STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	C 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from March 4, 2019 through March 8, 2019. The facility census the first day of the survey was 39. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey no deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility beginning March 4, 2019 and ending March 8, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the entrance day of the survey was thirty-nine (39) residents. The investigative sample totaled twelve (12). Abbreviations /definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; CNA - Certified Nurse's Aide; NP- Nurse Practitioner; MD-Medical Director; H & P-History and Physical; &-and; Geri chair- type of reclining chair; L - liter - unit of measurement; MDS - Minimum Data Set-standardized	F 000		

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

Electronically Signed | 04/05/2019

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 assessment forms used in nursing homes ; min - minute; ROM - Range of Motion, extent to which a joint can be moved safely; Nasal cannula- tube placed into nostrils to deliver oxygen.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was	F 609	1. On 3-1-19 a C.N.A. accused a nurse of	5/6/19

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F 609	Continued From page 2 determined that the facility failed to report an allegation of abuse for one (R19) out of one sampled residents reviewed for abuse: Findings include: Review of Facility Policy on Abuse, last revised 9/2016 documented, "An allegation of abuse, neglect or mistreatment shall always be treated seriously...As soon as possible, but within no more than twenty-four (24) hours of the suspected abuse, neglect or mistreatment, the Administrator shall notify the Office of Health Care Quality and the local police department...of the suspected abuse, neglect or mistreatment." 3/1/19 - The facility grievance log documented that a CNA accused a nurse of being verbally abusive toward R19. During an interview on 3/8/19 at 12:59 PM, E2 (DON) confirmed that the facility had failed to report the alleged abuse incident. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at exit conference on 3/8/19 at 2:40 PM.	F 609	telling a Resident "that's not my job" and classified the statement as abuse. The accusation of abuse was immediately investigated and R19 strongly denied it. R19 is alert and oriented x3. R19's response was "I don't know what she is trying to prove (referring to the C.N.A.) It didn't happen. It was determined that the C.N.A. was not happy with the nurse and the accusation was not substantiated. 2. All Residents have the potential to be affected by allegations of abuse or mistreatment. All allegations of abuse will be will be reported within 2 hours if supported or within 24 if indicated by policy. 3. All allegations will be thoroughly investigated and findings will be reported to the Division of Health Care Quality the ombudsman and potentially the police. Nursing Staff will be in-serviced regarding the need to report and the appropriate time frames for reporting. 4. The facility grievance log will be checked daily for one month to ensure all allegations of abuse or mistreatment are appropriately investigated and reported to the Division of Health Care Quality the ombudsman and potentially the police. If found to be in 100% compliance after one month of daily review of the Grievance Log, the Log will be checked three times a week for one month. If found to be in 100% compliance after one month of reviews of the Grievance Log, the log will be checked weekly. the log will continue to be checked weekly going forward and	

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F 609	Continued From page 3	F 609	the findings will be reported to the QAPI team.	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §	F 622		5/6/19

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F 622	Continued From page 4 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including cóntact information (C) Advance Directive information (D) All special instructions or precautions for	F 622		

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F 622	Continued From page 5 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure information was provided to the receiving provider for two (R18 and R30) out of two sampled residents reviewed for hospitalizations. The facility failed to include resident care plan goals in the transfer/discharge information. Findings include: 1. Review of R18's clinical record revealed the following: 11/29/18 - Transferred to the hospital. 1/2/18 - Transferred to the hospital. 3/7/19 - The clinical record review revealed no evidence that care plan goals for the 11/29/18 or 1/2/19 hospitalizations were sent to the receiving facility. 2. Review of R30's clinical record revealed the following: 11/22/18 - Transferred to the hospital. 2/18/19 - Transferred to the hospital. 3/7/19 - The clinical record review revealed no evidence that care plan goals for the 11/22/18 or 2/18/19 hospitalizations were sent to the receiving	F 622	1. In January 2019 the QA team discovered that Care Plan Goals were not being sent on all Resident transfers to the hospital. A Transfer to the Hospital Checklist, was developed to include sending Care Plans. See attachment A. R30 was a direct admit to the hospital from an outside provider. 2. All Residents have the potential to be affected by not having Care Plan goals sent to the hospital. The Transfer to Hospital Procedure was updated to include sending a copy of the care plan to receiving facility as soon as the facility is made aware of the transfer. See attachment B. 3. Nurses will be in-serviced in the new Transfer to the Hospital policy and Transfer Checklist on April 29th or 3oth. Copies of both have been posted in the Nursing Offices and the new Transfer Checklist has been made available to the Nursing staff.The Transfer to the Hospital Checklist has been updated to include sending the completed form to Medical. 4. All transfers will be reviewed to ensure all required information is sent to the	

