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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085025	A. BUILDING _____ B. WING _____	04/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

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E 000	Initial Comments An unannounced emergency preparedness survey was conducted at this facility from April 18, 2018 through April 25, 2018. The facility census the first day of the survey was 92. No deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from April 18, 2018 to April 25, 2018. 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 92. The survey sample size was 35. Abbreviations / definitions in this report are as follows: ADL's- activities of daily living such as dressing, bathing and toileting; ADON - Assistant Director of Nursing; Antidepressant - drug to counter depression; Anxiety- general term for several disorders that cause nervousness, fear, apprehension and worrying; CNA - Certified Nurse's Aide; Coccyx - tailbone; Contracture - joint limitations with fixed high resistance to passive stretch of a muscle; DON - Director of Nursing; End Stage Renal Disease (ESRD) Chronic irreversible renal failure. Also known as Chronic Kidney Disease Stage 6. The state where renal replacement therapy is needed, either dialysis or transplant;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Maureen Sling NHA Executive Director 5/31/18

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 Extensive Assistance - While the resident performed part of the activity over the last 7 day period, help of the following type was provided 3 or more times: weight bearing support; full staff performance during part (but not all) of the last 7 days; OR resident involved in activity, staff provide weight-bearing support; Grief counseling - a form of psychotherapy that aims to help people cope with grief and mourning following the death of loved ones, or with major life changes that trigger feelings of grief; lbs - pounds; LPN - Licensed Practical Nurse; Major Depressive Disorder - also known as depression, is a mental disorder characterized by at least two weeks of low mood that is present across most situations. It is often accompanied by low self-esteem, loss of interest in normally enjoyable activities, low energy, and pain without a clear cause; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); NHA- Nursing Home Administrator; NP - nurse practitioner; OT - occupational therapy; Peritoneal dialysis (PD) - a type of dialysis that uses the peritoneum in a person's abdomen as the membrane through which fluid and dissolved substances are exchanged with the blood. It is used to remove excess fluid, correct electrolyte problems, and remove toxins in those with kidney failure; Podiatry - The branch of medicine that deals with the diagnosis, treatment, and prevention of diseases of the human foot; Pressure ulcer/PU- sore area of skin that develops when the blood supply is cut off; Psychiatric (Psych) - relating to mental illness or its treatment;	F 000		

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F 000	Continued From page 2 Psychiatrist - a physician who specializes in the diagnosis and treatment of mental disorders; Psychologist - a person who treats mental disorders by psychological rather than medical means; PT - physical therapy; RD - Registered Dietitian; RN - Registered Nurse; Suicidal ideation (suicidal thoughts)- thinking about or an unusual preoccupation with suicide; UM-unit manager.	F 000		
F 550 SS=D accept	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550	1. On 5/26/18 E12 (a covering practicioner that is not usualy in the facility) was advised of the center's request for education on the proper procedure for entering a resident's room Knock, pause, identify self, and ask permission to enter. 2. All residents have the potential to be affected. 3. The Corporate Medical Director has collaborated with the facility and developed a orientation checklist for our Medical Practitioners. The orientation checklist includes the proper procedure for entering a resident's room . (see attachment # _1_)	

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F 550	Continued From page 3 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that for one (R80) out of 35 sampled residents, the facility failed to ensure that R80 was treated with dignity and respect. Findings include: On 4/18/18 at 11:22 AM, while the surveyor was interviewing R80, E12 (NP) walked into R80's room without knocking. E12 started talking to R80. E12 did not identify herself until R80 asked who she was, at which time E12 introduced herself as a physician's nurse practitioner. Findings were reviewed with E1 (NHA) and E2 (DON) on 4/25/18 at approximately 3:20 PM.	F 550	The Staff Educator will review and complete the Medical Staff orientation checklist with each of the facility practitioners, and upon entry of a new practitioner. The DON/designee will conduct weekly audits on Medical Practitioners to monitor if they are using the proper procedure before entering a resident's room. The facility will also conduct ongoing random monitoring of all staff compliance with use of the proper procedure for entering a resident's room. (see attached Monitoring tool #__2___) 4. Results of audits will be reviewed in the facility monthly QAPI meeting until 100% compliance i s achieved for 3 months.	6/15/18
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584	1. In room West 104: • The hole on the wall left of the window was repaired on 4/25/18. • The wallpaper behind the pull curtain was repaired on 5/25/18. • The chipped wall behind the window was repaired on	

