

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

PRINTED: 12/16/2015
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G013 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 12/08/2015 |
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| NAME OF PROVIDER OR SUPPLIER MARY CAMPBELL CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 4641 WELDIN RD WILMINGTON, DE 19803 |
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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 |
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| W 000 | INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at this facility from December 2, 2015 through December 8, 2015. 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 67. The survey sample size was fifteen (15) clients. Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; ED-Executive Director; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA- Certified Nursing Assistant; Anterior chest wall-front of the body; DC - discontinue; DLTCRP-Division of Long Term Care Residents Protection; EMR - electronic medical record; ER - Emergency Room; Gurney - metal stretcher with wheels and siderails; mg - milligrams; MAR - medication administration record; POS - physician order sheet; RCT - Resident Care Technician; Keppra - seizure medication; Seizure - abnormal electrical activity in the brain causing repetitive muscle jerking. | W 000 | | |
| W 153 | 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as | W 153 | Federal Tag W153 – STAFF TREATMENT OF CLIENTS SECTION A (Individual Impacted) As was evidenced in the findings, The Mary Campbell Center (MCC) failed to immediately notify the Division of Long Term Care Residents Protection (DLTCRP) in two incidents alleging neglect, one incident of alleged abuse and one incident of significant injury of unknown source. Those residents found to have been affected by the deficient practice received appropriate intervention and no negative outcome resulted despite the facilities failure to report timely (within 8 hours). All allegations of abuse, neglect, mistreatment, financial exploitation and misappropriation of resident property will be investigated according to state and federal regulations. MCC Policy and Procedure titled, "Prevention of Abuse, Neglect, Mistreatment, Financial Exploitation, and Misappropriate of Resident Property, Investigation and Reporting of Alleged Incident, and Corrective Actions" (ANM P&P) including the section on "Reporting" was updated on 12/18/15 (SEE ATTACHMENT 1). The MCC Resident Incident Report was revised to include an updated section on timely reporting requirements (SEE ATTACHMENT 2). | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Brynn Stoboy</i> | TITLE <i>Executive Director</i> | (X6) DATE <i>12-23-15</i> |
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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 other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| W 153 | <p>Continued From page 1</p> <p>injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that for 4 (C9, C15, C13 and C14) out of 15 sampled clients, one sustained a significant injury of unknown source, one had an allegation of abuse and two allegations of neglect were reported immediately to the state agency (DLTCRP). Findings include:</p> <p>1. Review of the facility's incident report record stated that on 10/5/15, C9 was noted to be experiencing increased discomfort and was noted to have swelling to her left anterior chest wall. Her physician was contacted and an X-ray was ordered on 10/5/15. The result of the X-ray indicated an evidence of a dislocated left shoulder. C9 was sent to the ER and was treated.</p> <p>The record stated that this significant injury of unknown source was reported to the state agency, the DLTCRP on 10/7/15, 2 days after it was discovered and not immediately as the regulation required.</p> <p>In an interview with E3 (Assistant ED) on 12/4/15 at approximately 10:30 AM, she acknowledged this finding.</p> <p>2. Review of C15's incident record report dated 10/16/15 and timed 10:50 PM revealed C15's allegation that E7 (RCT) handled her roughly while washing her. According to C15, E7 put her</p> | W 153 | <p>SECTION B (Identification of other residents) On 12/18/15, all 2015 reportable incident files were reviewed to determine if the incident was reported timely to the Division of Long Term Care Residents Protection. There were 9 additional incidents that were not reported timely (within 8 hours) - 6 allegations of abuse, 2 allegations of neglect and 1 fall with ED transport for evaluation. All staff will be trained on the state and federal reporting requirements.</p> <p>SECTION C (System Changes) The root cause was inconsistent awareness by staff to report incidents within 8 hours as the regulation required. A memo directive, dated 12/18/15 was sent by email to staff regarding direction for the incident reporting responsibility (SEE ATTACHMENT 3). The In-service Educator/Designee will conduct training with all employees on MCC ANM P&P emphasizing the reporting guidelines (SEE ATTACHMENT 1). The In-service Educator/Designee will provide training to all nurses on the revised MCC Resident Incident Report process to ensure incidents are reported timely (SEE ATTACHMENT 2).</p> |

