

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

**LTC Residents Protection**  
**DEC 07 2009**  
**Director's Office**

PRINTED: 11/23/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>08G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/10/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>STOCKLEY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>26351 PATRIOTS WAY GEORGETOWN, DE 19947</b>
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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 000	<b>INITIAL COMMENTS</b>	W 000		
W 128	<p>An unannounced annual survey and complaint visit was conducted at this facility from November 2, 2009 through November 10, 2009. The deficiencies contained in this report are based on observation, interviews, review of clients' records and review of other facility documentation as indicated. The facility census the first day of the survey was seventy-two (72). The survey sample totaled ten (10) client and two (2) sub-sampled residents for focused review.</p> <p><b>483.420(a)(6) PROTECTION OF CLIENTS RIGHTS</b></p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview it was determined that for one (C7) out of 10 sampled clients the facility failed to ensure the client was free from an unnecessary drug and physical restraint for medical and dental appointments and failed to ensure an active treatment program was in place to decrease the use of the restraints. Findings include:</p> <p>Cross refer W297 and W312.</p> <p>C7 had a restraint service plan for the use of a physical restraint (papoose board) for some dental procedures and a drug (sonata, a hypnotic medication to induce sleep) for medical / dental appointments. The client used the papoose board</p>	W 128	<p><b>W128</b></p> <p>The interdisciplinary team met on 11/23/09 and reviewed strategies to implement for Resident C7 to reduce his dependency on drugs and physical restraint during medical and dental appointments. The plan will be developed, staff trained, and all components made part of his ELP by 1/1/2010. <b>1/1/2010 and ongoing</b></p> <p>A review of Medical Dental packets has been completed and other residents needing an active treatment program to reduce use of drugs and physical restraints during medical/dental appointments will be reviewed by their interdisciplinary team and strategies implemented by 1/15/2010. <b>1/15/2010 and ongoing</b></p> <p>A standardized outline of suggested strategies that can be individualized will be made available for interdisciplinary teams to use in program planning to reduce dependency on drugs and physical restraints. <b>1/15/2010</b></p> <p>The Programming and Medication Review Committee will be reminded of their responsibility to provide a technical review of the plan to ensure</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Adelle Mears Wembler</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>12-2-09</i>
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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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W 128	Continued From page 1 on 11/19/08 and the sonata on 11/19/08 and 1/22/09.  Record review revealed that until July 2008 the facility had an outside contractor with the support of staff implementing a program called "Practice without Pressure" to reduce the use of physical restraints and drugs for medical / dental treatment. Interviews on 11/9/09 with the QMRP (E2) and Administrator (E1) revealed that there were no programs or procedures put in place to replace the Practice program. It was confirmed in these interview that C7 had no plan in place to reduce the use of the physical and drug restraints for medical /dental treatment.	W 128	programmatic plans are in place to decrease the use of drugs and physical restraints before they approve requests. <b>12/2/09 and ongoing</b>  The QMRP will establish an objective regarding the use of drugs and restraints for each resident and address the progress through their monthly reviews. <b>1/15/2010 and ongoing</b>  The Office of Quality Management will complete spot checks of the medical/dental restraint packets for required programs and implementation. <b>2/1/2010 and ongoing</b>		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.  This STANDARD is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to implement the facility's written policies and procedures, thus, failed to identify an allegation of neglect for one (C4) out of 10 sample clients. Findings include:  Review of the facility's incident report dated 11/19/08 documented that a certified nursing assistant (CNA), E8 reported that she had observed another CNA, E9 give water to C4. E8 documented that E9 replied that "we've been giving it to him". "Later, (name of Registered Nurse) E10 came to E8 and told me that she (E10) gives him food and C4 is doing good and she would bring it up at the high priority meeting."	W 149	<b>W149</b> The specific case was re-reviewed by the Executive Director on November 16, 2009. The entire case was reported to LTCRP investigative unit on November 19, 2008, their findings which were received April 7, 2009, including that they did not substantiate any neglect. This was also reflected in the letter to the family member. The appropriate corrective measures will be taken with the nurse involved by <b>12/18/09</b>  This is an isolated incident. All other cases from November 2008 through November 2009 were reviewed and no other deficiencies were found. <b>11/12/09</b>  A memo was sent out to all nurses regarding following physician's orders. <b>Exhibit A 11/25/09</b>  The Director of Nursing will be added to the automatic reporting of PM 46 cases at the time it is reported to LTCRP. They will also receive the findings of the cases. The reported incidents will continue to be brought to the facility's Executive		

