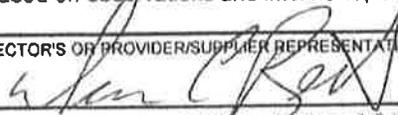


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/07/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHURCHMAN VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713</b>	
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F 000	INITIAL COMMENTS  An unannounced annual and complaint survey was conducted at this facility from 12/17/14 through 1/7/15. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 90. The Stage 2 survey sample size was 37.  Abbreviations used in this 2567 are as follows:  NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; LPN - Licensed Practical Nurse; UM - Unit Manager; DSD - Dining Services Director; ADSD - Assistant Director of Dining Services; CNA - Certified Nurse's Aide; ADLs - Activities of Daily Living; MDS - Minimum Data Set (standardized assessment forms used in nursing homes);	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was	F 241	F 241 1. Employees observed entering rooms without knocking were in-serviced by the Nurse Practice Educator prior to January 7, 2015 on the need to knock and wait at residents' doors prior to entry. Instructors for all CNA programs at the facility have been notified of the need to knock and wait prior to entry into residents' rooms. They addressed the issue with each of their students that day. 2. All residents could potentially be affected by this practice. Center management and nurses will observe daily for staff knocking and waiting for response prior to entry in the resident rooms. Any staff, volunteers, or students found to not knock and wait will be in-serviced on the spot. 3. All staff and clinical instructors shall be in-serviced by the Nurse Practice Educator on dignity, knocking and getting permission to enter resident rooms.	03/03/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

ADMINISTRATOR

(X6) DATE

1/26/15  
2/9/15

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 241	Continued From page 1 determined that the facility failed to maintain or enhance nine (R42, R44, R68, R73, R78, R88, R144, R197 and R198) out of 37 Stage 2 sampled residents' dignity and respect in full recognition of his or her individuality. The facility failed to ensure staff and nursing students knocked and/or requested permission to enter residents rooms prior to entering. Findings include:  1. On 12/18/14 at 8:22 AM, E6 (CNA) knocked and entered R144's room without asking permission to enter. R144 confirmed that he did not give permission for E6 to enter his room.  2. On 12/19/14 at 8:20 AM, NS (nursing student) #1 knocked and entered R88's room without asking permission to enter.  3. On 12/19/14 at 8:25 AM, NS #5 knocked and entered R73 and R68's shared room without asking permission to enter.  4. On 12/19/14 at 8:30 AM, NS#2 knocked and entered R78's room without asking permission to enter.  5. On 12/19/14 at 8:40 AM, NS#3 knocked and entered R42's room without asking permission to enter.  6. During an interview with R44 on 12/17/14 at 2:40 PM, E9 (CNA) entered the room without first knocking and/or asking for permission to enter. E9 acknowledged at this time that he did not knock before entering the room.  7. On 12/17/14 at 3:19 PM, while R44's room	F 241	F 241 (cont.) <b>4. Nurse Practice Educator or designee shall conduct Dignity Audits per the following schedule: random sample of 5% of staff and nursing students weekly until four weeks consecutive weeks of compliance, then monthly until four consecutive months of 100% compliance at which time the Quality Assurance / Performance Improvement (QAPI) Committee shall determine if full compliance has been achieved. Performance on the audit shall be reported to the QAPI Committee monthly</b>	

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F 241	Continued From page 2 observation was being completed, E10 (CNA) entered the room without knocking and/or asking for permission to enter. E10 acknowledged that she did not knock before entering the room.  8. During the medication (med) pass observation on 12/22/14 at 9:28 AM, E24 (CNA) knocked and entered R197's room without waiting for a reply.  9. During the med pass observation on 12/22/14 at 9:30 AM, E24 (CNA) knocked and entered R198's room without waiting for a reply.  Findings were reviewed with E1 (NHA) and E2 (DON) on 12/23/14 at 1:20 PM.	F 241	F 246  1. Patient's call bell was placed within reach immediately upon discovery 2. Rooms for all call-bell dependent patients were audited by January 7, 2015. None were found to be out of reach. Center management and nurses will observe daily on rounds for resident call bell access. If a call bell is not within reach of the resident, it will be immediately corrected and the assigned nurse assistant in-serviced. 3. All CNAs and clinical instructors shall be in-serviced by the Nurse Practitioner on the need for call bells to be within reach for all patients. 4. Nurse Practice Educator, or designee shall conduct Call Bell Audits per the following schedule: random sample of 5% of patient rooms weekly until four weeks consecutive weeks of compliance, then monthly until four consecutive months of 100% compliance at which time the Quality Assurance / Performance Improvement (QAPI) Committee shall determine if full compliance has been achieved. Performance on the audit shall be reported to the QAPI Committee at least quarterly by the Nurse Practice Educator, or designee.	03/03/2015
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  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.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to accommodate one (R116) out of 37 Stage 2 sampled residents with regard to the call bell being within reach. Findings include:  On 12/17/14 at 1:55 PM, R116 was observed seated in a wheelchair next to her bed. The call	F 246		