Regina Coffey Executive Director

12-23-15

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| W 153 | <p>Continued From page 2</p> <p>on a gurney to give her a shower after coming out from the swimming pool. E7 was rushing and being rough and caused her leg to get caught in the siderail while washing and dressing her. C15 refused to be cared for by E7. According to C15, the incident occurred on 10/15/15 during the day and C15 reported it to E6 (CNA). The incident was written on 10/16/15 and was reported to the state agency on 10/17/15, and not immediately, as the regulation required.</p> <p>This incident was discussed with E1 (NHA), E2 (DON) and E3 on 12/8/15 at approximately 3:00 PM.</p> <p>3. The following was reviewed in facility documents pertaining to C13:</p> <p>2/7/15 7:30 AM - a facility incident report documented that C13 was found with disposable undergarments that were heavy with urine and BM at first check at 7:15 AM.</p> <p>2/8/15 10:20 AM - the facility reported this allegation of neglect to the State agency over 24 hours after it was identified by staff.</p> <p>These findings were reviewed with E1 and E2 on 12/8/15 at 2:30 PM. No further information on the delay in reporting was available.</p> <p>4. The following was reviewed in facility documents pertaining to C14:</p> <p>2/6/15 8:30 AM (incorrectly documented should be 2/7/15) - a facility incident report documented C14 came to the nurses station to report that she was not changed last night and was soaked.</p> | W 153 | <p>SECTION D (Success Evaluation)</p> <p>At the weekly Senior Manager Rounds meeting, The Mary Campbell Center reportable incidents will be reviewed and signed off on to ensure that the timely reporting has occurred in 100% of the incidents.</p> <p>At the monthly Human Rights Committee Meeting all cases of reportable incidents are reviewed. As a part of the process, The MCC Abuse, Neglect, Mistreatment Check-list has been revised (SEE ATTACHMENT 4). The Checklist will be reviewed to ensure that timely reporting occurred in 100% of the incidents.</p> <p>The corrective actions above will become permanent procedures. In addition, the Senior Case Manager/ QDDP/Designee will present the summary report of the Human Rights Committee findings to the Quarterly Quality Assurance Meeting.</p> | 2/5/16 |

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| W 153 | Continued From page 3 2/8/15 10:30 AM - the facility reported this allegation of neglect to the State agency over 24 hours after it was identified by staff. | W 153 | | | |
| W 368 | These findings were reviewed with E1 and E2 on 12/8/15 at 2:30 PM. No further information on the delay in reporting was available. 483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and interview it was determined that for one (C12) out of 15 sampled clients the facility failed to ensure medication was administered in accordance with the physician's orders. C12 missed 3 doses of seizure medication resulting in seizure activity. Findings include: The following was reviewed in C12's clinical record: 3/3/15 - According to progress notes and the physician's orders the client was admitted to the facility. Orders included a seizure medication (Keppra) to be administered twice a day. 3/3 - 3/5/15 - MAR documented that Keppra was administered as ordered. 3/6 - 3/7/15 - MAR noted that the Keppra had been discontinued with the notation of DC in the administration box. The MAR lacked evidence of administration for 4 doses. | W 368 | Federal Tag W 368 –With Cross Reference for State 3204.9.8.4.4 <i>"The system for drug administration must assure that all drugs are administered in compliance with the physician's orders."</i> SECTION A (Individual Impacted) As was evidenced in the findings, the discontinued medication for C12 was re-ordered on 3/7/15 and medication administration began on 3/8/15. There were no additional doses missed nor further incidents of improper discontinuation of the medication. A Medication Error Report was completed on 12/8/15 (Attachment 5). The nurse identified as having caused the omission and subsequent errors has been separated from employment. SECTION B (Identification of other residents) An audit of all new and discontinued physician medication orders for the past 60 days will be performed by staff nurses as assigned to assure that all medications are being administered as prescribed. Any errors or omissions will be documented using the revised MCC Medication Error Report (Attachment 6) and necessary follow up and/or corrective action will be completed by February 5, 2016. | | |