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F 622	Continued From page 6 facility. During an interview with E2 (DON) on 3/8/19 at 2:20 PM revealed that care plan goals were not sent to the receiving facilities. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at exit conference on 3/8/19 at 2:40 PM.	F 622	receiving facility and Transfer checklists will be retained in Medical and reviewed for accuracy. RN supervisor's will review all transfers to ensure compliance. Findings will be reported to the QAPI team.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625		5/6/19

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F 625	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R18 and R30) out of two sampled residents for hospitalizations the facility failed to provide the bed-hold notice upon transfer to the hospital as required. Findings include: Review of the facility policy on Transfer to Hospital last revised 12/2019, under Procedure, Transfer, #9 documented "Give a copy of the Bed Hold Policy and retain a signed copy for Residents chart." Review of the facility policy on Bed Hold last revised 8/2017, and under Procedure, #1 documented "The Home's bed-hold policy will be given to the Resident/Resident Representative upon...transferred to the hospital." 1. Review of R18's clinical record revealed: 11/29/18 - Transferred to the hospital. 3/7/19 - The clinical record review revealed no evidence that a bed hold notice upon transfer to the hospital on 11/29/18 was provided. During an interview on 3/7/19 at 1:45 PM E3 (ADON) explained that the facility was not sending bed hold forms with residents going to the hospital on the date R18 was hospitalized. 2. Review of R30's clinical record revealed the following: 11/22/18 - Transferred to the hospital.	F 625	1. In January 2019 the QA team discovered that Bed Hold Policy were not being sent on all Resident transfers to the hospital. A Transfer to the Hospital Checklist, was developed to include giving the Resident or responsible part a copy of the Bed Hold policy. See attachment A. 2. All Residents have the potential to be affected by not having Bed Hold presented to either the Resident or responsible party upon transfer to the hospital or therapeutic leave. A Copy of the transfer checklist has been posted in the Nursing Offices and has been made available to the Nursing staff. The Transfer to the Hospital Checklist has been updated to include sending the completed form to Medical. 3. Nurses will be in-serviced in the new Transfer Checklist on April 29th or 3oth. RN supervisors will review all transfer to ensure all required components including the Bed hold were completed. 4. All transfers will be reviewed by the ADON to ensure the Bed Hold policy was given to either the Resident or Resident representative. Transfer checklists will be retained in Medical and reviewed for accuracy. Findings will be reported to the QAPI team.	

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F 625	Continued From page 8 2/18/19 - Transferred to the hospital. 3/7/19 - The clinical record review revealed no evidence that a bed hold notice upon transfers to the hospital on 11/22/18 and 2/18/19 were provided. During an interview with E2 (DON) on 3/8/19 at 2:20 PM it was confirmed that bed hold notices were provided upon transfer. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at exit conference on 3/8/19 at 2:40 PM.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to conduct an assessment that accurately reflected the status of one (R19) out of three residents reviewed for resident assessment. Findings include: Review of R19's clinical record revealed the following: 1/2/19 - The annual MDS documented impairments of the right and left lower extremities and no therapies were being received. 1/4/19 - Therapy notes from E7 (Restorative CNA) state that "resident attend(s) (therapy) twice a week" 3/5/19 at 10:49 AM - During an interview, R19	F 641	1. R19's MDS was corrected and re-submitted. 2. All Residents have the potential to be affected by inaccurate coding. The Maintenance PT C.N.A. is now giving a copy of her schedule to the RNAC and describing what exercise the Residents are doing to ensure accurate coding on the MDS. 3. The ADON or RN supervisor will review the Restorative or Maintenance program and review the MDS for accuracy. Section O will be completed by the RNAC with the Maintenance CNA. 4. Every MDS will be reviewed for	5/6/19

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F 641	Continued From page 9 explained that, after the interview, R19 would be going to therapy for a knee impairment. 3/8/19 at 11:40 AM - Review of therapy attendance records with E7 (Restorative CNA) revealed that R19 did attend therapy on 12/27/18. This finding was immediately confirmed by E3 (ADON). These findings were reviewed with E1 (NHA), E2 (DON), and E3 at exit conference on 3/8/19 at 2:40 PM.	F 641	accuracy by the DON or designee for one month. If found to be 100% accurate for one month then four MDS's will be reviewed monthly for two months. If found to be 100% accurate then all new or annual MDS's will be reviewed 6 months and if 100% accuracy has been achieved it will be determined to be corrected. Findings will be presented to the QA team.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other facility documentation it was determined that for one (R30) out of one sampled resident for accident review the facility failed to ensure that R30 received adequate supervision to prevent accidents. On 11/22/18 at 2:30 AM R30 fell in the television room when left unsupervised resulting in an emergent transfer to the hospital. Later it was confirmed that R30 had suffered harm with an injury of a broken hip. Findings include: Review of R30's clinical record revealed the following:	F 689	1. R30 has recovered. R30 does not sleep in a bed as s/he has COPD requiring O2 and most often sleeps in the geri-chair in the TV room. 2. All Resident have the potential for falls with injury. Nursing staff will be in-serviced on the importance of appropriate handoff especially of Residents with dementia and lack of safety awareness. 3. During the night hours rounding times will be staggered so that during rounds	5/8/19

