

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  1093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ <b>LTC Residents Protection</b> B. WING _____	(X3) DATE SURVEY COMPLETED  MAR 05 2010 01/13/2010
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MASONIC HOME OF DELAWARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE 4800 LANCASTER PIKE WILMINGTON, DE 19807 <b>Director's Office</b>
---	--

(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 initial certification survey was conducted at this facility from January 4, 2010 through January 13, 2010. The facility census on the entrance day of the survey was 17 residents. The survey sample was composed of 8 residents. The survey process included observations and resident, family and staff interviews. Also included in the survey process was the review of clinical records and facility policies and procedures.	F 000	<b>A. Corrective Action – F226 (#1)</b> F226 (#1)B18 background check performed 1/10/2010, B19 background check performed 1/10/2010 & background check performed 1/18/2010. F226 (#2) A new policy will be implemented to ensure all staff members comply with attending this required in-services.	1/18/10
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on review of personnel files, interviews, review of facility documentation and policy and procedures, it was determined that the facility failed to ensure that a thorough background investigation was completed for three (B18, B19 and B20) of twenty-one sampled employees and that the annual abuse training was completed for three (T5, T7 and T17) of eighteen sampled employees. Findings include:  1. A memo regarding background checks dated 1/8/2010 by the State Investigative Administrator revealed that three employees were not in compliance with the requirement for complete background checks. The Record Request form for the fingerprinting for B18 and the Record Request form for the current facility for B19 and B20 were not available.	F 226	<b>B. Identification of other employees</b> (#1)-To ensure all employees including contract services employees have been fingerprinted for background checks all supervisor &/or managers will notify Human Resources when hiring new employees to include any contractual employees in their department to provide proof that background checks are complete. (#2)- All employees are listed individually per department on the master employee sheet.  <b>C. System Implemented</b> (#1)-No applicant will start employment until a background check or proof of a background check has been performed and presented to the Human Resource manager. (#2)- Annual abuse/neglect training will be offered at various dates & times in the month of February. The Director of Social Services will organize & facilitate this training to educate all employees on abuse and neglect in the long term care environment. Employees will be required to sign-up in advanced for a scheduled session. Employees will be required to sign-in when attending the training to ensure accurate recordkeeping.	2/28/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 3/5/2010
---	-----------------------------	-----------------------

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>MASONIC HOME OF DELAWARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4800 LANCASTER PIKE WILMINGTON, DE 19807</b>	
(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 226	Continued From page 1	F 226	<b>F226, Continue</b>	
F 253 SS=C	<p>2. The date of hire for T5, T7 and T17 was 8/11/1987, 10/30/2003 and 5/18/2008, respectively. The Social Worker confirmed that the abuse and neglect training records for 2009 were not available for these employees.</p> <p>According to the Operational Policy and Procedure Manual, the annual in-service training shall include mistreatment, neglect and abuse. There was no evidence that these employees had received the abuse and neglect training.</p> <p><b>483.15(h)(2) HOUSEKEEPING/MAINTENANCE</b></p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations on 1/5/2010 and interviews, it was determined that the facility failed to provide the housekeeping and maintenance services in a sanitary and orderly manner as reflected by malfunctioning staff toilet, dusty ceiling vent, and damaged and unpainted repaired walls. Findings include:</p> <p>1. Observations at 9:20 AM of the female restroom for the kitchen staff revealed that a damaged wall next to a malfunctioning toilet which were below a dusty ceiling vent. The Food Service Director confirmed these observations.</p> <p>2. Observations at 1:00 PM of resident room 115 revealed that the bathroom wall by the soap dispenser was damaged. Additionally, repaired walls throughout the Health Center were not</p>	F 253	<p><b>D. Quality Assurance Monitoring</b> (#1)-A checklist of new hires and status of background checks will be monitored by Human Resource manager to make sure that all employees are in compliance. The number of completed background checks will be reported on the monthly Quality Assurance report and reviewed during the quarterly Quality Assurance meeting. (#2)-The Director of Social Services will inform in writing the Executive Director and the department managers of those staff members who have failed to participate in the abuse/neglect training sessions. For those employees who do not attend a training session on abuse/neglect disciplinary action will be taken.</p> <p><b>F 253 SS=C</b></p> <p><b>A. CORRECTIVE ACTION</b> 1.) The damaged dry wall was repaired and painted. The internal parts of the malfunctioning toilet were removed and replaced. The dusty ceiling vent was removed, cleaned and returned to the ceiling. A Kotex feminine product dispenser was installed in the ladies staff restroom, the dispenser will be maintained by the Highfield assistant comptroller. A sanitary waste repository was installed in the ladies restroom. A monthly cleaning log has been placed in the staff restroom to ensure that issues related to housekeeping and maintenance services are corrected in a timely matter. 2.) The wall around the soap dispenser in resident room 115 were repaired, sanded and painted. Other walls through-out the Health Care Center were repaired, sanded and painted.</p>	1/16/10  1/11/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  1093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/13/2010
NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF DELAWARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4800 LANCASTER PIKE WILMINGTON, DE 19807		
(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 2 painted. These observations were confirmed on 1/6/2010 at 3:00 PM during the maintenance tour with the Environmental Services Director.	F 253	<b>F 253 SS=C, Continue</b>		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS  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, 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.  This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and staff interviews it was determined that the facility developed care plans that failed to address behaviors of resistance to care exhibited by 2 residents (#1 and #3) and their regime of psychotropic medications with measurable goals and specific interventions. Findings include:  The facility policy "Care Plans-Comprehensive"	F 280	<b>B. IDENTIFICATION OF OTHER STAFF</b> 1.) Food Service Director will in-service staff in cleaning log in restrooms. Director of Facility Management will collect cleaning logs on a monthly basis. 2.) Staff and residents are encouraged to submit Avoid Verbal Order's (AVO) when maintenance issues are observed, so that the maintenance crew can respond within 72 hours. <b>C. SYSTEMS IMPLEMENTED</b> 1.) Food Service Director has assigned staff member to clean the kitchen staff's restroom daily. Director of Facility Manager will collect logs on a monthly basis. 2.) Maintenance crew will take corrective action within 72 hours of receiving AVO. <b>D. QUALITY ASSURANCE MONITORING</b> 1.) Director of Facility Management will collect cleaning log on a monthly basis, so issues related to housekeeping and maintenance services are addressed in a regular and timely manner. Logs will be maintained as a part of the monthly cleaning log binder. Director of Facility Management will make weekly walk around visual inspections. Findings will be noted in the monthly Quality Assurance report and reviewed in quarterly Quality Assurance meeting 2.) Director of Facility Management will maintain an AVO binder and make weekly walk around visual inspections. Findings will be noted in the monthly Quality Assurance report and reviewed in quarterly Quality Assurance meeting		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MASONIC HOME OF DELAWARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4800 LANCASTER PIKE WILMINGTON, DE 19807</b>
---	--

