

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

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2015
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NAME OF PROVIDER OR SUPPLIER JEANNE JUGAN RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 185 SALEM CHURCH ROAD NEWARK, DE 19713
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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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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from June 18, 2015 through June 24, 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 40. The Stage 2 survey sample size was 23.</p> <p>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; CNA - Certified Nurse's Aide; MDS - Minimum Data Set-standardized assessment form used in nursing homes; FSD - Food Service Director; mg - milligram, unit of mass; r/t - related to; UTI - Urinary Tract Infection; PT - Physical Therapy; EMR - Electronic Medical Record; Cataract - clouding of the normally clear lens of the eye; Furosemide - medication that rids the body of excess fluid; Edema - retention of fluid into body tissues resulting in swelling; Continent - full control of bladder and/or bowel function; Incontinent/incontinence - loss of control of bladder and/or bowel function; Occasionally incontinent - less than 7 episodes of incontinence during a 7 day look back period;</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dr. Cecile Zeringue</i>	TITLE <i>adm</i>	(X6) DATE <i>7/22/15</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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F 000	Continued From page 1 Frequently incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period; Voiding Diary - a record of voiding (urinating) and leakage (incontinence) time of urine for 72 hours and/or 3 days; Cognitive-thinking, memory functions; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; BIMS - Brief Interview for Mental Status/tool used to measure mental abilities; Prolapsed uterus - condition in which a woman's uterus (womb) sags or slips out of its normal position and may slip enough that it drops partway into the vagina (birth canal), creating a lump or bulge. Rollator- rolling walker.	F 000			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272	1. An hourly Three Day voiding Diary was initiated on 6-27-15 and completed on 6-29-15 for R31. A new UI assessment has been done and her Care Plan updated. 2. All Residents have the potential to be affected by incomplete or inaccurate assessments. Going forward RNAC and/ or ADON will review all assessments to ensure accuracy. 3. A new Bowel and Bladder Management Policy and Procedure has been developed which includes having nurses review Bowel and Bladder diary	8-10-15	

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F 272	<p>Continued From page 2</p> <p>Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Cross refer to F315 Based on clinical record review, interview and review of facility documentation, it was determined that for one (R31) out of 23 Stage 2 sampled residents, the facility failed to comprehensively assess R31's urinary incontinence upon admission to the facility. Findings include:</p> <p>The facility policy for urinary incontinence, dated 3/2006, stated "Residents will be assessed for risk of urinary incontinence on admission, quarterly and as condition changes with the goal of promoting optimum bladder function...A three day bowel and bladder screening will be completed either through review of previously</p>	F 272	<p>every shift. Nurses will review new policy and procedure at next Nurses Meeting and those who are unable to attend will be given a copy of the policy. ADON will follow up with nurses who don't attend the Nurses' Meeting to ensure they understand their responsibility.</p> <p>See Attachments A & B DON/ ADON will review ADL assessments with each MDS (every 90 days, with significant change or following re-admission) This review will be ongoing and results will be reported to the QA team quarterly.</p> <p>See Attachment C</p>	
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F 272	<p>Continued From page 3</p> <p>existing flow sheet or a Bowel and Bladder Diary...Upon completion of the three day screening a licensed nurse will complete a Urinary Incontinence Risk form...The licensed nurse will attempt to determine the type of incontinence and will implement a (sic) individualized careplan...".</p> <p>R31 was admitted to the facility on 12/23/14 with diagnoses that included dementia and prolapsed uterus (for which treatment had been declined).</p> <p>R31's clinical record revealed a Three Day Bowel and Bladder Screening form, dated 12/24/14 through 12/26/14. This form consisted of one entry from midnight through 6 AM, and was then broken down in two (2) hour intervals. There were no entries noted from 3 PM through 12 midnight during the 3 days designated on the screening form. The screening form was incomplete and failed to capture hourly intervals of when R31 was incontinent. Analysis of this screening form lacked sufficient data to allow the development of an individualized toileting plan for R31.</p> <p>R31's Urinary Incontinence Risk Assessment form, dated 12/26/14, stated the resident exhibited urine leakage when changing position, coughing or sneezing. Despite this noted leakage, the form failed to identify that R31 had urinary incontinence and was marked as "no incontinence." Additionally, this form stated R31 always recognized the urge to urinate.</p> <p>The 12/30/14 admission MDS assessment identified R31 as being occasionally incontinent during the seven (7) day look back period.</p> <p>During an interview on 6/24/15, E2 (DON) stated</p>	F 272		
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F 272	Continued From page 4 that the Three Day Bowel and Bladder Screening form, dated 12/24/14, and the Urinary Risk assessment, dated 12/26/14, were incomplete and/or inaccurate. The facility failed to ensure a comprehensive and accurate assessment was completed of R31's urinary continence status. This finding was discussed with E1 (NHA), and E2 on 6/24/15 at approximately 12:45 PM.	F 272			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280	1. R 28's care plan was revised to change the intervention "Ambulates with wheeled walker" to "Ambulates with wheeled walker in room for short distances only from bed or chair to bathroom and back with staff assistance." 2. All Residents have the potential to be affected by inaccurate ambulation status. RNAC and ADON will review all Care plans for accuracy utilizing Resident Information Sheet See Attachment D 3. A new policy and procedure for Care Plans has been written which states that changes in ADL status will be written on the Care Plan within seven days. See Attachment E 4. RNAC and ADON will review 5 Care Plans weekly until 100% accuracy, then 3 Care Plans weekly until 100% accuracy is assured,	8-10-15	

