

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

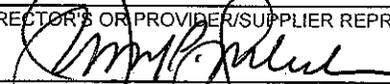
PRINTED: 08/07/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08E027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2009
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NAME OF PROVIDER OR SUPPLIER MARY CAMPBELL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4641 WELDIN ROAD WILMINGTON, DE 19803
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(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
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F 000	INITIAL COMMENTS An unannounced annual survey visit was conducted at this facility from July 27, 2009 through July 30, 2009. 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 three (3) and the survey sample totaled three (3) active residents. One sub-sample resident was included for medication pass observation.	F 000		
F 226 SS=B	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, employee record reviews and staff interview, it was determined that the facility failed to ensure that four (4) of six (6) Resident Care Technicians (RCT 's) staff persons received abuse training on an annual basis (E1 through E5). Findings include: Review of employee files indicated that E1 (hired 4/11/05), E2 (hired 6/23/05), E4 (hired 4/17/06), and E5 (hired 10/30/02) had no evidence the staff had received abuse training on their anniversary dates. All four employees showed that they had their last abuse training on 4/2/08. Review of the facility Policy and Procedure entitled "Investigation of alleged Incidents of	F 226	Those employees identified during the survey as not having abuse, neglect and mistreatment training on or before their anniversary date will receive their training immediately. An audit of Abuse, Neglect and Mistreatment in-service attendance will be conducted (see attachment 2). Employees that have not received training during the past year will be in-serviced. A policy and procedure was developed, (see attachment 3) In-Service Education, stating the requirements for employees. The Staff Educator will maintain a tickler system indicating employee's anniversary dates and education requirements met or not met for record keeping. Mandatory In-services will be offered quarterly to employees. The Staff Educator will review employee in-service attendance monthly.	9/1/09 8/13/09 8/13/09 9/15/09 9/15/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 8/15/09
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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 226	Continued From page 1 Abuse, Neglect, Mistreatment, Financial Exploitation, Misappropriation of Resident property", section E (Training), indicated that, "All employees of the facility will be trained upon hire and at least annually thereafter on facility policies and federal guidelines pertaining to Abuse, Neglect, Mistreatment, Financial Exploitation, and Misappropriation of Resident Property." Interview with the Staff Development Nurse during the survey revealed that abuse training is required to be provided yearly.	F 226	Department Managers and HR Manager will be informed of any employee not in compliance. Data will be reviewed at the quarterly Quality Assurance Committee meeting for effectiveness of plan.	9/15/09
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to administer medications as ordered for one (SSR1) client observed during the medication pass and had an error rate of 8%. Findings include: Observation of medication administration on 7/28/09 at 10:20 AM revealed that staff nurse, E12 crushed two tablets of ciorazepate (anti-anxiety medication) 3.75 mg. (milligram), one tablet of primidone (anti-seizure medication) 250 mg., and two tablets of senna (laxative medication) 50mg. and proceeded to mix these medications with vanilla pudding. In addition, whole capsule of Lyrica (neuropathic pain medication) 50 mg. was added to the above mixture. Observation of the actual administration of the	F 332	A medication error report (see attachment 4) will be completed by any nurse found to have made a medication error. The Medication Error Report Questionnaire is completed by the nurse and the attending physician is notified of the error. The nurse answers a series of questions that will help the nurse to identify what may have caused the deficient practice and increase his/her awareness to prevent further errors. Previous medication error records were reviewed and there were no trends identified exhibiting these deficient practices. The Staff Educator will conduct training for the nursing staff to review the basics of medication administration. This will be completed within 30 days (September 15, 2009).	9/15/09

