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 _____	C 07/31/2019

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	W 000		

An unannounced complaint survey was conducted at this facility from July 30, 2019 through July 31, 2019. The deficiencies contained in this report were based on observation, interview, review of clients' records and review of other facility documentation as indicated. The facility census the first day of the survey was 48. The survey sample totaled three residents and one sub-sampled resident.

Abbreviations/definitions used in this report are as follows:

AED - Assistant Executive Director;
ADON - Assistant Director of Nursing;
ED - Executive Director;
CM - Case Manager;
DON - Director of Nursing;
Left parietal scalp hematoma -is a bleeding underneath the scalp in the upper left region of the skull;
NHA- Nursing Home Administrator;
RCT - Resident Care Technician;
SCM-Senior Case Manager;
QIDP - Qualified Intellectual Disabilities Professional.

W 149 STAFF TREATMENT OF CLIENTS — W 149
CFR(s): 483.420(d)(1)

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

This STANDARD is not met as evidenced by:
Based on review of the facility policy and procedure and interview, it was determined that

W 149
"The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client."

SECTION A (Individual Impacted)
Resident (R1) was impacted by this deficient practice.

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

Regina F Coffey — Executive Director — 8/29/19

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 149	Continued From page 1 the facility failed to develop and implement written policies and procedures which incorporated the current definition for neglect. Findings included: The CMS Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) Regulations, with a revision date of 4/13/18, stated the definition for neglect as: "Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Staff failure to intervene appropriately to prevent self-injurious behavior may constitute neglect Staff failure to implement facility safeguards, once client to client aggression is identified, may also constitute neglect." Cross refer F153. The facility's policy and procedure, titled Prevention of Abuse, Neglect, and Exploitation Investigation and Reporting of Alleged Incidents, and Corrective Action, with a revision date of 8/8/18 indicated: "...C. Identification and Definitions: Regulations for ICF/IID and Long-Term Care Nursing Facilities define abuse, neglect, and exploitation, as follows:... Neglect: 1. Includes situation that constitutes evidence of neglect if residents are involved in serious incidents caused by one or more of the following: a. Includes lack of attention to physical needs of the resident including , but not limited to toileting, bathing, meals and safety..." There was a lack of evidence, that the facility's policy incorporated the current CMS definition for neglect.	W 149	*W149, continued* **SECTION B (Identifying Other Residents)** All residents had the potential to be affected by the deficient practice. **SECTION C (System Changes)** The facility's "Prevention of Abuse, Neglect and Exploitation, Investigation and Reporting of Alleged Incidents and Corrective Actions" policy was revised to comply with the CMS definition of neglect. (Attachment A) Mary Campbell Center staff, consultants, and Unidine Lifestyles partners will be trained on the revised policy. **SECTION D (Success Evaluation)** The Executive Director, Assistant Executive Director, Director of Nursing and/or Assistant Director of Nursing will review fall incidents to ensure there was no evidence of a failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." An audit tool has been developed for reviewing falls to ensure compliance with the facility's Prevention of Abuse, Neglect and Exploitation, Investigation and Reporting of Alleged Incidents and Corrective Actions" policy. (Attachment B)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 149	Continued From page 2 The findings were reviewed on 7/31/19 beginning at approximately 3:00 PM, during an exit meeting with E1(AED) and E2 (DON).	W 149	*W149, continued* The review process will begin August 19, 2019 and continue until 100% compliance is achieved for six consecutive months. Audit results will be reviewed at quarterly Quality Assessment & Assurance Committee meetings	9-27-19
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review, interview, and review of the facility policy and procedure, it was determined that for one (R1) out of two sampled residents who had experienced a fall, the facility failed to immediately report an allegation of neglect. Findings included: CMS Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) Regulations, with a revision date of 4/13/18, stated the definition for neglect as: "Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." The facility's policy and procedure, titled Prevention of Abuse, Neglect, and Exploitation Investigation and Reporting of Alleged Incidents, and Corrective Action, with a revision date of 8/8/18 indicated: "...C. IDENTIFICATION AND DEFINITIONS: Regulations for ICF/IID and Long-Term Care	W 153	*W 153* *"The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures."* **SECTION A** **(Individual Impacted)** Resident (R1) was impacted by this deficient practice. On 5/10/19, the RCT's involved in the incident were educated by the DON regarding use of proper sling size. SigmaCare (EHR) care plans were updated to include sling sizes for residents who use mechanical lifts for transfers. On 5/28/19, the Staff Educator sent the following SigmaCare message to Healthcare staff: "In SigmaCare, under the Resident Summary page, the Transfers option under the CNA tab has been updated to reflect the correct sling size for any residents using the ceiling lift. Please not that the size of the sling is determined by physical therapy. Thank you"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 153	Continued From page 3	W 153	*W 153, continued*	