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F 280	<p>Continued From page 5</p> <p>Based on record review and interview, it was determined that the facility failed to ensure that one (R28) out of 23 Stage 2 sampled resident's care plan was revised after each assessment. Findings include:</p> <p>R28 had diagnoses that included dementia and cataract.</p> <p>According to the quarterly MDS assessment, dated 2/10/15, R28 was independent for daily decision-making skills, required extensive assistance of one staff with all activities of daily living [such as bathing and dressing], except for eating and personal hygiene, and used a walker for ambulation. R28 was assessed as a high risk for falls related to lack of safety awareness and use of an assistive device (walker) for ambulation.</p> <p>On 5/26/15, R28 was ambulating with her walker into the dining room while accompanied by a CNA, when her knees buckled and she knelt on the floor. She was able to get back on her feet with the assist of 2 staff.</p> <p>On 5/28/15 a PT evaluation was ordered after the fall and an initial evaluation was completed on 6/2/15.</p> <p>On 6/15/15, while being escorted to therapy by PT, R28's knees gave out again and she was lowered to the floor. R28 sustained a bruise on her left knee.</p> <p>R28 completed therapy services on 6/18/15.</p> <p>During an interview on 6/22/15 at approximately 2:45 PM, E13 (PT) stated that plans had changed</p>	F 280	<p>then review Care Plans as each MDS is scheduled. Care Plan reviews will then continue indefinitely . Findings will be reported weekly to DON and Administrator. Findings will also be reported at the quarterly QA meetings until 100% accuracy is maintained for six months.</p>	
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F 280	<p>Continued From page 6</p> <p>for R28 due to cognitive issues and problems with motor control. E13 stated the focus was more on wheelchair mobility training to minimize the need for R28 to ambulate in the facility. R28 was only to walk from her bed to the bathroom (15 feet) with a wheeled walker and with staff assistance for safety. Due to a cognitive decline, R28's ability to follow verbal instructions was declining. E13 stated that this change in R28's goals and plans was discussed with the staff.</p> <p>The facility established a care plan dated 8/23/12, last updated 6/15/15, with the Focus problem "...High risk for falls r/t lack of safety awareness, utilizes assistive device for ambulation". The interventions included: Balance brace bilaterally in walking shoes daily; Encourage (R28) to look in the direction she is walking; (R28) needs to be evaluated for, and supplied with appropriate adaptive equipment or devices as needed-wheeled walker.</p> <p>Review of the above "updated" care plan, provided by E3 (ADON) on 6/22/15, contained written documentation, dated 6/15/15, that stated, "use wheelchair for ambulation". The interventions failed to be revised to specify that R28 was only to use a walker for ambulating from her bed to the bathroom with assist of staff and that a wheelchair was to be used for all other mobility throughout the facility. The care plan's interventions continued to reflect that R28 was independently ambulatory.</p> <p>This finding was discussed with E1 (NHA), E2 (DON) and E3 on 6/24/15 at approximately 12:45 PM.</p>	F 280			