Regina J. Cobley Executive Director 12-23-15

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| W 368 | Continued From page 4 3/7/15 2:00 PM - A nurse's note documented that at 11:30 AM C12 experienced a one minute and 15 second episode of seizure activity. It was documented that medication to relax the client was administered at 12:15 PM and again at 2:00 PM. 3/7/15 - A new physician's order was obtained for Keppra twice a day and administration of same was documented on the MAR starting on 3/8/15 at 6:00 AM. However, progress notes documented that a dose of Keppra was administered at 6:00 PM on 3/7/15. 12/7/15 2:35 PM - Interview with E2, DON revealed that there was no medication error report completed for this incident. E2 confirmed the medications were not administered. 12/8/15 around 9:30 AM - Follow-up interview with E2 revealed that this initially was handled as a pharmacy concern related to the EMR and not as a medication error until further review on 12/7/15 during the survey. It was further revealed that the original Keppra order was discontinued by a nurse in the EMR on 3/5/15 for unknown reasons. The omission of the medication was identified when the client experienced seizure activity on 3/7/15 and a new physician's order was obtained. It was unclear why the facility failed to conduct a complete analysis of the contributing factors for this medication omission. C12 missed three doses of seizure medication resulting in an onset of seizure activity. These findings were reviewed with E1 (NHA) and E2 on 12/8/15 at 2:30 PM. | W 368 | <p>SECTION C (System Changes) A protocol has been developed that reconciles physician orders within The Mary Campbell Center Electronic Health Record; "Physicians Orders Reconciliation" (Attachment 7). Nurses responsible for reconciling physicians orders will complete a "Physician's Order Review Log" each day (Attachment 8). A lesson plan will be developed by The Staff Educator and all nursing staff will receive training on this protocol by February 5, 2016. Any nurses identified as not following protocol will be counseled and re-educated as necessary.</p> <p>SECTION D (Success Evaluation) An audit tool has been developed (Attachment 9) which targets staff nurse compliance with following the established E.H.R. Protocol to assure that medications are administered in compliance with the physician's orders. The QAPI Nurse and her designee will complete 2 chart audits per week will be conducted until 100% compliance is maintained for two months. Following that, 1 chart audit will be conducted weekly until 100% compliance is maintained for 2 months.</p> | 2/5/16 |

Regina Scobbey

Executive Director

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Regina Coffey Executive Director 12-23-15



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAMES OF FACILITY: Mary Campbell Center

DATE SURVEY COMPLETED: December 08, 2015

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| <p>3201 3201.1.0 3201.1.2</p> | <p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey and complaint visit was conducted at this facility from December 2, 2015 through December 8, 2015. 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 67. The survey sample size was fifteen (15) clients.</p> <p>Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; ED-Executive Director; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA- Certified Nursing Assistant; Anterior chest wall-front of the body; DC - discontinue; DLTCRP-Division of Long Term Care Residents Protection; EMR - electronic medical record; ER - Emergency Room; Gurney - metal stretcher with wheels and siderails; mg - milligrams; MAR - medication administration record; POS - physician order sheet; RCT - Resident Care Technician; Keppra - seizure medication; Seizure - abnormal electrical activity in the brain causing repetitive muscle jerking</p> <p>Regulations for Skilled and Intermediate Care Facilities Scope</p> | | |