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W 149	Continued From page 2  The review of the Department of Health and Social Services policy and procedure titled PM 46 included a standard of taking actions to protect the client from further harm.  Review of the facility's investigative file/PM 46 dated 11/26/08 included a physician's order dated 7/11/08 to discontinue any food or water, "NPO" (nothing by mouth) due to C4's inability to swallow without aspirating. The file included a written statement from E10 dated 11/20/08 which documented that E10 had fed C4 a small amount of pureed food using techniques utilized by the speech therapist.  An interview with the Executive Director (E1) on 11/10/09 at approximately 11:45 AM revealed that the facility failed to determine that E10 fed C4 without a physician's order.	W 149	Staff meetings for review and any other recommendations or follow-up.  <b>11/25/09 and ongoing</b>  The Executive Director and Office of Quality Management, will at least quarterly, review the Administrative Incident Reports and PM 46 Investigations including findings received from LTCRP and the follow-up to be completed by the facility staff. <b>2/1/10 and ongoing</b>  Nurse Supervisors will review records periodically to ensure adherence to all physician's orders. <b>1/25/2010 and ongoing</b>	
W 153	<b>483.420(d)(2) STAFF TREATMENT OF CLIENTS</b>  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.  This STANDARD is not met as evidenced by: Based on record review and interview it was determined that for one sub-sampled client (C11) the facility failed to immediately report an injury of unknown source. Findings include:  Review of an incident report concerning C11 dated 6/29/09 and timed 3:50 PM documented	W 153	<b>W153</b> After the licensing survey, the therapist provided documentation that the incident had been reported to them, but did not document in the resident's record. The therapist will be asked to complete a late entry in the resident's record. <b>Exhibit B 12/4/09</b>  Also review of the same documentation forwarded via e-mail revealed that the incident was reported to the QMRP on 6/29/09 at the same time it was reported to the therapist. <b>Exhibit B 6/29/09</b>  The facility has reviewed Administrative Incident Reports from November 2008 through November 2009 and found no other incidents. <b>11/12/09 &amp; ongoing</b>  The facility also reports injuries of unknown source based on the December 16, 2004, CMS clarification of injuries of unknown source. This states "An injury should be classified as an injury of unknown source when both of the following conditions are met:	

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W 153	Continued From page 3 staff found a bruise that measured 7 by 4 inches, dark red to purple in color with greenish edges to the right buttock / hip area. It further noted that a bruise to this area was noted on 6/24/09 to the same area but smaller in size. There was no evidence of an incident report for that bruise.  The report noted immediate notification to the administrator / executive director (E1) but the state agency was not notified. This was confirmed in interview on 11/11/09 with E1.	W 153	<ul style="list-style-type: none"> <li>• The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; <b>and</b></li> <li>• The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries at one particular point in time or the incidence of injuries over time."</li> </ul>	
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS  The facility must have evidence that all alleged violations are thoroughly investigated.  This STANDARD is not met as evidenced by: Based on record review and interview it was determined that for one sub-sampled client (C11) the facility failed to thoroughly investigate an injury of unknown source. Findings include:  Review of an incident report concerning C11 dated 6/29/09 and timed 3:50 PM documented that staff found a bruise that measured 7 by 4 inches, dark red to purple in color with greenish edges to the right buttock / hip area. It further noted that a bruise to this area was noted on 6/24/09 to the same area but smaller in size. There was no evidence of an incident report for that bruise.	W 154	The facility will ensure that all documentation relative to the incidents is received and maintained in the file. The Executive Director will send out needed follow-up issues to the Program Administrator, QMRP, Director of Residential Services and Director of Nursing for all Administrative Incident Reports. <b>11/25/09 and ongoing</b>  The Executive Director and Office of Quality Management, will at least quarterly, review the Administrative Incident Reports and PM 46 Investigations including findings received from LTCRP and the follow-up to be completed by the facility staff. <b>2/1/10 and ongoing</b>	
	The incident report indicated the QMRP (E4) and the PT/OT therapist (E5) were notified and therapy would investigate since it appeared to happen during transfer. An interview with the QMRP on 11/9/09 revealed she was not made		<b>W154</b> After the licensing survey, the therapist provided documentation that the incident had been reported to them but did not document in the resident's record. The therapist will be asked to complete a late entry in the resident's record. <b>Exhibit B 12/4/09</b>  Also review if the same documentation forwarded via e-mail revealed that the incident was reported to the QMRP on 6/29/09 at the same time it was reported to the therapist. <b>Exhibit B 6/29/09</b>	

