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) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Jeanne Jugan Residence

DATE SURVEY COMPLETED: March 6, 2020

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 from March 2, 2020 through March 6, 2020. 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.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**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.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed March 6, 2020: F684, F697, F730, and F880.		

Provider's Signature _____ Title _____ Date _____

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 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH 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
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from March 2, 2020 through March 6, 2020. 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. There were no deficiencies identified related to the Emergency Preparedness Survey.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility beginning March 2, 2020 and ending March 6, 2020. 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 twenty one (21). 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; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		4/30/20

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

Electronically Signed | 07/20/2020

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 684	Continued From page 1 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R32) out of five residents reviewed for unnecessary medications, the facility failed to ensure that physician orders for stool testing was completed. Findings include: 3/14/18 - A physicians order was initiated to have R32's stool tested for blood every three months. 6/24/19 and 12/17/19 - Progress notes documented that stools tested negative. 3/5/2020 at 2:00 PM - During an interview, E2 (DON) revealed that evidence could not be found that a stool test was completed in September 2019. Findings were reviewed with E1 (NHA), E2 and E3 (ADON) on March 6, 2020 during the exit conference beginning at approximately 3:20 PM.	F 684	Resident R32 had the potential to be affected by no having Stool for OB being completed. However, R32□s H&H was found to be within normal limits. All Residents who have orders for stool OB's every three months have the potential to be affected by not having stool for occult blood being completed. Through root cause analysis it was determined that the E.H.R. was not being utilized to its fullest potential to generate a listing of when Stool OB□s are due for all Residents. A audit of Resident charts was conducted to ensure all ordered stool OB testing was completed. Systemic changes have been made to include: 1. RN supervisors will generate a list for the nurses which will need to be dated when stool OB□s are done. 2. All stool OB□s will now be completed in: March, June, September and December. 3. The goal is for all stool OB□s to be completed by the 15th. 4. RN supervisors will review the lists on the 15th and notify the DON if any stool OB□s are outstanding. 5. RN	

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F 684	Continued From page 2	F 684	supervisors, if necessary, will notify each shift until all testing is completed. 6. MD will be notified by the DON by the 20th of the month if stool OB has not been conducted with the the reason why for new orders. 7. In order to maintain the schedule of March, June, September and December any Resident who starts a blood thinner or is admitted on off moths will have a H&H checked per our Medical Director. RN supervisors will ensure this is completed through chart audits. See attachment for policy for stool ob testing and education provided to nursing staff. RN supervisors will review the EHR each designated month for orders for stool OB testing and generate a report each designated month until 100% successful for 3 months. Then every other designated month until 100% successful in that all testing was completed as ordered for one year, it will then be determined that the problem has been corrected. The first review was conducted in March of 2020. All Residents who had orders for stool OB testing was completed. A report was submitted to the QA team on April 30, 2020.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 697		4/30/20

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F 697	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R33) out of one sampled resident reviewed for pain management, the facility failed to identify the residents pain management goals. Findings include: Review of R33's clinical record revealed: 6/6/18 - A care plan related to pain did not include R33's pain goal. 1/20/2020 - A quarterly pain assessment indicated that R33 had pain. The assessment lacked R33's goal for an acceptable pain level. 1/21/2020 - A quarterly MDS assessment documented that R33 had frequent pain. February 2020 - The most recent orders on the medication administration record documented that R33 took Valium for muscle spasms, Oxycodone for chronic pain, Tylenol for chronic pain and Gabapentin (for nerve pain) for muscle spasms. Orders included: "Document pain intensity on a scale of 0-10, 0= no pain and 10 = worst pain possible three times a day." Without assessing a resident for their desired pain goal it would be impossible to determine the effectiveness of the pain management interventions. 3/5/2020 2:15 PM - During an interview with R33 it was established that R33 has chronic pain. During an Interview on 3/5/2020 at 3:00 PM, E4 (RN) revealed that there was a document where the acceptable pain goal was recorded. E4 was	F 697	R33□s acceptable pain goal was immediately obtained and careplan updated to reflect the same. All Residents have the potential to be affected by not having their acceptable pain goal identified. A record review was conducted for all Residents to ensure an acceptable pain score was identified on their care plan. In=service Director/ ADON will educate all nurses on the importance of identifying and documenting Residents acceptable pain level Through root cause analysis it was determined that as the facility moved into using E.H.R for medication administration and assessments and away from paper the acceptable pain goals were not always being identified. The acceptable pain goal is now included on every shifts pain assessment in the E.H.R. and on the admission checklist. See attachment A. Residents care plans will be reviewed for acceptable pain goal each week on the weekly schedule until 100% compliance has been achieved each quarter. There after twelve care plans will be reviewed each quarter until 100% compliance has been obtained. Then new care-plans will be reviewed for one year and report submitted to the QA team the first report was submitted on 4/30/20.	