except

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F 584	Continued From page 4 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to provide	F 584	4/25/18. • The foot board of the bed was repaired/replaced on 5/25/18. The wheelchair in room W110's missing left armrest was replaced on 4/25/18. 2. All resident's room have the potential to be affected. Environmental Rounds will be held with the ED, maintenance director and housekeeping director to generate an initial master task list. Grand Environmental rounds will be held on 5/30; 6/1, and 6/5. Corrective action and repairs to rooms will be scheduled and corrections made accordingly. (see attached #3) Plans have been made for a facility " wheelchair clinic" to be held on 5/31/18. This clinic will allow the center an opportunity to identify other wheelchair repair/ needs that may exist. Immediate adjustments will be made, parts will be ordered if needed, and repairs to wheelchairs will be made accordingly. (see attached # 4) 3. Weekly environmental monitoring rounds will be completed by the ED/designee. 25% of the rooms will be audited weekly. Observations will include but not limited to the general condition of the room; painting, condition of furniture, and wallpaper. In addition wheelchairs will be monitored during the ongoing routine cleaning for future repair needs. (see attached monitoring tool #5) 4. Results of audits will be reviewed in monthly QA & A until 100% compliance is achieved for 3 months.	6/15/18

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F 584	Continued From page 5 housekeeping and maintenance for all rooms (Room W104, and Room W110) in the facility. Findings include: Observations were made during the phase 2 environmental check on 4/25/18 from 10:00 AM to 10:30 AM revealed the following: Room W 104 - The wall to the left of the window had a hole; - The wallpaper in the room behind the pull curtain was in disrepair; - The wall below to the right of the window was chipped; - The foot of the bed's bedboard was in disrepair; Room W110 - The wheel chair was missing the left armrest. Findings were confirmed with E14 (facility maintenance director) on 4/25/18 at approximately 10:30 AM. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/25/18 at approximately 3:20 PM. .	F 584		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656	1. R59' and R74's nutritional care plans were revised on 4/24/18 to include measurable weight goals. R59's ADL care plan was revised on 4/23/18 to include a measurable ADL goal. R14 had a care plan for depression added on 4/25/18. 2. All residents with nutritional and ADL's care plans have the potential to be affected.	

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F 656	Continued From page 6 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to develop and implement comprehensive care plans with measurable goals for 3 (R14, R59 and R74) out of 35 sampled residents in the areas of	F 656	The Registered Dietitian will complete a review of all current in house resident's nutritional care plan goals. Care plan goals will be evaluated to see if they meet the Specific and Measureable parameters. Goals will be revised as needed. The Unit Managers will complete an in house review of all current resident's ADL care plan goals. Care plan goals will be evaluated to see if they meet the Specific and Measureable parameters. . Goals will be revised as needed. All residents that have depressive symptoms have the potential to be affected. The Social Worker/designee will audit all current in house residents that trigger for depression on their MDS. The resident's record will be audited and monitored for a corresponding depression care plan. Corrections/Revisions will be made accordingly. (cross reference attachement # 6) 3. On 6/6/2018 the facility IDT will participate in a refresher training on the basics of writing care plans i.e. including specific measurable goals. The ED/designee will re-educate the IDT on the RAI process including CAAs and the need to develop a plan of care for residents that need support i.e. for depression. Weekly the DON/designee will audit the plans of care for any new admission or change in condition MDS. These records will be monitored for compliance with nutrition, depression, and ADL, care plans	

