

**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: April 10, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced Annual and Complaint survey was conducted at this facility from April 7, 2026, through April 10, 2026. 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 first day of the survey was (twenty-one) 21. The investigative sample totaled (fifteen) 15 residents.</p> <p>Abbreviations/definitions used in this report are as follows:</p> <p>CEO - Chief Executive Officer; DON - Director of Nursing; DSM - Dining Services Manager; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RN - Registered Nurse.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>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 require-</b></p>	<p><b>3201.5.5.3</b></p> <p>A) During the survey ending on 4/10/26, the Surveyor upon reviewing the Dietary Manager requirements, noted that E8 and E15 did not meet the requirements for a Delaware BCC background check. B) Though no Residents were negatively impacted, the facility recognizes all Residents have the potential to be affected by this deficient practice. It was noted that E15 did not have the results of the DE BCC eligibility letter on file. The HR Director and the Administrator have been actively looking for a full time CFPM that meets the requirements, since the last full time Dietary Director resigned without completing her required notice. 4/22/26 HR and Administrator hired their own full time CFPM (making them a staff employee and not a contracted employee) meeting the requirements of a Delaware BCC. Results were received on 4/24/2026. The full time Dietary Director started work with LSP on 4/28/2026. C) Root cause analysis revealed the previous HR Director accepted improper documentation in place of the BCC eligibility letter. The previous full time Dietary Director, who met the DE requirements, resigned without completing her required notice. This left the facility to find a replacement for the full time Dietary Director meeting the requirements immediately. Although, HR and the administrator were actively looking for a full-time qualified replacement, which are in scarce supply, for the</p>	<p>5/25/2026</p>

Provider's Signature Mrs Cecile Zeringue Title Admin Date 5/8/26



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<p>3201.5.0</p> <p>3201.5.5</p> <p>3201.5.5.1</p> <p>3201.5.5.3</p> <p>3201.5.5.4</p> <p>3201.5.5.5</p> <p>S/S - D</p>	<p>ments of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement was not met as evidenced by:</p> <p>Cross Refer to the CMS 2567 – L survey completed April 10, 2026: cross refer: F688, F730, F801 and F812.</p> <p><b>Personnel/Administrative</b></p> <p><b>The facility shall have written personnel policies and procedures. Personnel records shall be kept current and available for each employee, and include the following:</b></p> <p><b>Results of tuberculosis screening</b></p> <p><b>Results of criminal background check</b></p> <p><b>Results of mandatory drug testing</b></p> <p><b>Result of Adult Abuse Registry check.</b></p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Based on interview and review of facility documentation, it was determined that for one (E8) out of six employees reviewed for staffing, the facility's personnel records lacked evidence of tuberculosis screening results, criminal background checks, mandatory drug testing and adult abuse registry checks. Findings include:</p> <p>2/12/26 – E8's first day in the facility.</p> <p>4/10/26 9:00 AM – A review of the facility's list of contracted employees revealed that E8 was</p>	<p>interim, they contracted with a food service company to provide a qualified full time CFPM. The contracted company failed to provide the facility with a staff member meeting the full time DE requirements. The facility should have verified with the contracted company E8's ability to meet the full time DE requirements prior to E8's start date. LSP should have verified with the contract company that the DE BCC background check was completed prior to the contract Dining Manager starting. 4/22/26 HR and Administrator hired their own full time Dietary Manager (making them a staff employee and not a contracted employee) meeting the requirements. A full time Dining Manager's DE BCC background check results were obtained on 4/24/2026 and he started work with LSP on 4/28/2026. HR director will audit all current contracted staff and all current employees for the DE BCC background check to ensure current compliance. In the event that a current contracted staff member or facility employee does not meet the DE BCC requirement they will not work at LSP until the DE BCC background check results have been met. Moving forward the HR director will ensure that all new contracted staff have the results of the DE BCC background check prior to their start date to ensure they meet the DE BCC requirements. Current HR director will audit all current employees to ensure BCC documentation is on file. Onboarding checklist has been created and will be utilized</p>	