(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 2 painted. These observations were confirmed on 1/6/2010 at 3:00 PM during the maintenance tour with the Environmental Services Director.	F 253		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS</p> <p>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.</p> <p>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, 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 clinical record reviews and staff interviews it was determined that the facility developed care plans that failed to address behaviors of resistance to care exhibited by 2 residents (#1 and #3) and their regime of psychotropic medications with measurable goals and specific interventions. Findings include:  The facility policy "Care Plans-Comprehensive"</p>	F 280	<p><b><u>Corrective Action</u></b> F280 Resident (#1) Comprehensive Care Plan has been revised to now include problem #4 Anxiety: measurable goals &amp; interventions are in place to address resistance to care as exhibited by ill-behaviors.</p> <p><b><u>Identification of other Residents</u></b> All residents have the potential to be affected. Those identified either by Diagnosis, medications or day to day behavioral monitoring will be care planned for their condition.</p> <p><b><u>System Implemented</u></b> Care Plan Coordinator will review charts weekly to ascertain revisions and updates have been added to the Comprehensive Care Plan.</p> <p><b><u>Quality Assurance Monitoring</u></b> The Director of Nursing or designee will report care planned residents with monthly Quality Assurance Report, as well as during Quarterly QA Meeting.</p>	<p>1/4/10</p> <p>2/28/10</p> <p>2/28/10</p> <p>2/28/10</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MASONIC HOME OF DELAWARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4800 LANCASTER PIKE WILMINGTON, DE 19807</b>
---	--

(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 3</p> <p>states "...2. The Comprehensive Care Plan is based on a thorough assessment...Assessments of residents are ongoing and care plans are revised as information about the resident and the residents's condition change. 3. Each resident's Comprehensive Care Plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with the identified problems...e. Reflect treatment goals, timetables and objectives in measurable outcomes..."</p> <p>1. Review of the clinical record revealed Resident #1 had diagnoses that included senile dementia of the Alzheimer type with psychotic episodes, depression, anxiety, hypertension, degenerative joint disease and ambulatory dysfunction. Further review of the clinical record revealed that Resident #1 exhibited behavior resistant to care as demonstrated by refusal of meals, medications, bathing and personal care during the 7-3 shift and 3-11 shift between June 13, 2009 and July 22, 2008. Additionally review of the clinical record revealed that Resident #1 was receiving psychotropic medications that included an anti-depressant, anti-anxiety medications and antipsychotic medication that required monitoring every six months.</p> <p>Review of the care plan dated 6/17/09 and updated care plan dated 10/19/09 revealed failure of the facility to identify and to address the problem of Resident #1's behavior of resistance to care and medication regime with measurable goals and specific interventions. These findings were reviewed and confirmed by L1 (acting DON) on 1/13/2010.</p> <p>2. Clinical record review revealed Resident #3</p>	F 280	<p><b><u>Corrective Action</u></b> F280 Resident (#3) Comprehensive Care Plan has been revised to now include problem #6 <b>Agitation: measurable goals &amp; interventions are in place to address resistance to care as exhibited by ill-behaviors.</b></p> <p><b><u>Identification of other Residents</u></b> All residents have the potential to be affected. Those identified either by Diagnosis, medications or day to day behavioral monitoring will be care planned for their condition.</p> <p><b><u>System Implemented</u></b> Care Plan Coordinator will review charts weekly to ascertain revisions and updates have been added to the Comprehensive Care Plan.</p> <p><b><u>Quality Assurance Monitoring</u></b> The Director of Nursing or designee will report care planned residents with monthly Quality Assurance Report, as well as during Quarterly QA Meeting.</p>	<p>2/10/10</p> <p>2/10/10</p> <p>2/28/10</p> <p>2/28/10</p>
-------	---	-------	--	---

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MASONIC HOME OF DELAWARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4800 LANCASTER PIKE WILMINGTON, DE 19807</b>
---	--

