

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

PRINTED: 08/20/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/11/2010
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NAME OF PROVIDER OR SUPPLIER  METHODIST COUNTRY HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 4830 KENNETT PIKE WILMINGTON, DE 19807
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F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>An unannounced annual survey was conducted at this facility from August 2, 2010 through August 11, 2010. The deficiencies contained in this report are based on observations, staff interviews, review of clinical records, facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was forty-two (42). The survey sample totaled twenty (20) residents.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>	F 225	<p>F Tag 225</p> <p>A. Facility had reported allegation of request on resident #R53 and misappropriation of property for resident #R13 late but before survey occurred.</p> <p>B. All related incident reports from the health center during the period of December 2009 to present will be reviewed by the acting DON to ensure that all incidents of allegation of neglect and misappropriation of property were reported to the DLTCRP within allowed time frame. <b>Attachment #1.</b></p> <p>C. To ensure that all similar incidents are reported appropriately in the future nurses will receive education on the procedure for reporting. <b>Attachment # 2.</b> The DON or</p>	8/30/10  8/27/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jericho A. White, NHA Executive Director</i>	TITLE NHA Executive Director	(X6) DATE 8/30/2010
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</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, interview and review of other facility documents, it was determined that the facility failed to immediately report an allegation of neglect and misappropriation of property for two (R53 and R13) out of 20 sampled residents to the state agency. R53 had an unwitnessed fall with injuries which required being sent to the hospital and R13 reported missing personal property. Findings include:</p> <p>Cross refer F323. 1. On 7/24/10 at approximately 4:00 PM, R53 was found on the bathroom floor with her head against the wall by E4 (CNA) and E5 (RN). A laceration was noted on back of R53's head that was bleeding frank red blood. R53 was sent to the emergency room for evaluation of a head injury. R53 returned to the facility with a contusion and ten (10) staples to the laceration on the back of her head.</p> <p>The facility's policy entitled, "Incidents and Reporting to DLTCRP (state agency) was reviewed. Reportable incidences included "Fall with Injury... Any suspected Abuse/Mistreatment/Neglect."</p>	F 225	<p>designee will audit all written incidents weekly to ensure reporting compliance. <b>Attachment # 3A.</b></p> <p>D. The results of the audit will be reported at the monthly/quarterly QI meeting starting in September 2010. <b>Attachment #3B.</b></p>	

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F 225	<p>Continued From page 2</p> <p>During an interview on 8/9/10 at 4:30 PM, E3 (RN/Nurse Manager) stated that she faxed both the initial and 5 day follow-up report on 7/27/10, when she found them. Although E5 (Registered Nurse/RN) had completed the incident report on 7/24/10, it was never faxed to the state.</p> <p>The facility failed to immediately report to the state agency an unwitnessed fall for R53 that resulted in an injury. Findings were acknowledged during an interview on 8/9/10 with the administrative staff.</p> <p>2. The facility procedure entitled "Staff Treatment of Residents,.. " , Section VII, " Reporting/Response ", stated that after notification of misappropriation of resident property, the designated community staff would immediately complete the Division of Long Term Care Residents Protection (DLTCRP) Incident Report form, completed by the nurse supervisor or designee, and then faxed to DLTCRP.</p> <p>During an interview with R13 on 8/2/10, the resident stated that she lost two framed floral pictures (with September or November printed at the bottom of picture) that were stored behind her bedroom door. R13 and E6 (companion care giver) stated during a second interview on 8/9/10 that they had reported the missing items to E7 (LPN) on 12/23/09.</p> <p>The facility incident report, "Suspected Abuse/Mistreatment/Neglect Report Form" was completed by E7 on 12/23/09 when R13 reported the pictures missing. E7 stated in the report that the resident reported the pictures missing on 12/23/09 but wanted to check with</p>	F 225		

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F 225	Continued From page 3 family members before officially reporting it missing. The facility failed to immediately report this incident to the State Agency. It was not reported until 12/29/09, 6 days later.  Review of a facility incident report, dated 12/29/09, revealed that on 12/28/09, R13 alleged that two pictures were missing. The facility investigated and was unable to locate the missing pictures. Although the facility gave R13 one picture similar to the one the resident had, the other one was still missing.	F 225		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  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:	F 280	F Tag 280 A. The care plan for resident # R53 was immediately updated. <b>Attachment #4.</b> B. An audit will be done of each resident's fall care plan to ensure it contains all interventions in place presently. <b>Attachment #5.</b> C. Changes to resident's fall care plans will be reviewed at the weekly interdisciplinary staff meeting and documented directly to the residents plan of care at that time. An audit to ensure that all the changes to resident's fall care plans are documented will be done weekly by the DON or designee. <b>Attachment #6.</b> D. The results of the weekly audit will be reported in the monthly/quarterly QI meeting starting in September 2010. <b>Attachment # 7.</b>	8/9/10  9/3/10  8/24/10  9/15/10