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F 656	Continued From page 7 depression, dialysis, position/mobility, and nutrition. Findings include: 1. Review of R59's clinical record revealed the following: a. R59 was admitted to the facility on 3/10/18 with a history including stroke with resultant right sided weakness and difficulty swallowing. Review of R59's admission nutrition assessment (completed by E10 [RD]), dated 3/12/18, stated his height was 5 feet, 10 inches tall and he weighed 133 pounds. Review of R59's nutrition care plan, dated 3/12/18, listed a goal for "Weight- improved...". The care plan goal was non-specific and not measurable; it lacked the ability to be evaluated. A progress note, written by E10 on 3/20/18, stated that R59 lost a few pounds, he was on supplements (to gain weight) in the past and he was ordered a dietary supplement to be given twice a day. R59 was observed on 4/19/18 at 2:52 PM, 4/20/18 at 10:32 AM and 12:25 PM, 4/23/18 at 8:10 AM, 8:40 AM, 12:05 PM, 1:20 PM, and 1:41 PM, and 4/24/18 at 10:34 AM. R59 was very thin and had a variable appetite. E10 was interviewed on 4/24/18 at 11:05 AM and findings were reviewed. E10 stated that the nutrition goal as written implied that she wouldn't want R59's weight to be less than it was on admission (133 pounds). After further discussion, E10 agreed that R59's goal as written was not measurable.	F 656	including specific measurable goals. (see attached Monitoring tool # 7 a & b) 4. Results of audits will be reviewed in monthly QA & A until 100% compliance is achieved for 3 months.	6/15/18

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F 656	Continued From page 8 b. Review of R59's ADL care plan, dated 3/10/18, listed the goal "I want to improve." The care plan was non-specific and unmeasurable; it lacked the ability to be evaluated. Review of R59's admission MDS, dated 3/17/18, stated R59 required extensive to total staff assistance with all ADL's (bathing and dressing for example), except eating. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/25/18 at approximately 3:20 PM. Cross refer 740 2. Review of R14's clinical record revealed: R14 was admitted to the facility on 10/13/17 with diagnoses that included major depressive disorder. R14's admission MDS, dated 10/20/17, stated that R14 had depression and received antidepressants for the past 7 days. R14 was seen by E8 (Psychologist) on 10/17/17 for an initial consult and noted that R14 was depressed. On 11/2/17, R14 was seen by E9 (Psychiatric NP) for an initial consultation and wrote in her note that R14 was experiencing increased depression since losing her son to suicide prior to the resident coming to the facility.	F 656		

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F 656	Continued From page 9 Review of R14's care plan revealed that R14 did not have a depression care plan. On 3/22/18, E9 completed another consultation that stated R14 was crying during the exam and had suicidal ideation. The note stated that R14 said she would shoot herself in the head if she had a gun. A depression care plan was still not initiated after this consultation and the care plan was not updated to include that R14 had suicidal ideation. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/25/18 at approximately 3:20 PM. 3. Review of R74's clinical record revealed: a. R74 was admitted to the facility on 6/21/17 with diagnoses that included end stage renal disease with dependence on peritoneal dialysis. Review of R74's care plan revealed lack of any plan of care for R74's peritoneal dialysis including monitoring of his peritoneal dialysis catheter site. b. Review of R74's care plan developed on 6/25/17 and edited on 12/26/17 and 3/20/18, revealed short term goals of "weight - improved" by target dates of 3/26/18 and 6/20/18, respectively. The care plan did not specify the weight planned for in either instance. R74's weight went from 203.2 lbs on 10/26/17 to 192.2 lbs on 12/26/17, 186.5 lbs on 1/25/18, and 210 lbs on 4/24/18. These findings and the absence of measurable goals were confirmed by E10 (RD) on 4/25/18 at	F 656		

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F 656	Continued From page 10 11 AM. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/25/18 at approximately 3:20 PM. .	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) accept §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and	F 657	1. R59's ADL's care plan was revised on 4/23/18 to r reflect that the resident no longer receives PT and OT services. 2. All residents that have been discharged from PT and OT services have the potentially be affected An in house audit of all residents discharged from therappy in the past 60 days will be completed to validate that their care plan reflect the current therapy status. Corrections to care plans will be made accordingly. 3. The Regional Clinical services Nurse will educate the IDT team on the morning meeting process including census review, payer status changes, therapy start/stops and resident condition changes. The IDT will review the therapy changes and the specific resident's plan of care during the morning meeting . The care plan will be updated to reflect the change in status. Weekly the DON/designee will audit 50% of residents discharged from therapy for accuracy of care plans. (cross refrence / tool # 7a & 7 b) 4. Results of audits will be reviewed in monthly QA & A until 100% compliance is achieved for 3 months.	6/15/18