(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 4</p> <p>had diagnosis that included frontal lobe dissociation with Parkinson's disease, meningioma of the frontal lobe, aphasia, dementia with delusions and hospice care. Review of nurses' notes documented between 9/28/09 and 10/9/09 during the day and evening shifts revealed that Resident #3 displayed behaviors of screaming, yelling and kicking that was observed and directed toward staff. Resident #3's medication regime included anti-anxiety, antipsychotic and anticonvulsant medications.</p> <p>Further review of the clinical record revealed the facility developed a care plan dated 11/10/09 without measurable goals and specific interventions to address actual behaviors exhibited by Resident #3. Review of the above referenced care plan also revealed the absence of the development of measurable goals or the implementation of specific interventions that addressed psychotropic medications received by Resident #3.</p> <p>Theses findings were reviewed and confirmed with L1(acting DON), L2 (staff nurse) and ED (executive director) on 1/13/2010.</p>	F 280		
F 281 SS=D	<p>483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review and review of facility policies and procedures it was determined that the facility failed to provide the necessary care and services</p>	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2010</b>	
NAME OF PROVIDER OR SUPPLIER  <b>MASONIC HOME OF DELAWARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4800 LANCASTER PIKE WILMINGTON, DE 19807</b>		
(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 281	<p>Continued From page 5</p> <p>that met professional standards of clinical practice for 1 resident (#SS1) out of eight residents in the sample. Findings include:</p> <p>Clinical record review revealed Resident #SS1 had diagnoses that included GERD (gastroesophageal reflux disease). Review of the clinical record also revealed a "Physician's Order" form dated January (20)10 with an order that stated Omeprazole DR 20mg capsule (For Prilosec DR 20mg Caps) 1 capsule by mouth daily "Give 30-60 minutes before meals".</p> <p>Observations of medication administration during the day shift on 1/6/2010 revealed that Resident #SS1 received the above medication after breakfast. When questioned by this surveyor on 1/6/2010 the medication nurse, L3, stated Resident #SS1 refused to take any medications by mouth before the breakfast meal. During further questioning L3 confirmed that the facility had instead administered Omeprazole DR 20mg to Resident #SS1 after breakfast and without notification of her physician. These findings were reviewed and confirmed with L2 on 1/6/2010 and 1/12/2010.</p> <p>The facility policy "Medication Administration" states "Medications are administered as prescribed in accordance with manufacturer's specifications, good nursing principles and practices...Procedures...Medication Administration...1. Medications are administered in accordance with written orders of the prescriber...3. Medication administration timing parameters include the following...a. Medications to be given on an empty stomach or before (ac) meals are to be scheduled for administration 30 minutes to 2 hours prior to meals...".</p>	F 281	<p><b><u>Corrective Action</u></b> F281 Resident (#SS1) Medical Director was contacted immediately regarding resident. Time of medication administration for Omeprazole was changed to 0630. Resident is now accepting medication at 0630.</p> <p><b><u>Identification of other Residents</u></b> A review of all Medication Administration Records was done to ascertain that no other resident who is receiving Proton Pump Inhibitors was affected by incorrect time of administration.</p> <p><b><u>System Implemented</u></b> All nurses will be given a copy of the Medication Administration P&amp;P, which will require a signed receipt to be placed in file. Also each nurse will be required to attend a yearly in-service regarding the facility's Medication Policy presented by our Consultant Pharmacist.</p> <p><b><u>Quality Assurance Monitoring</u></b> The Director of Nursing or designee will maintain in-service records for nurse's compliance. The Consultant Pharmacist will monitor MAR's monthly.</p>	<p>1/6/10</p> <p>1/6/10</p> <p>2/28/10</p> <p>2/28/10</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2010</b>																					
NAME OF PROVIDER OR SUPPLIER  <b>MASONIC HOME OF DELAWARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4800 LANCASTER PIKE WILMINGTON, DE 19807</b>																						
(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 281	Continued From page 6	F 281	<b>F323 SS=E</b>																						
F 323 SS=E	<p>The facility failed to comply with facility policy and procedures to ensure that Resident #SS1 received the medication, Omeprazole DR 20mg capsule 1 capsule by mouth daily 30 - 60 minute before meals, as prescribed by her physician.</p> <p><b>483.25(h) ACCIDENTS AND SUPERVISION</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, it was determined that the facility failed to maintain an environment free of hazards as reflected by unsafe hot water temperatures, and nonfunctioning night lighting. Findings include:</p> <p>1. Observations of unsafe hot water temperatures include the following:</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Time</th> <th>Location</th> </tr> </thead> <tbody> <tr> <td>1/5/10</td> <td>12:45 PM</td> <td>Rm 116</td> </tr> <tr> <td>117.5</td> <td></td> <td></td> </tr> <tr> <td>1/5/10</td> <td>12:55 PM</td> <td>Rm 111</td> </tr> <tr> <td>115.3</td> <td></td> <td></td> </tr> <tr> <td>1/5/10</td> <td>1:00 PM</td> <td>Rm 115</td> </tr> <tr> <td>118.1</td> <td></td> <td></td> </tr> </tbody> </table> <p>An interview with the Environmental Services</p>	Date	Time	Location	1/5/10	12:45 PM	Rm 116	117.5			1/5/10	12:55 PM	Rm 111	115.3			1/5/10	1:00 PM	Rm 115	118.1			F 323	<p><b>A. CORRECTIVE ACTION 1</b></p> <p>1.) Maintenance takes water temperature reading in 6 units two times a day and takes corrective action as required. Director of Facility Management will maintain a log of water temperature readings.</p> <p>2.) Each night light unit was inspected and determined to need a new bulb installed, 25 watt bulbs were installed in each night light fixture. Director of Facility Management will inspect that nights lights are functional as part of weekly walk around.</p> <p><b>B. IDENTIFICATION OF OTHER STAFF AND RESIDENTS</b></p> <p>1.) Staff and residents are encouraged to submit AVO's when irregular water temperatures are noticed.</p> <p>2.) Staff and residents are encouraged to submit AVO's when it noticed that night lights are not functioning.</p> <p><b>C. SYSTEMS IMPLEMENTED 1</b></p> <p>1.) Maintenance crew will take corrective action within 72 hours of receiving AVO.</p> <p>2.) Maintenance crew will take corrective action within 72 hours of receiving AVO.</p> <p><b>D. QUALITY ASSURANCE MONITORING</b></p> <p>1.) Maintenance crew will take corrective action within 72 hours of receiving AVO. Director of Facility Management will maintain a log of water temperature readings. Director of Facility Management will maintain an AVO binder and make weekly walk around inspections. Findings will be noted in the monthly Quality Assurance report and reviewed in quarterly Quality Assurance meeting. Maintenance crew will take corrective action within 72 hours of receiving AVO.</p>	1/29/10  1/7/10
Date	Time	Location																							
1/5/10	12:45 PM	Rm 116																							
117.5																									
1/5/10	12:55 PM	Rm 111																							
115.3																									
1/5/10	1:00 PM	Rm 115																							
118.1																									

