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

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

**STATE SURVEY REPORT**



**NAME OF FACILITY: The Mary Campbell Center** **DATE SURVEY COMPLETED: December 5, 2024**

| 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.**<br><br>An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from December 2, 2024, through December 5, 2024. The deficiencies contained in this report are based on observation, interview, review of clinical records and other facility documentation, as indicated. The facility census on the first day of the survey was sixty-seven (67). The survey sample size was eleven (11) residents. | | |
| **3201** | **Regulations for Skilled and Intermediate Care Nursing 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.**<br><br>**This requirement is not met as evidenced by:**<br><br>Cross Refer to the CMS 2567-L survey completed December 5, 2024: W154. | | |

Kathleen Cyphoni - Ordaire Executive Director 12/27/24

Provider's Signature Title Date

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 08G013 | A. BUILDING _____ B. WING _____ | C 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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E 000 Initial Comments

An unannounced annual and complaint survey was conducted at this facility from December 2, 2024 through December 5, 2024. The facility census was 67 on the first day of the survey.

In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.

W 000 **INITIAL COMMENTS**

An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from December 2, 2024 through December 5, 2024. The deficiencies contained in this report are based on observation, interview, review of clinical records and other facility documentation, as indicated. The facility census on the first day of the survey was sixty-seven (67). The survey sample size was eleven (11) residents.

Abbreviations/definitions used in this report are as follows:

CNA- Certified Nursing Assistant;
DON - Director of Nursing;
ED - Executive Director;
LPN - Licensed Practical Nurse;
RCT - Resident Care Technician;
**RN** - Registered nurse.

Cerebral Palsy - a group of neurological disorders

E 000 A.Based on the deficiency cited on Form CMS-2567, the facility failed to thoroughly investigate four out of five allegations of neglect. The residents included in the sample who did not receive a full investigation of their allegations, as required by regulation, are identified as C4, C5, C6, and C7.
B.This is an issue that could potentially have impacted residents with previous allegations investigated. We will review the previous six months' investigations utilizing the updated checklists.. To be completed by ED and DON. Completed by 1/19/25
C.The system changes that have been made are as follows:

a..Two checklists have been created to ensure investigations are complete and thorough. These checklists will be consolidated into a single form completion by 1/19/25

b.The DON or designee initiates and oversees the investigation with the support and review of Human Resources(as appropriate) or designee and of the Executive Director or Administrator on Call. Implemented 12/24/24 and ongoing.

c.Final approval of a complete and thorough investigation is determined by the Executive Director or in the absence of the Executive Director by the Administrator on Call. Implemented 12/23/24 and ongoing.

D.The QA Audit form and Investigation checklist will be maintained and reviewed through the investigation to ensure that a thorough investigation is completed, and regulations are followed.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kathleen Appramian-Adelaine TITLE Executive Director (X6) DATE 12/27/24

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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that affect a person's ability to move, balance, and maintain posture.

W 154 STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) W154

. The facility must have evidence that all alleged violations are thoroughly investigated.

This STANDARD is not met as evidenced by:

Based on interview, record review and a review of other facility documentation as indicated, it was determined for four (C4, CS, C6, and C7) out of five investigative sampled clients, the facility failed to thoroughly investigate allegations of neglect. Findings include:

A policy titled "Preventtion of Abuse Neglect, and Exploitation, Investigation and Reporting of Alleged Incidents, and Corrective Actions" dated 3/22/24 stated "..... Investigative reports are completed as indicated for all allegations. A thorough investigation includes at minimum: the collection of all interviews, statements, physical evidence and any pertinent maps, pictures or diagrams; review of all information related to the allegation; resolution of any discrepancies; summary of conclusions; and recommendations for action both to safeguard all the clients during the investigation and after the

WOOD e.Each investigation will be reviewed within the QAPI process to ensure a thorough investigation was completed. Completed by 1/19/25

f.staff training on the updated procedures. Completed by 1/19/25

Success will be evaluated through the QAPI process to ensure we have met the regulation as stated in W154: Completed by 1/19/25

a. The collection of all interviews, statements, physical evidence and any pertinent maps, pictures or diagrams:
b. Review of all information related to the allegations:
c. Resolution of any discrepancies:
d. Summary of conclusions and
e. Recommendations for action both to safeguard all the clients during the investigations and after the completion of the report. Completed by 1/19/25 and ongoing for a through e.
f. The facility will monitor the next 5 investigations or until 100% successful investigation process is confirmed through a second level review by the Policy nurse or designee.

completion of the report. If patterns of possible abuse, neglect, mistreatment or injuries of unknown source are identified during the review, or the facility incident report logs for the past three months indicate an extremely high incident rate, then a full review of all alleged violations of abuse, nelect or mistreatment, as well as injuries of unknown source for the past three months should be completed."