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F 657	Continued From page 11 interview, it was determined that the facility failed to review and revise one (R59) out of 35 sampled residents' care plans to reflect that R59 was no longer receiving PT and OT services due to consistent refusals. Findings include: cross refer F656, example 1b. Review of R59's clinical record revealed the following: Review of R59's ADL care plan due to stroke and right sided weakness, dated 3/10/18, listed interventions including OT and PT will evaluate and treat as recommended. Review of the Comprehensive Admission Care Conference, dated 3/21/18, included R59 and his wife as attendees. Notes from the conference stated that R59 refused PT and stated he didn't want to do it and OT was trialing a splint (for the right hand) to prevent further contractures. R59 was observed on 4/19/18 at 2:52 PM, 4/20/18 at 10:32 AM and 12:25 PM, 4/23/18 at 8:10 AM, 8:40 AM, 12:05 PM, 1:20 PM, and 1:41 PM, and 4/24/18 at 10:34 AM. R59's right hand was contracted into a balled fist and he stated that he was unable to move it. During an interview on 4/23/18 at 8:40 AM, R59 denied that he had a splint for his right hand and he stated that he does not get therapy. E11 (OT Director) was interviewed on 4/23/18 at 2:58 PM. E11 stated that R59 refused to participate in OT, he did not want a splint, and he did not meet his goals. A copy of the Discharge Summary, dated 3/28/18, was provided by E11. The Discharge Summary confirmed that R59	F 657		

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F 657	Continued From page 12 refused the right hand splint, as well as to have a restorative nursing program set up, and there was no progress from baseline on 3/12/18 to discharge from OT on 3/28/18. E6 (RN-UM) was interviewed on 4/23/18 at 3:37 PM and E6 confirmed that R59's ADL care plan was not reviewed and revised to reflect that the resident no longer received PT and OT services due to refusals. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/25/18 at approximately 3:20 PM.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and interview, it was determined that the facility failed to follow their policy and have accurate weekly skin assessments for one (R58) out of 35 sampled residents to meet professional standards of quality. Findings include: Review of the facility's Skin and Wound Care Management Program, effective 2/1/18, stated, "... Assessment... Weekly... licensed nurse performs a head to toe skin check of the resident and documents findings on the Treatment Administration Record... licensed nurse documents using the following... I= Skin Intact,	F 658	1. R59 weekly skin check was reviewed and supportive documentation was corrected . 2. All residents that have open areas on their skin at the time of their weekly skin checks have the potential be affected. A full house audit of the most recent weekly skin checks on residents with open areas will be conducted to monitor for accuracy of documentation. Corrections will be made accordingly. 3. The Staff Educator will re-educate licensed nurses on how to accurately document on weekly skin checks for residents that have open areas.(See attached # 8a) The Regional Clinical Nurse , ED, and DON completed a review of the existing system and process within the electronic medical record. Revisions to the prompts in the system were submitted to corporate office for review. The DON/designee will audit 25% of weekly skin checks on resident's that have open areas for accuracy in documentation. (see monitoring tool # 8b)	

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F 658	Continued From page 13 N= Skin not Intact... If N is documented, then a corresponding Wound Management entry or Non Pressure Wound Observation is initiated or available with wound information...". Review of R58's clinical record revealed the following: R58 was admitted to the facility on 3/9/18 on hospice services. Review of R58's at risk for skin breakdown care plan, dated 3/22/18, included an intervention for weekly skin assessments by a licensed nurse. On 4/12/18, R58 was identified with pressure ulcers on her tailbone and right buttock. Review of weekly skin checks revealed that R58's skin was incorrectly identified as I-intact on 4/12/18 and 4/19/18. On 4/12/18, R58 was already identified with 2 pressure ulcers. The right buttock wound was healed as of 4/19/18, however, R58 continued to have a pressure ulcer on her tailbone. E13 (RN-UM) was interviewed on 4/25/18 at 12:44 PM and findings reviewed. E13 confirmed findings and stated that sometimes licensed staff interpret the I (intact) to mean there are no new skin areas, although this was not what the policy stated. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/25/18 at approximately 3:20 PM.	F 658	4. Results of audits will be reviewed in monthly QA & A until 100% compliance is achieved for 3 months.	6/15/18
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		