Provider's Signature Regina J. Coffey Title Executive Director Date 12-23-15



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| <p>3201.6.0 3201.6.10 3201.6.10.1 .5</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 reference.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed December 08, 2015: W153 and W368.</p> <p>Services To Residents</p> <p>Infection Control</p> <p>The infection control coordinator shall maintain records of all nosocomial infections and corrective actions related to those infections to enable the committee to analyze clusters or significant increases in the rate of infection and to make recommendations for the prevention and control of additional cases.</p> <p>Based on record review and interview it was determined that the facility failed to make recommendations for the prevention and control of additional infection cases when clusters were identified.</p> <p>Findings include:</p> <p>Record review of the facility's <i>Monthly Infection Control Surveillance Report</i> dated August 2015 revealed that a cluster was identified of 3 residents on the same unit with respiratory tract</p> | <p>3201.6.10.1.5 Infection Control</p> <p>The Infection Control Coordinator shall maintain records of all nosocomial infections and corrective actions related to those infections to enable the committee to analyze clusters or significant increases in the rate of infection and to make recommendations for the prevention and control of additional cases.</p> <ol style="list-style-type: none"> Record review of the facility's <i>Monthly Infection Control Surveillance Report</i> dated August 2015 revealed that a cluster was identified of three residents on the same unit with respiratory tract infections. Record review of the <i>Monthly Infection Control Surveillance Report</i> dated October 2015 revealed a cluster was identified of two residents on the same unit with urinary tract infections. <p>Neither report mentioned recommendations for the prevention and control of additional cases of these infections.</p> | |

Provider's Signature *Begonia Campbell* Title *Executive Director* Date *12-23-15*



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| | <p>infections.</p> <p>Record review of the <i>Monthly Infection Control Surveillance Report</i> dated October 2015 revealed a cluster was identified of 2 residents on the same unit with urinary tract infections.</p> <p>Neither report mentioned recommendations for the prevention and control of additional cases of these infections.</p> <p>Findings were confirmed in interview with E4 (RN) on 12/4/15 at 10:40 AM.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 12/8/15 at 2:30 PM.</p> | <p>SECTION A (Individual Impacted) Recognizing that proper Hand Hygiene is the most effective method of preventing the spread of infection, facility-wide Hand Hygiene training was provided on August 25, 2015 and August 28, 2015. This was in response to the respiratory tract infection trend identified in August 2015. At that time, training was also provided on MRSA Prevention and The Mary Campbell Center's Influenza Vaccination Policy. Training was provided by the Staff Educator and Infection Control Nurse.</p> <p>The Infection Control Nurse is responsible for making and implementing recommendations for the prevention and control of spread of infection. The Infection Control nurse did not develop or implement interventions to address the infections cited on the October 2015 <i>Monthly Infection Control Surveillance Report</i>.</p> <p>SECTION B (Identification of other residents) Infection surveillance will be performed on a routine basis to prevent, to the extent possible, the onset and spread of infection. The Infection Control Nurse will analyze the number and type of infections to identify clusters or significant increases in the rate of infection. The Infection Control Nurse will use records of infection incidence to improve the infection control processes and outcomes by taking corrective actions, as indicated. The <i>Monthly Infection Control Surveillance Report</i> will include information about infections and corrective actions related to those infections to enable the Infection Control Committee to analyze clusters or significant increases in the rate of infection.</p> <p>SECTION C (System Changes) The Infection Control Nurse did not identify a trend in infections, or implement interventions to prevent or control additional cases of these infections.</p> <p>Infection surveillance will be performed on a routine basis to prevent, to the extent possible, the onset and spread of infection. The Infection Control Nurse will analyze the</p> | |

Provider's Signature Regina J. Cobbley Title Executive Director Date 12-23-15



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| | | <p>number and type of infections to identify clusters or significant increases in the rate of infection. The Infection Control Nurse will use records of infection incidence to improve the infection control processes and outcomes by taking corrective actions, as indicated. The <i>Monthly Infection Control Surveillance Report</i> will include information about infections and corrective actions related to those infections to enable the Infection Control Committee to analyze clusters or significant increases in the rate of infection. The Infection Control Nurse is responsible for the corrective action.</p> <p>SECTION D (Success Evaluation) Effective 2/5/16, the <i>Monthly Infection Control Surveillance Report</i> will be audited on a monthly basis by the Director of Nursing to ensure trends in infections have been identified and appropriate interventions implemented. The expectation will be 100% compliance with this process by the Infection Control Nurse. Once 100% achieved for 6 consecutive months, audits will be discontinued. ATTACHMENT 10. (Infection Control Surveillance Report Audit Tool.) The Director of Nursing will present a summary of the audit findings at the Quarterly Quality Assessment and Assurance Committee meetings.</p> | 2/5/16 |