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F 247	Continued From page 4 same room since admission on 5/22/14. E17 stated that R144's current roommate came on 12/16/14, the one prior to that was 12/10/14 and the roommate prior to that was 11/12/14. E17 confirmed there were no Transfer/New Roommate Change Forms completed for R144's last 3 roommate changes.  E4 (UM) was interviewed on 12/22/14 at 1:30 PM. E4 stated as soon as it is known that a new roommate is coming, either the admission nurse, social service or the unit clerk (if she has time) tells the resident. When asked if the information was written anywhere, E4 stated, "we don't have time to write."  E19 (Unit Clerk) was interviewed on 12/22/14 at 1:40 PM. E19 stated that she verbally tells resident's sometimes when she knows they are getting a new roommate, but she does not write it down or enter the information in the computer.  The facility failed to have evidence that they notified R144 of his last 3 roommate changes (between 11/12/14 and 12/16/14).	F 247	F 247 (cont) They will be monitored monthly until four consecutive months of compliance is achieved. When four consecutive months of compliance has been observed, the Quality Assurance / Performance Improvement (QAPI) Committee shall determine if additional scrutiny is required. For Requested or Necessary Room Changes of existing patients: Social Services Director or designee shall monitor all requested room changes weekly until proof of proper notification is documented for four consecutive weeks, after which they shall be monitored monthly until four consecutive months of compliance is achieved. When four consecutive months of compliance has been observed, the Quality Assurance / Performance Improvement (QAPI) Committee shall determine if additional scrutiny is required. Performance on the audit shall be reported by the Director of Social Services to the QAPI Committee at least quarterly.	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observations and interviews made in resident rooms during the survey, it was determined that the bathroom doors, room walls	F 253	F 253 1. The Pull-cord in E-125B was replaced immediately upon discovery. The scratches and peeling paint observed on the walls, doors and toilet in E-105, E-120, E-111, W-102, W-109, W-122, W-123 were repaired by the Facility Maintenance Department prior to the conclusion of the survey team on .	<b>03/03/2015</b>

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F 253	Continued From page 5 and over bed light cords for eight (8) out of 35 rooms reviewed did not have adequate maintenance services. Findings include:  1. Observation on 12/17/14 at 3:00 PM of room E125B revealed the over bed light cord was too short.  2. Observation on 12/17/14 at 3:01 PM of room W123B revealed the walls in the bathroom had peeling paint and the over bed light cord was too short.  3. Observation on 12/18/14 at 8:50 AM of room E105 revealed scrapes on the inside of the bathroom door at the bottom, and along the wall in front of the toilet.  4. Observation on 12/18/14 at 9:15 AM of room E120 revealed scrapes on the inside of the bathroom door at the bottom.  5. Observation on 12/18/14 at 10:35 AM of room W122 revealed peeling paint on the left wall when entering the room.  6. Observation on 12/18/14 at 11:04 AM of room W102 revealed walls with peeling paint and a wall in disrepair by the heating/air conditioning unit.  7. Observation on 12/18/14 at 11:41 AM of room E111 revealed a scraped wall and chipped paint in front of the bathroom toilet.  8. Observation on 12/18/14 at 11:51 AM of room W109 revealed the left wall, when entering the room, had peeling paint.  The above listed findings were confirmed by E5	F 253	F 253 (cont)  1/7/2015. An audit of all fixtures and pull-cords shall be conducted by the Maintenance Department and repairs made by the date of substantial completion. Facility Administrator shall conduct in-service for the Maintenance staff on the need for proper care and preventive maintenance for pull cords and resident room fixtures by the date of substantial compliance The Administrator or designee shall conduct weekly audits of 5% of resident rooms weekly until four consecutive weeks of compliance is established. Then the audits shall occur monthly until four consecutive months of compliance is establish, at which time the Quality Assurance / Performance Improvement (QAPI) Committee shall determine if the issue has been sufficiently addressed. These audits shall be shared with the facility's QAPI Committee, monthly.	03/03/2015	

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F 253	Continued From page 6 (Environmental Services Director) during an interview during the environmental tour on 12/22/14 at approximately 2:30 PM.	F 253	F 253 (cont)	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, it was determined that the facility failed to administer eye drop medication that met professional standards of quality for 2 (R63 and R78) out of 37 Stage 2 sampled residents. Findings include:  The facility policy, entitled Medication Administration: Eye (Drops and Ointments), last revised on 1/2/14, stated, "... Instill drops... After administering medication, instruct... to close eyes gently... Remove excess solution... with tissue. Use a fresh tissue for each eye...".  1. During the medication (med) pass for R63 on 12/22/14 at approximately 9:10 AM, E22 (LPN) was observed using the same area of the tissue to dab each eye after eye drops were administered causing potential for cross-contamination of organisms.  Findings were confirmed with E22 during an interview on 12/22/14 at 10:10 AM.  2. During the med pass on 12/22/14 at approximately 9:45 AM, E23 (RN) administered	F 281	F 281 1. E22 and E23 were counselled and in-serviced on the proper method of administering eye drops and ointments by the Nurse Practice Educator. 2. An audit of patients receiving medications or nursing procedures for eye care shall be conducted and documented by the Director of Nursing or designee to ensure proper technique is utilized. 3. In-service of facility's policy and procedure for medication administration for the eye shall be conducted by the Nurse Practice Educator for all nurses. 4. Nurse Practice Educator, or designee shall conduct a Med Pass Audit on all patients receiving eye drops and/or ointments weekly until four consecutive weeks of compliance, then monthly until four consecutive months of 100% compliance at which time the Quality Assurance / Performance Improvement (QAPI) Committee shall determine if the full compliance has been achieved. Performance on the audit shall be reported to the QAPI Committee at least quarterly by the Nurse Practice Educator, or designee.	03/03/2015