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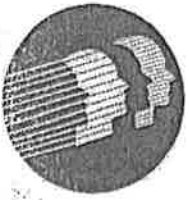
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<p>3201.6.0</p> <p>3201.6.9.2</p> <p>3201.6.9.2.4</p>	<p>assigned as agency Dining Services Manager (DSM). Review of E8's personnel record revealed missing evidence of the 2-step tuberculosis screening, recent criminal background check, mandatory drug testing and recent adult abuse registry check from E8's agency employer.</p> <p>4/10/26 9:30 AM – During an interview, E4 (HR) confirmed that the facility did not have a file of E8's pre-employment background check paperwork. E4 stated, "I sent an email to [V1, Agency CEO] on 4/8/25 and told him that the survey team picked [E8] as part of the review sample and I requesting for the background check paperwork to be sent to me as soon as possible." E4 continued to state, "[V1] replied to my email and stated that [E8] was an emergency temporary service person and that her role normally does not interact with any residents." E4 further stated that V1 did not require all of these background documentation for E8's employment in Maryland.</p> <p>4/10/26 12:00 PM – Findings were discussed with E1 (NHA).</p> <p>4/10/26 3:10 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (CEO) during the Exit Conference.</p> <p><b>Services to Residents</b></p> <p><b>Specific Requirements for Tuberculosis</b></p> <p><b>Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a baseline two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as</b></p>	<p>for all new hires to ensure compliance with the BCC prior to new hires starting at the facility. (see attached) Administrator or her designee will review and verify that all new employees hired in the facility meet the DE BCC new employee hire requirements prior to their start.</p> <p>D) The HR Director or her designee will ensure there is a DE BCC background check result for all contracted employees and current staff by May 25, 2026. After May 25, 2026 and 100% compliance is achieved/maintained, this deficiency will be considered resolved. Audits will continue monthly. In addition to monthly audits as new employees are hired in the facility their onboarding checklist will be completed to ensure they meet the requirements. Results of audits will be presented at the facility's QAPI meetings. Audit schedules will be adjusted as deemed necessary.</p> <p><b>3201.5.5.1</b></p> <p>A) During the survey ending on 4/10/26, the Surveyor upon reviewing the Dietary Manager requirements, noted that E8 did not meet the requirements for a negative 2 step TB screening or negative chest xray or negative QuantiFERON test. B) Though no Residents were negatively impacted, the facility recognizes all Residents have the potential to be affected by this deficient practice. The HR Director and the Administrator have been actively looking for a full time CFPM that meets the requirements, since the</p>	



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<p>3201.6.9.2.4.2 S/S - D</p>	<p><b>Quantiferon. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services....</b></p> <p><b>Any person having a positive skin test, but a negative X-ray shall receive an annual evaluation for signs and symptoms of active TB if they cannot provide documentation of completion of treatment for LTBI (latent TB infection).</b></p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Based on interview and review of the facility documentation, it was determined that for one (E8) out of six employees reviewed, the facility failed to ensure E8 met the minimum pre-employment requirements for tuberculosis screening. Findings include:</p> <p>2/12/26 – E8's first day in the facility as agency dining services manager. E8 was missing evidence of the 2-step tuberculosis screening from E8's agency employer.</p> <p>4/10/26 9:30 AM – During an interview, E4 (HR) confirmed that the agency did not have a file of E8's tuberculosis screening. E4 further stated that V1 (Agency CEO) did not require the 2-step tuberculosis screening for E8's employment in Maryland.</p> <p>4/10/26 12:00 PM – Findings were discussed with E1 (NHA).</p>	<p>last full time Dietary Director re-signed without completing her required notice. 4/22/26 HR and Administrator hired their own full time CFPM (making them a staff employee and not a contracted employee) meeting the requirements of a negative TB result. Results were received on 4/24/2026. The full time Dietary Director started work with LSP on 4/28/2026.</p> <p>C) Root cause analysis revealed the previous full time Dietary Director, who met the DE requirements, re-signed without completing her required notice. This left the facility to find a replacement for the full time Dietary Director meeting the requirements immediately. Although, HR and the administrator were actively looking for a full-time qualified replacement, which are in scarce supply, for the interim, they contracted with a food service company to provide a qualified full time CFPM. The contracted company failed to provide the facility with a staff member meeting the full time DE requirements. The facility should have verified with the contracted company E8's ability to meet the negative TB result prior to E8's start date. LSP should have verified with the contract company that the negative TB results were completed prior to the contract Dining Manager starting. 4/22/26 HR and Administrator hired their own full time Dietary Manager (making them a staff employee and not a contracted employee) meeting the requirements. A full time Dining Manager's negative QuantiFERON results were obtain 4/23/2026 with a</p>	