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F 315 F 315 SS=D	Continued From page 7 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interviews and review of facility documentation, it was determined that for one (R31) out of 23 Stage 2 sampled residents, the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to restore as much normal bladder function as possible. The facility failed to comprehensively assess R31's bladder function on admission, failed to develop an individualized toileting plan and failed to re-assess when a decline in bladder continence occurred. Findings include: The facility policy for urinary incontinence, dated 3/2006, stated "Residents will be assessed for risk of urinary incontinence on admission, quarterly and as condition changes with the goal of promoting optimum bladder function...A three day bowel and bladder screening will be completed either through review of previously existing flow sheet or a Bowel and Bladder	F 315 F 315	1. A new hourly Three Bowel and Bladder Diary was initiated on 6-27-15 and completed on 6-29-15 for R31. R31's Care Plan has been updated to reflect current individualized toileting plan. 2. All Residents have the potential to be affected by inaccurately assessing and re-assessing bladder function. Going forward RNAC and ADON will review all current assessments to ensure accuracy. 3. A Bowel and Bladder Management Policy and Procedure has been developed which includes having the nurses review Bowel and bladder diary every shift until completion or review of flow sheet or PCC toileting pattern prior to completing UI Assessment. Any decline in bladder continence will be reported immediately to IDT team. The new Policy and Procedure will be presented to Nurses and the next Nurses Meeting on July 29. Nurses who are unable to attend will be given a copy of the policy. ADON will follow up with nurses who don't attend the Nurses' Meeting to ensure they understand their responsibility. See Attachment A 4. DON/ ADON will review ADL Assessments with each MDS (q 90 days, with significant change or following	8-10-15	

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F 315	<p>Continued From page 8</p> <p>Diary...Upon completion of the three day screening a licensed nurse will complete a Urinary Incontinence Risk form...The licensed nurse will attempt to determine the type of incontinence and will implement a (sic) individualized careplan..."</p> <p>R31 was admitted to the facility on 12/23/14 with diagnoses that included dementia and prolapsed uterus (for which treatment had been declined). Review of admission orders, dated 12/23/14 revealed R31 was receiving Furosemide 20 mg every other day for edema.</p> <p>R31's clinical record revealed a Three Day Bowel and Bladder Screening form, dated 12/24/14 through 12/26/14. This form consisted of one entry from midnight through 6 AM, and was then broken down into two (2) hour intervals. There were no entries noted from 3 PM through 12 midnight during the 3 days designated on the screening form. The screening form was incomplete and failed to capture hourly intervals of when R31 was incontinent. Analysis of this screening form lacked sufficient data to allow the development of an individualized toileting plan for R31.</p> <p>R31's Urinary Incontinence Risk Assessment form, dated 12/26/14, stated the resident exhibited urine leakage when changing position, coughing or sneezing. Despite this noted leakage, the form failed to identify that R31 had urinary incontinence and was marked as "no incontinence." Additionally, this form stated R31 always recognized the urge to urinate.</p> <p>According to the 12/30/14 admission MDS assessment, the BIMS indicated R31's daily</p>	F 315	re-admission) This review will be ongoing and results will be reported to the QA team quarterly.		

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F 315	<p>Continued From page 9</p> <p>decision making skills were severely impaired, she was independent for transfers, and required supervision and set up help from staff for toilet use and hygiene. This same MDS stated that a trial of a toileting program had been completed with a response of decreased wetness, and that a current toileting plan was in place. The 12/30/14 MDS assessment identified R31 as being occasionally incontinent during the seven (7) day look back period.</p> <p>A care plan, initiated 12/31/14, for the focus "has Urge and Stress bladder incontinence r/t Dementia, uterine prolapse, history of UTI, included the interventions, "establish voiding patterns, Incontinent: check every 2 hours and as needed for incontinence." Review of the clinical record lacked evidence of a scheduled toileting plan that was based on analysis of a complete 3 day voiding diary and established voiding patterns.</p> <p>Review of CNA documentation from 1/1/15 through 3/10/15 revealed staff was documenting they were "encouraging to toilet every 2 hours and at least once during hours of sleep".</p> <p>According to the 3/17/15 quarterly MDS assessment, the BIMS indicated R31's daily decision making skills were severely impaired, she was independent for transfers, and required limited assist of one staff for toilet use. This MDS stated R31 was on a current toileting plan. The 3/17/15 MDS assessment identified R31 was now frequently incontinent during the seven (7) day look back period. Despite this decline in urinary continence, the facility failed to re-assess R31, and failed to develop an individualized toileting plan based on established voiding patterns.</p>	F 315			

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F 315	<p>Continued From page 10</p> <p>The 3/17/15 Urinary Incontinence Risk Assessment was once again incorrectly completed. It noted R31 had leakage when changing position, coughing or sneezing, yet it stated there was no incontinence. The form also stated R31 always recognized the urge to urinate.</p> <p>CNA documentation revealed the facility continued to document they were encouraging R31 to toilet every two (2) hours while awake and at least once during hours of sleep from 3/17/15 through 6/22/15.</p> <p>The 6/9/15 quarterly Urinary Risk Assessment stated R31 was frequently incontinent, had leakage when changing position, coughing or sneezing and occasionally recognized the urge to urinate.</p> <p>On 6/22/15 at 3:15 PM, an interview was conducted with E10 (CNA) and E11 (CNA), both of which took care of R31 regularly. E10 stated that the resident takes herself to the bathroom but will at times call for assistance if unable to manage her hygiene needs. E11 stated the resident is very confused and has very bad short term memory. E10 and E11, both stated the resident was incontinent and that although she goes to the bathroom by herself they check on her every 2 hours to take her or to check if she is wet. E11 also stated that at times they have to check the trash to see if the resident left wet incontinence pads after toileting herself.</p> <p>On 6/23/15 at approximately 9:00 AM, R31 was observed ambulating back to her room using a rollator. During an interview with R31 at this time, she first stated that she goes to the bathroom by</p>	F 315		

