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 ICF/ID **DATE SURVEY COMPLETED:** December 21, 2023

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 on-site Recertification, Emergency Preparedness and Complaint Survey was conducted at the above-named ICF/IID facility from 12/18/23 to 12/21/23 resulted in a finding of substantial compliance respective to the applicable federal Conditions of Participation (CoP) 42 CFR 483. No State deficiencies were identified.		
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.**		

Provider's Signature Thomas Shea (Jan 18, 2024 09:00 EST) Title Interim Executive Director, NHA Date Jan 18, 2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G013	A. BUILDING _____ B. WING _____	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY CAMPBELL CENTER	4641 WELDIN RD WILMINGTON, DE 19803

(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
W 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Delaware Health and Social Services, Division of Healthcare Quality. An unannounced on-site Recertification and Complaint Survey was conducted at the above-named ICF/IID facility from 12/18/23 to 12/21/23 resulted in a finding of substantial compliance respective to the applicable Conditions of Participation (CoP) 42 CFR 483, Subpart I with the following standard-level deficiencies listed below.	W 000	**A. Immediate Corrective Action for Individual Impacted:** Resident's (C6) skin impairment was healed prior to the survey. No immediate corrective action was necessary.	
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interviews, record reviews, and facility policy review, the facility failed to ensure one client (Client (C) 6) was provided nursing services which included *measurements and a description of the injuries* the client sustained during pool therapy. Findings include: Review of a policy provided by the facility titled "Wound Assessments, Documentation and Notification," dated 10/12/2011 indicated ". . .Resident wounds will be assessed and documented weekly when identified and PRN (as needed) when indicated. . ." There was no evidence in the facility policy which indicated wounds should be described and measured to determine if the area was healing or declining.	W 331	**B. Residents with potential to be affected:** All residents have the potential to be affected by this deficient practice. **C. Systemic Changes to Ensure Compliance:** An Impaired Skin Integrity Policy & Procedure was developed. (Attachment A). Licensed nurses will be educated on the Impaired Skin Integrity Policy & Procedure by 2/19/24. Impairments to residents' skin integrity are documented in the Accident/ Incident Report found in the electronic medical record (Attachment B).	

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

Thomas Shea (Jan 18, 2024 08:59 EST)

Interim Executive Director, NHA

Jan 18, 2024

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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W 331	Continued From page 1 Review C6's undated "Resident Face Sheet," located in the client's electronic medical record (EMR) indicated the client was admitted to the facility 11/04/15 with diagnoses that included cerebral palsy and epilepsy. Review of a document provided by the facility titled "Accident," dated 07/20/22 indicated C6 sustained abrasions on the tips of his/her bi-lateral toes which were actively bleeding. The report indicated the client did not have his/her pool shoes on while actively walking in the pool. The document revealed the client's toes were cleaned with normal saline and covered in bandages. Review of a document provided by the facility titled "Nursing-24 Hour Post Incident Assessment," dated 07/21/22 indicated C6 sustained injury to the tips of his/her toes. During an interview on 12/19/23 at 12:01 PM, the Quality Assurance Performance Improvement/Registered Nurse (QAPI/RN) stated there was no documentation in C6's clinical record which would show measurements were taken along with a description of his injuries. During an interview on 12/19/23 at 2:30 PM, the Medical Director stated it was his/her expectation the wound would have been measured and a description of the area documented.	W 331	**C. Systemic Changes to Ensure Compliance: (*Cont.*)** In addition, licensed nurses provide a thorough description of the injury in the Wound/Skin Record (Attachment C). Licensed nurses will then assess the area of concern weekly and as needed and document their observation in the Wound/Skin Record until the area is healed. **D. Success Evaluation** An Impaired Skin Integrity Audit tool (Attachment D) has been developed to evaluate compliance with the Impaired Skin Integrity Policy & Procedure. The Nursing Supervisor or designee will complete Impaired Skin Integrity audits weekly until 100% compliance is met for four consecutive weeks. Then, they will complete audits every other week until 100% compliance is met for two consecutive weeks, followed by monthly audits until 100% compliance is met. Completed audit forms will be submitted to the Director of Nursing or designee for review. Audit results will be reported at quarterly Quality Assessment and Assurance (QAA) Committee meetings.	2/19/24