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F 281	Continued From page 7 eye drops to R78 and used the same area of the tissue to dab both eyes.  Findings were confirmed with E23 during an interview on 12/22/14 at 10:15 AM  The facility failed to follow their own policy to use a fresh tissue for each eye and to meet professional standards in removing excess eye drop solution without creating potential for cross-contamination of organisms from one eye to the other.	F 281		
F 312 SS=D	<b>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</b>  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that three (R116, R128 and R199) out of 37 Stage 2 sampled residents, who were unable to carry out activities of daily living, received the necessary services to maintain good grooming and personal hygiene. The facility failed to provide nail care for R116, R128 and R199. Findings include:  The facility's policy on ADLs included the "Clinical Competency Validation - Nail Care", last revised in 1/14, which stated, "Critical elements: ...Soaks one hand in basin of warm water. Removes hand	F 312	<b>F 312</b> 1. All three patients' fingernails were cleaned and trimmed as needed by January 7, 2015.  <b>F 312</b> 2. An audit of dependent patients shall be conducted for nail care and nail care provided, as appropriate by the Nurse Practice Educator. 3. In-Service requirements for clinical competency for nail care (attached) shall be included in all annual training competency sessions in 2015, and beyond. Annual competency sessions will be coordinated by the Nurse Practice Educator or designee. 4. Nurse Practice Educator, or designee shall conduct an audit of 5% of dependent patients for nail care weekly until four consecutive weeks of compliance, then monthly until four consecutive months of 100% compliance at which time the Quality Assurance / Performance Improvement (QAPI) Committee shall determine if full compliance has been achieved. Performance on the audit shall be reported to the QAPI Committee at least quarterly by the Nurse Practice Educator, or designee.	<b>03/03/2015</b>

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F 312	<p>Continued From page 8</p> <p>from basin and places on towel. Dries hand with towel. Soaks opposite hand while manicuring first hand; then dries. Trims nails straight across with clipper. Clean under nails with cotton tipped applicator or orangewood stick. Files nails smooth with nail file/emery board...".</p> <p>1. The quarterly MDS, dated 11/6/14, stated that R128's daily decision making was moderately impaired and he was totally dependent for personal hygiene and bathing with the assistance of one staff person.</p> <p>R128's ADL care plan, last reviewed in 11/2014, had a goal that the resident would complete self care with minimal assistance within 90 days with a target date of 2/3/15. Interventions included: "Assess resident's level of ADL skills; Encourage resident to make choices regarding ADL performance; Provide assistance and/or cueing to maximize current level of function; Provide verbal cues for safety and sequencing when needed...".</p> <p>Review of the ADL Flow Record for December 2014 revealed R128's performance code indicated total dependence for bathing as well as personal hygiene from 12/1/14 - 12/17/14.</p> <p>On 12/17/14 at 3:22 PM, R128 was observed with fingernails that were long and had dirt under them.</p> <p>In an interview, on 12/17/14 at 3:47 PM, E18 (CNA) confirmed the findings. E18 stated that usually day shift took care of R128's fingernails.</p> <p>The facility failed to ensure that R128, a resident who was dependent for personal hygiene and bathing, had clean and trimmed fingernails.</p>	F 312		

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F 312	Continued From page 9  2. R116 was admitted to the facility on 9/28/12. The annual MDS assessment, dated 8/14/14, stated R116's daily decision making skills were moderately impaired and that she was totally dependent on one staff member for personal hygiene needs.  The facility developed a care plan, last reviewed 11/12/14, for "... dependent for ADL care in ... grooming ..." due to a stroke and recent hip fracture [broken]. Interventions included, "...Encourage resident participation while providing appropriate ADL care ... Resident is dependent on 1 person for ... personal hygiene."  Observation on 12/18/14 at 8:16 AM, revealed that some of R116's fingernails on both hands were elongated and jagged with debris underneath. A second observation on 12/19/14 at 11:16 AM revealed that R116's fingernails remained untrimmed and dirty.  On 12/19/14 at 11:20 AM, E18 (LPN) was asked to observe R116's fingernails. E18 confirmed the findings. On 12/22/14 at 8:35 AM, R116 was observed to have her fingernails trimmed and clean.  Findings were confirmed with E2 (DON) during an interview on 12/23/14 at 8:28 AM. The facility failed to ensure that R116, a resident who was unable to carry out ADL's, received the necessary services to maintain good grooming and personal hygiene.	F 312		