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>MASONIC HOME OF DELAWARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4800 LANCASTER PIKE WILMINGTON, DE 19807</b>	
(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	Continued From page 7 Director confirmed the above hot water temperatures.	F 323	<b>F323 SS=E, Continue</b> 2.) Director of Facility Management will maintain an AVO binder and make weekly walk around visual inspections. Findings will be noted in the monthly Quality Assurance report and reviewed in quarterly Quality Assurance meeting.	
F 371 SS=F	<b>483.35(i) SANITARY CONDITIONS</b>  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  This REQUIREMENT is not met as evidenced by: Based on observations with the Food Service Director and staff interviews, it was determined that the facility failed to provide sanitary conditions for the storage of food. Findings include:  The following findings were observed on 1/5/2010:  1. Observations at 8:35 AM of the kitchen ice machine revealed that the tubing extended below the lip of the splash guard.  2. Observations at 9:00 AM of the ice cream freezer chest revealed that a thermometer was	F 371	<b>A. Corrective Action - F371</b> 1. The extended tubing below the lip of the splash guard was corrected by shortening the tubing to the correct length above the splash guard by Maintenance/Engineering on Thursday, January 7, 2010 2. A freezer thermometer was placed in ice cream chest on January 18, 2010. 3. To reduce the risk of utilizing dripping wet lids for meal service, additional lids are being sent to the department. These additional lids will ensure enough dome lids for each meal service, which will not require staff to have to wait to use just washed lids. The additional dome lids were shipped on Friday, February 19, 2010. 4. A covered receptacle was provided for the ladies toilet room on the lower level on Friday, January 8, 2010. 5. January 21, 2010, the dish washer data plate was identified on the lower right side of the machine temperature gauge. 6. Ten stove top burners were cleaned on Sunday, January 10, 2010. Staff have been instructed to proper method and frequency of cleaning burners. 7. On Wednesday, 1/6/2010 six skillets, three (3) 10½ and three (3) 14½ inch, encrusted with debris were removed from service. New skillets were ordered on Monday, February 22, 2010 from Sysco.	1/7/10 1/18/10 2/19/10 1/8/10 1/21/10 1/10/10 1/6/10