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F 697	Continued From page 4 unsure where it was currently located since the facility switched to a computerized medical record. During an interview on 3/6/2020 at 3:20 PM with E2 (DON), it was confirmed that R33 did not have a pain goal identified. E2 further revealed that an acceptable pain goal was added to R33's plan of care. These findings were reviewed with E1 (NHA) and E2 during the exit conference on 3/6/2020 at 3:20 PM.	F 697		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that nurse aide performance evaluations were completed at least once every 12 months for two (E7 and E8) out of five employees sampled. Findings include: 3/6/2020- Review of employee performance reviews revealed the following: - E7 (CNA) had a hire date of 8/3/12. The most recent date of evaluation was 8/3/18. - E8 (CNA) had a hire date 7/9/13. The most	F 730	No residents were affected by performance evaluations not being completed. All Residents have the potential to be affected by performance evaluations not being completed. E7 and E8 performance evaluation were completed. Immediately after the survey a audit of all employee files for performance reviews was conducted and any necessary performance evaluation was completed.	4/30/20

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F 730	Continued From page 5 recent date of evaluation was 7/19/18. During an interview on 3/6/2020 at 11:31 AM, E3 (ADON) confirmed that the facility was unable to provide evidence that performance reviews were completed at least once every twelve months for E7 (CNA) and E8 (CNA). These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 3/6/2020 at 3:20 PM.	F 730	We are now completing performance evaluations between the months of January through March. Performance evaluations are now being completed by administrative nurses for nurses and C.N.A.□s. Staff were notified through paycore of the systemic change. HR will be auditing all employee files to ensure all performance evaluations are completed annually and timely by March 15th and to include compentencies. The Administrator and DON will be notified of any which need to be completed so they ensure completion. All performance evaluation audits will be conducted every year by Human Resources and report submitted to the QA team.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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,	F 880		4/30/20

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F 880	Continued From page 6 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: (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.	F 880		

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F 880	Continued From page 7 §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 observation and interview it was determined that the facility failed to ensure the laundry room was maintained to prevent contamination of clean laundry. Findings include: 3/2/2020 10:27 AM - An observation of the soiled linen room revealed there was no evidence of negative pressure. E5 (Laundry Supervisor) confirmed there was no negative pressure and stated they were going to follow up with maintenance. 3/2/2020 2:33 PM - An observation of the soiled laundry room revealed there was no evidence of negative pressure. 3/3/2020 2:45 PM - An observation of the soiled linen room showed evidence of negative pressure. 3/6/2020 10:39 AM - An interview with E6 (Maintenance Director) revealed that the motor to ventilate the soiled linen room was not working and it was replaced on 3/3/2020. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 3/6/2020 at 3:20 PM.	F 880	No Residents were affected by the lack of negative pressure in soiled laundry as the door between the washer and soiled laundry was immediately shut. All Residents have the potential to be affected by the lack of negative pressure. The motor for the negative pressure was replaced on 3/3/20 and the door remained shut until the repair was completed. Laundry staff will check to ensure the negative pressure is operational and document findings daily. We will also continue the practice of not opening the doors between the soiled and clean linen. See attachment B The Laundry supervisor will review the Negative pressure check sheet daily for 2 weeks until 100% compliance has been obtained. Then 3 times a week for 2weeks until 100% compliance is achieved. Then weekly reviews will be conducted for 6 months and 100% compliance is obtained. A report will be submitted to the QA team quarterly. 4/30/20	