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F 332	Continued From page 2 above medications revealed SSR1 repeatedly utilized her tongue to expel the spoonfuls of the medication/ pudding mixture placed in the client's mouth. However, the whole capsule of Lyrica was consumed without difficulty. Record review revealed that the above medications were ordered to be given with breakfast. Further record review revealed that the client was more likely to take the medication if it was given in whole form with breakfast when the client was hungry. An interview with E12 on 7/28/09 at 10:40 AM revealed that the client had breakfast earlier the same morning at approximately at 9 AM.	F 332	Medication pass audits (see attachment 5) will be conducted monthly on every shift by the DOHS/ADOHS and or designee to assess the nursing staff's ability to safely administer medications. Any identified deficient practice will be reviewed with the nurse immediately to ensure compliance. There will be a review of the medication errors at the quarterly Quality Assurance Committee meeting. At that time, we will discuss the number of errors and type, identifying any trends, review follow-up training records and the need for additional training. (see attachment 6).		
F 428 SS=D	An interview with the Director of Nursing (DON), E11 on 7/28/09 at 1:30 PM confirmed that the above medications were not administered as ordered. 483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that the monthly drug regimen review by a licensed	F 428	The Pharmacy Consultant will conduct a Medication Drug Regimen review monthly and document findings on the Medication Drug Regimen form provided by the pharmacy and filed in the Physician Order section of each resident's record. In addition to the Medication Drug Regimen, the consultant provides a monthly report with comments and physician recommendations. The Pharmacist Consultant will receive a current resident census form (see attachment 7) upon his arrival. The Pharmacist Consultant will check off the resident's name as he reviews them during his site visit and return form to DOHS/ADOHS prior to exiting the building. The DOHS/ADOHS will discuss any discrepancies with the Consultant at that time. The DOHS/ADOHS and/or designee will review the Pharmacy Consultants Medication Drug Regimen report monthly as well as the Resident Census Form to identify any discrepancies and ensure that all residents have been reviewed.	8/13/09	8/13/09

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F 428	Continued From page 3 pharmacist was conducted for three residents (R1, R2, and R3). Findings include: Review of R2 's record lacked evidence of a monthly drug regime review for November ' 08. In addition, both R1 and R3 's drug regime was not reviewed for March ' 09 due to chart not being available for the pharmacist to review. Interview with the DON, E11 on 7/30/09 at 2 PM confirmed the above findings.	F 428	The Pharmacy Consultant will present the number of records reviewed each month at the quarterly Quality Assurance Committee meeting as well as any other relevant findings. The DOHS will review any discrepancies with the committee at that time, based on the census form information review.	
F 445 SS=F	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation of the laundry area on 7/27/09, and staff interviews, it was determined that the facility failed to handle and distribute linens so as to prevent the spread of infection. Findings include: 1. On 7/27/09 at 10:00 AM, observations of the laundry hot water boiler tank temperature gauges revealed the hot water supply temperature to the washers at 120 degrees Fahrenheit (versus the required temperature of a 160 degrees Fahrenheit minimum). Interview with the facility manager (E9) revealed that a booster may be inside the washers but he was unsure and he did not know how to test the temperature of the water to determine it met the 160 degrees Fahrenheit requirements. A copy of the manufacturer's brochure was requested to determine how this machine should be inspected for hot water	F 445	At this time, our hot water system cannot generate 160 degree water. Contractors will be contacted to evaluate/design 160 degree hot water feed to machine by 8/17/09. Implementation of new system, including a new temperature gauge, will be in place by 9/15/09. The new temperature gauge will be monitored on a weekly basis with the results reviewed at the quarterly Quality Assurance Committee meetings to ensure that standards are being met.	9/15/09

