

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/31/2019
NAME OF PROVIDER OR SUPPLIER MARY CAMPBELL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4641 WELDIN RD WILMINGTON, DE 19803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments	E 000			
	An unannounced annual and complaint survey was conducted at this facility from January 28, 2019 through January 31, 2019. The facility census the first day of the survey was 67 (sixty-seven). During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73.				
W 000	INITIAL COMMENTS	W 000			
	For the Emergency Preparedness survey, no deficiencies were cited.				
	An unannounced annual and complaint survey was conducted at this facility from January 28, 2019 through January 31, 2019. 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 the first day of the survey was 67. The sample size totaled 11 residents.				
	Abbreviations/definitions used in this report are as follows:				
	AED - Assistant Executive Director; ADON - Assistant Director of Nursing; ED - Executive Director; CM - Case Manager; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA- Nursing Home Administrator; NM - Nurse Manager; RN - Registered Nurse; RCT - Resident Care Technician;				

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

TITLE

(X6) DATE

02/19/2019

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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W 000	Continued From page 1 QIDP - Qualified Intellectual Disabilities Professional;	W 000			
W 129	<p>Comprehensive Functional Assessment - An assessment involving resident and all professions involved in their care and services; EMR - electronic medical record; Tylenol - over the counter pain medication.</p> <p>PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy.</p> <p>This STANDARD is not met as evidenced by: Based on observation, it has been determined that the facility failed to maintain personal privacy for one (C11) out of 11 clients reviewed, by discussing C11's medical needs in front of other clients and a visitor. Findings include:</p> <p>1/29/19 - During a random lunch observation between 12:10 PM and 12:35 PM on the Charmie Lane unit, E11 (RCT) was assisting C11 and loudly asked E10 (LPN), "Can you give C11 Tylenol? She's pulling on her left ear and when she does that, it's because it is hurting." E11 was in the center of the room and this surveyor was on one side of the room, while E10 was on the other side of the room at the time. There were a total of 12 clients, 6 staff members and 1 visitor in the dining room at the time.</p> <p>1/31/19 at 1:40 PM - Reviewed and confirmed with E1 (NHA, ED), E2 (AED) and E3 (DON) at</p>	W 129		3/15/19	

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W 129	Continued From page 2 exit conference.	W 129			
W 331	<p>NURSING SERVICES CFR(s): 483.460(c)</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on record review, interview and observations, it was determined for one (C3) out of 11 sampled residents, the facility failed to ensure shower equipment was used properly which resulted in a fall. Furthermore, C3 was moved from the floor to the shower gurney after the fall before being assessed by a nurse. Findings include:</p> <p>The following was reviewed in C3's clinical record:</p> <p>No Date: Owner's Manual for the shower stretcher/gurney "Warnings - Do not allow user to lean out of the device or shift weight in any manner, which may pose a tipping risk to the user or device. Always use your device's safety belt if a belt was provided."</p> <p>6/30/18 at 7:40 PM - Facility Incident Report - documents, that while C3 was receiving a shower the following occurred: E6 (Resident Care Technician) repositioned C3 to wash his/her back and C3 extended their arms pressing against the wall causing C3 to roll to the floor; E6 transferred C3 back to the gurney and called the nurse to assess; C3 sustained an abrasion to the left side of forehead; C3 was sent to the hospital for</p>	W 331		3/15/19	

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W 331	<p>Continued From page 3 further evaluation.</p> <p>7/9/18 - The nursing instructions for bathing was updated to include recommendations from therapy stated: use shower gurney; use bath blanket on gurney; use gurney; belt for safety. The nursing instructions also included C3 is totally dependent with a one person physical assist with bathing and for transfer is totally dependent two person physical assist, and mechanical lift for transfer.</p> <p>1/28/19 at 10:00 AM - An observation of a shower gurney in the hall on EZ Street unit revealed it was missing a part of the safety belt on the left side.</p> <p>1/28/19 at 10:30 AM - An interview with E8 (RCT) revealed the shower gurney in the hall was the only shower gurney on EZ Street unit after checking all the rooms.</p> <p>1/29/19 in the afternoon - An interview with E7 (Nurse Manager) revealed that the shower gurney observed on the unit was the one used by C3 and confirmed the left side of safety belt was missing. E7 stated the gurney might be out of service for maintenance repair. E7 later returned with a maintenance slip dated 1/28/19 confirming that it was waiting for repair of the safety belt. The safety belt was repaired within an hour of interview with E7.</p> <p>1/30/19 at 3:30 PM - During an interview E6 (RCT) revealed that on 6/30/19 when showering C3, E6 turned C3 to side to wash his/her back. C3 extended arms toward the wall and slipped off the shower gurney and onto the floor. E6 confirmed the side rail on that side was down</p>	W 331		