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F 315	Continued From page 11 herself and has no problem with incontinence. R31 then stated "I know my bladder and if I wait I dribble." Asked if she needed help cleaning herself up? First stated no she didn't, but then said sometimes she did. R31 also stated that she "can't wait long cause then its too late." On 6/23/15 at approximately 2:00 PM findings were reviewed with E2 (DON) and E5 (RNAC), On 6/24/15 at 10:13 AM, in an interview with E2, she acknowledged that the 3 day voiding diary was incomplete and that the facility would not be able to develop an individualized toileting plan based on it. E2 also confirmed that the Urinary Risk assessments completed on 12/26/14 and 3/17/15 were inaccurate, and after the 3/17/15 quarterly MDS indicated a decline in incontinence there was no further assessments completed. The facility failed to comprehensively assess R31's bladder function on admission, failed to develop an individualized toileting plan and failed to re-assess when a decline in bladder continence occurred.	F 315			
F 371 SS=E	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 371	A new splash guard made of plexi-glass was installed on 7-17-2015. Ladles were removed from pipe and put into a drawer on 6-18-2015 The wooden organizer was removed on 6-18-2015 and a plastic organizer was purchased. Hand sanitizer, lotion and soaps were	8-10-15	

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NAME OF PROVIDER OR SUPPLIER JEANNE JUGAN RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 185 SALEM CHURCH ROAD NEWARK, DE 19713		
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F 371	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observations (kitchen tour and dining) and interview, it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include: On 6/18/15 from approximately 8:45 AM to 10:00 AM during the kitchen tour with E8 (FSD) the following were observed: 1. One (1) hand sink lacked a splash guard to protect clean kitchen equipment and/or dishes from being contaminated during hand washing. Findings were acknowledged by E8. The facility failed to protect equipment from potential for contamination via splash. 2. The clean soup ladles were hanging on the wire cover pipe between two electrical boxes. The surface of the pipe is not considered easily cleanable, nor is the paint considered food safe. Findings were confirmed with E8, subsequently the ladles were moved and placed in the proper storage area. The facility failed to properly store clean ladles. 3. Clean dining utensils were stored in a wooden organizer, and this surface is not easily cleanable. Findings were acknowledged with E8. The facility failed to ensure that clean utensils were stored in an easily cleanable surface. 4. A hand sanitizer, lotion and soaps were stored next to the spice rack, which are considered ready to eat food items. Subsequently E8 immediately removed the listed chemicals away from the food items. The facility failed to	F 371	removed on 6-18-15. The sign that was posted explaining how to wash your hands which was on the Holy Family unit kitchenette was removed and replaced with a sign stating "Employees Must Wash hands" 1. No Residents were affected by the practices noted during the kitchen tour. 2. All Residents have the potential to be affected by the practices noted during the kitchen tour. Dietary Director or designee will check kitchen and pantry daily, to ensure these practices are no longer occurring 100% for eight weeks See Attachment E 3. The practices noted will be placed on the safety checklist and be reviewed monthly to ensure the practices do not re-occur. Staff from all departments rotate departments to review on a monthly basis. Safety checklist are returned to the DON at the beginning of each month and any safety issues are corrected immediately. See Attachments F & G 4. Administrator, DON and Dietary Director will meet weekly until noted practices have not re-occurred for four weeks. Then Bi weekly until noted practices have not re-occurred for four		

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F 371	Continued From page 13 separately store chemical products away from food items. On 6/18/15 at 12:00 PM during the dining observation the following was observed: 5. Observation of the handwashing station in the Holy Family wing revealed the absence of a visible sign notifying employees to wash their hands. Findings were acknowledged with E8. The facility failed to post a visible sign notifying employees to wash their hands. Findings were reviewed during the exit conference on 6/24/15 at approximately 1:10 PM with E1 (NHA) and E2 (DON).	F 371	weeks. Then, monthly until practice has not reoccurred for four months. When 100% success has been met in previously mentioned time frames, Safety Check List results will be reviewed quarterly at Safety Meetings.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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	F 431	1. No Residents were affected by only one nurse signing off on the narcotic check list as no narcotics are missing. At the time of survey there was one nurse signature on the narcotic check list as the oncoming nurse counts the narcotics and the off going nurse compares the number to each individual narcotic countdown sheet. Then the oncoming nurse signs the narcotic count sheet signifying two nurses counted and number was accurate. See Attachment H 2. No Residents had the potential to be affected by two nurses counting narcotics and only one nurse signing the narcotic checklist. The narcotic check list is a record of a drug count being done. Record of receipt of narcotics are maintained by	8-1-15