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F 280	<p>Continued From page 4</p> <p>Based on record review and interview, it was determined that the facility failed to ensure that the care plan was reviewed and revised for one (R53) resident out of 20 sampled residents. Findings include:</p> <p>Cross refer, F323</p> <p>1. R53 was admitted to the facility on 11/14/09 post hospitalization after a fall. Her diagnoses included status post left hip fracture with L (left) ORIF (Open Reduction Internal Fixation - an orthopedic surgical procedure which is utilized to treat severe fractures), Parkinson's disease, abnormality of gait, senile dementia, osteoporosis and osteoarthritis (a condition of chronic arthritis), spinal stenosis, adult failure to thrive and hypertension.</p> <p>Review of the clinical record revealed that R53 was assessed as a "High Risk" for falls. The clinical record indicated that R53 had experienced six (6) falls from 11/20/09 through 7/24/10.</p> <p>A. Review of the "Facility Internal Incident Report" dated 4/14/10 and timed 1800 (6 PM), included a fall assessment that recommended "possible hipsavers." The fall assessment indicated that the care plan was reviewed and updated. The "Immediate Plan of Action" stated to "Continue Plan of Care." However, review of the Fall care plan, dated 11/23/09, failed to list hip savers as an intervention.</p> <p>The "Facility Internal Incident Report," dated 6/19/10 and timed 0050 (12:50 AM), included a fall assessment which listed "hipster" as a protective device in use at the time. Again, the fall assessment indicated that the care plan had been reviewed and updated. The "Immediate</p>	F 280		

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F 280	<p>Continued From page 5</p> <p>Plan of Action" stated to "Continue Plan of Care." Review of R53's Fall care plan continued to lack evidence of hipsters/hip savers as interventions.</p> <p>B. The 6/21/10 POS (Physician Order Sheet) revealed orders for bed, chair alarms, and floor mat to be used.</p> <p>Review of another "Facility Internal Incident Report" and "Fall Assessment 12/12/07" attached form, both dated 7/21/10 and timed 1940 (7:40 PM), revealed that fall mat, hipsters, and alarms were in use and alarms sounding. However, review of the Fall Care plan failed to list these interventions that were in place.</p> <p>Even though multiple observations of R53 during the survey period revealed that bed and chair alarms were in use, R53's care plan did not reflect the current interventions being used. Findings that the facility failed to review and revise R53's care plan accordingly to include interventions necessary to ensure the resident's safety and well-being were reviewed with E2 (Assistant Director of Nursing) and E3 (Nurse Manager) on 8/9/10.</p>	F 280		
F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</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</p>	F 323	<p>F Tag 323</p> <p>A. Injury from fall occurred in the past. The assigned employee has been terminated.</p> <p>B. Other residents who cannot be left unattended in the bathroom are identified on the AccuNurse headset system. All nurses and aides have</p>	

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F 323	<p>Continued From page 6</p> <p>by: Based on record review, interview and review of other facility documents and hospital records, it was determined that the facility failed to ensure that one (R53) out of 20 sampled residents received adequate supervision to prevent accidents. R53, assessed as a high risk for falls, was left unattended on 7/24/10 while seated on the toilet in the bathroom, fell and sustained a laceration to the back of her head, requiring transportation to the emergency room and the placement of ten (10) staples. Findings include:</p> <p>R53 was originally admitted to the facility on 11/14/09 post hospitalization after a fall. Her diagnoses included status post left hip fracture with L (left) ORIF (Open Reduction Internal Fixation - an orthopedic surgical procedure which is utilized to treat severe fractures), Parkinson's disease, abnormality of gait, senile dementia, osteoporosis and osteoarthritis (a condition of chronic arthritis), spinal stenosis, adult failure to thrive and hypertension.</p> <p>Review of R53's Quarterly MDS (Minimum Data Set) Assessment, dated 5/12/10, indicated that R53 was coded "1" (modified independence) for cognitive skills for daily decision making and required limited assistance of one person for toilet use.</p> <p>R53's Fall Risk Assessment, dated 6/21/10, indicated a score of "7" (Score equal to or greater than 6 equals "high risk" for falls).</p> <p>Review of the clinical record revealed that R53 had a history of 5 other falls since admission: 2/16/10 without injury, 4/14/10 with a laceration to the back of her head - 1 staple, 6/13/10 without</p>	F 323	<p>access to this information at any point of care. <b>Attachment #8.</b></p> <p>C. All nurses and aides will be re-educated by the staff educator or designee on the requirement to check for toileting care of residents, especially safety needs when assisting residents. <b>Attachment #9.</b> Nurses and aides will be audited monthly by the nursing supervisors on their awareness of which specific residents in their care require stand-by assistance while toileting. <b>Attachment #10.</b></p> <p>D. The results of the periodic audits will be reported by the DON at the monthly/quarterly QI meetings beginning in September 2010. <b>Attachment #11.</b></p>	<p>8/27/10</p> <p>8/30/10</p> <p>9/15/10</p>