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  1093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/13/2010
NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF DELAWARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4800 LANCASTER PIKE WILMINGTON, DE 19807		
(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 8 not available.  3. Observations at 9:10 AM of a stack of ready-to-use plate domes were dripping wet.  4. Observations at 9:20 AM of the toilet room used by the female kitchen staff revealed that a covered receptacle was not provided.  The following findings were observed on 1/6/2010:  5. Observations at 10:30 AM of the dish washer revealed that the data plate was not available.  6. Observations at 10:40 AM of the stove revealed that the ten (10) burners had a thick accumulation of carbon debris.  7. Observations at 10:45 AM of the overhead rack revealed that the food-contact and non food-contact surfaces of three of 10 and ½ inch outside diameter (OD) and three of 14 and ½ inch OD frying pans were encrusted with debris.  8. Observations at 11:05 AM of a table by the food line revealed that two trays of covered frozen roast pork were being thawed at room temperature.  9. An interview with the Food Service Director on 1/8/2010 at 8:50 AM confirmed that the screening of the kitchen staff of exposure to foodborne diseases in the past was not documented.  10. Observations on 1/11/2010 at 8:25 AM revealed that non pasteurized eggs were being stored in the refrigerator. The cook confirmed that non pasteurized eggs were served.	F 371	<b><u>B. Identification of other sanitary conditions – F371, Continue</u></b>  6. The monthly sanitation inspection has been revised to include the burners on the stock. Procedure has been identified to properly clean the burners to be completed by the cooks. Frequency of cleaning is weekly.  7. Monthly sanitation audit to include condition of frying pans. Pans noted with encrusted debris will attempt to be cleaned. If cleaning is not sufficient, new pans will be ordered & encrusted pans will be discarded. <u>The identified pans were discarded 1/8/2010.</u>  8. Staff will receive in-service on proper thawing techniques. Techniques also posted in department to serve as reminder of proper procedure.  9. To ensure that all employees are presented with food borne illness risk exposure, the candidate interview forms have been presented to existing staff utilizing the State of Delaware form.  10. Pasteurized eggs have been ordered for the dining service department, effective Monday 1/25/2010. Staff has been informed of the change and how to identify a pasteurized egg.  11. Food Service Director to complete monthly maintenance audit of department. Any items noted on the audit that are out of compliance will be reported to the Maintenance/ Engineering Manager within 72 hours for corrective action to be completed.		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/13/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>MASONIC HOME OF DELAWARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4800 LANCASTER PIKE WILMINGTON, DE 19807</b>		
(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	<p>Continued From page 8 not available.</p> <p>3. Observations at 9:10 AM of a stack of ready-to-use plate domes were dripping wet.</p> <p>4. Observations at 9:20 AM of the toilet room used by the female kitchen staff revealed that a covered receptacle was not provided.</p> <p>The following findings were observed on 1/6/2010:</p> <p>5. Observations at 10:30 AM of the dish washer revealed that the data plate was not available.</p> <p>6. Observations at 10:40 AM of the stove revealed that the ten (10) burners had a thick accumulation of carbon debris.</p> <p>7. Observations at 10:45 AM of the overhead rack revealed that the food-contact and non food-contact surfaces of three of 10 and ½ inch outside diameter (OD) and three of 14 and ½ inch OD frying pans were encrusted with debris.</p> <p>8. Observations at 11:05 AM of a table by the food line revealed that two trays of covered frozen roast pork were being thawed at room temperature.</p> <p>9. An interview with the Food Service Director on 1/8/2010 at 8:50 AM confirmed that the screening of the kitchen staff of exposure to foodborne diseases in the past was not documented.</p> <p>10. Observations on 1/11/2010 at 8:25 AM revealed that non pasteurized eggs were being stored in the refrigerator. The cook confirmed that non pasteurized eggs were served.</p>	F 371	<p><b><u>F371, Continue</u></b> <b><u>C. System Implemented</u></b></p> <p>1. Audit document will be part of the unit account visit protocol by the District Manager for the Dining Services Department. Items reviewed during this visit will be followed up with the VP/CFO (or designee) for status update of requested repair.</p> <p>2. Freezer Log to be instituted for ice cream freezer to allow documentation of daily temperature of the ice cream freezer ensuring proper holding temperature for product. Food Service Director to monitor compliance of temperatures logged. Any documented temperature outside acceptable range to will be reported to Maintenance Department for repair. If equipment cannot be repaired a new chest will be requested from ice cream vendor.</p> <p>3. In-service staff on proper drying method for dome lids. Utilize (or purchase) racks for drying. No wet lids will be allowed for service.</p> <p>4. The inspection tool will be updated and the Asst. Director will be responsible for completion of the audit. Items noted on the report requiring corrective action will be reviewed with the Food Service Director.</p> <p>5. The Food Service Director has communicated the location of the data plate to the Dining Services Staff, Executive Director and District Manager for any future reference requests.</p> <p>6. The Food Service Director will complete the monthly inspection. Any items noted as not compliant will have a corrective action completed. Failure to completed proper scheduled cleaning will be grounds for disciplinary action.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>MASONIC HOME OF DELAWARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4800 LANCASTER PIKE WILMINGTON, DE 19807</b>	
(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	<p>Continued From page 8 not available.</p> <p>3. Observations at 9:10 AM of a stack of ready-to-use plate domes were dripping wet.</p> <p>4. Observations at 9:20 AM of the toilet room used by the female kitchen staff revealed that a covered receptacle was not provided.</p> <p>The following findings were observed on 1/6/2010:</p> <p>5. Observations at 10:30 AM of the dish washer revealed that the data plate was not available.</p> <p>6. Observations at 10:40 AM of the stove revealed that the ten (10) burners had a thick accumulation of carbon debris.</p> <p>7. Observations at 10:45 AM of the overhead rack revealed that the food-contact and non food-contact surfaces of three of 10 and ½ inch outside diameter (OD) and three of 14 and ½ inch OD frying pans were encrusted with debris.</p> <p>8. Observations at 11:05 AM of a table by the food line revealed that two trays of covered frozen roast pork were being thawed at room temperature.</p> <p>9. An interview with the Food Service Director on 1/8/2010 at 8:50 AM confirmed that the screening of the kitchen staff of exposure to foodborne diseases in the past was not documented.</p> <p>10. Observations on 1/11/2010 at 8:25 AM revealed that non pasteurized eggs were being stored in the refrigerator. The cook confirmed that non pasteurized eggs were served.</p>	F 371	<p><b><u>C.System Implemented-F371Continue</u></b></p> <p>7. The Food Service Director will complete the monthly inspection. Any items noted as not compliant will have a corrective action completed.</p> <p>8. Pull and Prep Sheets for food production will identify date of food pull to allow for proper thawing under refrigeration. These sheets will be presented to cooks as part of their production protocols for the week. Food Service Director or Asst. Director will audit compliance. Failure to follow proper procedure will be grounds for disciplinary action.</p> <p>9. Effective, January 22, 2010, the interview and new hire packet for dining service employees includes the State of Delaware forms. This document is now part of the requirement for all dining service employees to be hired and entered into the payroll system. The new hire documents are listed on the Unidine website in a folder identified as Delaware HR forms. This packet of information has been reviewed by the Food Service Director and District Manager. Unidine has also forwarded the information to the facility HR Manager for review and acceptance. The cover sheet denotes what documents are to be presented and filed by the facility HR Manager for auditing compliance and record keeping. A matrix has been created for review by the Food Service Director and HR Manager.</p> <p>10. To ensure safe, pasteurized eggs will be used in the dining service department, the item number for pasteurized eggs has been identified and added to the food order guide. Non-pasteurized eggs can no longer be ordered for use in the department.</p>	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  1093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/13/2010
NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF DELAWARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4800 LANCASTER PIKE WILMINGTON, DE 19807		
(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	<p>Continued From page 8 not available.</p> <p>3. Observations at 9:10 AM of a stack of ready-to-use plate domes were dripping wet.</p> <p>4. Observations at 9:20 AM of the toilet room used by the female kitchen staff revealed that a covered receptacle was not provided.</p> <p>The following findings were observed on 1/6/2010:</p> <p>5. Observations at 10:30 AM of the dish washer revealed that the data plate was not available.</p> <p>6. Observations at 10:40 AM of the stove revealed that the ten (10) burners had a thick accumulation of carbon debris.</p> <p>7. Observations at 10:45 AM of the overhead rack revealed that the food-contact and non food-contact surfaces of three of 10 and ½ inch outside diameter (OD) and three of 14 and ½ inch OD frying pans were encrusted with debris.</p> <p>8. Observations at 11:05 AM of a table by the food line revealed that two trays of covered frozen roast pork were being thawed at room temperature.</p> <p>9. An interview with the Food Service Director on 1/8/2010 at 8:50 AM confirmed that the screening of the kitchen staff of exposure to foodborne diseases in the past was not documented.</p> <p>10. Observations on 1/11/2010 at 8:25 AM revealed that non pasteurized eggs were being stored in the refrigerator. The cook confirmed that non pasteurized eggs were served.</p>	F 371	<p><b>C. System Implemented-F371 Continue</b></p> <p>11. Audit document will be part of the unit account visit protocol by the District Manager for the Dining Services Depart. Items reviewed during this visit will be followed up with the VP/CFO (or designee) for status update of requested repair.</p> <p><b>D. Quality Assurance Monitoring</b></p> <p>1. Review of monthly audit will be reported in monthly Quality Assurance report and reported during Quarterly Quality Assurance meeting.</p> <p>2. Review of monthly temperature logs will be reported in monthly Quality Assurance report and reported during Quarterly Quality Assurance meeting.</p> <p>3. Food Service Director or Asst. Director to audit process ensuring compliance of proper drying protocol.</p> <p>4. The results of the audit will be included in the Monthly Quality Assurance Report and reviewed during the quarterly Quality Assurance meeting.</p> <p>5. N/A.</p> <p>6. The Food Service Director will review the inspection with the District Manager during the unit visit. Any disciplinary actions are reviewed with DM prior to presentation to staff. Findings will be noted in the monthly Quality Assurance report and reviewed in quarterly Quality Assurance meeting .</p> <p>7. The Food Service Director will review the inspection with the District Manager during the unit visit. Findings will be noted in the monthly Quality Assurance report and reviewed in quarterly Quality Assurance meeting.</p>		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  1093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/13/2010
NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF DELAWARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4800 LANCASTER PIKE WILMINGTON, DE 19807	
(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 9	F 371	<p><b><u>D. QA Monitoring-F371, Continue</u></b></p> <p>8. Findings will be noted in the monthly Quality Assurance report and reviewed in quarterly Quality Assurance meeting. Disciplinary actions will be reviewed by District Manager prior to presentation to staff member.</p> <p>9. The matrix will be included in the monthly Quality Assurance report and reviewed in quarterly Quality Assurance meeting.</p> <p>10. Copies of the vendor invoices through out the month will be monitored for the purchase of the pasteurized eggs. This information will be included in the monthly Quality Assurance report. A vendor compliance report is provided quarterly to the Unidine District Manager. This report allows a review of the products ordered by the dining service department. The information of this report will be provided to the Food Service Director for inclusion in the quarterly Quality Assurance meeting.</p> <p>11. Review of monthly audit will be reported in monthly Quality Assurance report and reported during Quarterly Quality Assurance meeting.</p> <p><b><u>A. Corrective Action – F497</u></b> NA1 was performed 4/29/2009 but omitted from being placed in Human Resource folder at that time. NA2 was performed 5/3/2009 but omitted from being placed in Human Resource folder at that time.</p> <p><b><u>B. Identification of other Employees</u></b> Human Resource manager to identify employees on a monthly basis that are due for an annual evaluation &amp; email department managers the list of employees in their department with evaluation due dates.</p>	1/12/10
F 497 SS=D	<p>11. Observations on 1/11/2010 at 8:50 AM revealed that two (2) of fourteen (14) ceiling lights were not functioning.</p> <p>483.75(e)(8) REGULAR IN-SERVICE EDUCATION</p> <p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on a review of facility documentation and staff interview, it was determined that the facility failed to insure that two (2) of five (5) sampled nursing assistants (NA) received the mandatory annual performance review in a timely manner. Findings include:</p> <p>1. NA1 was hired 4/1/2004. Review of the personnel file revealed the latest annual performance date of 4/29/2008.</p> <p>2. NA2 was hired 5/4/2002. Review of the personnel file revealed the latest annual performance date of 5/3/2008.</p>	F 497		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>MASONIC HOME OF DELAWARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4800 LANCASTER PIKE WILMINGTON, DE 19807</b>	
(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 497	Continued From page 10	F 497	<b><u>F497, Continue</u></b>	
F 514 SS=D	<p>An interview on 1/8/2010 at 3:15 PM with the Human Relations Director confirmed these findings.</p> <p><b>483.75(l)(1) CLINICAL RECORDS</b></p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview it was determined that the facility failed to maintain complete and accurate records of abnormal involuntary movement for 1 resident (#1) out of 8 residents in the sample. Findings include:</p> <p>Cross refer F280, example #1. Review of the clinical record revealed that Resident #1 was prescribed antipsychotic medication and required monitoring for the development or increase of abnormal involuntary movement. Further review of the clinical record revealed that the current "Abnormal Involuntary Movement" form completed for Resident #1 was dated 6/23/09.</p>	F 514	<p><b><u>C. System Implemented</u></b> Checklist to evaluate on a week-to-week basis to make sure evaluations are performed by managers. Reminder emails will be sent to managers when not received by date due.</p> <p><b><u>D. Quality Assurance Monitoring</u></b> Review of employee evaluations will be reported in monthly Quality Assurance report and reported during Quarterly Quality Assurance meeting.</p>	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  1093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/13/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF DELAWARE	STREET ADDRESS, CITY, STATE, ZIP CODE 4800 LANCASTER PIKE WILMINGTON, DE 19807
--	--