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F 445	Continued From page 4 temperatures and if the washer had a booster. The brochure was not provided at exit. 2. On 7/27/09 at 11:50 AM during the tour with maintenance staff (E9), the exhaust vent of the laundry area in the first floor (by C mechanical room) was not exhausting the air out of the room. On 7/27/09 at 10:45 AM, Charmie Lane exhaust vent was not exhausting in the resident laundry room. Interview with staff (E9) confirmed this finding.	F 445	Renovations in progress during survey have been completed and the exhaust fan in the laundry area is now operational. The resident laundry room fan was inspected and cleaned on 7/28/09 and is now operating properly.	7/28/09
F 467 SS=B	483.70(h)(2) OTHER ENVIRONMENTAL CONDITIONS - VENTILATION The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observations of resident bathrooms, and staff interviews, it was determined that the facility failed to maintain adequate ventilation as reflected by malfunctioning exhaust vents. Findings include: On 7/27/09, the bathroom exhaust vents in resident rooms 2, 6, 7, 8, and 9 were found to have no negative air flow exiting the room through the ceiling exhaust unit. Interview with facility services staff E9 confirmed this finding.	F 467	All laundry room exhaust fans will be inspected for proper operation by 8/21/09. Any found to not be operating properly will be repaired immediately. An audit has been developed for inspection of laundry room exhaust fans that includes use of a paper suction test (attachment 8). The results of these monthly audits will be reviewed at the quarterly Quality Assurance Committee meetings to ensure that standards are being met. Upon discovering some fans were not exhausting immediate action was taken and the problem was corrected. The exhaust duct exit screens to the outside were dirty and were cleaned the next day. The fans are now exhausting properly. All other facility exhaust fans will be inspected for proper operation by 8/21/09.	8/21/09 8/17/09 Quarterly 7/28/09
F 500 SS=C	483.75(h) USE OF OUTSIDE RESOURCES If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an	F 500	During all future monthly room checks, a paper suction test will be performed to ensure proper operation of exhaust system. The Resident Room Safety Audit was updated to reflect this (attachment 9). If any exhaust fans are found to be malfunctioning during the audit, they will be repaired immediately. Also, a yearly cleaning of outdoor insect screens will be performed. The results of these audits will be reviewed at the quarterly Quality Assurance Committee Meeting to assure that standards are being met. The Contract for the Medical Director was obtained and signed and placed in the Contract Book.	8/21/09 8/17/09 Quarterly 7/28/09

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F 500	<p>Continued From page 5 arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section.</p> <p>Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility contract book documentation and staff interviews, it was determined that the facility failed to maintain a contract for the medical director and x-ray services although services were rendered to residents. Findings include:</p> <p>Review of the contract book on 7/27/09 revealed there was no medical director or x-ray services agreement although there was evidence that the facility was providing medical and x-ray services.</p> <p>Interview with the Executive Director (E7) and the director of nursing (E8) confirmed this finding. A contract for the medical director was signed on 7/28/09. A copy of the x-ray contract (which was not available during the survey or exit of the facility) was faxed on 8/4/09. The agreement states the facility entered into a commencement date agreement July 1, 2009.</p>	F 500	<p>The Contract for Mobilex/USA X-Ray Services Contract was obtained and placed in the Contract Book with the commencement agreement date of July 1, 2009. A copy of the Contract for Mobilex/USA X-Ray Services Contract was faxed.</p> <p>A listing of all Contracts with outside professionals providing services to Facility residents was reviewed and updated.</p> <p>A Quality Assurance Audit Tool has been created to list all current Contracts for outside professionals providing services to residents. The audits conducted will assure the Contracts are present, reviewed and current. (See attachment 10 - Quality Assurance Program- Contracts with Outside Professional Providing Services to Residents-Use of Outside Resources)</p> <p>The Assistant Director for Quality Assurance will audit the Contract Book monthly utilizing The Contract Book-Use of Outside Resources Audit Tool. In cases where contracts/agreements are expired, changed or discontinued, the Assistant Director for Quality Assurance will remove the document and forward to the appropriate manager for follow-up.</p> <p>The Assistant Director for Quality Assurance will present audit results at the quarterly Quality Assurance Committee meeting to ensure standards are met.</p>	<p>8/4/09</p> <p>8/12/09</p> <p>8/21/09</p> <p>Monthly</p> <p>Quarterly</p>
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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNPs AND NFs	PROVIDER # 08E027	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 7/30/2009
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F 497	<p>483.75(e)(8) REGULAR IN-SERVICE EDUCATION</p> <p>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. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility employee record reviews and staff interview, it was determined that the facility failed to ensure that two (1) of ten (10) Certified Nursing (also called RCTs, Resident Care Technicians) staff (E6) received their annual evaluation. Findings include:</p> <p>Staff record review on 7/28/09 revealed that E6 did have a performance review (PR) developed but was not signed. In an interview on 7/28/09, the director of nursing stated that the nursing assistant (E6) annual evaluation was not given yet and not signed. On 8/2/09, a copy of the signed PR was faxed to the surveyor.</p> <p>A signed copy of the Certified Nursing Assistant (Resident Care Technician) performance review was faxed. (8/2/09)</p> <p>A copy of the unsigned Certified Nursing Assistant (Resident Care Technician) performance review will be sent via certified mail for review, signature and return. (8/21/09)</p> <p>The Human Resources Department will establish a database for all current Certified Nursing Assistants reflecting their anniversary date. (7/30/09) A Policy and Procedure, "Annual Employee Evaluations" has been developed. (See attachment 1, "Annual Performance Evaluations")</p> <p>The Director of Health Care Services and the Assistant Director of Health Care Services will be notified of any unsigned evaluations that are needed for the employee's personnel file. (8/14/09)</p> <p>The database will be audited quarterly by the Human Resources Department. Health Care Managers will be apprised of any outstanding Certified Nursing Assistant performance reviews in need of signature. Audit results will be shared at the quarterly Quality Assurance Committee meeting. (Quarterly)</p> <p>The Assistant Director for Quality Assurance will conduct a review of the database and six employee personnel record review audits per quarter to assure that the Director of Health Care Services and/or the Assistant Director of Health Care Services completes an annual performance evaluation that is reviewed and signed by each Certified Nursing Assistant. (Quarterly)</p>
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The above isolated deficiencies pose no actual harm to the residents