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F 323	<p>Continued From page 7</p> <p>injury, 6/19/10 with a 3-4 cm hematoma with 1 cm laceration lengthwise on the occipital area requiring 7 sutures, and 7/21/10 - without injury.</p> <p>R53's "ADL Plan of Care," dated 7/6/10 which the CNAs can access via their headphones from "AccuNurse," revealed "Cautions: Assistance needed for toileting transfer; Do not leave unattended in bathroom; and "High risk for falls."</p> <p>Review of R53's nurse's notes, dated 7/24/10 and timed 1600 (4 PM) stated, "Resident found on bathroom floor with head against the wall. Laceration on back of head, bleeding frank red blood..." The physician was called and ordered R53 to be sent to the hospital for evaluation. The daughter was notified and requested that her mother be assessed by the Hospice nurse before going to the hospital. Meanwhile, the wound was cleaned and a compression dressing and ice were applied.</p> <p>Another nurse's note, dated 7/24/10 and timed 1730 (5:30 PM) stated, "On call RN vs (visited) from... Hospice. Pt (Patient) with large laceration on back of head bleeding uncontrolled. ..." R53 was sent to the hospital emergency room after the nurse from Hospice visited.</p> <p>A nurse's note dated 7/24/10 and timed 2345 (11:45 PM) stated, "Resident returned from (name) Hospital c sutures &amp; dsg to back of head..."</p> <p>The "Facility Internal Incident Report," dated 7/24/10 and timed 1600 (4 PM), revealed that R53 was "alert/oriented," and stated that the resident was "found on bathroom floor with head against the wall. Laceration noted on back of</p>	F 323		

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F 323	<p>Continued From page 8</p> <p>head, bleeding frank red blood. Compression dsq applied. Ice pak applied."</p> <p>Review of E4's, the CNA (certified nurse's aide), assigned to R53, witness statement stated that "While passing ice &amp; water, R53 rang her call light. She wanted to go to the bathroom about 3:30 PM. I assisted her in her wheelchair and into the bathroom. I locked the wheelchair and said to R53, 'I'll give you a few moments.' I passed out ice &amp; water to R2's room, and came back to R53. She was on the bathroom floor, I called for the nurse, (E5) to help. Blood from R53's head was noticed - I got the lift and E5 &amp; I helped her into her wheelchair - R53 faced into the bathroom with her head at the wall near the door, the wheelchair was still locked &amp; facing the toilet."</p> <p>The hospital "Emergency Physician Record," dated 7/24/10, revealed R53 was seen at 21:15 (9:15 PM) for a head injury from a fall with "mild"... pain, "dazed", with "headache". The scalp wound was described as "3.0 cm (centimeter)" in length, and was closed with "10 staples." The Clinical Impression revealed a "contusion" to the head and a "laceration" to the scalp.</p> <p>Review of the facility's report entitled, "SWIF"(report used to track "Skin, Weight, Infection, Falls"), dated "7-20 to 7-27-10," regarding R53 stated, " 7/24/10 @ (at) 1600 (4 PM) Left in bathroom unattended ---ER 10 staples (abrasion head --- CNA terminated.)"</p> <p>Review of E4's employee file on 8/9/10, revealed that a "Conduct/Performance" review was conducted on 8/2/10 with E2, the ADON (Assistant Director of Nursing), and resulted in</p>	F 323		