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3105.3.0	<p>4/10/26 3:10 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (CEO) during the Exit Conference.</p> <p><b>3105 Title 16 Health and Safety Delaware Administrative Code</b></p> <p><b>Criminal History and Drug Testing for Nursing and Similar Facilities</b></p> <p><b>Definitions "Background Check Center (BCC)" means the electronic system which combines data streams from various sources within and outside the State in order to assist an employer in determining the suitability of a person for employment in a nursing facility or similar facility, or home care agency as those terms are defined in the enabling statute. See 29 Del.C. §7972.</b></p> <p><b>"BCC consent form" means the form provided by DHSS which informs the Applicant of the scope of the BCC, the Applicant's legal obligations, and the legal sanctions for failure to provide complete and accurate information. "DHSS" means the Department of Health and Social Services. DHSS owns and operates the BCC. "DLTCRP" means the Division of Long Term Care Residents Protection, Department of Health and Social Services. The Division is responsible for background checks for licensed facilities.</b></p> <p><b>"Master List" is the list maintained by the BCC for each employer. The list contains the names of all persons who: -Are employed in the employer's facility in 16 Del.C. 1141(b)(5);... -Are self-employed individuals working as an independent contractor for the employer....</b></p>	<p>test date of 4/6/2026. Dietary Manager started work with LSP on 4/28/2026. HR director will audit all current contracted staff for negative TB results to ensure current compliance. In the event that a current contracted staff member does not meet the negative TB results requirement they will not work at LSP until we obtain the negative TB results. Moving forward the HR director will ensure that all new contracted staff have the negative TB results prior to their start date to ensure they meet the DE negative TB requirements.</p> <p>D) The HR Director or her designee will ensure there is a negative TB result for all contracted employees by May 25, 2026. After May 25, 2026 and 100% compliance is achieved/maintained, this deficiency will be considered resolved. Audits will continue monthly. Results of audits will be presented at the facility's QAPI meetings. Audit schedules will be adjusted as deemed necessary.</p> <p><b>3201.5.5.4</b></p> <p>A) During the survey ending on 4/10/26, the Surveyor upon reviewing the Dietary Manager requirements, noted that E8 did not meet the requirements for a negative drug screening.</p> <p>B) Though no Residents were negatively impacted, the facility recognizes all Residents have the potential to be affected by this deficient practice. The HR Director and the Administrator have been actively looking for a full time CFPM that</p>	

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<p>3105.4.0</p> <p>3105.4.1</p> <p>S/S – D</p>	<p><b>Persons Subject to the Law</b></p> <p>All persons working in facilities are required to be on the Master List of the BCC. New applicants must be processed through the BCC and will automatically be placed on the Master List if hired. Current employees, whether grandfathered or not, must be added to the Master List through the process directed by DLTCRP</p> <p>This requirement was not met as evidenced by:</p> <p>Based on interview, review of facility documentation and the BCC website, it was determined that two (E8 and E15) out of six facility and agency staff reviewed was not on the Hired Master List of the BCC. Findings include:</p> <p>1. 2/12/26 – E8's first day in the facility as an agency dining service manager.</p> <p>4/10/26 9:00 AM – Review of E8's pre-employment records lacked evidence of the mandatory drug screen and fingerprint letter completed by her current agency employer.</p> <p>4/10/26 9:30 AM – During an interview, E4 (HR) stated that E8's agency employer did not enter her information into the BCC website.</p> <p>Review of the BCC website revealed that E8 was not on the Master List of the BCC under the agency employer name.</p> <p>4/10/26 12:00 PM - Finding was discussed with E1 (NHA).</p> <p>2. 10/17/23 – E15's first day in the facility as licensed practical nurse.</p>	<p>meets the requirements, since the last full time Dietary Director resigned without completing her required notice. 4/22/26 HR and Administrator hired their own full time CFPM (making them a staff employee and not a contracted employee) meeting the requirements of a negative drug screening. Results were received on 4/22/2026. The full time Dietary Director started work with LSP on 4/28/2026.</p> <p>C) Root cause analysis revealed the previous full time Dietary Director, who met the DE requirements, resigned without completing her required notice. This left the facility to find a replacement for the full time Dietary Director meeting the requirements immediately. Although, HR and the administrator were actively looking for a full-time qualified replacement, which are in scarce supply, for the interim, they contracted with a food service company to provide a qualified full time CFPM. The contracted company failed to provide the facility with a staff member meeting the negative drug screening. The facility should have verified with the contracted company E8's ability to meet the negative drug screening result prior to E8's start date. LSP should have verified with the contract company that the negative drug screening results were completed prior to the contract Dining Manager starting.</p> <p>4/22/26 HR and Administrator hired their own full time Dietary Manager (making them a staff employee and not a contracted employee) meeting the requirements. A full time Dining</p>	