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LTC Residents Protection
AUG 18 2009
Director's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) SURVEY COMPLETED C 07/30/2009
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W 000

INITIAL COMMENTS

W 000

An unannounced annual survey and complaint visit was conducted at this facility July 27, 2009 through July 30, 2009. The facility census the first day of the survey was 63. The survey sample totaled ten (10) clients.

W 369

483.460(k)(2) DRUG ADMINISTRATION

W 369

The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.

This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to administer medications as ordered for one (SSR1) client observed during the medication pass. Findings include:

Observation of medication administration on 7/28/09 at 10:20 AM revealed that staff nurse, E12 crushed two tablets of clorazepate (anti-anxiety medication) 3.75 mg. (milligram), one tablet of primidone (anti-seizure medication) 250 mg., and two tablets of senna (laxative medication) 50mg. and proceeded to mix these medications with vanilla pudding. In addition, whole capsule of Lyrica (neuropathic pain medication) 50 mg. was added to the above mixture.

Observation of the actual administration of the above medications revealed SSR1 repeatedly utilized her tongue to expel the spoonfuls of the medication/ pudding mixture placed in the client's mouth. However, the whole capsule of Lyrica was consumed without difficulty.

Record review revealed that the above

A medication error report (see attachment 1) will be completed by any nurse found to have made a medication error. The Medication Error Report Questionnaire is completed by the nurse and the attending physician is notified of the error. The nurse answers a series of questions that will help the nurse to identify what may have caused the deficient practice and increase his/her awareness to prevent further errors.

Previous medication error records were reviewed and there were no trends identified exhibiting these deficient practices. The Staff Educator will conduct training for the nursing staff to review the basics of medication administration. This will be completed within 30 days (September 15, 2009).

Medication pass audits (see attachment 2) will be conducted monthly on every shift by the DOHS/ADOHS and or designee to assess the nursing staff's ability to safely administer medications. Any identified deficient practice will be reviewed with the nurse immediately to ensure compliance.

There will be a review of the medication errors at the quarterly Quality Assurance Committee Meeting. At that time, we will discuss the number of errors and type, identifying any trends, review follow-up training records and the need for additional training. (see attachment 3).