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F 323	<p>Continued From page 9</p> <p>E4's "Termination" because she "... failed to follow resident plan of care which resulted directly with resident safety and injury..."</p> <p>During an interview on 8/9/10 at 4:30 PM, E2 was questioned regarding what part of the plan of care was not followed. E2 stated, "specifically, that the CNA left the resident unattended in the bathroom." E2 and E3 (Registered Nurse) stated that R53 was "not to be left alone in the bathroom since at least the 6/19/10 fall, possibly even the 4/14/10 fall." Both confirmed that R53 should not have been left alone in the bathroom and stated that was the reason for E4's termination on 8/2/10.</p> <p>The facility failed to provide adequate supervision to prevent an accident for R53 on 7/24/10 when R53 was left unattended in the bathroom, fell and was injured. Subsequently, R53 was sent to ER and received 10 staples to a laceration on her head. Findings of "Harm" were acknowledged by E1 (Administrator), E2, and E3.</p>	F 323		
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 371	<p>F Tag 371-Sanitary Conditions Refrigerator in DW out of temperature compliance</p> <p>A. Unable to determine if any specific resident was affected.</p> <p>B. Had the potential to affect all residents</p> <p>C. Staff in-serviced on the proper way to take and respond to temperature readings.</p> <p><b>Attachment #12.</b></p> <p>Temperature continues to be checked and recorded twice daily.</p>	8/11/10



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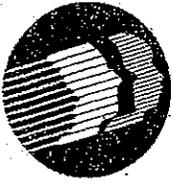
NAME OF PROVIDER OR SUPPLIER  METHODIST COUNTRY HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 4830 KENNETT PIKE WILMINGTON, DE 19807
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 372	<p>Continued From page 11</p> <p>dumpster area, and staff interviews, it was determined that the facility failed to keep the garbage and refuse compactor covered to prevent pest harborage. Findings include:</p> <p>Observation on 8/2/10 at 9:35 AM of the dumpster and compactor area outside the kitchen with E11 (chef) and E12 (dining services manager) revealed a refuse compactor with an uncovered opening. Bees were observed inside and around the compactor area. The opening was large enough to allow rodents and other pest access to the garbage and provided harborage for unwanted pests in the facility.</p> <p>On 8/2/10, interview with E8 (maintenance supervisor) and E13 (food service director) confirmed this finding. On 8/11/10 at 9:15 AM, E8 stated the vendor would be providing a cover for the compactor.</p>	F 372		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085003	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 8/11/2010
NAME OF PROVIDER OR SUPPLIER METHODIST COUNTRY HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4830 KENNETT PIKE WILMINGTON, DE	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 246	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and resident interview, it was determined that the facility failed to ensure that one resident (R3) out of 20 sampled residents had reasonable accommodation of their needs. The facility failed to ensure that R3's closet doors in his living room area were repaired in a timely manner. Findings include:</p> <p>Observations on 8/9/10 at 8:45 AM revealed that R3's closet doors were missing in his living room area. During the interview with R3 on 8/9/10, R3 stated that he had talked to E8 (maintenance supervisor) about three months ago about repairing the closet doors because it was difficult for him to open them. Subsequently, the doors were removed. R3 suggested to E8 that curtains be hung in place of the doors to cover the contents so they would not be visible.</p> <p>Staff interview with E8 on 8/10/10 revealed that R3 had discussed his concern with him sometime in June or July 2010. Review of maintenance work requests revealed a request, dated on 7/20/10, for the installation of curtains on R3's closet doors. As of 8/11/10, this had not been addressed.</p>		
F 256	<p>483.15(h)(5) ADEQUATE &amp; COMFORTABLE LIGHTING LEVELS</p> <p>The facility must provide adequate and comfortable lighting levels in all areas.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to provide adequate and comfortable lighting levels for three (R22, R23, R51) of 20 residents sampled. The bathroom lights above the sink were burned out. Findings include:</p> <p>Observations of R22's, R23's, and R51's bathrooms during the environmental tour with E9 (General Services Director) and E10 (Environmental Services Team Leader) on 8/5/10 at 11:00 AM revealed that the lights above the sink were not working. E9 stated he would check them after the inspection as he thought it could be an electrical wiring concern as they just had completed remodeling the wing.</p> <p>Interview with E9 on 8/5/10 at 3:00 PM revealed the light bulbs were burned out and needed to be replaced.</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents



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**NAME OF FACILITY:** Methodist Country House

**DATE SURVEY COMPLETED:** August 11, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>An unannounced annual survey was conducted at this facility from August 2, 2010 through August 11, 2010. The deficiencies contained in this report are based on observations, staff interviews, review of clinical records, facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was forty-two (42). The survey sample totaled twenty (20) residents.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Cross refer to CMS 2567-L survey date</p>	