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<p>3105.9.0</p> <p>3105.9.1</p> <p>S/S-D</p>	<p>4/10/26 9:03 AM – Review of E15’s pre-employment records lacked evidence that her fingerprint was completed with a letter of eligibility.</p> <p>4/10/26 9:32 AM – During an interview, E4(HR) confirmed and stated that she was not the HR personnel at the time of E15’s pre-employment period on October 2023. E4 stated that E15 submitted a copy of a credit card transaction dated 10/5/23 as proof of payment of E15’s background check services required by the state board of nursing as E4 just became a nurse when the facility hired her. E4 continued and stated, “It looks like the HR person at that time accepted that credit card transaction receipt as proof of [E15’s] background check services and finger printing, but it was not coming from the facility or long-term care – and it was not done through the BCC.”</p> <p>Review of the BCC website revealed that on 4/9/25, E8’s application information, registry check, criminal history under the [facility name] was created with a status date of 4/17/25. All were marked “Pending Results”. In addition, E8’s name was not on the Master List of the BCC as hired employee on the facility.</p> <p>4/10/26 12:00 PM - Finding was discussed with E1 (NHA).</p> <p>4/10/26 3:10 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (CEO) during the Exit Conference.</p> <p><b>Drug Tests</b></p> <p><b>The BCC provides an electronic conduit through the Delaware Health Information</b></p>	<p>Manager’s negative drug screening results were obtain 4/22/2026 with a test date of 4/22/2026. Dietary Manager started work with LSP on 4/28/2026. HR director will audit all current contracted staff for negative drug screening results to ensure current compliance. In the event that a current contracted staff member does not meet the negative drug screening results requirement they will not work at LSP until we obtain the negative drug screening results. Moving forward the HR director will ensure that all new contracted staff have the negative drug screening results prior to their start date to ensure they meet the DE negative drug screening requirements.</p> <p>D) The HR Director or her designee will ensure there is a negative drug screening result for all contracted employees by May 25, 2026. After May 25, 2026 and 100% compliance is achieved/maintained, this deficiency will be considered resolved. Audits will continue monthly. Results of audits will be presented at the facility’s QAPI meetings. Audit schedules will be adjusted as deemed necessary.</p> <p><b>3201.5.5.5</b></p> <p>A) During the survey ending on 4/10/26, the Surveyor upon reviewing the Dietary Manager requirements, noted that E8 did not meet the requirements verification that E8 was not listed on the Adult Abuse Registry.</p>	

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	<p><b>Network (DHIN) to transmit the results of a drug test from a DHIN participating laboratory to the employer. An employer that chooses not to engage a DHIN-participating laboratory will certify that a drug test has been secured by checking a box in the BCC. If the box is checked, it constitutes a representation that a drug test which complies with statutory requirements, 11 Del.C. 1142, has been secured prior to hiring.</b></p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Based on interview, review of facility documentation provided to the surveyor and review of the BCC website, it was determined that the facility's contracted staffing agency failed to certify on the BCC website that a drug test was performed prior to hiring one (E8) out of six facility and agency staff reviewed. Findings include:</p> <p>Review of facility documentation provided revealed that E8 (agency dining service manager) was assigned to work at the facility prior to a mandatory drug test screening. E8 lacked evidence of a drug test performed when she was assigned to work in the facility on 2/12/26.</p> <p>4/10/26 9:33 AM – During an interview, E4(HR) confirmed and stated that according to V1 (Agency CEO), E8 did not have a drug screen completed prior to her reporting to the facility on 2/12/26. E4 further stated that V1 did not require mandatory drug screening for E8's employment in Maryland.</p>	<p>B) Though no Residents were negatively impacted, the facility recognizes all Residents have the potential to be affected by this deficient practice. The HR Director and the Administrator have been actively looking for a full time CFPM that meets the requirements, since the last full time Dietary Director resigned without completing her required notice. 4/22/26 HR and Administrator hired their own full time CFPM (making them a staff employee and not a contracted employee) verified they were not listed on the Adult Abuse Registry. Results were received on 4/22/2026. The full time Dietary Director started work with LSP on 4/28/2026.</p> <p>C) Root cause analysis revealed the previous full time Dietary Director, who met the DE requirements, resigned without completing her required notice. This left the facility to find a replacement for the full time Dietary Director meeting the requirements immediately. Although, HR and the administrator were actively looking for a full-time qualified replacement, which are in scarce supply, for the interim, they contracted with a food service company to provide a qualified full time CFPM. The contracted company failed to provide verification to the facility the contracted staff member was not listed on the Adult Abuse Registry. The facility should have verified with the contracted company E8's ability to verify that the contracted employee was not listed on the Adult Abuse Registry prior to E8's start date. 4/22/26 HR and Administrator</p>	