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1. On 12/02/24 a review was initiated of an incident involving C4 who reported on 04/02/24 C4 had a bowel movement (BM) in his/her brief around 5 am, engaged the call light for help, and was told by Registered Nurse 1 (RN1) that he/she would need to wait until the next shift arrived to be changed.

On 12/02/24 at 12:35 PM an interview with C4 revealed that he/she recalled the incident and repeated it as described above. C4 added he/she knows RN1 well, because of RN1's lengthy employment at the facility. C4 added that RN1 has always been helpful in the past, but did not know why he/she should have to wait for the next shift to arrive to have a spoiled brief changed.

On 12/04/24 a record review for C4 revealed diagnoses including Cerebral palsy, Paraplegia, Anxiety disorder, attention deficit hyperactivity disorder, and Primary insomnia, among others. C4's Individual Program Plan, dated 01/31/24, documented training in "learning and practicing strategies to improve memory and thought organization" to decrease cognitive loss/dementia.

A review of the "Bowel Movement Log" for C4, dated April 2024, revealed no BM was initially recorded for 04/02/24, however a late entry correction documented a BM on 04/01/24. A second late entry correction marked out the 04/01/24 entry and documented a BM on 04/02/24 at 8:00 AM.

An interview with RN1 on 12/05/24 at 6:30 AM revealed a denial that RN1 told C4 to wait until the next shift arrived to have C4's brief changed. RN1 reported responding to C4's call light around

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5:00 AM, but upon entering C4's room found him/her asleep with the CPAP machine attached and operating. RN1 added there was no smell of urine or fecal matter in the room at that time. RN1 reported returning to C4's room at 5:30 **AM** to administer Synthroid and finding C4 was awake. During administration of Synthroid, RN1 said C4 reported he/she had not had a bowel movement since given a suppository on the evening of 12/01/24. RN1 said there was no reason to doubt what C4 said was true and there was no indication that C4 had a BM. RN1 reported C4 became agitated and asked RN1 to call the pool to let the pool staff know C4 would not be present for a scheduled pool appointment since there had been no result from his suppository. RN1 reported explaining to C4 that the pool staff were not on duty at 5:45 AM but would make sure they got the message when they arrived.

RN1 reported being taken off the schedule for 04/03/24. RN1 Inquired about the reason for that change and was told the schedule was changed due to an allegation of neglect. RN1 added there was never an explanation of how C4 was neglected and RN1 did not understand when managers presented a copy of the call light procedure and directed RN1 to sign it. RN1 maintained no one ever told him/her, and he/she never understood what he/she did wrong. RN1 reported asking the investigator where the information came from that RN1 told C4 to wait until the next shift came to work before being changed. RN1 stated the investigator responded that C4 was very well known to the investigator and some of the information communicated was not verbal but was facial expressions that the investigator could interpret. RN1 added he/she

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had been C4's nurse for the last 10 years and knew him/her very well and suspected the investigator may have misunderstood C4's facial expressions because in RN1's experience with C4 he/she has always been able to clearly express communication verbally.

The facility incident report (#84704) dated 04/02/24 at 8:00AM documented RN2 responded to C4's call light being activated on 04/02/24 at 8:00 AM and C4 told RN2 the nurse assigned on the previous shift told C4 to wait to be changed until the next shift. RN2 talked with C4, checked him/her, and advised him/her that his/her assigned Resident Care Technician (RCT1) would come to change him/her in a few minutes.

On 12/05/24 at 7:45 AM an interview with RCT1 revealed he/she was on duty on 12/02/24 at 7:45 AM and was the staff member who checked and changed C4 around 8:00 AM. RCT1 said he/she recalled the incident, and the fecal matter was moist and appeared to be fresh. RCT1 said he/she had experienced changing briefs with fecal matter that was dried and appeared to have been present for some time, but that is not what he/she found on the morning of 12/02/24. RCT1 added that he/she failed to document the bowel movement on C4's Output Log, which caused him/her to be placed on "BM alert" to cue staff to be aware he/she might be constipated and to help determine if more intrusive interventions were indicated. RCT1 added that he/she realized he/she did not document the output on his/her Output Log a few days later and corrected the log to indicate he/she had a bowel movement on 04/02/24 around 8:00 AM.