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F 312	<p>Continued From page 10</p> <p>3. R199 was admitted to the facility on 12/12/14. The admission MDS assessment, dated 12/19/14, stated R199's daily decision making skills were moderately impaired and that he needed extensive assistance of one staff person for personal hygiene needs.</p> <p>The "Admission Nursing Assessment", dated 12/12/14, revealed that R199 required assistance due to right arm weakness.</p> <p>The facility developed a care plan, dated 12/15/14, for "...decreasing ability to perform ADL ... in: ... grooming ..." due to a collarbone fracture and deconditioning (physical decline in functioning) and stated to "provide extensive assistance for bathing/showering ...".</p> <p>Observation on 12/17/14 at 2:13 PM, revealed R199's middle and ring fingernails on his left hand were dirty. A second observation on 12/18/14 at 3 PM revealed that R199's fingernails remained dirty. A third observation on 12/19/14 at 11:46 AM revealed that R199's fingernails (index, middle and ring) were dirty on his left hand.</p> <p>On 12/19/14 at approximately 3 PM, E3 (UM) confirmed that R199's fingernails were dirty and stated that he would ensure that they were cleaned. E2 was also present during this interview. E2 confirmed that although R199 received a shower on 12/17/14, the facility failed to provide nail care for R199 who was unable to carry out his own ADLs.</p>	F 312	<p>F 323</p> <p>1. Regarding Fall Mats: Fall mats were placed immediately upon discovery on the cited resident. Regarding Unattended Medication Cart: The cart was locked immediately after it was brought to the attention of the LPN.</p> <p>2. Regarding Fall Mats: An audit of patients requiring fall mats shall be conducted by the Director of Nursing or designee to ensure they are properly in place. Housekeeping and nursing staff shall be in-serviced by the Nurse Practice Educator and/or the Environmental Services Director on the proper placement of fall mats. Regarding Unlocked Medication Cart: An audit was completed on all medication carts by January 7, 2015. No other carts were found to be unlocked.</p> <p>3. Regarding Fall Mats: Nurse Practice Educator and Environmental Services Director shall work together to provide in-service training to CNAs and Environmental Services Staff on keeping safety devices in place. Regarding Unlocked Medication Cart: Nurse Practice Educator shall conduct in-service training on the necessity of locking unattended medication and treatment carts.</p>	03/03/2015
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident</p>	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085025</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/07/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHURCHMAN VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713</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	<p>Continued From page 11</p> <p>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 record review, observation and interview, it was determined that the facility failed to ensure that one (1) resident (R116) out of 37 Stage 2 sampled residents, had assistive devices (fall mats) in place as per the plan of care to prevent potential accidents. Additionally, the facility failed to ensure that the residents' environment remained as free of accident hazards as possible when the top half East Hall medication cart was observed unlocked and unattended. Findings include:</p> <p>1. R116 had a fall care plan, last reviewed on 11/12/14, with interventions that included, "... Implement the following safety precautions: low bed, bed alarm, 2 fall mats next to bed...".</p> <p>R116 was a fall risk with a recent fall out of bed on 12/16/14.</p> <p>On 12/19/14 at 11:10 AM, R116 was observed in bed, dressed and watching TV. Bed alarms were in place. A fall mat was in place on the left side of the bed. On the right side of the bed, the fall mat was standing on its edge, next to the wall, folded in half and not in place.</p> <p>On 12/19/14 at 11:30 AM, R116 remained in bed</p>	F 323	<p>F 323</p> <p>4. Nurse Practice Educator, or designee shall conduct the following audits: Regarding Fall Mats: 5% of patient rooms where fall mats are required shall be audited to ensure they are properly in place. Regarding Medication Carts: An audit of all unattended medication carts shall be conducted. Both of these audits shall occur weekly until four consecutive weeks of compliance, then monthly until four consecutive months of 100% compliance at which time the Quality Assurance / Performance Improvement (QAPI) Committee shall determine if full compliance has been achieved. Performance on the audit shall be reported to the QAPI Committee at least quarterly by the Nurse Practice Educator, or designee.</p>	03/03/2015

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F 323	<p>Continued From page 12</p> <p>with no fall mat in place on the right side of the bed. No staff was present working with the resident. During an interview immediately following this observation, E18 (LPN) reviewed R116's care plan with the surveyor and confirmed the findings. E18 stated that R116's CNA was on break. E18 immediately placed the fall mat on the floor to the right side of the bed. E4 (UM) joined the interview and stated that housekeeping must have cleaned the floor and failed to replace the fall mat.</p> <p>On 12/19/14 at 1:30 PM, E4 confirmed that she had spoken with housekeeping, who had failed to return the fall mat. The facility failed to ensure assistive devices (2 fall mats) were in place while R116 was in bed as per the plan of care.</p> <p>2. Observation on 12/17/14 at 11:55 AM revealed the top half East Hall medication cart was unlocked with no licensed nurse in view. Observation of this medication cart continued until 12:10 PM and revealed multiple staff and visitors walking by. E8 (LPN) was approached at the nurse's station and asked if she was in charge of the top hall medication cart and that it was unlocked. E8 went to check the cart and confirmed that it had been left unlocked and unattended.</p> <p>Findings were reviewed with E2 (DON) on 12/23/14 at approximately 11:00 AM.</p>	F 323		
F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, SS=D PALATABLE/PREFER TEMP	F 364	1. NS#4's instructor was notified of the deficient practice and the need to in-service the student on proper technique. Subsequent meals for R42 were served at the appropriate temperature.	03/03/ 2015
	Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is			

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F 364

Continued From page 13  
palatable, attractive, and at the proper  
temperature.

This REQUIREMENT is not met as evidenced  
by:

Based on observation and resident interview, it  
was determined that the facility failed to serve  
food that was palatable and at the proper  
temperature for one (R42) out of 37 Stage 2  
sampled residents. Findings include:

On 12/19/14 at 8:10 AM, R42 was observed  
sleeping with his breakfast tray uncovered, on the  
over bed table across from him. At 8:40 AM, 30  
minutes later, R42 was overheard stating that his  
eggs were cold.

In an interview on 12/19/14 at 8:40 AM, R42  
confirmed his eggs were cold. NS (nursing  
student) #4 stated they seemed warm. NS#4  
was advised that R42's tray was observed  
uncovered for at least 30 minutes. NS#4  
continued to feed R42 cold eggs.

Findings were reviewed with E1 (NHA) and E2  
(DON) on 12/23/14 at 1:25 PM.

F 371  
SS=F

483.35(i) FOOD PROCURE,  
STORE/PREPARE/SERVE - SANITARY

The facility must -

- (1) Procure food from sources approved or  
considered satisfactory by Federal, State or local  
authorities; and
- (2) Store, prepare, distribute and serve food  
under sanitary conditions

F 364

F 364 (cont)

2. Nursing Instructors were required  
to observe other students assigned  
to assist patients during meals and  
correct if necessary.