(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 497	Continued From page 10	F 497		
F 514 SS=D	<p>483.75(l)(1) CLINICAL RECORDS</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview it was determined that the facility failed to maintain complete and accurate records of abnormal involuntary movement for 1 resident (#1) out of 8 residents in the sample. Findings include:</p> <p>Cross refer F280, example #1. Review of the clinical record revealed that Resident #1 was prescribed antipsychotic medication and required monitoring for the development or increase of abnormal involuntary movement. Further review of the clinical record revealed that the current "Abnormal Involuntary Movement" form completed for Resident #1 was dated 6/23/09.</p>	F 514	<p><b><u>Corrective Action</u></b> F514 Resident (#1) An Abnormal Involuntary Movement Scale (AIMS) test was completed immediately upon notification from the survey team. Completed AIMS was placed in resident's chart. Next due date was documented on calendar at nurses station.</p> <p><b><u>Identification of other Residents</u></b> All residents requiring AIMS Test will have their names logged in the daily nursing calendar at nurses station, which will reflect the actual due date.</p> <p><b><u>System Implemented</u></b> All nurses will be in-serviced on location of calendar, given explanation on proper usage, and directed to check daily to ensure AIMS Test are not missed.</p> <p><b><u>Quality Assurance Monitoring</u></b> The Director of Nursing or designee will monitor calendar and nurses to ensure compliance.</p>	<p>1/6/10</p> <p>2/28/10</p> <p>2/28/10</p> <p>2/28/10</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  1093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/13/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF DELAWARE	STREET ADDRESS, CITY, STATE, ZIP CODE 4800 LANCASTER PIKE WILMINGTON, DE 19807
--	--

(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 514	Continued From page 11 In an interview conducted on 1/7/2010 with L2 (staff nurse) it was stated that monitoring was required every six months for the development or increase of abnormal involuntary movement. L2 also confirmed the absence of a completed "Abnormal Involuntary Movement" form that was due 12/09.	F 514		
F 518 SS=F	483.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS  The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.  This REQUIREMENT is not met as evidenced by: Based on a staff interview, it was determined that the facility failed to ensure that all staff receive annual training in emergency procedures. Findings include:  1. Interview with the Environmental Services Director on 1/7/2010 at 9:35 AM revealed that the entire staff had not received emergency procedures training during the year of 2009.	F 518	<p><b>F 518 SS=F</b></p> <p><b>A. CORRECTIVE ACTION</b> Highfield has a policy and procedure to conduct annual emergency and evacuation training. As an enhancement to this policy and procedure, Highfield has entered into an agreement with Croker Fire Drill Corporation (Croker) to conduct monthly fire drills. Staff will receive standup in-service after each drill. Staff will receive annual work place fire extinguisher training. Croker will also be conducting bi-annual Disaster Preparedness training through mock and tabletop drills.</p> <p><b>B. IDENTIFICATION OF OTHER STAFF</b> All staff members will sign in as proof of attendance at standup in-service following each fire drill.</p> <p><b>C. SYSTEMS IMPLEMENTED</b> Croker Fire Drill Corporation will conduct all fire drills and training.</p> <p><b>D. QUALITY ASSURANCE MONITORING</b> Croker Fire Drill Corporation service will be utilized to enhance training. Croker's report of drills and training will be made part of the monthly Quality Assurance report and reviewed in quarterly Quality Assurance meeting.</p>	3/12/10



**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**

MAR 05 2010

STATE SURVEY REPORT

**Director's Office**

NAME OF FACILITY: Masonic Home of Delaware

DATE SURVEY COMPLETED: January 13, 2010

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

**The State Report incorporates by reference and also cites the findings specified in the Federal Report.**

An unannounced annual survey was conducted at this facility from January 4, 2010 through January 13, 2010. The facility census on the entrance day of the survey was 17 residents. The survey sample was composed of 8 residents. The survey process included observations and resident, family and staff interviews. Also included in the survey process was the review of clinical records and facility policies and procedures.

