to be completed again on 7/1/09.</p> <p>2. All residents on psychotropic medications will be reviewed to insure the AIMES test is current and timely.</p> <p>3. All professional nurses will be inserviced on the policy regarding timeliness of AIMES testing.</p> <p>4. The RN Unit Manager/designee will conduct monthly audits of all residents on psychotropics for AIMES test completion. The RN/Unit Managers will report the findings to the QI/ Committee until substantial compliance is met.</p> <p>Attachment H</p>	<p>4/29/09</p> <p>4/29/09</p> <p>ongoing</p>

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 329	Continued From page 15 was not performed in order to develop a baseline to monitor for clinically significant adverse consequences of the medication regimen or to monitor for an unanticipated decline in order for the drug regimen to be modified when appropriate. 2. Resident #3 was admitted to the facility on 09/02/06 with paranoia psychosis. A review of Resident #3's physician order sheet revealed an order for Zyprexa with an order for an AIMS Test every 6 months (Jun/Dec). Record review reflected the AIMS test for June was not performed until 08/13/08. A review of facility policy and procedures for the AIMS testing, stated when a resident is initially placed on an anti-psychotic drug, the nurse will administer the AIMS test, again 30 days later and then every 6 months. Further, facility policy on Atypical Anti-Psychotic Medication states side effects of the medication will be monitored.	F 329			
F 371 SS=F	The facility failed to initiate and implement interventions to adequately monitor Residents #15 and #3 for any adverse side effects of the use of an antipsychotic medication. 483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 1. The Sussex and Lewes Unit dayroom refrigerators, flatware holders, and the microwaves have been cleaned. 2. The cleaning of the refrigerators, flatware holders, and microwaves will be put on a cleaning schedule for housekeeping to perform the service in all dayroom areas. 3. The housekeeping staff will be inserviced to the scheduled routine cleaning of the above stated areas. 4. The Director of Housekeeping will conduct weekly audits of the dayroom refrigerators, flatware holders, and microwaves to insure cleanliness. The findings will be reported to the QI/Compliance	3/6/09 4/29/09 4/29/09 ongoing	

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 371	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observations in the individual unit day / dining rooms, it was determined that the facility failed to store, distribute, and serve food under sanitary conditions. Findings include: 1. The Sussex unit day / dining room Frigidaire-brand refrigerator freezer was observed to have a dirty bottom surface where spills had dried / frozen. This room also had a flatware holder, containing flatware, that was dirty with crumbs and debris. The GE-brand microwave oven in this area had food debris and spatters on the interior surfaces. A follow-up observation of this room two days after the initial observation revealed the same findings. 2. The Lewes unit day / dining room Hotpoint-brand refrigerator freezer was observed to have a dirty bottom surface where spills had dried / frozen. The GE-brand microwave oven in this area had food debris and spatters on the interior surfaces.	F 371			
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425	F425 1. All medication carts were locked upon findings by surveyor. 2. Nurses involved were counceled on proper procedures for locking the medication cart. 1:1 inservicing provided immediately. 3. Professional Nursing staff will be inserviced regarding locking the medication cart. 4. A random audit of medication carts will be completed by the RN Unit Manager and reported to the QI/Compliance Committee for further recommendation. <i>Attachment II</i>	2/3/09 2/9/09 4/29/09 ongoing	

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958	
(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 425	Continued From page 17 the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure the safe storage of medications. Findings include: On 02/03/09 at 6:50 AM and 02/05/09 at 11:45 AM, 2 medication carts were left unlocked and unattended on the Sussex Wing. On 02/03/09 at 7:00 AM, one medication cart was left unlocked and unattended on the Henlopen Wing.	F 425		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to ensure staff washed their hands between resident to resident contact for three (3) occasions. Findings include: 1. On 2/6/09 a wound dressing change by Nurse # 3 was observed. After the treatment the nurse	F 444	F444 1. Nurses involved will receive 1:1 training on the proper handwashing procedure. 2. The RN Unit Manager will conduct random audits to insure that proper handwashing is completed during the medication pass and dressing changes. <i>Attachment J</i> 3. Professional nursing staff will be inserviced on appropriate handwashing techniques during medication pass and dressing changes. 4. . The data will be tracked and trended by the ADON and reported to the QI/Compliance Committee quarterly until substantial compliance is met.	3/16/09 4/29/09 4/29/09