Provider's Signature B. J. Maffett Title Executive Director Date 12-23-15



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| <p>3204.9.8 3201.9.8.4 3201.9.8.4.2 3204.9.8.4.4</p> | <p>Reportable incidents are as follows:</p> <p>Significant Injuries</p> <p>Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.</p> <p>Significant error or omission in medication/treatment, including drug diversion, which causes the resident discomfort, jeopardizes the resident's health and safety or requires periodic monitoring for up to 48 hours.</p> <p>Based on record review, interview and review of other facility documentation it was determined that for 4 (C8, C9, C10, and C12) out of 15 sampled residents the facility failed to report to the state agency significant injuries. Three residents had falls that required ER evaluation and one resident had a significant medication error. Findings include:</p> <p>The facility's policy and procedure dated 10/2013 for fall incidents and accidents documented:</p> <p>Policy – To ensure a high standard of care to the residents served at the Mary Campbell Center, any incident involving a fall of a resident requires an immediate assessment by nursing staff. This may include the need for an assessment in an acute medical treatment facility. The residents we serve are not always a reliable source of information for this assessment therefore a transfer to an acute setting may be required to rule out injury or need for additional treatment.</p> <p>Procedure #5 - Report the incident to Division of Long Term Residents Protection if it is</p> | <p><u>3204.9.8.4.2 Reportable Incidents</u></p> <p>SECTION A (Individual Impacted)</p> <p>As evidenced in the findings, The Mary Campbell Center (MCC) failed to follow facility policy and procedure to notify the Division of Long Term Care Residents Protection (DLTCRP) in three incidents where residents had falls with injuries that required Emergency Department (ED) evaluation. Those residents found to have been affected by the deficient practice received prompt medical evaluation and treatment and no negative outcome resulted despite the facilities failure to report. Going forward the facility has made necessary changes to reporting practices due to falls resulting in significant injury. MCC Policy and Procedure titled, "Prevention of Abuse, Neglect, Mistreatment, Financial Exploitation, and Misappropriation of Resident Property, Investigation and Reporting of Alleged Incident, and Corrective Actions" (ANM P&P) including the section on "Reporting" was updated on 12/18/15. (SEE ATTACHMENT 1.) The MCC Resident Incident Report was updated on 12/18/15 to ensure timely reporting for falls resulting in any injury. (SEE ATTACHMENT 2). MCC Policy and Procedure "Fall Incidents and Assessment" was revised 12/18/15 (SEE ATTACHMENT 11).</p> <p>SECTION B (Identification of other residents)</p> <p>On 12/18/15, all 2015 reportable incident files were reviewed to determine if the incident was reported to the DLTCRP. There were 3 additional falls resulting in ED evaluation that were not reported.</p> | |

Provider's Signature *Regina Coffey*

Title *Executive Director* Date *12-23-15*



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
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Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