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W 331	<p>Continued From page 4</p> <p>while bathing and there was no safety belt in use. E6 further revealed C3 was moved from the floor back to the gurney before calling the nurse to evaluate C3.</p> <p>1/31/19 at 11:00 AM - During an interview with E3 (DON) it was revealed that the practice for using the shower gurney was that side rails are engaged in the up position when showering residents.</p> <p>1/31/19 at 11:50 AM - During an interview E3 (DON) revealed that the standard of practice for a fall is to leave the resident in that position and a nurse would assess the resident before being moved.</p> <p>R3 sustained a fall due to staff leaving the side rail down when repositioning the resident on the gurney.</p> <p>1/31/19 at 1:40 PM - Reviewed and confirmed with E1 (NHA, ED), E2 (AED) and E3 (DON) at exit conference.</p>	W 331			



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Mary Campbell Center

DATE SURVEY COMPLETED: January 31, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<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 January 28, 2019 through January 31, 2019. 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 the first day of the survey was 67. The sample size totaled 11 residents.</p> <p>Abbreviations/definitions used in this report are as follows:</p> <p>AED - Assistant Executive Director; ADON - Assistant Director of Nursing; ED - Executive Director; CM - Case Manager; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA- Nursing Home Administrator; NM - Nurse Manager; RN - Registered Nurse; RCT - Resident Care Technician; QIDP - Qualified Intellectual Disabilities Professional;</p> <p>Comprehensive Functional Assessment - An assessment involving resident and all professions involved in their care and services; EMR - electronic medical record; Tylenol - over the counter pain medication.</p> <p>During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality,</p>		

Provider's Signature *Regina J. Coffey* Title Executive Director Date 2-18-19



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STATE SURVEY REPORT

NAME OF FACILITY: Mary Campbell Center

DATE SURVEY COMPLETED: January 31, 2019

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>3201.6.0</p> <p>3201.6.10</p> <p>3201.6.10.1</p> <p>3201.6.10.1.3</p> <p>3201.6.10.1.4</p> <p>3201.6.10.1.4.1</p>	<p>Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey completed January 31, 2019: W159 and W331.</p> <p>Services To Residents</p> <p>Infection Control</p> <p>Infection Control Committee</p> <p>The infection control committee shall establish written policies and procedures that describe the role and scope of each department/service in infections prevention and control activities.</p> <p>The Committee is responsible for the development and coordination of policies and procedures to accomplish the following:</p> <p>Prevent the spread of infections and communicable diseases.</p> <p>This requirement is not met as evidenced by:</p>	<p><u>State Tag 3201.6.10.1.4.1 – Services to Residents</u></p> <p><i>"The infection control committee shall establish written policies and procedures that describe the role and scope of each department/service in infections prevention and control activities."</i></p> <p><i>"The Committee is responsible for the development and coordination of policies and procedures to accomplish the following: Prevent the spread of infections and communicable diseases."</i></p> <p>SECTION A (Individual Impacted) Nebulizer mask and tubing was immediately removed from R5's room and discarded.</p> <p>SECTION B (Identification of other residents) Residents with orders for nebulizer treatments have the potential to be affected by this practice. Equipment for residents with current orders for nebulizer treatments was inspected to ensure it was dated within the last seven days.</p>	

Provider's Signature _____ Title _____ Date _____



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	<p>Based on observation and an interview, it was determined that the facility failed to establish a written infection prevention and control, for one (R5) of 10 sampled residents receiving respiratory care services. Findings include:</p> <p>1/29/19 at approximately 1:30 PM – During a random observation of R5’s room, a nebulizer set, which included the nebulizer mask and the tubing, with a date of 1/18/19 was in a plastic bag, located next to a nebulizer machine.</p> <p>1/29/19 at approximately 2:00 PM – A joint observation with E9 (RN, NM) confirmed that the facility’s practice was to dispose of the nebulizer set every 7 days, thus, this respiratory equipment should have been disposed on 1/25/19. E9 confirmed that R5 had a current, as needed order for nebulizer treatment, however, the last administration was on 1/25/19 at 10:00 PM.</p> <p>1/31/19 at approximately 11:35 AM – An interview with E3 (DON) confirmed that the nebulizer set should have been disposed on 1/25/19. E3 verbalized that she was uncertain if the facility had a policy, which indicated to dispose the nebulizer set after 7 days and would follow-up with the surveyor if there was such a policy.</p> <p>1/31/19 at approximately 1:40 PM - Findings were reviewed with E1 (ED), E2 (AED), and E3 (DON). No further information was provided to the surveyor.</p>	<p>SECTION C (System Changes) Physician orders for nebulizer treatments will be updated to include instructions to change mask assemblies weekly and to discard outdated equipment. The Nebulizer Equipment Policy (Attachment A) was revised to include instructions for discarding equipment after seven days. The Staff Educator/designee will re-educate licensed nursing staff on the appropriate care of nebulizer equipment. (Attachment B – Training Materials)</p> <p>SECTION D (Success Evaluation) An audit tool has been developed (Attachment C) which targets licensed nursing staff compliance with disposal of nebulizer equipment every seven days. Audits of nebulizer equipment will be performed by the Neighborhood Nurse Manager or designee weekly until 100% compliance is maintained for four consecutive weeks. Then, audits of nebulizer equipment will be performed monthly until 100% compliance is maintained for three consecutive months. Audit results will be reviewed quarterly by the Quality Assessment and Assurance Committee.</p>	<p>3/15/19</p>