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

PRINTED: 02/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2009
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 444	<p>Continued From page 18</p> <p>did not wash her hands. The nurse proceeded to take another resident back to her room to do a finger stick to test blood sugar. After doing the finger stick the nurse drew up and administered insulin to this resident. The nurse then washed her hands. The nurse failed to wash her hands between resident contacts.</p> <p>2. During a medication pass on 02/03/08 at 7:45 AM, Nurse #4 was observed hand washing, following the pass. After performing hand hygiene, Nurse #4 turned off the faucet with her bare hands. During the same medication pass, Nurse #4 donned gloves to provide direct resident contact care. Following resident care, Nurse #4 removed gloves in hallway, tossed soiled gloves in the medication cart receptacle and did not perform hand hygiene.</p> <p>A review of facility policy and procedures for Hand Hygiene indicated hand washing should always be performed before and after resident contact and that the faucet should be turned off with a clean paper towel.</p> <p>The facility failed to ensure that staff used appropriate hand washing techniques to prevent the spread of infection from one resident to another.</p>	F 444			

LTC Residents Protection

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085034	MULTIPLE COMPLETION A. BUILDING _____ B. WING _____ MAR 10 2009 Director's Office	DATE SURVEY COMPLETE: 2/9/2009
----------------------------------------------------------------------------------------------------------------	-----------------------------	-------------------------------------------------------------------------------------------------------------	------------------------------------------

NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE
--------------------------------------------------------------------------	-----------------------------------------------------------------------------------

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
---------------	-----------------------------------

F 166

483.10(f)(2) GRIEVANCES

A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

This REQUIREMENT is not met as evidenced by:

Based on interview and facility policy, it was determined that the facility failed investigate a grievance for one resident (#16) out of twenty-five (25) sampled residents. Findings include:

On 02/02/09, during the initial tour of the facility, Resident #16 stated he had a pair of slacks missing after sending them to the laundry approximately two-three months ago. He stated he reported the missing clothing to Nurse #1 who stated on 02/09/09 that she recalled the conversation with Resident #16 approximately four (4) weeks prior and subsequently reported it to the Assistant Laundry Supervisor. The Assistant Laundry Supervisor stated he recalled the conversation with both Nurse #1 and Resident #16. Facility policy and procedures for Resident Concerns/Grievances states all concerns will be documented by the department head/nurse on a specific form. Further, the department head/nurse had ten (10) days to complete a review and follow-up as necessary. There was no record for this particular concern on file.

Upon inquiry to the Housekeeping/Laundry supervisor by this surveyor on 02/03/09, a search was launched and the slacks were located within two hours and returned to Resident #16.

The facility failed to investigate a grievance for Resident #16 in a timely manner.

F 334

483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION

The facility must develop policies and procedures that ensure that --

- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
- (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
- (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
- (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
 - (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
 - (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --

- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085034	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 2/9/2009
----------------------------------------------------------------------------------------------------------------	-----------------------------	-------------------------------------------------------------	------------------------------------------

NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE
--------------------------------------------------------------------------	-----------------------------------------------------------------------------------

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
---------------	-----------------------------------

F 334	<p>Continued From Page 1</p> <p>receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility failed to ensure that the pneumococcal immunization was provided for one resident (#13) out of twenty-five sampled residents. Findings include:</p> <p>Resident #13, alert and oriented, was admitted to the facility on 08/09/08. Two months later on 10/02/08, she was offered both the influenza and pneumococcal immunizations. Initially, Resident #13 refused the pneumococcal. However, later, on the same date, she agreed to receiving the vaccine because she "does not know if she had before." Subsequent to 10/02/08, Resident #13 never received the pneumococcal vaccine.</p>
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------



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

Notice of Deficiency
LTC Residents Protection
MAR 10 2009
Director's Office

NAME OF FACILITY: Harbor Health Care

DATE SURVEY COMPLETED: February 9, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201 3201.6.0 3201.6.1 3201.6.1.1	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual and complaint visit was conducted at this facility from February 2, 2009 through February 9, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The census on the first day of the survey was one hundred sixty-two (162). The survey sample totaled twenty-five (25), twenty-two (22) active and three (3) closed records respectively. An additional six (6) sub-sampled residents were observation only.</p> <p>Regulations for Skilled and Intermediate Care Nursing Facilities</p> <p>Services to Residents</p> <p>General Services</p> <p>The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet</p>	

Provider's Signature: Nancy Saunders, R.N., MHA Title: Administrator Date: 3/9/09



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: Harbor Health Care

DATE SURVEY COMPLETED: February 9, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201.6.9</p> <p>3201.6.9.1</p>	<p>their medical, nursing, nutritional, and psychosocial needs.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 2/9/09, F309, F312, F314, F315, F323, F329.</p> <p>Housekeeping and Laundry Services:</p> <p>The facility shall employ sufficient housekeeping personnel and provide the necessary equipment to maintain a safe, clean, and orderly environment, free from offensive odors, for the interior and exterior of the facility.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 2/9/09, F253.</p>	<p>Cross reference CMS 2567-L Plan of correction for F 309, F312, F314, F315, F323, F329.</p>
<p>3201.6.12</p> <p>3201.6.12.2</p> <p>3201.6.12.2.3</p>	<p>Communicable Diseases</p> <p>Specific Requirements for Tuberculosis</p> <p>All facilities shall have on file results of tuberculin tests performed on all newly</p>	<p>Cross reference CMS 2567-L Plan of correction for F 253</p>