3. Instructors from all nursing  
schools will be notified by the  
Administrator to remind their  
students to serve hot meals at the  
appropriate temperature, as  
necessary. Nursing instructors and  
center nurses will observe meal time  
to assure that residents have  
appropriate temperature food and  
meals.

4. Nurse Practice Educator shall  
conduct random audits when nursing  
students are present to verify they  
are servicing hot meals. These audits  
shall be conducted weekly, until four  
consecutive weeks of compliance,  
then bi-weekly until compliant for  
four consecutive bi-weekly periods,  
then monthly until compliant for four  
consecutive months at which time  
the Quality Assurance / Performance  
Improvement (QAPI) Committee  
shall determine if full compliance has  
been achieved. Performance on the  
audit shall be reported to the QAPI  
Committee at least quarterly by the  
Nurse Practice Educator, or designee.

F 371

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NAME OF PROVIDER OR SUPPLIER  <b>CHURCHMAN VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713</b>		
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F 371	Continued From page 14  This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of facility documentation, it was determined that the facility failed to prepare and serve food under sanitary conditions with regard to handling food with bare or unclean gloved hands, lack of hand washing per facility policy, and lack of hair coverings per facility policy. These multiple observations were made on different times and dates. Findings include:  The facility's policy IC203 Hand Hygiene Titled: Infection Control Policies and Procedures, effective 2/15/01 and last revised on 10/1/13, stated, "adherence to hand hygiene practices is maintained by all Center personnel. To improve hand hygiene practices and reduce the transmission of pathogenic microorganisms hands must be washed with soap and water in the following situations: after removing gloves or other personal protective equipment ...before and after handling food ...".  The facility's policy 2.2 Personal Hygiene Titled: Food and Nutrition Services Policies and Procedures, effective 7/1/98 and last revised on 10/1/14, stated, "...Facial hair coverings are used to cover all facial hair ... Disposable gloves are single use items and are changed between tasks ...".  During the kitchen observation on 12/17/14 between 11:20 AM to 12:49 PM, the following were observed:	F 371	F 371 1. Employees identified were in-serviced on hand hygiene on or before January 7, 2105 by the Nurse Practice Educator. 2. No other patients were found to have been impacted by the practice. Hand hygiene will be observed at each meal by nurses on meal rounds and during dining service in the Dining Room. Staff will be immediately spoken to about deficit practice if observed. 3. All CNAs, Food Service Aides and Cooks shall be in-serviced by the Nurse Practice Educator and/or Food Service Director on hand hygiene and the need to wear gloves when handling food contact surfaces of tableware. 4. Nurse Practice Educator and Food Service Director shall conduct random audits at each of the meal times to ensure those who are plating and serving food are not touching food contact surfaces with ungloved hands. These audits shall be conducted weekly, until four consecutive weeks of compliance, then bi-weekly until compliant for four consecutive bi-weekly periods, then monthly until compliant for four consecutive months at which time the Quality Assurance / Performance Improvement (QAPI) Committee	03/03/2015	

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NAME OF PROVIDER OR SUPPLIER  <b>CHURCHMAN VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713</b>		
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F 371	<p>Continued From page 15</p> <ol style="list-style-type: none"> <li>1. At 12:00 PM, E13 (Cook 1) transferred a grilled cheese sandwich with her left unclean gloved hand and a spatula onto a plate. The unclean gloved hand touched several tongs prior to touching the sandwich.</li> <li>2. At 12:38 PM, E16 (dietary staff) entered the kitchen, proceeded to the freezer to get ice cream and then exited the kitchen without wearing a face net to cover his facial hair.</li> <li>3. E13 was observed changing her gloves at least 3 times between 12:00 PM to 12:43 PM without washing her hands between each glove change.</li> <li>4. At 12:44 PM, E13 plated a biscuit using her left unclean gloved hand that had touched several tongs prior to her picking up the biscuit.</li> <li>5. At 12:45 PM, E13 plated another biscuit using her left unclean gloved hand that had touched several tongs prior to her picking up the biscuit.</li> </ol> <p>During the first dining observation on 12/17/14 in the Main Dining Room's serving station, the following were observed:</p> <ol style="list-style-type: none"> <li>6. At 11:59 AM, E14 (Cook 2) was observed lifting the handle to open the griddle with his left gloved hand then proceeded to pick up a hot dog with the same gloved hand and place the hot dog on the counter behind him to chop it.</li> <li>7. At 12:01 PM, E14 was observed lifting the handle to open the griddle with his left gloved hand then proceeded to pick up two hot dogs off the griddle with the same gloved hand and place them in hot dog rolls to be served.</li> </ol>	F 371	<p>F 371 (cont)</p> <p>shall determine if full compliance has been achieved. Performance on the audit shall be reported to the QAPI Committee at least quarterly by a. the Nurse Practice Educator, or designee and b. the Food Service Director, or designee.</p>	