IAME OF FACILITY: Mary Campbell Center

DATE SURVEY COMPLETED: December 08, 2015

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| | <p>determined that any injury occurred as a result of the fall.</p> <p>The following facility records were reviewed for C9:</p> <p>a. 6/3/15 5:40 PM –Facility incident report documented that C9 was rocking in a chair at the dining room table. When she was turned to prepare to transfer she fell face forward onto the floor. She sustained an upper lip laceration, bruise to the left side of the forehead and a nose bleed. The resident was sent out to the ER for evaluation.</p> <p>6/4/15 5:25 AM – C9 returned to the facility with discharge diagnoses of bruise to the left hand, bruise to the right hand, bruise of the head, fall and a nose injury. A scan of the head was done in the ER and found to be negative for injury. The resident was to follow-up with the doctor in one week.</p> <p>There was no evidence that the facility reported this fall with ER evaluation to the State agency.</p> <p>b. 6/7/15 2:15 PM – Facility incident report documented that other clients' observed C9 flip over in her wheelchair after being bumped by another client. C9 was noted to have a bump to the left side of her head. She was sent to the ER for evaluation. Follow-up comments documented that the client returned from the hospital with no significant injuries.</p> <p>6/7/15 7:00 PM – Progress note documented that C9 returned from ER and was back to her baseline. ER discharge instructions documented diagnoses of concussion and fall. Scans of the head and neck revealed no evidence of a fracture.</p> <p>There was no evidence that the facility reported this fall with ER evaluation to the State agency.</p> <p>The following facility records were reviewed for C8:</p> <p>10/2/15 2:29 AM – Facility incident report that the client was found lying on the floor with her head between the night stand and the bed. The</p> | <p><u>3204.9.8.4.2, Continued</u></p> <p>Those residents found to have been affected by the deficient practice received prompt medical evaluation and treatment and no negative outcome resulted despite the facilities failure to report. MCC Policy and Procedure "Fall Incidents and Assessment" was revised to ensure all falls with ED evaluation are reported timely. (SEE ATTACHMENT 11).</p> <p>SECTION C (System Changes)</p> <p>A review of the previous MCC Policy and Procedure, "Fall Incidents and Assessment" was found to be unclear regarding the reporting procedure leading to the root cause of the deficient practice. A directive memo, dated 12/18/15, was sent by email to staff regarding direction for the timely incident reporting responsibility (SEE ATTACHMENT 3).The In-service Educator/Designee will conduct training with all employees on MCC ANM P&P focusing on the reporting guidelines for falls resulting in injury (SEE ATTACHMENT 1). The In-service Educator/Designee will conduct training on the revised MCC Policy and Procedure, "Fall Incidents and Assessment" (SEE ATTACHMENT 11) with administrators, managers and supervisors responsible for reporting falls resulting in injury.</p> <p>The In-service Educator/Designee will provide training to all nurses on the revised MCC Resident Incident Report (SEE ATTACHMENT 2). The training will be incorporated into the new hire orientation for the above listed staff.</p> | |

Provider's Signature *Byron J. Coffey* Title *Executive Director* Date *12-23-15*



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| | <p>client confirmed she hit her head and had swelling and reddened area to the upper left cheek. The client was sent to the ER for evaluation at 3:37 AM.</p> <p>10/2/15 6:50 AM – C8 returned to the facility from the ER. Discharge/transfer instructions documented a diagnosis of “fall from bed” and noted there were no obvious injuries found.</p> <p>There was no evidence that the facility reported this fall with ER evaluation to the State agency.</p> <p>The following facility records were reviewed for C10:</p> <p>2/2/15 1:52 PM –A facility incident report documented that C10 “was being positioned for transfer from power chair to commode...when he fell out of the chair on to the floor. Head and right knee are points of impact. Blood, small amount from mouth, from biting tongue during the fall”. E10 was sent to the ER at 2:24 PM for evaluation..</p> <p>2/2/15 -C10 returned to the facility from the ER. Discharge instructions documented C10 with a diagnosis of knee bruise.</p> <p>2/3/15- A Dental consultation for C10 documented “post fall evaluation of teeth, teeth splinted due to mobility from trauma”.</p> <p>During an interview on 12/8/15 with E9 (RN) on C10's unit and E8 (RN and nursing supervisor), it was confirmed that C10 suffered trauma to his teeth as a result of the fall on 2/2/15.</p> <p>There was no evidence that the facility reported this fall with ER evaluation to the State agency. 12/4 and 12/8/15 – Interviews with E1 (NHA) and E2 (Assistant ED) revealed that the facility's practice due to their special population was to send clients to the ER if they were non-verbal and have an unwitnessed fall or if there was any evidence the client hit their head. It</p> | <p>3204.9.8.4.2, Continued</p> <p>SECTION D (Success Evaluation) At the weekly Senior Manager Rounds meeting, The Mary Campbell Center reportable incidents will be reviewed and signed off on to ensure that the reporting regulation for falls resulting in significant injury is followed in 100% of the incidents.</p> <p>At the monthly Human Rights Committee Meeting all cases of reportable incidents are reviewed. The Mary Campbell Center Abuse, Neglect Mistreatment Checklist was revised (SEE ATTACHMENT 4). The checklist will be reviewed to ensure that the reporting regulation for falls resulting in significant injury is followed in 100% of the incidents.</p> <p>The corrective actions above will become permanent procedures. In addition, the Senior Case Manager/QDDP/Designee will present the summary report of the Human Rights Committee findings to the Quarterly Quality Assurance Meeting.</p> | <p>2/5/16</p> |