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F 431	<p>Continued From page 14 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 record review and staff interview, it was determined that the facility failed to ensure that a standard system of records (inventory) to account for the receipt and disposition of all controlled medications/drugs was conducted by two (2) licensed nurses at each shift. This deficient practice was found on two (2) out of 2 units. Findings include:</p> <p>A non- facility reference entitled "Basic Pharmacology for Nurses" 2014, page 95, stated "At the end of each shift, the contents of the controlled substance cabinet or controlled substance cart are counted (inventoried) by 2 nurses, one from the shift that is about to end and the other from the oncoming shift".</p> <p>Review of the first floor medication cart's controlled drug inventory sheets (Narcotic Check List) from 2/1/15 through 6/24/15 revealed the following: - on the 3-11 PM shifts and 11-7 AM shifts, the nurse on and/or off signatures of the second</p>	F 431	<p>the pharmacy. and the individual narcotic count down sheet is signed and dated. A copy of the receipt of the narcotic is also maintained in medical. Two nurses or one nurse and a pharmacist dispose of narcotics and this is documented on the individual count down sheet and signed by both professionals as well as on the drug disposition log, also by both professionals.</p> <p>An in- house review has been conducted and on the dates signatures were noted to be missing on the Narcotic Check List, the narcotic counts were documented as being accurate at the next shift. A new Narcotic Check List will ask for the two nurses who perform the narcotic check to both initial the document.</p> <p style="text-align: center;">See Attachment I</p> <p>3. A new Policy and Procedure has been developed clarifying that going forward both the off-going nurse and the oncoming must initial the Narcotic Check List confirming that two nurses conducted the narcotic count. The Policy and Procedure will be reviewed at the next Nurse's meeting which will be held on July29th at 2:30pm. A copy of the policy will be given to any nurse who is unable to attend the meeting.</p> <p style="text-align: center;">See Attachment J</p>	

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F 431	<p>Continued From page 15</p> <p>nurse were missing from 2/1/15 through 6/24/15; - on 2/21/15 the incoming nurse and outgoing nurse signatures were both missing on the 11-7 AM shift; - on 2/28/15 the second nurses' signatures were missing in all 3 shifts.</p> <p>The first floor medication cart's controlled Narcotic Check List lacked evidence of 2 nurses having completed the change of shift count, one from the incoming shift and one from the outgoing shift for the review period of 2/1/15 through 6/24/15.</p> <p>Additionally, on 6/24/15 at 10:30 AM, the first floor Narcotic Check List was prematurely signed off by E12 (RN/7-3 PM nurse) before 10:30 AM. In an interview with E12 on 6/24/15 at 10:30 AM, she confirmed she had signed off the 3 PM change of shift count in the morning, instead of waiting until the count was completed.</p> <p>Review of the second floor medication cart's Narcotic Check List from 3/1/15 through 6/24/15 revealed that counts were completed by 2 nurses (offgoing and oncoming), however on 3/1-3/2/15 on the 3-11 PM shift, 3/3/15 on the 7-3 PM shift, 4/12/15 and 4/21/15 on the 7-3 PM shift, the oncoming nurses' signatures were missing.</p> <p>Findings were discussed with E3 (ADON) on 6/24/15 at approximately 11:30 AM. Although the surveyor requested a copy of the facility's policy/procedure for change of narcotic shift counts, E3 stated she was unable to locate one.</p> <p>The facility failed to ensure that a standard system of records (inventory) to account for the receipt and disposition of all controlled</p>	F 431	<p>The ADON or RN Supervisor will review the Narcotic Check List on both units four times a week for three weeks ensuring signatures are in place at 100% accuracy, then two times a week for three weeks ensuring signatures are in place 100% of the time, then weekly for three weeks ensuring signatures are in place 100% of the time. Afterwards the Narcotic Check List will be reviewed monthly. Results will be reported to the Administrator and DON weekly until Narcotic Check List is being checked monthly. Findings will be reported at next four QA meeting and then discontinued unless for a problem is identified.</p>		