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F 689	Continued From page 10 6/16/18 at 6:40 AM - Incident Report - R30 had an unwitnessed fall in the room next to the bed. An intervention was added to use better body placement in bed. 8/8/18 at 4:25 PM - Incident Report - R30 attempted to get out of the chair and slid on to the floor. An intervention was to use a sofa for rest instead of the recliner. 9/10/18 at 4:43 AM - Incident Report - R30 had an unwitnessed fall next to the bed when trying to go to the bathroom. Interventions were added to keep active during the day, ambulating more with a walker, and try later at bedtime. 9/22/18 at 10:35 AM - Incident Report - R30 had an unwitnessed fall from the love seat when R30 leaned over and fell forward. Intervention was to use geri chair during the day when tired. 11/1/18 at 8:30 PM - Incident Report - R30 had an unwitnessed fall when R30 was trying to put on slippers. Interventions included R30 needs to wait for assistance and to stay awake on days so s/he will sleep at night. 11/6/18 - A quarterly MDS assessment documented R30 with a severe cognitive impairment, required extensive assistance for transfers and toileting with one-person physical assist. Also, R30 was not steady; only able to stabilize with human assistance. 11/7/18 - A care plan, with the most recent update prior to the fall that resulted in a broken hip, included the approaches to ensure appropriate footwear with non-skid soles when ambulating; hourly safety checks; provide a safe environment; physical therapy evaluate and treat as ordered.	F 689	there will always be one person on the floor in case there is a need for direct supervision. Additionally break times will be changed so that only one person of the four on duty is on break at a time to ensure appropriate supervision on the floors. Nurses and C.N.A.'s will document on a Potential for Injury log when they are monitoring someone who may be restless and likely to fall, the time of monitoring and who replaces them for break or restroom breaks will be documented on the form to assure anyone who needs direct supervision is never left alone. 4. DON or designee will monitor the Potential for Injury log daily until 100% compliance has been obtained for one month. Then the Potential for Injury log will be monitored 3 times a week for one month until 100% compliance is obtained. It will be determined that problem has been corrected, however the Potential for Injury log will then be monitored weekly at Falls Committee meetings and final report will be submitted to QAPI.	

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F 689	Continued From page 11 11/22/18 at 2:20 AM - An incident form documented "Resident was in the chair in the TV room. Fell out of the chair on the left side on the floor, holding right hip/thigh."... resident stated 'Oh it Hurts.'... Denied hitting head, denied anyone harming he/she." Review of witness statements obtained by the facility documented: 11/22/18 at 2:20 AM - E10 (CNA) in the rest room. 11/22/18 at 2:20 AM - E9 (RN) in nursing office. 11/22/18 at 2:20 AM - E8 (RN) in nursing office. No staff were present in the TV room and R30 experienced an unwitnessed fall. 11/22/18 at 2:30 AM - Progress Notes documented "The resident was in the chair in the TV room and fell, was on the left side on the floor. 'Oh, my leg hurts here,' pointing to the right hip and thigh, resident was rubbing the area and was guarded not to bend the knee. Resident returned to room via lift. Stated, 'My arm hurts.'" R30 was pointing to the right arm and right shoulder. "Able to move right arm, full ROM to area." At 2:30 AM E11 (Nurse Practitioner) notified of fall. "An order to send to emergency room for evaluation was obtained. Family notified that resident would be transferred to emergency room at 2:31 AM. Family is going to meet the resident at the hospital. 911 called for transport. Unit manager notified at 2:55 AM. Paramedics arrived at 2:58 AM and resident was taken to the emergency room. No bruising noted or other skin injuries. Resident would not extend right leg, wanted to	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	C 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

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F 689	Continued From page 12	F 689		

keep it bent due to pain. Denied hitting head."

11/22/18 at 2:55 AM - Progress note - "911 was called R30 was transported to emergency room for treatment." Later it was confirmed R30 sustained a broken hip as a result of the fall.

Review of the facility investigation revealed R30 was out of bed and in the TV room for supervision. The resident was left unattended/unsupervised and fell.