Nursing Facilities define abuse, neglect, and exploitation, as follows:...
Neglect:
1. Includes situation that constitutes evidence of neglect if residents are involved in serious incidents caused by one or more of the following:
a. Includes lack of attention to physical needs of the resident including , but not limited to toileting, bathing, meals and safety..
F. REPORTING:...3....Any incident involving alleged abuse (verbal, physical or emotional) or any incident involving serious bodily injury must be reported to the Division of Health Care Quality, but no later than two hours after the allegation/incident occurs. All other alleged incidents must be reported within 8 hours..."

Cross refer W 149.

The review of R1's clinical record, the facility's incident report and the facility's investigation revealed the following :

4/1/01 - R1 admitted to the facility with diagnoses including epilepsy and adjustment disorder.

5/9/19 9:00 PM - The facility's Accident Report documented that R1 was being transferred into bed from a shower chair using a sling and R1 fell through the sling. R1 appeared to have hit his/her head on the floor, E6 (RCT) notified the nurse who immediately performed assessment. "...resident reported pain in back of head, resident was transported to hospital for evaluation." "Contributing factors: resident has involuntary spasms."

5/9/19 9:00 PM - A hand written Incident Witness Statement by E6 (RCT) documented "...while

SECTION B
(Identifying Other Residents)
All residents had the potential to be affected by the deficient practice. Falls from 5/1/19-7/31/19 will be audited using the Audit for Tags W-153, 3201.9.6 Tool to identify falls that may have been the result of neglect. If the audit of fall documentation reveals evidence of neglect, the incident will be immediately reported to the Division of Healthcare Quality. (See Attachment B)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 153	Continued From page 4	W 153		

transferring [R1] kept moving [his/her] and in no time [R1] slip (sic) out of the sling to the floor."

5/9/19 10:24 PM - A hand written Incident Witness Statement by the second RCT involved in the transfer of R1, E7 ((RCT) documented "At 9"15 PM, I walked into room (#) and (Name of E6/RCT) was about to transfer (Name of R1). So I assisted with the transfer and when (Name of R1) got into the air, (Name of R1) started to move around. Then [R1] fell through the sling and hit [R1] head on the floor."

5/9/19 10:52 PM - The CT (special X-ray like test) Report from the hospital confirmed the presence of a left parietal scalp hematoma.

5/10/19 - Clinical Practice Referral/Training was completed by E2 (DON) for both of the RCTs (E6 and E7) involved in the transfer of R1 on 5/9/19. Verbal education was provided regarding safety/ensuring resident was secure in sling during transfer, minimize resident movement during transfers and ensure appropriate sizing of sling. Both RCTs verbalized understanding of education provided and demonstrated what he/she would do differently.

5/15/19 - The Nursing 24 Hour Post Incident Assessment documented that the facility's Fall Committee had determined R1 fell out of the sling during transfer due to spasticity. Recommendation was for staff to be educated on use of proper sized sling.

5/15/19 1:28 PM - An e-mail from E3 (ADON) was sent to E1 (AED), with carbon copy of the same e-mail to E2 (DON) and E8 (SCM/QIDP) which documented, during an onsite visit by

W 153, Continued

SECTION C
(System Changes)
The facility's "Prevention of Abuse, Neglect and Exploitation, Investigation and Reporting of Alleged Incidents and Corrective Actions" policy states "any incident involving alleged abuse (verbal, physical or emotional) or any incident involving serious bodily injury must be reported immediately to Division of Health Care Quality, but not later than two hours after the allegation/incident occurs. All other alleged incidents must be reported within 8 hours." (Attachment A)
MCC staff, consultants and contracted partners will be re-trained on the need to report all suspected abuse, neglect or exploitation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 153	Continued From page 5	W 153	*W 153, continued*	

DHQC's Investigator, E7 (RCT) verbalized that E6 (RCT) had used R1's roommate's (SSR1's) extra large sling instead of R1's large sling and this may have contributed to the fall.