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<p>3105.10.0 3105.10.4 S/S- D</p>	<p>4/10/26 12:00 PM - Finding was discussed with E1 (NHA). 4/10/26 3:10 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (CEO) during the Exit Conference.</p> <p><b>Further Facility/Employer Responsibilities</b></p> <p><b>The employer must ensure that no Applicant is employed without first receiving the results of the Applicant's mandatory drug test.</b></p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Based on review of facility documentation provided to the surveyor and review of the BCC website, it was determined that the facility contracted to work one (E8) out of six facility and agency staff reviewed without first receiving mandatory drug test results. Findings include:</p> <p>2/12/26 – E8's first day in the facility as an agency dining services manager.</p> <p>Review of facility documentation provided revealed that E8 was an agency employee assigned to work as dining services manager effective 2/12/26 with no drug test results.</p> <p>4/10/26 9:33 AM – During an interview, E4(HR) confirmed and stated that according to V1 (Agency CEO), E8 did not have a drug screen completed prior to her reporting to the facility on 2/12/26. E4 further stated that V1 did not require mandatory drug screening for E8's employment in Maryland.</p>	<p>hired their own full time Dietary Manager (making them a staff employee and not a contracted employee) meeting the verification requirements and not listed on the Adult Abuse Registry. A full time Dining Manager's Adult Abuse Registry results were obtained on 4/22/2026 and he started work with LSP on 4/28/2026. HR director will audit all current contracted staff to verify each contracted employee is not listed on the Adult Abuse Registry. In the event that LSP is unable to verify the contracted employee is not listed on the Adult Abuse Registry, they will not work at LSP until verification is obtained. Moving forward the HR director will ensure that verification that new contracted staff are not listed on the Adult Abuse Registry prior to their start date.</p> <p>D) The HR Director or her designee will ensure verification is obtained that the contracted employee is not listed on the Adult Abuse Registry by May 25, 2026. After May 25, 2026 and 100% compliance is achieved/maintained, this deficiency will be considered resolved. Audits will continue monthly. Results of audits will be presented at the facility's QAPI meetings. Audit schedules will be adjusted as deemed necessary.</p>	



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	<p>4/10/26 12:00 PM - Finding was discussed with E1 (NHA).</p> <p>4/10/26 3:10 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (CEO) during the Exit Conference.</p>		