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F 431	Continued From page 16	F 431		
F 514 SS=D	<p>medications/drugs was conducted by two (2) licensed nurses at each shift.</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented for one (R14) out of 23 Stage 2 sampled residents. The facility failed to ensure that R14's safety checks documentation recorded by CNA's was completed and/or accurate for two shifts on June 19, and June 22, 2015. Findings include: Review of CNA documents entitled, "30 Minute Safety Checks," on 6/22/15 at 4:41 PM for R14 revealed there were blanks on 6/19/15 during the hours of 8:00 AM to 2:30 PM. This same</p>	F 514	<p>1. R14's records have been legally corrected.</p> <p>2. All Residents have the potential to be affected by incomplete or inaccurate records. The two CNA's involved with the inaccurate record have been in-serviced. See Attachment K</p> <p>3. In-Service Director/ ADON will ensure all CNA's receive education on the necessity of complete and accurate documentation. Education of the requirement for complete and accurate documentation will also be included in orientation for new CNA's.</p> <p>4. Nurses and or Unit Supervisors will review CNA's flow sheets daily for one week after ensuring 100% accuracy, will then review every other day for one week of ensuring 100% accuracy, then weekly for four weeks of ensuring 100% accuracy. Monthly reviews will be conducted for six months. Findings will be verbally reported to Administrator and DON. Report of findings will be submitted to QA Committee.</p>	8-10-15

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F 514	<p>Continued From page 17</p> <p>document also revealed that on 6/22/15 between the hours of 11:30 PM to 2:00 AM (going into 6/23/15) signatures were already prematurely signed off by E14 (CNA) at 4:41 PM.</p> <p>During an interview on 6/22/15 at 4:42 PM, E9 (RN) reviewed the EMR and confirmed that R14 was in the building that day and not at any outside appointments.</p> <p>Findings were reviewed and confirmed by E3 (ADON) on 6/22/15 at 4:44 PM.</p> <p>The facility failed to maintain a clinical record for R14 that was complete and accurately documented. Findings were reviewed during the exit conference on 6/24/15 at approximately 1:10 PM with E1 (NHA) and E2 (DON).</p>	F 514		



**DELAWARE HEALTH
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Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Jeanne Jugan Residence

DATE SURVEY COMPLETED: June 24, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from June 18, 2015 through June 24, 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 40. The Stage 2 survey sample size was 23.</p> <p>Abbreviations used in this 2567 are as follows: <u>NHA</u> - Nursing Home Administrator; <u>DON</u> - Director of Nursing; <u>ADON</u> - Assistant Director of Nursing; <u>RN</u> - Registered Nurse; <u>RNAC</u> - Registered Nurse Assessment Coordinator; <u>CNA</u> - Certified Nurse's Aide; <u>MDS</u> - Minimum Data Set-standardized assessment form used in nursing homes; <u>FSD</u> - Food Service Director; <u>mg</u> - milligram, unit of mass; <u>r/t</u> - related to; <u>UTI</u> - Urinary Tract Infection; <u>PT</u> - Physical Therapy; <u>EMR</u> - Electronic Medical Record; <u>Cataract</u> - clouding of the normally clear lens of the eye; <u>Furosemide</u> - medication that rids the body of excess fluid; <u>Edema</u> - retention of fluid into body tissues resulting in swelling; <u>Continent</u> - full control of bladder and/or bowel function; <u>Incontinent/incontinence</u> - loss of control of bladder and/or bowel function;</p>		
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Provider's Signature *L. Leibel Zeringue* Title *Adm* Date *7/22/15*



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<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>Occasionally incontinent - less than 7 episodes of incontinence during a 7 day look back period; <u>Frequently incontinent</u> - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period; <u>Voiding Diary</u> - a record of voiding (urinating) and leakage (incontinence) time of urine for 72 hours and/or 3 days; Cognitive-thinking, memory functions; <u>Dementia</u> - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; <u>BIMS</u> - Brief Interview for Mental Status/tool used to measure mental abilities; <u>Prolapsed uterus</u> - condition in which a woman's uterus (womb) sags or slips out of its normal position and may slip enough that it drops partway into the vagina (birth canal), creating a lump or bulge. <u>Rollator</u> - rolling walker</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</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</p>		