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F 371	<p>Continued From page 16</p> <p>During an observation on 12/19/14 in the East Wing, the following was observed:</p> <p>8. At 7:53 AM, E21 (CNA) was observed handing a waffle slice with her bare right hand to R88, who was eating breakfast in bed.</p> <p>Findings were confirmed by E21 during an interview on 12/19/14 at 8:01 AM.</p> <p>During the second dining observation on 12/22/14 between 11:35 AM to 12:30 PM, the following were observed:</p> <p>9. E15 (Cook 3) was observed changing her gloves at least 8 times without washing her hands between each glove change.</p> <p>10. E14 (Cook2) was observed changing his gloves at least 4 times without washing his hands between each glove change.</p> <p>11. From 11:45 AM to approximately 12:20 PM, E16 (dietary staff) was observed serving plated food in the Main Dining Room with exposed facial hair (beard).</p> <p>12. At 12:14 PM, E15 (Cook 3) was observed using tongs with gloved hands to place french fries on a plate then proceeded to pick up a grilled cheese with the same gloved hands and place it onto the same plate.</p> <p>13. At 12:16 PM, E15 was observed touching a resident's order form with her right gloved hand and then she proceeded to pick up a sandwich to plate after she had reached into a potato chip bag to pull out and place chips on the plate with the same gloved hands.</p>	F 371			



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F 431	<p>Continued From page 18</p> <p>controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility records and interviews, it was determined that the facility failed to ensure that a system for the reconciliation of controlled medications (medications whose use and distribution is tightly controlled by regulations) was performed by two licensed nurses at each shift change in 2 out of 2 hallways (4 out of 4 medication carts). Findings include:</p>	F 431			

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F 431	<p>Continued From page 19</p> <p>The facility policy entitled, "Controlled Drugs: Management of", last reviewed on 5/15/14, stated, "... Ongoing Inventory of Controlled Drugs (Shift Count) ... Count must be performed by two licensed nursing staff ... The two licensed nursing staff must be those who are relinquishing and accepting the narcotic keys... Both licensed nursing staff sign the Shift Count Page in the 'Controlled Substances Book' to acknowledge completion of the shift count...".</p> <p>Review of the facility's narcotic count forms on 12/22/14 at 2 PM revealed the following:</p> <p>a. Review of the East Front Cart (East Hallway) from 10/1/14 through 12/21/14 revealed that for 26 out of 246 shifts; either the nurse going off duty or the nurse coming on duty failed to sign the "Shift Count" form. In addition, there were two (2) missing shift inventory counts where both the nurse going off duty and the nurse coming on duty failed to sign the form.</p> <p>b. Review of the East Back Cart (East Hallway) from 10/1/14 through 12/21/14 revealed that for 21 out of 246 shifts; either the nurse going off duty or the nurse coming on duty failed to sign the "Shift Count" form. In addition, there were two (2) missing shift inventory counts where both the nurse going off duty and the nurse coming on duty failed to sign the form.</p> <p>c. Review of the West Front Cart (West Hallway) from 10/1/14 through 12/21/14 revealed that for 11 out of 246 shifts; either the nurse going off duty or the nurse coming on duty failed to sign the "Shift Count" form.</p>	F 431			