9/15/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrators

(X6) DATE

8/16/09

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 369	Continued From page 1 medications were ordered to be given with breakfast. Further record review revealed that the client was more likely to take the medication if it was given in whole form with breakfast when the client was hungry. An interview with E12 on 7/28/09 at 10:40 AM revealed that the client had breakfast earlier the same morning at approximately at 9 AM. An interview with the Director of Nursing (DON), E11 on 7/28/09 at 1:30 PM confirmed that the above medications were not administered as ordered.	W 369			
W 426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by: On 7/27/09 at 11:30 AM, the hot water temperature in resident room 101, 102 103, 107 110, and dining room in Comfort Zone unit hand sinks was measured at 123.8, 123, 122, 122, 121.8 and 117.3 degrees Fahrenheit respectively. The hot water temperature in resident room 101, 107 room showers was measured at 115, 115, and 114 degrees Fahrenheit respectively. Interview with E9 on 7/28/09 indicated the hot water temperatures were measured below 110 degrees Fahrenheit.	W 426	Upon discovering temperatures exceeding 110 degrees, immediate action was taken and the problem was corrected. A contractor was then called in to evaluate/repair water temperature mixing valve. Inspections of the entire facility on 7/28 revealed that no other fixtures available to residents were affected by this issue. An audit form (attachment 4) was modified to reflect that, in five rooms per wing, water temperatures will be checked on a weekly, instead of monthly, basis. If, during the audit, temperatures are found to be too high, they will be adjusted immediately. The results of these audits will be reviewed at the quarterly Quality Assurance Committee meetings to assure that standards are met.	7/27/09 7/28/09 8/13/09 Quarterly	



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care Residents Protection

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3 Mill Road, Suite 308
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STATE SURVEY REPORT

LTC Residents Protection
AUG 18 2009
Director's Office

NAME OF FACILITY: The Mary Campbell Center

DATE SURVEY COMPLETED: July 30, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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The State report incorporates by reference and also cites the findings specified in the Federal reports.

An unannounced annual survey and complaint visit was conducted at this facility July 27, 2009 through July 30, 2009. The facility census the first day of the survey was 63. The survey sample totaled thirteen (13). Ten (10) ICF/MR clients and three (3) Nursing Review Clients.

3201 Regulations for Skilled and Intermediate Care Nursing Facilities

3201.6.0 General Services:

3201.6.1.1 The skilled care nursing facility shall provide to all patients the care deemed necessary for their comfort, safety, nutritional requirements and general well being.

This requirement was not met as evidenced by:

Cross-refer to CMS 2567-L survey date completed 7/30/2009, W369, F332.

A medication error report (see attachment 1) will be completed by any nurse found to have made a medication error. The Medication Error Report Questionnaire is completed by the nurse and the attending physician is notified of the error. The nurse answers a series of questions that will help the nurse to identify what may have caused the deficient practice and increase his/her awareness to prevent further errors. Previous medication error records were reviewed and there were no trends identified exhibiting these deficient practices. The Staff Educator will conduct training for the nursing staff to review the basics of medication administration. This will be completed within 30 days (September 15, 2009). Medication pass audits (see attachment 2) will be conducted monthly on every shift by the DOHS/ADOHS and or designee to assess the nursing staff's ability to safely administer medications. Any identified deficient practice will be reviewed with the nurse immediately to ensure compliance. There will be a review of the medication errors at the quarterly Quality Assurance Committee Meeting. At that time, we will discuss the number of errors and type, identifying any trends, review follow-up training records and the need for additional training. (see attachment 3).