Provider's Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  08A006	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  04/10/2026
NAME OF PROVIDER OR SUPPLIER  JEANNE JUGAN RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE  185 SALEM CHURCH ROAD , NEWARK, Delaware, 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
E0000	Initial Comments  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.	E0000		
F0000	INITIAL COMMENTS  An unannounced annual and complaint survey was conducted at this facility from April 7, 2026, through April 10, 2026. 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 first day of the survey was 21. The investigative sample totaled 15 residents.  Abbreviations/definitions used in this report are as follows:  CEO - Chief Executive Officer;  DON - Director of Nursing;  LPN - Licensed Practical Nurse;  Minimum Data Set (MDS) - standardized assessment forms used in nursing homes;  NHA - Nursing Home Administrator;  ROM - Range of Motion;  RN - Registered Nurse;	F0000		
F0801 SS = F	Qualified Dietary Staff  CFR(s): 483.60(a)(1)(2)  §483.60(a) Staffing  The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service,	F0801	A) During the survey ending on 4/10/26, the Surveyor upon reviewing the Dietary Manager requirements, noted that E8 did not meet the requirements for a full time Certified Food Protection Manager (CFPM).  B) Though no Residents were negatively impacted, the facility recognizes all Residents have the potential to be affected by this deficient practice.	05/25/2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0801 SS = F	<p>Continued from page 1 taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.</p> <p>This includes:</p> <p>§483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-</p> <p>(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.</p> <p>(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.</p> <p>(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.</p> <p>(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.</p> <p>§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.</p> <p>(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-</p> <p>(A) A certified dietary manager; or</p> <p>(B) A certified food service manager; or</p> <p>(C) Has similar national certification for food service</p>	F0801	<p>Continued from page 1</p> <p>The HR Director and the Administrator have been actively looking for a full time CFPM that meets the requirements, since the last full time Dietary Director resigned without completing her required notice. 4/22/26 HR and Administrator hired their own full time CFPM (making them a staff employee and not a contracted employee) meeting the requirements.</p> <p>C) Root cause analysis revealed the previous full time Dietary Director, who met the DE requirements, resigned without completing her required notice. This left the facility to find a replacement for the full time Dietary Director meeting the requirements immediately. Although, HR and the administrator were actively looking for a full-time qualified replacement, which are in scarce supply, for the interim, they contracted with a food service company to provide a qualified full time CFPM. The contracted company failed to provide the facility with a staff member meeting the full time DE requirements. The facility should have verified with the contracted company E8's ability to meet the full time DE requirements prior to E8's start date. 4/22/26 HR and Administrator hired their own full time Dietary Manager (making them a staff employee and not a contracted employee) meeting the requirements. HR and the administrator are also looking for another CFPM to hire, to be present when the full time CFPM is not available.</p> <p>D) The HR Director or her designee will ensure there is a full time CFPM present in the facility daily x 1 week, then three times a week x 3 weeks, and then weekly x4 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 monthly. Results of audits will be presented at the facility's QAPI meetings. Audit schedules will be adjusted as deemed necessary.</p>	05/25/2026

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F0801 SS = F	<p>Continued from page 2 management and safety from a national certifying body; or</p> <p>D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or</p> <p>(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and</p> <p>(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and</p> <p>(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, it was determined that the facility failed to comply with the Delaware Food Code Certified Food Protection Manager Requirements. Findings include:</p> <p>Delaware Food Code:</p> <p>2-102.12 Certified Food Protection Manager</p> <p>(A) At least one employee, the PERSON IN CHARGE at the time of inspection, shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM.</p> <p>4/7/26 – During the survey of the facility at approximately 10:00 AM, an interview with E8 (Dining Services Manager), revealed that there was only one CFPM. E8 works on Tuesdays and Thursdays and for the other days, there is not a CFPM present. Today 4/7/26 E8 left at 1:00 PM.</p> <p>4/7/26 – During an interview with E8 at approximately 11:00 AM, the findings were confirmed.</p> <p>4/10/26 3:10 PM - Findings were reviewed with E1</p>	F0801		05/25/2026

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F0801 SS = F	Continued from page 3 (NHA), E2 (DON) and E3 (CEO) during the Exit Conference.	F0801		05/25/2026
F0812 SS = F	<p>Food Procurement,Store/Prepare/Serve-Sanitary</p> <p>CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements.</p> <p>The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation and interview, it was determined that the facility failed to comply with Delaware Food Code storage and sanitation procedures.</p> <p>Delaware Food Code:</p> <p>3-305.11 Food Storage.</p> <p>(A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD:</p> <p>(1) In a clean, dry location;</p> <p>(2) Where it is not exposed to splash, dust, or other contamination; and</p> <p>(3) At least 15 cm (6 inches) above the floor.</p> <p>4/7/26 – During the survey of the facility at</p>	F0812	<p>A) The turkeys that were noted on the floor of the outdoor freezer were removed from the freezer and disposed in the trash. The sanitation solution in the red bucket, used for food contact surfaces, was adjusted to the appropriate Quat Sanitation level.</p> <p>B) Although no staff or Residents were affected by food items on the floor of the freezer or the PPM level of the sanitation solution for food contact surfaces, all Residents and staff have the potential to be affected by the food items on the floor of the freezer or the PPM level of the sanitation solution.</p> <p>C) Root cause analysis showed that the Dietary Manager was responsible for the walk throughs of the freezer and PPM of the sanitation solution. Due to not having the Dietary Manager available full time, the facility did not have oversight to ensure this was being completed. 4/22/26 a Full time Dietary Manager was hired. It will be the responsibility of the Cook or their designee, to walk through and verify that all food is stored properly in the freezer on a daily basis. It will also be the responsibility of the Cook, to prepare the sanitation bucket prior to each meal prep and to test and document the ppm., assuring that sanitation solution is =&gt;200PPM three times a day, with each red bucket change. It will be the Dietary Manager's responsibility to ensure the Cook is completing the logs on a daily basis. The Dietary Manager and the Inservice Director will work together to ensure all kitchen and dietary staff are in serviced on freezer walk throughs and PPM guidelines on the sanitation solution. They will complete a competency demonstrating understanding. This must be completed by 5/8/26. If not completed by that time frame, kitchen staff will be removed from the schedule until completed. Moving forward all newly hired kitchen/dietary staff will be in serviced on this topic at their new employee orientation.</p> <p>D) The Cook or their designee will walk through and verify that all food is stored properly in the freezer daily. It will also be the responsibility of the Cook, to prepare the sanitation bucket prior to each meal prep and to test and document the PPM, assuring that the sanitation solution is =&gt;200PPM three times a day, with each red bucket change, for food prep surfaces. It will be the Dietary Manager's responsibility to ensure the Cook is completing the logs on a daily basis. The walk throughs will continue on a daily basis, and the sanitation solution audit checks will continue to be three times a day.</p>	05/25/2026