Provider's Signature *Dee C. Zeringue* Title *adm* Date *7/22/15*



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3201.3-304.12	<p>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 June 24, 2015 F272, F280, F315, F371, F431, and F514.</p> <p>In-Use Utensils Between-Use Storage During pauses in Food preparation or dispensing food, Food preparation and dispensing UTENSILS shall be stored:</p> <p>(A) Except as specified under ¶ (B) of this section, in the FOOD with their handles above the top of the food and the container.</p> <p>(B) In FOOD that is not TIME/TEMPATURE CONTROLLED FOR SAFETY FOOD with their handles above the top of the FOOD within containers or EQUIPMENT that can be closed such as bins of sugar, flour, or cinnamon.</p> <p>(C) On a clean portion of the FOOD preparation table or cooking EQUIPMENT only if the in-use UTENSIL and the FOOD-CONTACT surface of the FOOD preparation table or cooking EQUIPMENT are cleaned and SANITIZED at a frequency specified under §§4-602.11 and 4-702.11;</p> <p>(D) In running water of sufficient velocity to flush particulates to the drain, if used with moist FOOD such as ice cream or mashed</p>	<p>Cross Refer to CMS 2567-L survey Completed June 24, 2015 F272, F280, F315, F371, F431 and F514</p> <p>Soup Ladles were removed from pipe and put into a drawer on 6-18- 2015</p> <p>1. No Residents were affected by the practice (Soup Ladles hanging from pipe) noted during the kitchen tour.</p> <p>2. All Residents have the potential to be affected by the practice noted during the kitchen tour. Dietary Director or designee will check kitchen and pantry daily, to ensure the practices is no longer occurring 100% for eight weeks See Attachment E</p> <p>3. The practice noted will be placed on the safety checklist and be reviewed monthly to ensure the practice does not re-occur. Staff from all departments rotate departments to review on a monthly basis. Safety checklist are returned to the DON at the beginning of each month and any safety issues are corrected immediately. See Attachment F</p> <p>4. Administrator, DON and Dietary Director will meet weekly until noted practice has not re-occurred for four weeks. Then Bi weekly until</p>	<p>8-10-15</p> <p>8-10-15</p>

Provider's Signature *Dr Cecile Zingue* Title *adm* Date *7/22/15*



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3201.4-903.11	<p>potatoes;</p> <p>(E) In a clean , protected area location if the UTENSILS such as ice cream scoops, are used only with a food that is not TIME/TEMPATURE CONTROL FOR SAFETY FOOD; or</p> <p>(F) In a container of water, if the water is maintained at a temperature of at least 57°C (135F°) and the container is cleaned at a frequency specified under Subparagraph 4-602.11(D)(7).</p> <p>This requirement is not met as evidenced by: Based on observation on 6/18/15 at 9:25 AM that the clean soup ladles were hanging on the wire cover pipe between 2 electrical boxes. The surface of the pipe is not considered easily cleanable, nor is the paint considered food safe. The food service director immediately acknowledged the existence and has moved the ladles to the proper food storage area.</p> <p>Equipment, Utensils, Linens, and Single-Service and Single- Use Articles (A) Except as specified ¶(D) of this section,I cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored:</p> <p>(1) In a clean dry location; (2) Where they are exposed to splash, dust, or other contamination; and (3) At least 15c (6 inches) above the floor. (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under ¶ (A) of this section and shall be stored:</p> <p>(1.) In a clean, dry location</p>	<p>noted practice has not re-occurred for four weeks then monthly until practice has not re-occurred for four months. When 100% success rate has be met after successive reviews practice will be reviewed and quarterly Safety Meetings.</p> <p>Wooden utensil organizer was a removed on 6-18-2015 and a plastic organizer purchased.</p> <p>1. No Residents were affected by the practice (Utensils stored in plastic organizer) noted during the kitchen tour. 2. All Residents have the potential to be affected by the practice noted during the kitchen tour. Dietary Director or designee will check the Holy Family pantry daily, to ensure the practices is no longer occurring 100% for eight weeks See Attachment E 3. The practice noted will be placed</p>	8-10-15

Provider's Signature A. Cecil Zeringue Title adm Date 7/22/15



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DATE SURVEY COMPLETED: June 24, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201.6-301.14	<p>(2.) Covered or inverted.</p> <p>(C) SINGLE- SERVICE and SINGLE-USE ARTICLES shall be stored as specified under ¶(A) of this section and shall be keep in the original protective PACKAGE or stored by using other means that afford protection from contamination until used.</p> <p>(D) Items that are kept in closed PACKAGES may be stored less than 15cm (6 inches) above the floor on dollies, pallets, racks, and skids that are designed as specified under § 4-204.122.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on observation on 6/18/15 at 9:45 AM that the clean dining utensil is stored in wooden organizer. The material is not considered easily cleanable in commercial food kitchen, therefore must be replaced by easily cleanable surfaces. The food service director immediately acknowledged and will replace with appropriate organizer.</p> <p>Hand washing Signage</p> <p>A sign or poster that notifies FOOD EMPLOYEES to wash their hands shall be provided at all HANDWASHING SINKS used by FOOD EMPLOYEES and shall be clearly visible to FOOD EMPLOYEES</p> <p>This requirement is not met as evidenced by:</p> <p>Based on observation on 6/18/15 at 12:00 PM that the hand washing station at the Holy Family wing does not have proper hand washing signage. The food service director</p>	<p>on the monthly safety checklist and be reviewed monthly to ensure the practice does not re-occur. Staff from all departments rotate departments to review on a monthly basis. Safety checklist are returned to the DON at the beginning of each month and any safety issues are corrected immediately.</p> <p>See Attachment F</p> <p>4. Administrator, DON and Dietary Director will meet weekly until noted practice has not re-occurred for four weeks. Then Bi weekly until noted practice has not re-occurred for four weeks then monthly until practice has not re-occurred for four months. When 100% success rate has be met after successive reviews practice will be reviewed and quarterly Safety Meetings.</p> <p>The sign stating how to was your hands was removed and a sing posted stating that employees must wash hands was posted 6-18- 2015</p> <p>1. No Residents were affected by the practice (sign directing how to wash hands) noted during the kitchen tour.</p> <p>2. All Residents have the potential to be affected by the practice noted during the kitchen tour. Dietary Director or designee will check holy family pantry daily, to ensure</p>	8-10-15