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: Harbor Health Care

DATE SURVEY COMPLETED: February 9, 2009

SECTION **STATEMENT OF DEFICIENCIES** **ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED**

admitted residents and newly hired employees, and annually thereafter on all employees. A tuberculin test as specified, done within the twelve months prior to employment, or a chest x-ray showing no evidence of active tuberculosis shall satisfy this requirement for asymptomatic individuals. If an individual was previously documented as a positive reactor or has a history of hypersensitivity to the PPD test, a negative chest x-ray shall meet this requirement.

This requirement is not met as evidenced by:

Resident #23 was admitted to the facility on 11/06/08. The first step PPD was given on 11/07/08 followed by the second step on 11/13/08. There was no evidence on the Medication Administration Record or in the chart that either PPD had been read.

Persons who do not have a significant reaction to the initial tuberculin test shall be retested within 7-21 days to identify those who demonstrate delayed reactions. Initial tests done within one year of a previous test need not be repeated in 7-21 days.

This requirement is not met as evidenced by:

3201.6.12.2.6

1. Resident #23 has been discharged
Resident #20's PPD was re-administered.

2/9/09

2. All residents will be reviewed by medical records to insure the 2-step PPD was completed on admission.

4/29/09

3. Professional Nurses will be inserviced on proper procedure for administering PPD immunizations.

4/29/09

4. All new admissions will be audited by the Medical Records Department to insure compliance. The findings will be reported to the QI/Compliance Committee by the ADON unit substantial compliance is met. Attachment 1

ongoing



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: Harbor Health Care

DATE SURVEY COMPLETED: February 9, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.12.3	Resident #20 was admitted to the facility on 12/09/08. The first step PPD (Tuberculin test) was administered upon admission and negative. Medication administration records reflect the second step was to be given on 12/18/08 but was never performed. This finding was confirmed with the Unit Manager of Sussex Wing on 01/06/09 at 12:30 PM.	
3201.6.12.3.2	<p>Immunizations</p> <p>All facilities shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control unless medically contraindicated.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 2/9/09, F334.</p>	
3201.7.0	Plant, Equipment and Physical Environment	
3201.7.5	Kitchen and Food Storage Areas	
3201.7.5.1	Facilities shall comply with the Delaware Food	<p>Cross reference CMS 2567-L Plan of Correction F334</p>



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLICRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Harbor Health Care

DATE SURVEY COMPLETED: February 9, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>16 Del. C., Chapter 11, Subchapter II, §1121</p>	<p>Code.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 2/9/09, F371.</p> <p>Patient's Rights</p> <p>Patient's Rights</p> <p>(8) Every patient and resident shall receive from the administrator or staff of the facility a courteous, timely and reasonable response to requests, and the facility shall make prompt efforts to resolve grievances. Responses to requests and grievances shall be made in writing upon written request by the patient or resident.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 2/9/09, F166.</p> <p>Reporting Requirements</p> <p>(a) Any employee of a facility or anyone who provides services to a patient or resident of a</p>	<p>Cross reference CMS 2567-L Plan of Correction F371</p> <p>Cross reference CMS 2567-L Plan of Correction F166</p>
<p>16 Del. C., Chapter 11, Subchapter III, § 1132</p>	<p>Reporting Requirements</p> <p>(a) Any employee of a facility or anyone who provides services to a patient or resident of a</p>	<p>Cross reference CMS 2567-L Plan of Correction F166</p>



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: Harbor Health Care

DATE SURVEY COMPLETED: February 9, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>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 exploited shall immediately report such abuse, mistreatment, neglect or financial exploitation to the Department by oral communication. A written report shall be filed by the employee or service provider within 48 hours after the employee or service provider first gains knowledge of the abuse, mistreatment, neglect or financial exploitation.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 2/9/09, F225.</p>	<p>Cross reference CMS 2567-L Plan of Correction F225</p>



**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

Page 7 of 9

NAME OF FACILITY: Harbor Health Care

DATE SURVEY COMPLETED: February 9, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	----------------------------------------------------	-----------------------------------------------------------------------------------------------

	Blank	Page
--	-------	------



**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

DATE SURVEY COMPLETED: February 9, 2009

NAME OF FACILITY: Harbor Health Care

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	----------------------------------------------------	-----------------------------------------------------------------------------------------------

	Blank	Page
--	-------	------



**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

Page 9 of 9

NAME OF FACILITY: Harbor Health Care

DATE SURVEY COMPLETED: February 9, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	----------------------------------------------------	-----------------------------------------------------------------------------------------------

	Blank	Page
--	-------	------