9/16/10

*Handwritten signature: [Illegible]*



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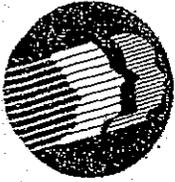
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DATE SURVEY COMPLETED: August 11, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p><b>3201.7.5</b> <b>3201.7.5.1</b></p>	<p>completed 8/11/10, F225, F246, F256, F280 and F323.</p> <p><b>Kitchen and Food Storage Areas</b></p> <p><b>Facilities shall comply with the Delaware Food Code.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 3-501.16 (A), 5-402.10 and 5-501.113 (B).</p> <p><b>3-501.16 Potentially Hazardous Food, hot and Cold Holding.*</b></p> <p><i>Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under § 3-501.19, potentially hazardous food shall be maintained:</i></p> <p>(B) At 5°C (41°F) or less, except as specified under ¶ (C) of this section and §§ 3-501.17, 3-501.18, and 4-204.111.</p> <p>Cross refer to CMS 2567-L survey date completed 8/11/10, F371 example #1.</p> <p><b>5-402.10 Establishment Drainage System.</b></p> <p><b>Food establishment drainage systems, including grease traps, that convey sewage shall be designed and installed as specified</b></p>	<p>F Tag 225</p> <ul style="list-style-type: none"> <li>A. Facility had reported allegation of request on resident #R53 and misappropriation of property for resident #R13 late but before survey occurred.</li> <li>B. All related incident reports from the health center during the period of December 2009 to present will reviewed by the acting DON to ensure that all incidents of allegation of neglect and misappropriation of property were reported to the DLTCRP within allowed time frame. <b>Attachment #1.</b></li> <li>C. To ensure that all similar incidents are reported appropriately in the future nurses will receive education on the procedure for reporting. <b>Attachment # 2.</b> The DON or designee will audit all written incidents weekly to ensure reporting compliance. <b>Attachment # 3.</b></li> <li>D. The results of the audit will be reported at the monthly/quarterly QI meeting starting in September 2010.</li> </ul> <p>F Tag 246-Reasonable Accommodation of needs</p> <ul style="list-style-type: none"> <li>A. Curtain was installed on 8/25/10.</li> <li>B. All resident rooms inspected with surveyor on 8/9/10 and found no other missing doors.</li> <li>C. General Services Manager or designee will conduct weekly environmental rounds to ensure closet doors working in order. <b>Attachment #16.</b></li> <li>D. General Services Manager or designee will review weekly audits and will be monitored at monthly QI meetings.</li> </ul> <p>F Tag 256-Adequate Lighting</p> <ul style="list-style-type: none"> <li>A. Light bulbs replaced on 8/9/10.</li> <li>B. All resident rooms inspected with surveyor on 8/9/10 and found no other burned out light bulbs.</li> <li>C. General Services Manager or designee will conduct weekly environmental rounds to ensure light bulbs are working. <b>Attachment #17</b></li> <li>D. General Services Manager or designee will review weekly audits and will be monitored at Monthly QI meetings.</li> </ul>