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F 431	Continued From page 20  d. Review of the West Back Cart (West Hallway) from 10/1/14 through 12/21/14 revealed that for 16 out of 246 shifts; either the nurse going off duty or the nurse coming on duty failed to sign the "Shift Count" form. In addition, there was one (1) missing shift inventory count where both the nurse going off duty and the nurse coming on duty failed to sign the form.  The facility failed to ensure that narcotic inventory counts were reconciled by two nurses during shift changes multiple times from 10/1/14 through 12/21/14.  Findings were confirmed with E2 (DON) on 12/22/14 at 2:10 PM.	F 431	F 441 1. Trashcan lids were immediately removed from all med carts so staff would not be required to open them with their hands. E22, E23, E25 and E26 were in-serviced on proper hand hygiene relevant to med passes and sanitizing multi-use equipment between patients. 2. A review was completed of all residents at risk of being affected by alleged practices. 3. In-services shall be provided by the Nurse Practice Educator or designee to all nurses regarding hand hygiene relevant to med passes. CNAs shall be in-serviced on hand hygiene relevant to the sanitizing of multi-use equipment between patients. 4. Nurse Practice Educator shall conduct med pass audits to ensure appropriate hand hygiene is practiced. These audits shall occur weekly until four consecutive weeks of compliance, then bi-weekly until compliant for four consecutive bi-weekly periods, then monthly until compliant for four consecutive months at which time the Quality Assurance / Performance Improvement (QAPI) Committee shall determine if full compliance has been achieved. Performance on the audit shall be reported to the QAPI Committee at least quarterly by the Nurse Practice Educator, or designee.	03/03/2015
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES 'D PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>086025</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/07/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHURCHMAN VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713</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)	(X8) COMPLETION DATE	
F 441	<p>Continued From page 21</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, facility documentation, and interviews, it was determined that the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection related to handwashing technique and/or gloving for eight (R63, R78, R88, R106, R116, R128, R130 and R200) out of 37 Stage 2 sampled residents. Findings include:</p> <p>The facility's policy entitled, "IC203 Hand Hygiene", last revised on 10/1/13, stated, "...Wash hands with soap and water in the following situations: after removing gloves ...; Before and after direct patient care; Immediately after contact with blood, body fluids, or other potentially infectious materials; After toilet use; before and after handling food... To wash hands</p>	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085025</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/07/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHURCHMAN VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713</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 441	<p>Continued From page 22</p> <p>with soap and water; Wet hands with warm (not hot) water, apply soap to hands, and rub hands vigorously for at least 15 to 20 seconds covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. Use towel to turn off faucet...".</p> <p>The facility's policy entitled, "IC201 Cleaning and Disinfecting" with an effective date of 9/1/14, stated, "... Clean and disinfect items/environment according to risk of infection category... Non-critical items are objects that do not come into contact with mucus membranes, but do come into contact with intact skin (e.g. (for example), blood pressure cuff... stethoscope... These items require cleaning between patient use...".</p> <p>1. During the medication (med) pass on 12/22/14 at approximately 9:10 AM, E22 (LPN) was stopped before drawing up Insulin in a syringe for R63 because she contaminated her hand on the lid of the trash can on the side of the medication cart just before this. The lid covered the entire trash can so that it required being lifted each time trash was discarded.</p> <p>2. During the med pass on 12/22/14 at 9:20 AM, E22 gave an insulin injection in R63's abdomen and then gave the resident eye drops without changing gloves between sites.</p> <p>Findings were confirmed with E22 during an interview on 12/22/14 at 10:10 AM.</p> <p>3. During the med pass observation on 12/22/14 at approximately 9:45 AM, E23 (RN) was observed contaminating her hand, while preparing medications for administration, on the</p>	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/07/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHURCHMAN VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713</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 441	<p>Continued From page 23</p> <p>trash lid which was ajar, on the side of the med cart.</p> <p>Findings were confirmed with E23 during an interview on 12/22/14 at 10:15 AM.</p> <p>Findings were reviewed with E2 (DON) on 12/22/14 at approximately 10:30 AM. E2 stated that she would remove the lids from the trash cans on the sides of the med carts.</p> <p>4. On 12/19/14 at 7:56 AM, E25 (CNA) was observed performing handwashing at the sink in R88's room. After washing her hands, E25 dried her hands with paper towels, used the paper towels to turn off the faucet and then used the soiled paper towels to redry her left hand before discarding. This posed a potential for infection and cross contamination. Immediately afterward in an interview, E25 confirmed the findings.</p> <p>5. On 12/19/14 at 8:18 AM, E26 (CNA) was observed doing vital signs with the Dinamapp machine (an electronic blood pressure machine) on R106. Without handwashing or sanitizing her hands after working with R106, she proceeded to R116 and did her vital signs.</p> <p>On 12/19/14 at 8:18 AM. E26 failed to clean the Dinamapp between residents as per the facility policy that stated to clean multi-patient equipment between patients.</p> <p>6. On 12/19/14 at 8:21 AM, E26 was observed doing vital signs with the Dinamapp on R116. Without handwashing or sanitizing her hands, she then proceeded to do vital signs on R200.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  <b>CHURCHMAN VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713</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)	(X6) COMPLETION DATE
F 441	Continued From page 24  On 12/19/14 at 8:22 AM, E26 failed to clean the Dinamapp between residents as per the facility policy that stated to clean multi-patient equipment between patients.  During an interview on 12/19/14 at 8:24 AM, E26 confirmed the findings. E26 stated that she usually does wash her hands, but "just forgot". She then used the hand sanitizer on the wall in the hallway between R116's and R200's rooms.  During an interview on 12/19/14 at 1:29 PM, E26 was interviewed regarding the facility policy with the use of multi-patient equipment. E26 confirmed that she did not clean the dinamapp machine between residents, but that staff were supposed to clean the equipment with bleach wipes.  7. On 12/17/14 at 3:35 PM, E18 (CNA) was observed washing his hands at the sink after assisting R128 with his urinal. E18 washed his hands, then incorrectly shut off the faucet with his bare hands and proceeded to dry his hands.  The facility failed to ensure staff wash their hands according to accepted professional practice to help prevent the spread of infection.  During an interview, on 12/17/14 at 3:40 PM, E18 confirmed the findings.	F 441	F 502  1. An attempt was made to obtain UA immediately and several attempts later but the patient refused. 2. Nurse Managers conducted New Admissions Chart Audit to ensure that all orders were taken off. 3. Nurse Practice Educator conducted in-service for all nurses prior to the surveyors' exit regarding proper steps when orders are received by admitting nurse and on chart checks to assure all orders have been transcribed. 4. Unit Managers shall conduct audits of all new admissions orders for accuracy. Director of Nursing or designee shall report results monthly to the Quality Assurance / Performance Improvement (QAPI) Committee until four consecutive months without error, then quarterly until four consecutive quarters without error at which time the QAPI Committee shall determine if full compliance has been achieved.	03/03/2015
F 502 SS=D	483.75(j)(1) ADMINISTRATION  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness	F 502		

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NAME OF PROVIDER OR SUPPLIER  <b>CHURCHMAN VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713</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 502	<p>Continued From page 25 of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R3) out of 37 Stage 2 sampled residents the facility failed to ensure timely laboratory services. Findings include:</p> <p>Readmission orders, dated 12/5/14, stated R3 was to have a urinalysis (UA/diagnostic test used to determine presence of infection in the urine) and urine culture and sensitivity (C&amp;S/test to find and identify germs [usually bacteria] that may be causing an infection and to determine which antibiotic will best treat the infection) completed on 12/16/14.</p> <p>Review of R3's clinical record and the laboratory sign out log lacked evidence that the above testing was completed on or about 12/16/14.</p> <p>On 12/22/14 at approximately 3:00 PM, E4 (UM) was interviewed regarding the UA and C&amp;S. E4 was unable to locate any results and upon calling the facility's laboratory provider was told that no urine had been received for testing on R3 on or about 12/16/14. E4 stated that the nurse who picked up the order should have written it on the treatment administration record (TAR), completed a laboratory request slip and written it in the laboratory book. E4 confirmed none of these were completed. The facility failed to ensure that laboratory services were provided.</p> <p>Findings were reviewed with E2 (DON) during an interview on 12/23/14 at approximately 11:00 AM.</p>	F 502	<p>F 502</p> <ol style="list-style-type: none"> <li>1. An attempt was made to obtain UA immediately and several attempts later but the patient refused.</li> <li>2. Nurse Managers conducted New Admissions Chart Audit to ensure that all orders were taken off.</li> <li>3. Nurse Practice Educator conducted in-service for all nurses prior to the surveyors' exit regarding proper steps when orders are received by admitting nurse and on chart checks to assure all orders have been transcribed.</li> <li>4. Unit Managers shall conduct audits of all new admissions orders for accuracy. Director of Nursing or designee shall report results monthly to the Quality Assurance / Performance Improvement (QAPI) Committee until four consecutive months without error, then quarterly until four consecutive quarters without error at which time the QAPI Committee shall determine if full compliance has been achieved.</li> </ol>	03/03/2015