Provider's Signature *[Signature]*

Title Administrator

Date 8/16/09



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3201.7.3.1.3	<p>Plant, Equipment, and Physical Environment:</p> <p>Hot water accessible to residents shall not exceed 110 degrees F.</p> <p>This requirement was not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 7/30/2009, W426.</p>	<p>Upon discovering temperatures exceeding 110 degrees, immediate action was taken and the problem was corrected. A contractor was then called in to evaluate/repair water temperature mixing valve.</p> <p>Inspections of the entire facility on 7/28/09 revealed that no other fixtures available to residents were affected by this issue.</p> <p>An audit form was modified (attachment 4) to reflect that, in five rooms per wing, water temperatures will be checked on a weekly, instead of monthly, basis. If, during the audit, temperatures are found to be too high, they will be adjusted immediately. The results of these audits will be reviewed at the quarterly Quality Assurance Committee meetings.</p>
3201.7.6.1	<p>Sanitation and Laundry:</p> <p>The facility shall provide for the safe storage of cleaning materials, pesticides and other potentially toxic materials.</p> <p>This requirement was not met as evidenced by:</p> <p>1. On 7/27/09 at 9:50 AM, a cleaning cart was observed in the dock with chemicals such as disinfectant and lemon drop was accessible and unlocked. On 7/27/09 at 10:05 AM, the "C" mechanical room across kitchen was observed unlocked. The room was storing cleaning chemicals such as Oasis 144 sanitizer, Oasis 133, and Ecolab wash bottles.</p>	<p>Cleaning chemicals were removed from accessible areas throughout the facility on 7/28/09. The E-Zee Street Soiled Utility room was locked by The Executive Director on 7/28/09 and staff was instructed to keep the room locked. All housekeeping and utility staff were advised that chemicals must remain secured (attachment 5). Housekeeping policies and procedures to this effect were updated on 8/10/09 (attachment 6) and all housekeeping/utility staff will receive formal training of revised policies by 8/21/09.</p>



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	<p>On 7/27/09 a closet in the Charmie Lane dining room was observed storing white board cleaner, Epicleaner, syringes with converter tips.</p> <p>On 7/27/09 at 11:10 AM, the janitor closet door in the Ezee Street unit was observed unlocked and contents accessible (such as disinfectant spray cans, three dial bottles (liter), spic-and-span disinfectant 32 oz. bottle, acid bowl cleaner (quart), gallon of bleach. Additionally, a housekeeping cart with chemicals on the top was observed in the hallway of the Ezie street unlocked and accessible to residents and children.</p> <p>On 7/28/09 at 12:45 PM, hazardous cleaning chemicals were observed on the Ezee Street resident medicine waiting area nurses station under the sink cabinet.</p> <p>On 7/28/09 at 2:15 PM, a cleaning cart was observed with hazardous cleaning chemical contents accessible to residents and children on the Comfort Inn unit. The staff was observed cleaning the wall of the dining area with a rag (by room 12-1).</p> <p>4. On 7/27/09, 7/28/09, and 7/29/09, the Ezee street soiled linen room was observed unlocked and contents accessible. A box of biohazards</p>	<p>The facility floor plan was reviewed and all doors and cabinets that will be used for chemical storage identified on 8/11/09. A contracted vendor was contacted and assessed all doors in question on 8/11/09 and will submit recommendations for installation of keypad locks. Locks will be installed on all identified doors by 9/15/09. Housekeeping carts will be fitted for locked compartments where all chemicals will be stored when not in use by 9/15/09.</p> <p>A Quality Assurance Audit tool has been developed (attachment 7) and will be implemented a minimum of four times per month to monitor compliance with proper storage of chemicals. Results of audits will be reviewed at quarterly Quality Assurance Committee meetings.</p>



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3201.7.6.3.1	<p>materials containing bags of wet contents, used-up needle boxes.</p> <p>For on -site laundry processing, the facility shall:</p> <p>Provide a room under negative air pressure for receiving, sorting, and washing soiled linen. Washers must be supplied with hot water of 160 degrees F.</p> <p>This requirement was not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 7/30/2009, F445.</p>	<p>At this time, our hot water system cannot generate 160 degree water.</p> <p>Contractors will be contacted to evaluate/design 160 degree hot water feed to machine by 8/17/09. Implementation of new system, including a new temperature gauge, will be in place by 9/15/09.</p> <p>The new temperature gauge (attachment 8) will be monitored on a weekly basis with the results reviewed at the quarterly Quality Assurance Committee meetings to ensure that standards are being met.</p>