**Regulations for Skilled and Intermediate Care Nursing Facilities**

**Services to Residents**

**General Services**

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.

3201

3201.6

3201.6.1

3201.6.1.1

3201.6.1.1 - Cross Refer to F323 and F253

F323 Completed 1/29/2010

F253 Completed 1/7/2010

Provider's Signature *Reginald M. Williams* Title Executive Director Date 3/5/2010



**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: Masonic Home of Delaware**

**DATE SURVEY COMPLETED: January 13, 2010**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.5	Cross refer to the CMS 2567-L survey report with completion date 01/13/2010, F323, F253	
3201.6.5.7	<p><b>Nursing Administration</b></p> <p>The assessment and care plan for each resident shall be reviewed/ revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.</p> <p>This requirement is not met as evidenced by:</p>	<p><u>3201.6.5.7 – Cross Refer to F280</u></p> <p>F280 (#1) Completed 2/28/2010 F280 (#2) Completed 2/28/2010</p>
3201.6.11	<p><b>Medications</b></p> <p>Cross refer to the CMS 2567-L survey report with completion date 01/13/2010, F280.</p>	
3201.6.11.1	<p><b>Medication Administration</b></p>	
3201.6.11.1.5	<p>Medications shall be given only to the individual resident for whom the prescription or order was issued, and shall be given in accordance with the prescriber's instructions.</p> <p>This requirement is not met as evidenced by:</p>	<p><u>3201.6.11.1.5 – Cross Refer to F281</u></p> <p>F281 Completed 2/28/2010</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:** Masonic Home of Delaware

**DATE SURVEY COMPLETED:** January 13, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.7.0	Cross refer to the CMS 2567-L survey report with completion dated 01/13/2010, F281.	
3201.7.5	Plant, Equipment and Physical Environment	
3201.7.5.1	Kitchen and Food Storage Areas	
3201.7.5.1	Facilities shall comply with the Delaware Food Code.	
	This requirement is not met as evidenced by:	
	Based on dietary observations throughout the survey, it was determined that the facility failed to comply with sections 2-201.11 (C) (D), 3-202.14 (A), 3-501.13 (A), 4-204.112 (B), 4-204.113 (A), 4-601.11 (B) (C), 4-903.11 (B) (1), 5-202.11 (A), 5-501.17 and 6-501.11 of the State of Delaware Regulation Governing Public Eating Places. Findings include:	
	2-201.11 Responsibility of the Person in Charge to Require Reporting by Food Employees and Applicants.*	
	The Permit Holder shall require Food Employee applicants to whom a conditional offer of employment is made and Food Employees to	
		F371, Example #9 Completed 2/28/2010
		<u>3201.7.5.1 – Cross Refer to F371, Example #9</u>



**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: Masonic Home of Delaware**

**DATE SURVEY COMPLETED: January 13, 2010**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>report to the Person In Charge, information about their health and activities as they relate to diseases that are transmissible through Food. A Food Employee or applicant shall report the information in a manner that allows the Person In Charge to prevent the likelihood of foodborne disease transmission, including the date of onset of jaundice or of an illness specified under ¶ (C) of this section, if the Food Employee or applicant:</p> <p>(C) Had a past illness from an infectious agent specified under ¶ (A) of this section; or</p> <p>(D) Meets one or more of the following high-risk conditions:</p> <p>(1) Is suspected of causing, or being exposed to, a confirmed disease outbreak caused by S. Typhi, Shigella spp., E. coli 0157:H7, or hepatitis A virus including an outbreak at an event such as a family meal, church supper, or festival because the Food Employee or applicant:</p> <p>(a) Prepared food implicated in the outbreak,</p> <p>(b) Consumed food implicated in the outbreak, or</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: Masonic Home of Delaware**

**DATE SURVEY COMPLETED: January 13, 2010**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>(c) Consumed food at the event prepared by a person who is infected or ill with the infectious agent that caused the outbreak or who is suspected of being a shedder of the infectious agent.</p> <p>(2) Lives in the same household as a person who is diagnosed with a disease caused by S. Typhi, Shigella spp., E. coli 0157:H7, or hepatitis A virus, or</p> <p>(3) Lives in the same household as a person who attends or works in a setting where there is a confirmed disease outbreak caused by S. Typhi, Shigella spp., E. coli 0157:H7, or hepatitis A virus.</p> <p>Cross-refer to CMS 2567-L survey date completed 1/13/2010, F371, example #9.</p> <p><b>3-202.14 Eggs and Milk Products, Pasteurized.*</b></p> <p>(A) Liquid, frozen, and dry eggs and egg products shall be obtained pasteurized.</p> <p>This regulation is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed</p>	<p><b><u>3-202.14 – Cross Refer to F371, Example #10</u></b></p> <p>F371, Example #10 1/25/2010</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: Masonic Home of Delaware**

**DATE SURVEY COMPLETED: January 13, 2010**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>1/13/2010, F371, example #10.</p> <p><b>3-501.13 Thawing.</b></p> <p>Except as specified in ¶ (D) of this section, Potentially Hazardous Food shall be thawed:</p> <p>(A) Under refrigeration that maintains the food temperature at 5°C (41°F) or less, or at 7°C (45°F) or less as specified under ¶ 3-501.16 (C).</p> <p>This regulation is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 1/13/2010, F371, example #8.</p> <p><b>4-204.113 Warewashing Machine, Data Plate Operating Specifications.</b></p> <p>A warewashing machine shall be provided with an easily accessible and readable data plate affixed to the machine by the manufacturer that indicates the machine's design and operating specifications including the:</p> <p>(A) Temperatures required for washing, rinsing, and sanitizing.</p> <p>This regulation is not met as evidenced by:</p>	<p><b><u>3-501.13 – Cross Refer to F371, Example #8</u></b></p> <p>F371, Example #8 Completed 1/22/2010</p> <p><b><u>4-204.113 – Cross Refer to F371, Example #5</u></b></p> <p>F371, Example #5 Completed 1/21/2010</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 11