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F 677	Continued From page 14 approved §483.24(a)(2) 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 observations, record reviews, and interviews, it was determined that the facility failed to provide the necessary services to maintain good nail grooming for two (R14 and R30) residents who were unable to carry out activities of daily living, out of 35 sampled residents. Findings include: 1. Review of R14's clinical record revealed: R14 was admitted to the facility on 10/13/17. R14's admission MDS, dated 10/20/17, stated that R14 required extensive assistance with personal hygiene, which included nail trimming. R14 had a care plan, last reviewed on 1/5/18, for the problem that R14 required assistance with ADL care. Approaches included that R14 required 1 staff member's assistance with personal hygiene to assist with daily hygiene and grooming. During an interview on 4/18/18 at 10:21 AM, R14 stated that she wanted her toenails cut and they had not been cut since she had been living in the facility (October 2017; approximately 6 months ago). She stated that she told her CNA and nurse about needing her toenails cut. E6 (Unit Manager, RN) was interviewed on 4/24/18 at 1:20 PM, and stated that only podiatry cuts the residents toenails. He stated that R14's	F 677	1. R14 was seen by the podiatrist on 5/8/18. R30's nails were trimmed on 5/8/18. 2. All residents that need extensive assistance with ADLs and/or podiatry services have the potential to be affected. The Unit Managers/designee will conduct an audit of all current resident's toenails. Podiatry will be consulted as indicated. All residents that need extensive assistance with ADLs have the potential to be affected. Personal Care Rounds as part of a focus review on all resident's that need extensive assist with ADL's will be completed by the DON/designee and permanent caregivers. Residents will be monitored for unidentified personal hygiene issues. Corrections to personal hygiene will be made accordingly. (See attached personal Rounds Care tool #___9___) 3. The Corporate Medical Director developed a orientation checklist for Practitioners. The checklist includes a reference to the process for logging of referrals into the consultation book. The Staff Educator will review the orientation checklist with all practitioners. (cross reference/ attachement #1) The Unit Manager/designee will update the resident's Point of Care profile to increase the awareness of the C.N.A.'s staff to provide ongoing monitoring and nail care as needed for those that require extensive assistance with ADLs.	

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F 677	Continued From page 15 name was written in the podiatry book on 4/3/18 and that he wrote that R14 needed to be seen by the podiatrist as soon as possible to have her toenails cut. He confirmed that R14 had not been seen by the podiatrist yet, but she was first on the list when the podiatrist comes to the facility. When asked when R14 was last seen by podiatry, E6 stated that she had not been seen by the podiatrist since being in the facility. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/25/18 at approximately 3:20 PM. 2. R30's most recent MDS on 2/8/18 indicated that the resident requires extensive assist in personal hygiene. On 4/18/18 at 2:07 PM, the resident was observed to have long dirty discolored finger nails. Finding was reviewed and confirmed with E1 and E2 during the exit conference on 4/25/18 at approximately 3:20 PM.	F 677	Weekly the DON/designee will audit the consultation book for compliance/ follow through by the Practitioners Weekly the DON/designee will audit 25% of residents that trigger for the need extensive assistance to assess if they present with acceptable personal hygiene. Caregivers will receive feedback if issues are identified and corrections will be made accordingly. (see Monitoring tool # 10) 4. Results of audits will be reviewed in monthly QA & A until 100% compliance is achieved for 3 months.	6/15/18
F 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.	F 740		