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F0812 SS = F	<p>Continued from page 4 approximately 10:00 AM, an observation of the outdoor walk-in freezer revealed three turkeys were lying on the floor of the outdoor walk-in freezer.</p> <p>4/7/26 – During an interview with E8 and E6 (Cook) at approximately 11:00 AM, the findings were confirmed.</p> <p>7-204.11 Sanitizers, Criteria.</p> <p>Chemical SANITIZERS, including chemical sanitizing solutions generated on-site, and other chemical antimicrobials applied to FOOD-CONTACT SURFACES shall:</p> <p>(A) Meet the requirements specified in 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (Food-contact surface sanitizing solutions)</p> <p>4/7/26 – During the survey of the facility at approximately 10:00 AM, an observation of E8 testing the sanitation solution in the red bucket used to sanitize food prep surfaces, revealed the Quat Sanitation Level of 0PPM. E8 immediately prepped a new bucket, and retesting revealed the appropriate level of 300 PPM of Quat Sanitation solution.</p> <p>4/7/26 – During an interview with E8 at approximately 10:00 AM, the findings were confirmed.</p> <p>4/10/26 3:10 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (CEO) during the Exit Conference.</p>	F0812	<p>Continued from page 4 After 1 month of 100% compliance, this deficiency will be considered resolved. All findings will be reported to the QAPI team.</p>	05/25/2026
F0688 SS = D	<p>Increase/Prevent Decrease in ROM/Mobility</p> <p>CFR(s): 483.25(c)(1)-(3)</p> <p>§483.25(c) Mobility.</p> <p>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and</p> <p>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p>	F0688	<p>A) During the survey ending on 4/10/26, the Surveyor upon reviewing Residents for ROM, noted that R3 did not have her ordered splint in place to her left hand. DON, MD, and ADON decided to change the splint order application time for R3 to be signed off at 7am during am care. That will ensure the splint is applied earlier in the morning prior to religious services or Resident going off the unit.</p> <p>B) Though no Residents were negatively 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 an In service training on Splint use and ROM and have attendees complete a competency to demonstrate understanding on how to put on/take off the splints. CNAs and Nurses, will be required to complete this training. CNAs and Nurses will be reminded to view splint use under the care plan, order screen, and kardex in PCC.</p>	05/25/2026

