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: Jeanne Jugan Residence

DATE SURVEY COMPLETED: March 21, 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. An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility beginning March 19, 2024, through March 21,2024. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was twenty-three (23) residents. The sample totaled twenty (20) residents.	Cross Refer to the CMS 2567-L survey completed March 21, 2024: E0037, F609, F880 and F943.	
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 21, 2024: E0037, F609, F880 and F943.		

Provider's Signature *Sr Cecile Zeringue* Title *adm* Date *4/10/24*

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 03/21/2024

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 19, 2024 through March 21, 2024. The facility census was 23 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 interview and document review, Emergency Preparedness deficiencies were identified.	E 000		
E 037 SS=D	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		7/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 04/10/2024

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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(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under

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arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under

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arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients,

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personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.
This REQUIREMENT is not met as evidenced by:
Based on documement review it was determined that the facility failed to ensure that two (E18 and E19) out of eight (8) staff reviewed received annual Emergency Preparedness training, findings include:

3/21/24 12:28 PM - Review of the staff training worksheet provided by E5 (RN) revealed:

1. E18 received last Emergency Preparedness

E 037

A) During the survey ending on 3/21/24, the Surveyor upon reviewing the staff training worksheet, noted that E18 and E19 had not completed their annual Emergency Preparedness training within the last 12 months per the facility policy.

B) Though no Residents were negatively impacted, the facility recognizes all Residents have the potential to be

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E 037	Continued From page 5 training on 10/14/21. 2. E19 received last Emergency Preparedness training on 8/18/22. Findings were reviewed with E1 (NHA) and E3 (DON) during the exit conference on 3/21/24 at 3:00 PM.	E 037	affected by this deficient practice. The Director of In-Services/Staff education will conduct a focused review of all Active Employees who have not completed their annual Emergency Preparedness training in the last 12 months. If any are identified, they will be required to complete their training prior to being placed back on the schedule. C) Root cause analysis revealed though the facility had several In-service dates available to the active staff to complete their annual Emergency Preparedness throughout the year and those Employees were contacted to complete the training, some remained non-compliant. Human Resources and the In-service Director discussed a need for a consequence for non- compliant staff with this annual training and it was decided they will not be able to work (taken off the schedule) until it is completed. D) The In-service Director will audit all Active staff Emergency Preparedness training completion dates. Employees will be removed from the schedule if this In-service was last completed over 12 months ago, until their In-service completion is up to date. The audit will be completed weekly until 100% compliance is achieved for 3 consecutive weeks. Then the audit will be conducted monthly x3 months, if 100% compliance is achieved/maintained, this deficiency will be considered resolved. Audits will continue on a monthly basis. Results of audits will be presented at the facility's	

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E 037	Continued From page 6	E 037	QAPI meetings. Audit schedules will be adjusted as deemed necessary.	
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility beginning March 19, 2024 through March 21, 2024. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was twenty three (23) residents. The sample totaled twenty (20) residents. Abbreviations/definitions used in this report are as follows: ADON- Assistant Director of Nursing; CCHS (Christiana Care Health System)- a Hospital; CNA- Certified Nurse Aide; DON- Director of Nursing; LPN- Licensed Practical Nurse NHA- Nursing Home Administrator; Ombudsman- A person who promotes nursing home resident rights and quality of care; RN- Registered Nurse; SW- Social Worker; Allegation - A claim that someone has done something illegal or wrong; Depression - Mental disorder with feelings of sadness or a mood disorder that causes a persistent felling of sadness and loss of interest that affects how you feel, think and behave; Edema - Retention of fluid into the tissue resulting in swelling; Hypertension - Pressure in the blood vessels is	F 000		

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F 000	Continued From page 7 too high; Peripheral Vascular Disease - A circulatory condition in which narrowed blood vessels reduce blood flow to the limbs; Substantiate - Provide evidence to support or prove the truth of.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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	F 609		7/1/24

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F 609	Continued From page 8 by: Based on interview and review of other facility documentation, it was determined that the facility failed to immediately report to the State Agency for one (R128) out of two residents reviewed for abuse. Findings include: Review of R128's clinical record revealed: 8/23/23 - Review of the facility investigation of an alleged physical abuse revealed the following: - On 8/23/23 2:15 PM, E2 (DON) informed E9 (SW) that R128 reported E15 (CNA) "beat her up" in her room. E20 (RN) performed a physical check of R128 ' s body from head to toe and reported not finding any bruises that would substantiate R128's allegation. - On 8/23/23 2:50 PM, E9 went to R128's room to discuss the incident with R128. E9 spoke briefly with R128 and inquired about R128's well-being and if R128 wanted to discuss anything. R128 said she was tired and did not feel like having a visit at this time. 8/25/23 11:25 AM - A report was submitted to the State Agency by E4 (ADON). 3/20/24 1:03 PM - During an interview E9 said, " ...(E3) reported the allegation of abuse to me." In, addition E9 said, "...I believe the reporting time for abuse is within 24 hours." 3/20/24 2:15 PM - An interview with E3 confirmed, the facility was aware of the late reporting. In addition, E3 stated that the facility had documented on the five day follow up report submitted to the State Agency, "...In the future, allegations of abuse will be reported immediately."	F 609	1. On 8/23/23 R128 alleged physical abuse by staff and reported E15 "beat her up" in her room. E20 (RN) performed a physical check of R128's body from head to toe and reported no findings of any bruises that would substantiate R128's allegation. E9(SW) attempted to discuss the allegation with the Resident for more information, but the Resident refused and requested E9 to return the next morning to discuss. Though the facility attempted to investigate the allegation immediately, and it was found to be unsubstantiated, they failed to report the allegation to the state agency within the required 2 hours. 2. All Residents have the potential to be affected by allegations of abuse or mistreatment. All allegations of abuse will be reported within 2 hours if supported (even if there is little information to report) or within 24 hours 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. All 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 by the Social Worker 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	

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F 609	Continued From page 9 The facility failed to ensure that an event reported by a resident of alleged abuse was reported State Agency. in the required two hours. Findings were reviewed with E1 (NHA) and E3 (DON) during the exit conference on 3/21/24 at 3:00 PM.	F 609	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 the findings will be reported to the QAPI 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, 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:	F 880		7/1/24

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(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.