There was lack of evidence, that the facility identified an allegation of neglect and immediately reported this allegation.

7/31/19 9:15 AM - An interview with E7 (RCT) revealed that he/she reported to E2 (DON) on 5/10/19 that the wrong sling was used in transferring R1 on the night of 5/9/19, when R1 had experienced a fall. E7 verbalized that he/she entered R1's room to assist E6 (RCT) who had R1 secured in the sling.

7/31/19 9:30 AM - An interview with E6 (RCT) revealed that he/she recalled, prior to placing the sling on R1 on the evening of 5/9/19, he/she had observed R1's name on the sling, which was in R1's closet. E6 denied that he/she used the wrong size sling, by using R1's roommate's (SSR1's) sling in performing R1's transfer.

7/31/19 10:30 AM - During an interview with E2 (DON), E2 confirmed that he/she investigated R1's fall, which occurred on 5/9/19. E2 verbalized that on the next day 5/10/19, E2 was made aware by E7 (RCT) that SSR1's sling was used to perform the transfer and it was the wrong size to transfer R1. In response to this new information, E2 went into R1's room and observed a sling in R1's closet with R1's name. In addition, two slings were observed hanging in SSR1's closet with SSR1's name. E2 verbalized when the fall occurred on 5/9/19, no staff observed the sling to confirm that the wrong sling was utilized. E2 indicated in response to this fall,

SECTION D

(Success Evaluation) The Executive Director, Assistant Executive Director, Director of Nursing and/or Assistant Director of Nursing will review fall incidents to ensure there was no evidence of a failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." An audit tool has been developed for reviewing falls to ensure compliance with the facility's Prevention of Abuse, Neglect and Exploitation, Investigation and Reporting of Alleged Incidents and Corrective Actions" policy. (Attachment B) The review process will begin August 19, 2019 and continue until 100% compliance is achieved for six consecutive months. Audit results will be reviewed at quarterly Quality Assessment and Assurance Committee meetings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 153	Continued From page 6 E2 provided education to both E6 and E7, regarding safety/ensuring resident was secure in sling during transfer, minimizing resident movement during transfer and ensuring appropriate sizing of the sling. Furthermore, E2 verbalized that it was her/his understanding, the definition of neglect included "intent to harm and willful act" against a resident, thus, E2 determined that there was lack of intent to harm and not a willful act by E6 (RCT) or E7. Therefore, E2 confirmed that he/she did not identify this as an allegation of neglect. E2 The facility failed to identify an allegation of neglect and failed to immediately report the allegation, which was brought to the attention of the facility on 5/10/19. The findings were reviewed on 7/31/19 beginning at approximately 3:00 PM, during an exit meeting with E1(Assistant ED) and E2(DON).	W 153		9-27-19

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: Mary Campbell Center

DATE SURVEY COMPLETED: July 31, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from July 30, 2019 through July 31, 2019. The deficiencies contained in this report were based on observation, interview, review of clients' records and review of other facility documentation as indicated. The facility census the first day of the survey was 48. The survey sample totaled three residents and one sub-sampled resident.		
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.** **This requirement is not met as evidenced by:**		
3201.9.6	**All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection. The method of reporting shall be as directed by the Division.**	**3201.9.6** *"All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long-term Care Residents Protection. The method of reporting shall be directed by the Division."*	
3201.9.8	**Reportable incidents are as follows:**		
3201.9.8.2			