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F0688 SS = D	<p>Continued from page 5 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and interview it was determined that for one (R3) out of one resident reviewed for ROM the facility failed to ensure devices to prevent further decline in ROM were applied. Findings include:</p> <p>The facility policy on restorative nursing last updated December 2025 indicated, "The interdisciplinary team is responsible for working with residents to assist them in adjusting to their disabilities, to use their prosthetic devices..."</p> <p>Review of R3's clinical record revealed:</p> <p>8/22/24 - A physician's orders was written for R3 to receive a short splint to the left hand in the morning and off before supper. If splint is not tolerated, then apply stretch gauze wrap in a figure 8 pattern from the wrist and around the palm.</p> <p>3/25/25 - An initial evaluation and treatment for physical therapy documented that R3 had severe left-hand contracture.</p> <p>1/13/26- An annual MDS assessment documented that R3 had impairments to both upper extremities (hands) and moderate cognitive impairment.</p> <p>1/28/26 - R3's care plan for Parkinson's Disease was reviewed by the facility's interdisciplinary team. Interventions for the care plan included application of a short splint to the left hand in the morning and off at bedtime as tolerated. If the splint is not tolerated, then apply stretch gauze wrap in a figure 8 pattern from the wrist and around the palm.</p> <p>1/1/26 - 4/9/26 - Review of R3's clinical record revealed only one documented refusal for application of wraps and splints on 3/13/26.</p> <p>4/7/26 10:57 AM - R3 was observed in the common area of the facility without the ordered splint on her left hand. E13 (CNA) confirmed the observation. E13 was unaware that R3 wore a splint.</p> <p>4/8/26 9:22 AM - During a medication pass observation completed by E12 (LPN), R3 was observed without the ordered splint on her left hand.</p>	F0688	<p>Continued from page 5</p> <p>C) Root cause analysis revealed though the facility had the splint easily accessible, the staff were putting it on after the Resident returned from religious services and not during am care. It was also determined that there were times that the Resident refuses her splint or takes it off herself, but the nurses did not document the refusal or self-removal. DON, MD, and ADON decided to change the splint order application time to be signed off at 7am during am care. That will ensure the splint is applied earlier in the morning prior to religious services or Resident going off the unit.</p> <p>D) The In-service Director will ensure all CNAs and nurses have been In-serviced and completed the Splint and ROM competency. Employees will be removed from the schedule until their competency/in-service training is completed after 5/15/26. DON or her designee will do daily audits ensuring Splints are in place or documented refusals are noted until 100% compliance is achieved for 1 week. Then the audit will be completed three times weekly until 100% compliance is achieved for 3 consecutive weeks. Then the audit will be completed weekly, until 100% compliance is achieved for 4 weeks. Then the audit will be conducted monthly x 2 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 QAPI meetings. Audit schedules will be adjusted as deemed necessary.</p>	05/25/2026

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F0688 SS = D	Continued from page 6  4/8/26 1:36 PM - R3 was observed without the ordered splint device on her left hand. E12 (LPN) confirmed that R3 had not worn the ordered splint and had not refused the application of the splint. E12 then applied R3's splint.  4/9/26 10:47 AM - R3's splint was observed on the bedside table while R3 attended religious services.  4/9/26 10:55 AM - During an interview, E14 (CNA) confirmed that R3's splint device had not been applied.  4/9/26 11:11 AM - During an interview, E2 (DON) confirmed that the facility lacked evidence of refusal of R3 to wear ordered splint devices and wraps.  4/10/26 3:10 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (CEO) during the Exit Conference.	F0688		05/25/2026
F0730 SS = D	Nurse Aide Perform Review – 12Hr/Year 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 interview and review of facility documentation, it was determined that the facility failed to ensure that a performance review was completed at least every twelve months for one (E19) out of five sampled employees. Findings include:  4/10/26 10:00 AM - Review of the staff performance evaluations revealed that E19 (CNA) had a hire date of 3/29/22. A record review revealed lack of evidence of a performance evaluation for the past year and was confirmed by E4 (HR).  4/10/26 12:00 PM - Finding was discussed with E1 (NHA)  4/10/26 3:10 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (CEO) during the Exit Conference.	F0730	A) During the survey ending on 4/10/26, the Surveyor upon reviewing the staff performance reviews, noted that E19 did not have a completed performance review 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 affected by this deficient practice. The HR director will conduct a focused review of all Active Employees, who have been employed for more than 90 days, who have not had a performance review within the last 12 months. If any are identified, their supervisor will be required to complete the individual's performance evaluation and submit it to the HR director, prior to the staff members next working day.  C) Root cause analysis revealed the previous Human Resources Director and Previous CNA supervisor, who was a LPN, (supervisor of E19) failed to ensure proper filing of annual evaluations of employees. Although a completed performance evaluation for E19 was located (see attached), it was not signed by both the employee and their supervisor. The HR director and Administrator discussed a need for a consequence for non-compliant supervisors with submitting and reviewing annual evaluations on time and ensuring proper filing and signatures. It was decided written counseling will be conducted with each supervisor that was non-compliant with staff performance review submissions. The backup for CNA evaluations will be the RN supervisor. The HR director or her designee will audit performance	05/25/2026

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F0730 SS = D		F0730	Continued from page 7 reviews on a monthly basis to ensure timely completion for all employees.  D) The HR Director will audit all Active staff, who have been employed for more than 90 days, for performance reviews dated within the last 12 months. The audit will be completed within 3 weeks for 100% compliance. 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 QAPI meetings. Audit schedules will be adjusted as deemed necessary.	05/25/2026