**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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(302) 577-6661

**STATE SURVEY REPORT**

NAME OF FACILITY: Churchman Village

DATE SURVEY COMPLETED: January 07, 2015

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><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced annual and complaint survey was conducted at this facility from December 17, 2014 through January 7, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 90. The Stage 2 survey sample totaled 37 residents.</p> <p><b>Skilled and Intermediate Care Nursing Facilities</b></p> <p><b>Scope</b></p> <p>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</p>	

Provider's Signature

Title

ADMINISTRATOR

Date

2/24/15



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**STATE SURVEY REPORT**

NAME OF FACILITY: Churchman Village

DATE SURVEY COMPLETED: January 07, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>16 Del. C., Title 16, Chapter 11, §1162.</p>	<p>reference.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey exit date 1/7/2015, F241, F246, F247, F253, F281, F312, F323, F364, F371, F431, F441, and F502.</p> <p><b>Nursing staffing.</b></p> <p><b>(a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to dementia or a medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of (a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to dementia or a medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor,</b></p>	<p>Cross refer to the CMS 2567-L survey for the plan of correction regarding this citation (Federal Tags F-241, F-246, F-247, F-253, P-281, F-312, F-323, F-364, F-371, F-431, F-441, and F-502).</p> <p>Substantial Compliance on or before 03/03/2015</p>



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**STATE SURVEY REPORT**

**NAME OF FACILITY:** Churchman Village

**DATE SURVEY COMPLETED:** January 07, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p><b>unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations. Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles.</b></p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Based on observations and interviews, it was determined that the facility failed to ensure that all facility employees wear a nametag prominently displaying his or her full name and title. Findings include:</p> <p>1. Observation on 12/17/14 at 11:21 AM, revealed E20 (CNA/Certified Nurse's Aide) was not wearing a prominently displayed nametag. E20 confirmed at the time that she was not wearing her nametag.</p> <p>2. Observation on 12/17/14 at 3:19 PM revealed E10 (CNA) was not wearing a prominently displayed nametag. E10 stated at this time that she "forgot it in her other purse."</p> <p>3. Observation on 12/19/14 at 7:53 AM, revealed E21 (CNA) was not wearing a prominently displayed nametag. E21</p>	<ol style="list-style-type: none"> <li>1. Employees were dispatched to find/wear badges immediately upon discovery. Any employee who was unable to find their badge was provided a temporary badge that day.</li> <li>2. A review of other employees was conducted on the spot to ensure all had their badges in place. No other employees were found without proper identification.</li> <li>3. In-Service shall be provided to all employees by the Nurse Practice Educator and/or employee supervisors regarding the need for employee wear facility-provided badges at all times.</li> <li>4. Nurse Practice Educator or designee shall conduct employee badge audits to ensure badges are being worn appropriately. These audits shall occur weekly until four consecutive weeks of compliance, then bi-weekly until compliant for four consecutive bi-weekly periods, then monthly until four consecutive months until compliant for a four-month period at which time the Quality Assurance/Performance Improvement Committee shall determine if full compliance has been achieved. Performance on the audits shall be reported to the QAPI Committee at least quarterly by the Nurse Practice Educator or designee.</li> </ol> <p>Substantial Compliance on or before 03/03/2015</p>



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NAME OF FACILITY: Churchman Village

DATE SURVEY COMPLETED: January 07, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.7.0	<p>confirmed at the time that she was not wearing her nametag.</p> <p><b>Plant, Equipment and Physical Environment</b></p>	
3201.7.5	<p><b>Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.</b></p> <p><b>This requirement is not met as evidenced by:</b> Based on dining observations during the survey, it was determined that the facility failed to comply with sections 3-304.15 and 4-904.11.</p>	
3-304.15	<p><b>Gloves, Use Limitation</b> <b>(A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damage or soiled, or when interruption occur in the operation. P</b> <b>This requirement is not met as evidenced by:</b></p>	<p>Cross refer to the CMS 2567-Lsurvey for the plan of correction regarding this citation (Federal Tag 371).</p> <p>Substantial Compliance on or before 03/03/2015</p>



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STATE SURVEY REPORT

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NAME OF FACILITY: Churchman Village

DATE SURVEY COMPLETED: January 07, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
4-904.11	<p>Cross refer to the CMS 2567-I survey completed 1/6/15, F371, example 1.</p> <p><b>Kitchenware and Tableware</b></p> <p><b>(A) Single-Service and single-use articles and cleaned and sanitized utensils shall be handled, displayed, and dispensed so that contamination of food – and lip – contact surfaces is prevented.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Cross refer to the CMS 2567-L survey completed 1/6/15, F371, example 2.</p>	<p>Cross refer to the CMS 2567-L survey for the plan of correction regarding this citation (Federal Tag 371).</p> <p>Substantial Compliance on or before 03/03/2015</p>