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F 740	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R14) out of 35 sampled residents, the facility failed to provide the necessary behavioral health services to attain the highest practicable mental and psychological well-being. Findings include: Review of R14's clinical record revealed: R14 was admitted to the facility on 10/13/17 with diagnoses that included major depressive disorder and anxiety disorder. On 10/14/17 the physician ordered for R14 to have a psych consult for evaluation and treatment as needed. R14 was seen by E8 (Psychologist) on 10/17/17 for an initial consult. The consult stated that R14 had anxiety and depression present and was particularly upset about her son's suicide earlier in the year. The note stated that the resident declined therapy. R14 was seen by psychiatry on 11/2/17 for an initial consultation. E9 (Psychiatry NP) wrote in her note that R14 was experiencing increased depression and anxiety since losing her son to suicide prior to the resident coming to the facility. The recommendation for R14 from E9 included to "put in for psychology to see patient for grief counseling." There was no evidence that R14 was seen by psychology for grief counseling after the psychiatry consultation on 11/2/17. In addition, R14 did not have a depression care plan after	F 740	1. R14 has been referred to the psychologist for grief counseling and was seen on 5/25/18. 2. All residents that have been recommended for psychological consultation by the Psychiatric NP have the potential to be affected. The SSD/designee will complete a review of the Psychiatric NP recommendations for the past 90 days. These will be reviewed and monitored for needed follow up. The psychologist will be contacted accordingly. 3. The Corporate Medical Director developed a orientation checklist for Practitioners which includes how to place referrals in the consultation book. The center's Staff Developer will review the new orientation checklist with all practitioners. (cross reference/ attachment #1) The SSD/designee will review the Vista Med observations in the EMR weekly. Recommendations will be addressed as indicated. (see monitoring tool # 11a & 11b) 4. Results of audits will be reviewed in monthly QA & A until 100% compliance is achieved for 3 months.	6/15/18

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F 740	Continued From page 17 being admitted with depression and her depression being confirmed by psychiatry and psychology. On 3/22/18, E9 completed another consultation that stated that R14 was crying during the exam and had suicidal ideation. The note stated that R14 said she would shoot herself in the head if she had a gun. It was written that R14 was upset that her family did not visit anymore, but does not have the means to hurt herself. A depression care plan was still not initiated after this consultation and the care plan was not updated to include that R14 had suicidal ideation. On 4/18/18 at 10:29 AM, R14 was observed crying during the entire interview with the surveyor. During the interview she stated that she felt that nobody at the facility cared. During an interview on 4/24/18 at 3:45 PM, E8 stated that the only time he ever saw R14 was for an initial evaluation that all residents in the facility receive upon admission. He stated that he did not see her again after the recommendation by psychiatry for grief counseling and he was not aware of the recommendation. The facility failed to provide R14 with the recommended grief counseling after the psychiatry consultation on 11/2/17. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/25/18 at approximately 3:20 PM.	F 740		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

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F 842	Continued From page 18 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842	1. The Nursing progress notes for R59 on 4/7/18 at 11:10 PM, 4/8/18 at 11:30 PM, 4/21/18 at 11:34 PM and 4/22/18 at 11:38 PM were written by the same nurse. This has been reviewed with her, and coaching on how to view current therapy status in the EMR was demonstrated. 2. All residents that have been discontinued from therapy services have the potential to be affected. An audit of the progress notes for all residents that have discontinued from therapy in the past 60 days will be audited for accuracy. Clarifications will be made accordingly. 3. The Regional Clinical services Nurse will educate the IDT team on the morning meeting process including census review, payer status changes, therapy start/stops and resident condition changes. The IDT will review any therapy changes and the specific resident's progress notes for the first 24 hours post change during the morning meeting to validate accuracy . The DON/designee will educate the Nurse Managers & Nurse Supervisors on the Unit Huddles and the process for communicating & informing unit staff when a resident is no longer receiving therapy services. In addition, the licensed nursing staff will be in serviced on how to view Rehabilitation notes in Matrix. Weekly the DON/designee will audit 25% of the progress notes from residents that have been discontinued from therapy services. (cross reference Ftag 657's attachment #7a and #12)	

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F 842	Continued From page 19 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain medical records for one (R59) out of 35 sampled residents that were in accordance with accepted professional standards and practices. Findings include: cross refer to F657 Review of R59's clinical record revealed the following:	F 842	4. Results of audits will be reviewed in monthly QA & A until 100% compliance is achieved for 3 months.	6/15/18