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W 154	Continued From page 4 aware of the bruise until 7/1/09 when the facility investigator came to the unit to ask questions.  An interview with the facility investigator (E3) on 11/10/09 revealed he talked to three staff, made notes but did not take any statements and reported back to the administrator via e-mail. The e-mail concluded that it was unlikely that the bruising occurred during a seizure and that it probably happened during a mechanical lift transfer with the bedrails left up.  An interview with the therapist (E5) on 11/9/09 revealed that she had not been made aware of the incident and had not received a referral to look into the incident.  The facility lacked evidence of a thorough investigation of this large bruise of unknown source.	W 154	The facility has reviewed Administrative Incident Reports from November 2008 through November 2009 and found no other incidents.  <b>11/12/09 and ongoing</b>  The facility also reports injuries of unknown source based on the December 16, 2004, CMS clarification of injuries of unknown source. This states "An injury should be classified as an injury of unknown source when both of the following conditions are met: <ul style="list-style-type: none"><li>• The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and</li><li>• The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries at one particular point in time or the incidence of injuries over time."</li></ul>	
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS  If the alleged violation is verified, appropriate corrective action must be taken.  This STANDARD is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to identify from a staff statement that a physician's order was not followed. In addition, the facility failed to implement appropriate corrective action when intentional action by a staff person resulted in neglect for one (C4) out of 10 sampled clients. Findings include:  Cross refer W149. Review of the facility's investigative file/PM 46	W 157	The facility will ensure that all documentation relative to the incidents is received and maintained in the file. The Executive Director will send out needed follow-up issues to the Program Administrator, QMRP, Director of Residential Services and Director of Nursing for all Administrative Incident Reports.  <b>11/25/09 and ongoing</b>  The Executive Director and Office of Quality Management, will at least quarterly, review the Administrative Incident Reports and PM 46 Investigations including findings received from LTCRP and the follow-up to be completed by the facility staff.  <b>2/1/10 and ongoing</b>	