The investigation did not document interviews

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: with RCT1 or **RN1**, rather the narrative "Results ' of investigation" section of the investigation documented reviewing written statements. The ' failure to interview RN1 and RCT1 and any other witnesses excluded significant details that both RN1 and RCT1 were able to provide that could have changed the determination by the facility that RN1 failed to provide needed personal care.

'2. On 12/02/24 a review was initiated of an : incident involving Client 5 (CS) who reported on 03/06/24 at approximately 3:30 PM CS reported he/she was not wiped clean properly during a brief change on 03/05/24 on the 2:45PM to 10:45 PM shift by Resident Care Technician 2 (RCT2).

On 12/03/24 at 2:00 PM an interview with CS , verified the allegation as above. CS reported when RCT2 was on duty RCT2 was expected to complete two rounds of brief checks during the 2:45 PM to 10:45 shift. During the first round of checks RCT2 told CS repeatedly that he/she would complete the wiping clean process at the next brief check, however, he/she consistently failed to complete the wiping clean process. CS stated that he/she reported RCT2 was failing to clean him/her during brief changes a few weeks prior to this incident to the nurses, and RCT2 did better for a day or two, but then returned to him/her previous practice of not cleaning CS as part of required brief changes. CS added that RCT2 called him/her "Whiney" and a "Complainer" after he/she reported RCT2's failures to provide needed cleaning. CS reported RCT2's failures to provide cleaning during brief changes were ongoing and frequent and included frequent complaints about how hard it is to "roll" specific clients over for brief changes.

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A review of C5's record revealed diagnoses of "Cerebral palsy, major depression, paranoid schizophrenia, among others." Interviews with C5 on 12/02/24 at 1:25PM, 12/03/24 at 2:00PM, and 12/04/24 at 9:30 AM confirmed consistent details of RTC2's failures to provide needed care. Additionally, C5 reported feeling an obligation to report RTC2's failures, even though C5 was afraid of retaliation from RTC2, because many other people RTC2 provided care for were non-verbal and could not complain about poor care.

The facility investigation, Identified as #24-960, documented obtaining information from other staff members, verifying RCT2's failure to provide adequate perineal area care during brief changes. No staff statements or names were included in the facilities investigation. The facility investigation did not identify other clients and staff members' names who witnessed RCT2's failures to provide personal care during brief changes and referred to staff statements only as supporting evidence resulting in a determination this investigation did not meet the standard of a thorough investigation.

3. Review of C6's clinical record revealed:

12/2/2013 - C6 was admitted to the facility with diagnoses including, but not limited to, cerebral palsy and blindness.

3/6/24 4:58 PM -An incident report was submitted to the state agency reporting that RCT 2 (Resident care tech 2) did not complete incontinence care on C6 on 3/5/24 and an investigation was initiated.

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3/8/24 - A follow up report was submitted to the state agency documenting that it was confirmed that care was not provided for C6 on 3/5/24 and that RCT 2's employment was terminated on 3/7/24.

12/2/24 - A review of the facilities investigative packet lacked evidence of interviewing all direct care staff that were involved in care with C6 between 3/5/24 and 3/6/24.

12/4/24 2:20 PM - An interview with ED (Excutive Director) confirmed that the facilities investigative packet contained all documents related to the investigation.

4. Review of C7's clinical record revealed:

1/6/23 - C7 was admitted to the facility with diagnoses including, but not limited to, spastic quadreplegic cerebral palsy.

1/11/24 3:50 PM -An incident report was submitted to the state agency reporting that C7 did not receive incontinence care timely and an investigation was initiated.

1/15/24 -A follow up report was submitted to the state agency documenting that it was confirmed that care was not provided timely for C7 on 1/11/24 and that staff involved with C7's care will be educated on the facility policy related to responding to client's call bells. C7's plan of care was updated to reflect C7's preference on time to get out of bed in the morning.

12/2/24 - A review of the facilities investigative packet lacked evidence of all documentation related to the investigation except copies of the

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| W 154 | Continued From page 8<br>. reports of incident to the state agency.<br><br>12/4/24 2:20 PM - An interview with ED (Excutive Director) confirmed that the facilities investigative packet contained all documents related to the investigation.<br><br>12/5/24 1:30 PM - Findings were reviewed with ED (Excutive Director) and DON (Director of Nursing) during the exit conference. | W 154 | | |