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F 842	Continued From page 20 Review of the Comprehensive Admission Care Conference, dated 3/21/18, stated that R59 refused PT and stated he didn't want to do it. Review of the OT Discharge Summary revealed that R59 was discharged on 3/28/18. Nursing progress notes, dated 4/7/18 at 11:10 PM, 4/8/18 at 11:30 PM, 4/21/18 at 11:34 PM, and 4/22/18 at 11:38 PM, stated, "Receiving PT/OT services." R59 was not receiving OT and PT services at this time, thus the progress notes were inaccurate. E11 (OT Director) was interviewed on 4/23/18 at 2:58 PM. E11 stated that R59 refused to participate in OT which was the reason for his discharge. E6 (RN-UM) was interviewed on 4/23/18 at 3:37 PM. E6 confirmed that R59's ADL care plan was not reviewed and revised to reflect that the resident no longer received PT and OT services due to refusals. E6 further stated that nursing probably got confused as residents are usually receiving therapy services when they are newly admitted. The facility failed to have accurate documentation by nursing. R59's PT and OT was discontinued due to resident refusal, yet staff continued to document that R59 was receiving OT services. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/25/18 at approximately 3:20 PM.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 21 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880	1. E7 was educated on the proper technique for hand washing and was able to provide a successful return demonstration on 5/30/18. 2. All residents have the potential to affected. 3. The Staff Educator will re- educate the licensed nursing staff on the proper technique for hand washing. Competency Assessments will be completed. Visual reminder Hand washing prompts/tags will be distributed to all staff to wear on their name badges. Weekly the Staff Developer /designee will complete a random audit of 10 staff members from various departments ,for the proper technique for hand washing. If a break in technique is observed- coaching will occur with a return demonstration by the staff member. (see monitoring tool # 13a & 13 b) 4. Results of audits will be reviewed in monthly QA & A until 100% compliance is achieved for 3 months.	6/15/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of facility policy, it was determined that the facility failed to ensure proper infection control techniques for hand washing were implemented during wound care for two (R21 and R74) out of 35 sampled residents. Findings include: The facilities Handwashing and Use of Gloves policy, effective 12/27/16, stated under the hand washing procedure to, "vigorously rotate hands to assure that friction is applied with the soapy water	F 880		

accept - inservice sign up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085025	A. BUILDING _____ B. WING _____	04/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

(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 880	Continued From page 23 between fingers and back of the hands (at least 15-20 seconds-either time is acceptable, focus should be cleaning hands at right times)." 1. During wound care for R21's coccyx pressure ulcer on 4/24/18 at 9:24 AM, E7 (LPN) was observed washing her hands multiple times before R21's dressing change, in between the dressing change, and after the dressing change. During all of these hand washing observations, E7 was observed wetting her hands under the sink, putting soap on her hands, before applying any friction she stuck her hand directly under the water in the sink and rubbed her hands together to wash the soap off. The process during each of the hand washing observations took between 5 to 10 seconds. 2. During wound care for R74's right foot wound on 4/24/18 at 9:24 AM, E7 (LPN) was observed washing her hands multiple times before R74's dressing change, in between the dressing change, and after the dressing change. During all of these hand washing observations, E7 was observed wetting her hands under the sink, putting soap on her hands, before applying any friction she stuck her hand directly under the water in the sink and rubbed her hands together to wash the soap off. The process during each of the hand washing observations took between 5 to 10 seconds. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/25/18 at approximately 3:20 PM.	F 880		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Churchman Village

DATE SURVEY COMPLETED: April 25, 2018

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from April 18, 2018 to April 25, 2018. 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 92. The survey sample size was 35. **There were no deficiencies cited for the Emergency Preparedness survey.**		
3310	**Regulations for Skilled and Intermediate Care Facilities**		
3310.1.0	**Scope**		
3310.1.2	**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.** Cross Refer to the CMS 2567-L survey completed April 25, 2018: F550, F584, F656, F657, F658, F677, F740, F842, and F880.	Please Cross reference CMS 2567-POC submitted 5/31/18 KMB	6/15/18

Provider's Signature K Maureen Burns Title NHA, Executive Director Date 5/31/18