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W 157	Continued From page 5 dated 11/26/08 revealed that C4 had a physician's order dated 7/11/08 to discontinue any food or water, "NPO" (nothing by mouth) due to C4's inability to swallow without aspirating. The file included evidence (a written statement) from a staff nurse (E10) dated 11/20/08 which documented that E10 had fed C4 small amount of pureed food even though C4 had an order for no oral feeding.  Although the administrator (E1) reviewed the investigative file/PM46 on 12/1/08, the facility failed to identify that E10 failed to follow the physician's order of NPO, thus, failed to determine and implement appropriate corrective action for the above incident.  Findings reviewed with E1 on 11/10/09 at approximately 11:45 AM.	W 157	<b>W157</b> The specific case was re-reviewed by the Executive Director on November 16, 2009. The entire case was reported to LTCRP investigative unit on November 19, 2008, their findings which were received April 7, 2009, including that they did not substantiate any neglect. This was also reflected in the letter to the family member. The appropriate corrective measures will be taken with the nurse involved by  This is an isolated incident. All other cases from November 2008 through November 2009 were reviewed and no other deficiencies were found.  The Director of Nursing will be added to the automatic reporting of PM 46 cases at the time it is reported to LTCRP. They will also receive the findings of the cases. The reported will continue to be brought to the facility's Executive Staff meetings for review and any other recommendations or follow-up.  The Executive Director and Office of Quality Management, will at least quarterly, review the Administrative Incident Reports and PM 46 Investigations including findings received from LTCRP and the follow-up to be completed by the facility staff.	<b>12/18/09</b>  <b>11/12/09</b>  <b>11/25/09 and ongoing</b>  <b>2/1/10 and ongoing</b>	
W 297	483.450(d)(1)(iii) PHYSICAL RESTRAINTS  The facility may employ physical restraint as a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.  This STANDARD is not met as evidenced by: Based on record review and interview it was determined that for one out of ten sampled clients the facility failed to ensure that the use of a physical restraint was absolutely necessary for some dental procedures. The facility failed to implement a plan to reduce or discontinue the use of a papoose board on C7 for some dental procedures. Findings include:	W 297			

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W 297	<p>Continued From page 6</p> <p>C7 had a Medical/Dental Appointment Restraint Request/Service Plan dated 6/12/08 that included the use of a papoose board (a board with straps used to prevent client from moving) for some dental procedures so that (C7) does not cause injury to himself or others for example grabbing the instruments, pinching, scratching, etc. The plan for decreasing the use of restraints included a service plan that addressed tooth brushing and use of sedation for dental procedures and participation in the Practice without Pressure Program (program designed to desensitize clients slowly over time to certain procedures to reduce or eliminate the use of physical and chemical restraints).</p> <p>C7 was sedated and papooseed for a dental procedure on 11/19/08. The Practice without Pressure Program was discontinued at the facility in July of 2008. According to interviews with the QMRP (E2) and Administrator (E1) it was revealed that no program was put in place to replace the Practice without Pressure Program.</p> <p>Review of the record and interview with the QMRP (E2) on 11/9/09 confirmed that there was no individual program plan in place to reduce the use of physical and chemical restraints for dental appointments. There was no evidence that the facility implemented efforts to provide desensitization training or other behavioral and environmental changes to reduce the use of the physical restraint.</p> <p>This restraint service plan was renewed on 3/11/09 for the term of one year with no additional approaches to reduce the use of the papoose board.</p>	W 297	<p><b>W297</b></p> <p>The interdisciplinary team met on 11/23/09 and reviewed strategies to implement for Resident C7 to reduce his dependency on drugs and physical restraint during medical and dental appointments. The plan will be developed, staff trained, and all components made part of his ELP by 1/1/2010. <b>1/1/2010 and ongoing</b></p> <p>A review of Medical Dental packets has been completed and other residents needing an active treatment program to reduce use of drugs and physical restraints during medical/dental appointments will be reviewed by their interdisciplinary team and strategies implemented by 1/15/2010. <b>1/15/2010 and ongoing</b></p> <p>A standardized outline of suggested strategies that can be individualized will be made available for interdisciplinary teams to use in program planning to reduce dependency on drugs and physical restraints. <b>1/15/2010</b></p> <p>The Programming and Medication Review Committee will be reminded of their responsibility to provide a technical review of the plan to ensure programmatic plans are in place to decrease the use of drugs and physical restraints before they approve requests. <b>ongoing</b></p> <p>The QMRP will establish an objective regarding the use of drugs and restraints for each resident and address the progress through their monthly reviews. <b>1/15/2010 and ongoing</b></p> <p>The Office of Quality Management will complete spot checks of the medical/dental restraint packets for required programs and implementation. <b>2/1/2010 and ongoing</b></p>	

