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

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Jeanne Jugan Residence
COMPLETED: April 10, 2025

DATE SURVEY

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 3201.1.0 3201.1.2	**The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced annual and complaint survey was conducted at this facility from April 4, 2025, through April 10, 2025. 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-two (22.) The investigative sample totaled nine (9) residents. **Regulations for Skilled and Intermediate Care Facilities** **Scope** **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 April 10, 2025: F689.	A) During the survey ending on 4/10/25, the Surveyor upon reviewing Residents for accidents, noted that R11 did not have their footrests on their wheelchair while being pushed by staff. R11's footrests were immediately placed on her W/C by the DON. 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 a facility wide In service training on Wheelchair transportation and have attendees complete a competency to demonstrate understanding on how to put on/take off the footrests. Volunteers, Sisters, and staff involved with the Residents, will be required to complete this training. C) Root cause analysis revealed though the facility had the footrests for all the Residents that utilize a W/C, the Residents that are encouraged to pedal to maintain independence did not have their footrests attached to their wheelchair, making it not as easily accessible for staff and Residents to attach when a Resident requested to be pushed in the W/C when fatigued. It was also determined leaving the foot rests on all the time while a Resident is pedaling on their own, can also be a trip/safety hazard.	5/22/25

Provider's Signature Sr Cecile Zeringue Title Adm. Date 5/2/25

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		DON, ADON, and Administrator decided the facility will purchase footrest storage attachment for each W/C. That will make the footrests easily accessible when needed, yet not get in the way causing a trip/fall hazard when not in use. D) The In-service Director will ensure all volunteers, sisters, and staff that are involved with the Residents, have been In-serviced and completed the Wheel chair competency. Employees will be removed from the schedule until their competency/in-service training is completed after 5/8/25. DON or her designee will do daily audits ensuring footrests are on W/Cs and being utilized while Residents are being transported by staff 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.	

Provider's Signature Sr Cecile Zeringue Title Adm Date 5/2/25

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 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility from date April 4, 2025 through April 10, 2025. The facility census was twenty-two (22) on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from April 4, 2025 through April 10, 2025. 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 22. The investigative sample totaled 9 residents. Abbreviations/definitions used in this report are as follows: DON - Director of Nursing; NHA - Nursing Home Administrator; LPN - Licensed Practial Nurse; osteoarthritis - a type of joint disease that results from breakdown of joint cartilage and underlying bone; RN - Registered Nurse;	F 000		

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

Electronically Signed | 04/28/2025

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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F 000	Continued From page 1 BIMS - Basic Inventory of Mental Status, a structured assessment tool aimed at evaluating cognition in the elderly. BIMS score of 0-7 is reflective of severe cogntiion deficit, 8-12 refflects moderate cognition deficit and 13-15 score is reflective of normal cognition; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes;	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined that for one (R11) out of three residents reviewed for accidents, the facility failed to ensure that R11 had footrests on the wheelchair while being transported by staff. Findings included: Review of R11's clinical record revealed: 8/27/18 - R11 was admitted to the facility with diagnoses including, but limited to, osteoarthritis. 12/8/24 2:10 PM - A facility incident report submitted to the Division documented, "Resident was sitting in her wheelchair being pushed by staff to an activity, her left foot/shoe touched the wheelchair wheel, she leaned forward and fell to	F 689	A) During the survey ending on 4/10/25, the Surveyor upon reviewing Residents for accidents, noted that R11 did not have their footrests on their wheelchair while being pushed by staff. R11's footrests were immediately placed on her W/C by the DON. 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 a facility wide In service training on Wheelchair transportation and have attendees complete a competency to demonstrate understanding on how to put	5/22/25

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F 689	Continued From page 2 her knees. Resident noted to have discoloration to her left knee." 12/8/24 - R11's nursing progress note documented resident had pain of 7/10 and discoloration to her left knee. 12/8/24 - Care plan for R11was updated to include that resident use footrests on wheelchair when ambulating longer distances and being pushed by staff. 12/13/24 - The facility follow-up report to the Division documented, "Resident should have footrests in place on her wheelchair for longer distances and being pushed by staff." 1/27/25 - R11's quarterly MDS documented a BIMS score of 15 indicating a cognitively intact status. R11's clinical documents included an impairment to one of her lower extremities and required partial to moderate assistance with mobility in a wheelchair. 4/8/25 8:19 AM - R11 was observed being pushed in wheelchair by a staff member to the 2nd floor dining room. Her legs were crossed and lifted above the floor. The footrests were not observed on the wheelchair during transportation. 4/8/25 9:03 AM - R1 was observed being pushed in wheelchair by a staff member from the 2nd floor dining room. Her legs were crossed and lifted above the floor. The footrests were not observed on the wheelchair during transportation. 4/8/25 3:34 PM - During an interview, R1 stated, "Someone pushes me to the dining room. The footrests are used when I go out and not used in	F 689	on/take off the footrests. Volunteers, Sisters, and staff involved with the Residents, will be required to complete this training. C) Root cause analysis revealed though the facility had the footrests for all the Residents that utilize a W/C, the Residents that are encouraged to pedal to maintain independence did not have their footrests attached to their wheelchair, making it not as easily accessible for staff and Residents to attach when a Resident requested to be pushed in the W/C when fatigued. It was also determined leaving the foot rests on all the time while a Resident is pedaling on their own, can also be a trip/safety hazard. DON, ADON, and Administrator decided the facility will purchase footrest storage attachment for each W/C. That will make the footrests easily accessible when needed, yet not get in the way causing a trip/fall hazard when not in use. D) The In-service Director will ensure all volunteers, sisters, and staff that are involved with the Residents, have been In-serviced and completed the Wheel chair competency. Employees will be removed from the schedule until their competency/in-service training is completed after 5/8/25. DON or her designee will do daily audits ensuring footrests are on W/Cs and being utilized while Residents are being transported by staff until 100% compliance is achieved for 1 week. Then the audit will be completed three times weekly until 100%	

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F 689	Continued From page 3 facility." 4/9/25 9:10 AM - During an interview, E6 (LPN) stated, "Residents usually do use footrests unless being taken out of building. The residents that can self-propel can lift their feet." E6 (LPN) stated that she does not recall any training or in-service on wheelchair transport safety. 4/9/25 9:33 AM - During an interview, E3 (DON) stated, "Residents use footrests when going out of the building." This Surveyor asked E3 if staff received wheelchair transportation training after this incident occurred. E3 stated, "We talked about it with the aide involved, but there was no formal training." The facility failed to ensure R1 had footrests on her wheelchair while being transported by staff. 4/10/25 9:00 AM - Findings were reviewed at the exit conference with E1 (NHA) and E3 (DON).	F 689	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.	