1/22/19 - MDS Annual Assessment Summary documented R30 has had multiple falls in the past year, when resident attempted to walk without assist and lost balance; or leaned over when in wheel chair or chair and lost balance. R30 sustained "a right broken hip on 11/22/18 after a fall, and was hospitalized 11/22-29/18 for a surgical repair of the broken hip". Staff perform safety checks, and R30 utilizes a geri-chair or wheel chair for locomotion. MD H&P 1/13/19; Fall risk assessment 1/22/19; Fall notes 1/12/18, 1/16/18, 4/15/18, 6/6/18, 8/22/18, 9/10/18, 9/22/18, 11/1/18, 11/22/18, 1/12/19, 1/24/19."

3/8/19 at 10:46 AM - An interview with E5 (RN) revealed R30 "is often moved to the TV room from the bedroom because of restlessness so we can watch R30 and complete our paper work at the same time."

During a phone interview, on 3/8/19 at 12:14 PM with E4 (Physical Therapist), it was revealed that physical therapy has followed R30 for multiple falls prior to the broken hip. E4 further revealed that physical therapy worked with R30 for increased falls. R30 was evaluated for the 6/16/18 fall and recommendations from therapy were to increase the frequency of room checks

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F 689	Continued From page 13 and take R30 to a location like the television room to be more visible. These physical therapy recommendations were not added to the plan of care. During an interview with E2 (DON) on 3/8/19 at 12:58 PM it was confirmed the fall occurred when R30 was left alone unattended/unsupervised in the TV room at 2:30 AM after becoming restless in her room. Despite a history of unwitnessed falls and despite moving the resident to the TV room for observation and increased visibility due to restlessness, the resident experienced an unwitnessed fall resulting in injury when left alone and unsupervised in the TV room. These findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) at exit conference on 3/8/19 at 2:40 PM.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R19) out of one sampled residents reviewed for respiratory care and maintenance the facility failed to ensure that	F 695	1. R19's O2 tubing was changed and dated. 2. All Residents have the potential to be	5/8/19

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F 695	Continued From page 14 respiratory equipment was properly labeled. Findings include: Review of the facility policy on Oxygen Therapy, Nasal last revised 8/2018 documented under Procedure, #7 "Nasal cannula or mask and oxygen tubing is changed every 2 weeks and as needed." Review of R19's clinical records revealed the following: 1/17/19 - Review of care plan provided no information on changing the oxygen tubing. 3/3/19 - A physician's order documented "Oxygen via nasal cannula at 2 L/min..." During an interview on 3/5/19 at 10:49 AM R19 said that the oxygen tubing is "never changed." Observations made include: 3/5/19 at 10:49 AM - R19 was in room using the undated oxygen tubing. 3/8/19 at 10:00 AM - R19 was in room using the undated oxygen tubing. During an interview on 3/8/19 at 10:20 AM E6 (RN) explained that 11-7 shift changes R19's oxygen tubing. E6 did not know how this was documented. E6 explained that on 7-3 shift, a tag with the current date is placed on the tubing when it's changed. These findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) at exit conference on 3/8/19 at 2:40 PM.	F 695	affected by O2 tubing or equipment to be accurately dated. All Resident receiving O2 have been reviewed, tubing checked for acceptable dates and documentation is completed on the E-e-MAR. 3. Through root cause analysis it was determined that R19 is reasonably new to requiring O2. 3-11 and 11-7 were bot responsible for changing and dating of O2 tubing and equipment and R19 was not assigned to any specific shift. Moving forward 11-7 will be responsible for O2 tubing and equipment to decrease the potential for oversight. Nurse have been informed of the change. 4. RN supervisors will review all O2 tubing and equipment to ensure appropriate dateing is conducted and that an orders is on the e-Mar. The aforementioned will be conducted weelky for one month and if 100% compliance is obtained, it will be done bi-monthly. After 2 months of bi-weekly checks and complete and 100% compliance has been obtained it will be done monthly. If at the end of 6 months 100% compliance has been obtained we will determine the practice has been corrected and a final report will be sent to QAPI.	

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Jeanne Jugan Residence

DATE SURVEY COMPLETED: March 8, 2019

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 and complaint survey was conducted at this facility beginning March 4, 2019 and ending March 8, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the entrance day of the survey was thirty-nine (39) residents. The investigative sample totaled twelve (12).		
3201 **3201.1.0** **3201.1.2**	**Regulations for Skilled and Intermediate Care Facilities** **Scope** **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.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed March 8, 2019: F609, F622, F625, F641, F689, and F695.	Cross Refer to the CMS 2567-L survey completed March 8, 2019: F609, F622, F625, F641, F689, and F695.	

Provider's Signature Sr Cecile Zeringue Title Adm Date 4/5/2019