Provider's Signature Regina J Cobbley Title Executive Director Date 8/29/19

NAME OF FACILITY: Mary Campbell Center

DATE SURVEY COMPLETED: July 31, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	Neglect, mistreatment or financial exploitation as defined in 16 Delaware Code, §1131. This requirement is not met as evidenced by: Based on record review, interview, and review of the facility policy and procedure, was determined that for one (R1) out of two sampled residents who had experienced a fall, the facility failed to immediately report an allegation of neglect. Findings included: CMS Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) Regulations, with a revision date of 4/13/18, stated the definition for neglect as: "Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." The facility's policy and procedure, titled Prevention of Abuse, Neglect, and Exploitation Investigation and Reporting of Alleged Incidents, and Corrective Action, with a revision date of 8/8/18 indicated: "...C. IDENTIFICATION AND DEFINITIONS: Regulations for ICF/IID and Long-Term Care Nursing Facilities define abuse, neglect, and exploitation, as follows:... Neglect: 1. Includes situation that constitutes evidence of neglect if residents are involved in serious incidents caused by one or more of the following: a. Includes lack of attention to physical needs of the resident including, but not limited to toileting, bathing, meals and safety. F. REPORTING:...3....Any incident involving alleged abuse (verbal, physical or emotional)	*3201.9.6, continued* **SECTION A (Individual Impacted)** Resident (R1) was impacted by this deficient practice. Resident (R1) was impacted by this deficient practice. On 5/10/19, the RCT's involved in the incident were educated by the DON regarding use of proper sling size. SigmaCare (EHR) care plans were updated to include sling sizes for residents who use mechanical lifts for transfers. On 5/28/19, the Staff Educator sent the following SigmaCare message to Healthcare staff: "In SigmaCare, under the Resident Summary page, the Transfers option under the CNA tab has been updated to reflect the correct sling size for any residents using the ceiling lift. Please note that the size of the sling is determined by physical therapy. Thank you" **SECTION B** **(Identifying Other Residents)** All residents had the potential to be affected by the deficient practice. Falls from 5/1/19-7/31/19 will be audited using the Audit for Tags W-153, 3201.9.6 Tool to identify falls that may have been the result of neglect. If the audit of fall documentation reveals evidence of neglect, the incident will be immediately reported to the Division of Healthcare. (See Attachment B)	

Provider's Signature Regina S Cobbley Title Executive Director Date 8/29/19

NAME OF FACILITY: Mary Campbell Center

DATE SURVEY COMPLETED: July 31, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	or any incident involving serious bodily injury must be reported to the Division of Health Care Quality, but no later than two hours after the allegation/incident occurs. All other alleged incidents must be reported within 8 hours..." The review of R1's clinical record, the facility's incident report and the facility's investigation revealed the following: 4/1/01 - R1 admitted to the facility with diagnoses including epilepsy and adjustment disorder. 5/9/19 9:00 PM - The facility's Accident Report documented that R1 was being transferred into bed from a shower chair using a sling and R1 fell through sling. R1 appeared to have hit his/her head on the floor, E6 (RCT) notified nurse who immediately performed assessment. "...resident reported pain in back of head, resident was transported to hospital for evaluation." "Contributing factors: resident has involuntary spasms." 5/9/19 9:00 PM - A hand written Incident Witness Statement by E6 (RCT) documented "...while transferring [R1] kept moving [his/her] and in no time [R1] slip out of the sling to the floor." 5/9/19 10:24 PM - A hand written Incident Witness Statement by the second RCT involved in the transfer of R1, E7 (RCT) documented "At 9"15 PM, I walked into room (#) and (Name of E6/RCT) was about to transfer (Name of R1). So I assisted with the transfer and when (Name of R1) got into the air, (Name of R1) started to move around. Then	***3201.9.6, continued*** **SECTION C (System Changes)** The facility's "Prevention of Abuse, Neglect and Exploitation, Investigation and Reporting of Alleged Incidents and Corrective Actions" policy states "any incident involving alleged abuse (verbal, physical or emotional) or any incident involving serious bodily injury must be reported immediately to Division of Health Care Quality, but not later than two hours after the allegation/incident occurs. All other alleged incidents must be reported within 8 hours." (Attachment A) MCC staff, consultants, and contracted partners will be re-trained on the need to report all suspected abuse, neglect or exploitation. **SECTION D (Success Evaluation)** The Executive Director, Assistant Executive Director, Director of Nursing and/or Assistant Director of Nursing will review fall incidents to ensure there was no evidence of a failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." An audit tool has been developed for reviewing falls to ensure compliance with the facility's Prevention of Abuse, Neglect and Exploitation, Investigation and Reporting of Alleged Incidents and Corrective Actions" policy.	