9/16/10 *Michael Deane RN, Glenn DON*



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201.7.5 3201.7.5.1</p>	<p>completed 8/11/10, F225, F246, F256, F280 and F323.</p> <p><b>Kitchen and Food Storage Areas</b></p> <p><b>Facilities shall comply with the Delaware Food Code.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 3-501.16 (A), 5-402.10 and 5-501.113 (B).</p> <p><b>3-501.16 Potentially Hazardous Food, hot and Cold Holding.*</b></p> <p><i>Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under § 3-501.19, potentially hazardous food shall be maintained:</i></p> <p><b>(B) At 5°C (41°F) or less, except as specified under ¶ (C) of this section and §§ 3-501.17, 3-501.18, and 4-204.111.</b></p> <p>Cross refer to CMS 2567-L survey date completed 8/11/10, F371 example #1.</p> <p><b>5-402.10 Establishment Drainage System.</b></p> <p><b>Food establishment drainage systems, including grease traps, that convey sewage shall be designed and installed as specified</b></p>	<p>F Tag 280</p> <ul style="list-style-type: none"> <li>A. The care plan for resident # R53 was immediately updated. <b>Attachment #4 .</b></li> <li>B. An audit will be done of each resident's fall care plan to ensure it contains all interventions in place presently. <b>Attachment #5.</b></li> <li>C. Changes to resident's fall care plans will be reviewed at the weekly interdisciplinary staff meeting and documented directly to the residents plan of care at that time. <b>Attachment #6.</b> An audit to ensure that all the changes to resident's fall care plans are documented will be done weekly by the DON or designee and the results reported at the monthly/quarterly QI meeting beginning in September 2010 <b>Attachment #7.</b></li> <li>D. The results of the weekly audit will be reported in the monthly/quarterly QI meeting starting in September 2010.</li> </ul> <p>F Tag 323</p> <ul style="list-style-type: none"> <li>A. Injury from fall occurred in the past. The assigned employee has been terminated.</li> <li>B. Other residents who cannot be left unattended in the bathroom are identified on the AccuNurse headset system. All nurses and aides have access to this information at any point of care. <b>Attachment #8.</b></li> <li>C. All nurses and aides will be re-educated by the staff educator or designee on the requirement to check for toileting care of residents, especially safety needs will assisting residents. <b>Attachment #9.</b> Nurses and aides will be audited monthly by the nursing supervisors on their awareness of which specifies residents in their care require stand-by assistance while toileting. <b>Attachment #10.</b></li> <li>D. The results of the periodic audits will be reported by the DON at the monthly/quarterly QI meetings beginning in September 2010. <b>Attachment #11.</b></li> </ul>

*8/11/10 Doreen Greeneau Insurn DON*



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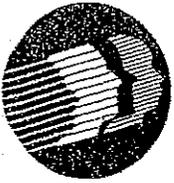
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<p>3201.7.5 3201.7.5.1</p>	<p>completed 8/11/10, F225, F246, F256, F280 and F323.</p> <p><b>Kitchen and Food Storage Areas</b></p> <p>Facilities shall comply with the Delaware Food Code.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 3-501.16 (A), 5-402.10 and 5-501.113 (B).</p> <p><b>3-501.16 Potentially Hazardous Food, hot and Cold Holding.*</b></p> <p><i>Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under § 3-501.19, potentially hazardous food shall be maintained:</i></p> <p>(B) At 5°C (41°F) or less, except as specified under ¶ (C) of this section and §§ 3-501.17, 3-501.18, and 4-204.111.</p> <p>Cross refer to CMS 2567-L survey date completed 8/11/10, F371 example #1.</p> <p><b>5-402.10 Establishment Drainage System.</b></p> <p>Food establishment drainage systems, including grease traps, that convey sewage shall be designed and installed as specified</p>	<p>F Tag 371-Sanitary Conditions Refrigerator in DW out of temperature compliance</p> <p>A. Unable to determine if any specific resident was affected.</p> <p>B. Had the potential to affect all residents</p> <p>C. Staff in-serviced on the proper way to take and respond to temperature readings Temperature continues to be checked and recorded twice daily. 8/11/10 Supervisor to verify and initial temperature log on a weekly basis Refrigerator has been replaced. 8/11/10</p> <p>D. Dining Service Director or designee will review results of audit weekly and will be submitted at monthly QI Meetings.</p>
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9/16/10 - *Shirley Greene* [Signature]



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	<p>under ¶ 5-202.11 (A).</p> <p>Cross refer to CMS 2567-L survey date completed 8/11/10, F371 example #2.</p> <p><b>5-501.113 Covering Receptacles.</b></p> <p><b>Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered:</b></p> <p><b>(B) With tight-fitting lids or doors if kept outside the food establishment.</b></p> <p>Cross refer to CMS 2567-L survey date completed 8/11/10, F372.</p>	<p>Meat Prep Sink does not have required air gap</p> <ul style="list-style-type: none"> <li>A. Unable to determine if any specific resident was affected.</li> <li>B. Had potential to affect all residents.</li> <li>C. Vendor has been issued a purchase order number to make necessary repair to retrofit air gap.</li> <li>D. Monthly audits of proper air gaps functioning/placement will be conducted by the Food Service Director or designee. Any deviation will be corrected immediately and documented accordingly. <b>Attachment #14.</b></li> </ul>
		<p>F Tag 372-Dispose Garbage and Refuse</p> <ul style="list-style-type: none"> <li>A. No residents were affected.</li> <li>B. Had the potential to affect all residents.</li> <li>C. Waste vendor will add a cover. <b>Attachment #18</b></li> <li>D. Monthly audit to ensure proper operation will be reported to QI committee. <b>Attachment #15</b></li> </ul>

Provider's Signature *Devin Pugh* Title *Admin DON* Date *9/16/10*