Provider's Signature Begonia Cobbley Title Executive Director Date 12-23-15



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| | <p>was further revealed that after conversation with the Director of DLTCRP in 2/2013, the facility was under the impression that they only needed to report to the State if the ER determined the client had a significant injury. They went on to state that their policy was developed based on information obtained through this conversation.</p> <p>Cross refer Federal 2567L tag W368 The following facility records were reviewed for C12:</p> <p>3/3/15 – C12 was admitted to the facility with a physician's order for seizure medication (Keppra) twice a day.</p> <p>3/6 – 3/7/15 – MAR noted that Keppra had been incorrectly discontinued with the notation DC in the administration box. There was no physician's order to discontinue the medication.</p> <p>3/7/15 2:00 PM – A nurse's note documented that at 11:30 AM C12 experienced a one minute and 15 second episode of seizure activity. It was documented that medication to relax the client was administered at 12:15 PM and again at 2:00 PM.</p> <p>The facility failed to follow the State regulation for reportable incidents.</p> <p>These findings were reviewed with E1 in 12/16/15 at approximately 10AM.</p> | <p><u>3204.9.8.4.4</u> <u>Federal Tag W368 –With Cross Reference for State</u></p> <p><i>"The system for drug administration must assure that all drugs are administered in compliance with the physician's orders."</i></p> <p>SECTION A (Individual Impacted)</p> <p>As was evidenced in the findings, the discontinued medication for C12 was re-ordered on 3/7/15 and medication administration began on 3/8/15. There were no additional doses missed nor further incidents of improper discontinuation of the medication. A Medication Error Report was completed on 12/8/15 (Attachment 5). The nurse identified as having caused the omission and subsequent errors has been separated from employment.</p> <p>SECTION B (Identification of other residents)</p> <p>An audit of all new and discontinued physician medication orders for the past 60 days will be performed by staff nurses as assigned to assure that all medications are being administered as prescribed. Any errors or omissions will be documented using the revised MCC Medication Error.</p> | |

Provider's Signature *Begina Coffey*

Title *Executive Director* Date *12-23-15*



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| | | <p><u>3204.9.8.4.4, Continued</u></p> <p>Report (Attachment 6) and necessary follow up and/or corrective action will be completed.</p> <p>SECTION C (System Changes)</p> <p>A protocol has been developed that reconciles physician orders within The Mary Campbell Center Electronic Health Record; "Physicians Orders Reconciliation" (Attachment 7). Nurses responsible for reconciling physicians orders will complete a "Physician's Order Review Log" each day (Attachment 8). A lesson plan will be developed by The Staff Educator and all nursing staff will receive training on this protocol. Any nurses identified as not following protocol will be counseled and re-educated as necessary.</p> <p>SECTION D (Success Evaluation)</p> <p>An audit tool has been developed (Attachment 9) which targets staff nurse compliance with following the established E.H.R. Protocol to assure that medications are administered in compliance with the physician's orders. The QAPI Nurse and her designee will complete 2 chart audits per week will be conducted until 100% compliance is maintained for two months. Following that, 1 chart audit will be conducted weekly until 100% compliance is maintained for 2 months.</p> | <p>2/5/16</p> |

Provider's Signature Regina Coffey Title Executive Director Date 12-23-15