Provider's Signature Regina J Cobbley Title Executive Director Date 8/29/19

NAME OF FACILITY: Mary Campbell Center

DATE SURVEY COMPLETED: July 31, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	[R1] fell through the sling and hit [R1] head on the floor." 5/9/19 10:52 PM - The CT Report from the hospital confirmed the presence of a left parietal scalp hematoma. 5/10/19 - Clinical Practice Referral/Training was completed by E2 (DON) for both of the RCTs (E6 and E7) involved in the transfer of R1 on 5/9/19. Verbal education was provided regarding safety/ensuring resident was secure in sling during transfer, minimize resident movement during transfers and ensure appropriate sizing of sling. Both RCTs verbalized understanding of education provided and demonstrated what he/she would do differently. 5/15/19 - The Nursing 24 Hour Post Incident Assessment documented that the facility's Fall Committee had determined R1 fell out of the sling during transfer due to spasticity. Recommendation was for staff to be educated on use of proper sized sling. 5/15/19 1:28 PM - An e-mail from E3 (ADON) was sent to E1 (AED), with carbon copy of the same e-mail to E2 (DON) and E8 (SCM/QIDP) which documented, during an onsite visit by DHQC's Investigator, E7 (RCT) verbalized that E6 (RCT) had used R1's roommate's (SSR1's) extra large sling instead of R1's large sling and this may have contributed to the fall. There was lack of evidence, that the facility identified an allegation of neglect and immediately reported this allegation. 7/31/19 9:15 AM - An interview with E7 (RCT) revealed that he/she reported to E2 (DON) on	(Attachment B) ***3201.9.6, continued*** The review process will begin on August 19, 2019 and continue until 100% compliance is achieved for six consecutive months. Audit results will be reviewed at quarterly Quality Assessment and Assurance Committee meetings.	

Provider's Signature Regina F Cobb Title Executive Director Date 8/29/19

NAME OF FACILITY: Mary Campbell Center

DATE SURVEY COMPLETED: July 31, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	5/10/19 that the wrong sling was used in transferring R1 on the night of 5/9/19, when R1 had experienced a fall. E7 verbalized that he/she entered R1's room to assist E6 (RCT) who had R1 secured in the sling. 7/31/19 9:30 AM - An interview with E6 (RCT) revealed that he/she recalled, prior to placing the sling on R1 on the evening of 5/9/19, he/she had observed R1's name on the sling, which was in R1's closet. E6 denied that he/she used the wrong size sling, by using R1's roommate's (SSR1's) sling in performing R1's transfer. 7/31/19 10:30 AM - During an interview with E2 (DON), E2 confirmed that he/she investigated R1's fall, which occurred on 5/9/19. E2 verbalized that on the next day 5/10/19, E2 was made aware by E7 (RCT) that SSR1's sling was used to perform the transfer and it was the wrong size to transfer R1. In response to this new information, E2 went into R1's room and observed a sling in R1's closet with R1's name. In addition, observed two slings hanging in SSR1's closet with SSR1's name. E2 verbalized when the fall occurred on 5/9/19, no staff observed the sling to confirm that the wrong sling was utilized. E2 indicated in response to this fall, E2 provided education to both E6 and E7, regarding safety/ensuring resident was secure in sling during transfer, minimizing resident movement during transfer and ensuring appropriate sizing of the sling. Furthermore, E2 verbalized that it was her/his understanding, the definition of neglect included "intent to harm and willful act" against a resident, thus, E2 determined that there was lack of intent to harm and not a willful act by E6 (RCT) or E7. Therefore, E2		

Provider's Signature Regina J Cobbley Title Executive Director Date 8/29/19

NAME OF FACILITY: Mary Campbell Center **DATE SURVEY COMPLETED: July 31, 2019**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	confirmed that he/she did not identify this as an allegation of neglect. The facility failed to identify an allegation of neglect and failed to immediately report the allegation, which was brought to the attention of the facility on 5/10/19. The findings were reviewed on 7/31/19 beginning at approximately 3:00 PM, during an exit meeting with E1(Assistant ED) and E2(DON).		9/27/19

Provider's Signature Regina Cobbley Title Executive Director Date 8/29/19

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: Mary Campbell Center

DATE SURVEY COMPLETED: July 31, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE

Provider's Signature Regina Gibbs Title Executive Director Date 8/29/19

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