§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:

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F 880	Continued From page 11 Based on record review and interview it was determined that the facility failed to have measures in place to prevent the growth of Legionella and other opportunistic waterborne pathogens when they did not identify areas in the facility where Legionella could grow and spread and failed to establish measures for monitoring of water testing. Findings include: The facility policy for the Legionella Water Management Program, last updated July 2017, indicated "As part of the infection prevention and control program, our facility has a water management program...The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaires disease. The water management program includes the following elements: A detailed description and diagram of the water system in the facility...identification of areas in the water system that could encourage growth and spread of Legionella and other water borne bacteria. The water management program will identify measures that are monitored". 8/19/21- The facility completed testing for Legionella in three areas of the facility. All areas were negative for the presence of Legionella. 3/21/24 12:57 PM - E5 (ICP) confirmed the facility had no current or past cases of Legionella. During an interview on 3/21/24 at 1:19 PM with E5 (ICP) and E12 (Maintenance Director) E12 reported that the facility "did random testing" however did not identify specific areas that could encourage the growth of Legionella. E12 also confirmed the facility did not have a diagram of	F 880	We've developed a diagram of our building to identify where hot spots might be for Legionella to grow (See attached building diagram). We've developed a flow chart for hot and cold water (See attached hot/cold water chart). We are implementing a monthly testing procedure. Maintenance will take chlorine readings from all the hot spot areas. Monthly water testing for chlorine with samples taken from the beginning supply on the first floor and 4 other samples from the end of the line in various places according to the diagram. Maintenance or their designee will flush water in the hot spot areas and areas of possible stagnated water (unoccupied rooms) at a frequency of once a month. (See attached testing form). They will setup for monthly room checks to run water for 30 seconds in rooms that are not occupied starting with May 2024. If chlorine is present they will notate that on the sheet and check again next month. If chlorine is not present, the water will have to be flushed until chlorine is present. The audit will be conducted monthly x3 months, if 100% compliance is achieved/maintained, this deficiency will be considered resolved. Audits will continue on a monthly basis.	

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 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12 the water system that identified possible areas for growth and that the current program did not have an established steps for frequency of water testing. Findings were reviewed with E1 (NHA) and E3 (DON) during the exit conference on 3/21/24 at 3:00 PM.	F 880		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure annual completion of abuse training for two (E18 and E19) out of eight staff reviewed. Findings include: The facility policy on abuse last updated 4/2023 indicated, "Staff and volunteers will receive education about resident mistreatment, neglect, and abuse, including injuries of unknown source	F 943	A) During the survey ending on 3/21/24, the Surveyor upon reviewing the staff training worksheet, noted that E18 and E19 had not completed their annual Abuse, Neglect, and Exploitation training within the last 12 months per the facility policy. B) Though no Residents were negatively	7/1/24

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

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F 943	Continued From page 13 exploitation, and misappropriation of property upon first employment and annually after that..". 3/20/24 10:01 AM - E5 (RN) Inservice Director was provided a worksheet requesting dates of staff training. 3/21/24 Review of the staff training worksheet provided revealed: - E18 last received training for abuse, neglect, and exploitation on 10/14/21. - E19 last received training for abuse neglect, and exploitation on 8/18/22. During an interview on 3/21/24 at 10:49 AM, E5 (RN) Inservice Director, confirmed the finding, and stated, "We send out an email blast for them to complete the trainings but they don't return them." Findings were reviewed with E1 (NHA) and E3 (DON) during the exit conference on 3/21/24 at 3:00 PM.	F 943	impacted, the facility recognizes all Residents have the potential to be affected by this deficient practice. The Director of In-Services/Staff education will conduct a focused review of all Active Employees who have not completed their annual Abuse, Neglect, and Exploitation training in the last 12 months. If any are identified, they will be required to complete their training prior to being placed back on the schedule. C) Root cause analysis revealed though the facility had several In-service dates available to the active staff to complete their annual Abuse, Neglect, and Exploitation training throughout the year and those Employees were contacted to complete the training, some remained non-compliant. Human Resources and the In-service Director discussed a need for a consequence for non- compliant staff with this annual training and it was decided they will not be able to work (taken off the schedule) until it is completed. D) The In-service Director will audit all Active staff Abuse, Neglect, and Exploitation training completion dates. Employees will be removed from the schedule if this In-service was last completed over 12 months ago, until their In-service completion is up to date. The audit will be completed weekly until 100% compliance is achieved for 3 consecutive weeks. Then the audit will be conducted monthly x3 months, if 100% compliance is achieved/maintained, this deficiency will	

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F 943	Continued From page 14	F 943	be considered resolved. Audits will continue on a monthly basis. Results of audits will be presented at the facility's QAPI meetings. Audit schedules will be adjusted as deemed necessary.	