NAME OF FACILITY: Masonic Home of Delaware

DATE SURVEY COMPLETED: January 13, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>Cross-refer to CMS 2567-L survey date completed 1/13/2010, F371, example #5.</p> <p><b>4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.</b></p> <p><b>(B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.</b></p> <p><b>(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt food residue and other debris.</b></p> <p><b>These regulations are not met as evidenced by:</b></p> <p>Cross-refer to CMS 2567-L survey date completed 1/13/2010, F371, example #7.</p> <p><b>4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.</b></p> <p><b>(B) Clean equipment and utensils shall be stored as specified under (A) of this section and shall be stored:</b></p> <p><b>(1) In a self-draining position that allows air</b></p>	<p><b><u>4-601.11 – Cross Refer to 371, Example #7</u></b></p> <p>F371, Example #7 Completed 1/22/2010</p> <p><b><u>4-903.11 – Cross Refer to 371, Example #3</u></b></p> <p>F371, Example #3 Completed 1/19/2010</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: Masonic Home of Delaware**

**DATE SURVEY COMPLETED: January 13, 2010**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>drying.</p> <p><b>This regulation is not met as evidenced by:</b></p> <p>Cross-refer to CMS 2567-L survey date completed 1/13/2010, F371, example #3.</p> <p><b>5-202.11 Approved System and Cleanable Fixtures.*</b></p> <p><b>(A) A plumbing system shall be designed, constructed, and installed according to law.</b></p> <p><b>This regulation is not met as evidenced by:</b></p> <p>Cross-refer to CMS 2567-L survey date completed 1/13/2010, F371, example #1.</p> <p><b>5-501.17 Toilet Room Receptacle, Covered.</b></p> <p><b>A toilet room used by females shall be provided with a covered receptacle for sanitary napkins.</b></p> <p><b>This regulation is not met as evidenced by:</b></p> <p>Cross-refer to CMS 2567-L survey date completed 1/13/2010, F371, example #4.</p>	<p><b><u>5-202.11 – Cross Refer to 371, Example #1</u></b></p> <p>F371, Example #1 Completed 1/7/2010</p> <p><b><u>5-501.17 – Cross Refer to 371, Example #4</u></b></p> <p>F371, Example #4 Completed 1/8/2010</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: Masonic Home of Delaware**

**DATE SURVEY COMPLETED: January 13, 2010**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p><b>6-501.11 Repairing.</b></p> <p>The physical facilities shall be maintained in good repair.</p> <p>This regulation is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 1/13/2010, F371, example #11.</p> <p><b>Emergency Preparedness</b></p> <p>The staff on all shifts shall be trained on emergency and evacuation plans. Evacuation routes shall be posted in a conspicuous place at each nursing station.</p> <p>This regulation is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 1/13/2010, F518 example #1.</p> <p><b>Posting of inspection summary and other information and public meetings.</b></p> <p>(a) Each facility shall prominently and conspicuously post for display in a public area of the facility that is readily available to resident, employees and visitors the following:</p> <p><b>16 Del. C., Chapter 11, Subchapter I, § 1108</b></p>	<p><b>6-501.11 – Cross Refer to 371, Example #11</b></p> <p>F371, Example #11 Completed 1/8/2010</p> <p><b>3201.8.4 – Cross Refer to F518, Example #1</b></p> <p>F518, Example #1 Completed 3/7/2010</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: Masonic Home of Delaware**

**DATE SURVEY COMPLETED: January 13, 2010**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p><b>16 Del. C., Chapter 11, Subchapter IV, § 1141</b></p>	<p><b>(4) A notice in the form prescribed by the Department stating that informational materials relating to the compliance history of the facility are available for inspection at a location in the facility specified by the sign. The notice shall also provide the telephone number to reach the Division to obtain the same information concerning the facility.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Observations throughout the survey revealed that the telephone number of the Survey Agency was not prominently and conspicuously posted. These observations were confirmed by a family interview.</p> <p><b>(c) Criminal background checks.</b></p> <p><b>No employer who operates a nursing home or a management company or other business entity that contracts to operate a nursing home may hire any applicant without obtaining a report of the person's entire criminal history record from the State Bureau of Identification and a report of the person's entire federal criminal history pursuant to the Federal Bureau of Investigation appropriation of Title II of Public Law 92-544.</b></p>	<p><b><u>16 Del. C., Chapter 11, Subchapter 1, 1108</u></b></p> <p><b><u>A. Corrective Action</u></b> Based on observations throughout the survey revealed that the telephone number of the Survey Agency was not prominently and conspicuously posted. Required information was posted as of 1/8/2010 and a poster was ordered.</p> <p><b><u>B. Identification of other systems</u></b> Agency telephone number has been placed in Masonic Home's resident grievance policy &amp; procedure, advertised in the residents newsletter, will be given out at the annual Residents Rights in-service, posted on the public bulletin board and placed in the admission packet.</p> <p><b><u>C. System Implemented</u></b> A poster in the form prescribed by the Department was displayed in a prominently and conspicuously public area and will be continued to be posted on the public board readily available to residents, employees, and visitors.</p> <p><b><u>D. Quality Assurance Monitoring</u></b> Regular quarterly check of the public board to ensure the posted information is up to date and has not been removed.</p> <p>Completed Date 1/8/2010</p> <p><b><u>16 Del. C., Chapter 11, Subchapter IV, 1141 – Cross Refer to F226, Example #1</u></b></p> <p>Completed 1/20/2010</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:** Masonic Home of Delaware

**DATE SURVEY COMPLETED:** January 13, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p><b>This requirement is not met as evidenced by:</b></p> <p>Cross-refer to CMS 2567-L survey date completed 1/13/2010, F226, example #1.</p>	