Provider's Signature *A. Beal Zeringue* Title *adm* Date *7/22/15*



NAME OF FACILITY: Jeanne Jugan Residence

DATE SURVEY COMPLETED: June 24, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201.7-201.11	<p>has acknowledged and will address the issue.</p> <p>Separation</p> <p>POISONESS and TOXIC MATERIALS shall be stored so they cannot contaminate FOOD, EQUIPMENT, UTENSILS, LINENS, and SINGLE-SERVE and SINGLE-USE ARTICLES by:</p> <p>(A) Separating the POISONOUS or TOXIC MATERIALS by spacing or partitioning; and</p> <p>(B) Locating the POISONOUS or TOXIC MATERIALS in an area that is not above FOOD, EQUIPMENT, UTENSILS, LINENS, and SINGLE-SERVICE or SINGLE-USE ARTICLES. This paragraph does not apply to EQUIPMENT and UTENSIL cleaners and SANITIZERS that are stored in WAREWASHING areas for availability and convenience if the materials are stored to prevent contamination of FOOD, EQUIPMENT, UTENSILS, LINENS, SINGLE-SERVICE, and SINGLE-USE ARTICLES.</p> <p>This requirement is not met as evidenced by: Based on observation on 6/18/15 at 10:00 AM that the hand sanitizer, lotion and soaps were stored next to the spice rack. The improper storage of such material could</p>	<p>the practices is no longer occurring 100% for eight weeks</p> <p>See Attachment E</p> <p>3. The practice noted will be placed on the safety checklist and be reviewed monthly to ensure the practice does not re-occur. Staff from all departments rotate departments to review on a monthly basis. Safety checklist are returned to the DON at the beginning of each month and any safety issues are corrected immediately.</p> <p>See Attachment G</p> <p>4. Administrator, DON and Dietary Director will meet weekly until noted practice has not re-occurred for four weeks. Then Bi weekly until noted practice has not re-occurred for four weeks then monthly until practice has not re-occurred for four months. When 100% success rate has be met after successive reviews practice will be reviewed and quarterly Safety Meetings.</p> <p>Hand sanitizer, lotion and soaps were removed on 6-18-2015 6-18- 2015</p> <p>1. No Residents were affected by the practice (Hand sanitizer, lotion and soaps near spice rack) noted</p>	<p>8-10-15</p>

Provider's Signature *Dr. Cecil Zeringue* Title *adm* Date *7/22/15*



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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STATE SURVEY REPORT

NAME OF FACILITY: Jeanne Jugan Residence

DATE SURVEY COMPLETED: June 24, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>contaminate the spices, which are considered ready to eat. The food service director rectified the issue immediately.</p>	<p>during the kitchen tour.</p> <p>2. All Residents have the potential to be affected by the practice noted during the kitchen tour. Dietary Director or designee will check kitchen and pantry daily, to ensure the practices is no longer occurring 100% for eight weeks See Attachment E</p> <p>3. The practice noted will be placed on the safety checklist and be reviewed monthly to ensure the practice does not re-occur. Staff from all departments rotate departments to review on a monthly basis. Safety checklist are returned to the DON at the beginning of each month and any safety issues are corrected immediately. See Attachment F</p> <p>4. Administrator, DON and Dietary Director will meet weekly until noted practice has not re-occurred for four weeks. Then Bi weekly until noted practice has not re-occurred for four weeks then monthly until practice has not re-occurred for four months. When 100% success rate has be met after successive reviews practice will be reviewed and quarterly Safety Meetings.</p>	

Provider's Signature *Cecil Zeringue* Title adm Date 7/22/15