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W 312	<p><b>483.450(e)(2) DRUG USAGE</b></p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview it was determined that C7 had a Medical/Dental Appointment Restraint Request / Service Plan dated 6/12/08 for the use of Sonata (hypnotic/sleep medication) up to 30 mg or Ativan (anxiety medication) up to 6 mg with the objective of having medical/dental services such as clinics, diagnostic tests and treatments in a safe manner. The plan for decreasing the use of restraints included a service plan that addressed tooth brushing and use of sedation for dental procedures and participation in the Practice without Pressure Program (program designed to desensitize clients slowly over time to certain procedures to reduce or eliminate the use of physical and chemical restraints).</p> <p>The client used Sonata before optometry clinic on three occasions in 2008 and one in January 2009. Sonata was used for a dental visit 11/19/08 along with a physical restraint (papoose board).</p> <p>Review of the record and interview with the QMRP (E2) on 11/9/09 confirmed that there was no individual program plan in place to reduce the use of physical and chemical restraints for medical and dental appointments. There was no evidence that the facility implemented efforts to provide desensitization training or other</p>	W 312	<p><b>W312</b></p> <p>The interdisciplinary team met on 11/23/09 and reviewed strategies to implement for Resident C7 to reduce his dependency on drugs and physical restraint during medical and dental appointments. The plan will be developed, staff trained, and all components made part of his ELP by 1/1/2010.</p> <p style="text-align: right;"><b>1/1/2010 and ongoing</b></p> <p>A review of Medical Dental packets has been completed and other residents needing an active treatment program to reduce use of drugs and physical restraints during medical/dental appointments will be reviewed by their interdisciplinary team and strategies implemented by 1/15/2010.</p> <p style="text-align: right;"><b>1/15/2010 and ongoing</b></p> <p>A standardized outline of suggested strategies that can be individualized will be made available for interdisciplinary teams to use in program planning to reduce dependency on drugs and physical restraints.</p> <p style="text-align: right;"><b>1/15/2010</b></p> <p>The Programming and Medication Review Committee will be reminded of their responsibility to provide a technical review of the plan to ensure programmatic plans are in place to decrease the use of drugs and physical restraints before they approve requests.</p> <p style="text-align: right;"><b>ongoing</b></p> <p>The QMRP will establish an objective regarding the use of drugs and restraints for each resident and address the progress through their monthly reviews.</p> <p style="text-align: right;"><b>1/15/2010 and ongoing</b></p> <p>The Office of Quality Management will complete spot checks of the medical/dental restraint packets for required programs and implementation.</p> <p style="text-align: right;"><b>2/1/2010 and ongoing</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>08G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/10/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>STOCKLEY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>26351 PATRIOTS WAY GEORGETOWN, DE 19947</b>
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W 312  W 455	<p>Continued From page 8 behavioral and environmental changes to reduce the use of the chemical restraint.</p> <p><b>483.470(I)(1) INFECTION CONTROL</b></p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on staff observation, it was determined that staff failed to maintain good hygiene practices. Findings include:</p> <ol style="list-style-type: none"> <li>1. During medication pass observation on 11/9/09 at approximately 10 AM, staff nurse (E12) retrieved an empty medication package from the trash bag for SSR#2. Without washing her hands, E12 proceeded to open two capsules of cranberry supplements and one capsule of doxycycline hyclate 100 mg. and poured the contents of the capsule in a medication cup.</li> <li>2. Observation of an activity staff (E13) on 11/3/09 at approximately 10:21 AM revealed that after washing her hands with soap and water, E13 turned off the faucet with her left bare hand.</li> <li>3. Observation on 11/3/09 around 4:30 PM during a medication pass revealed that after touching C7 in attempt to administer eye drops nurse E11 washed his hands turning the faucet off with bare hands.</li> </ol>	W 312  W 455	<p><b>W455</b> Infection Control Practitioner attended nursing meeting on 11/18/09 to discuss standard precautions, hand hygiene practices, and isolation techniques. Ongoing training will continue. <b>11/18/09 and ongoing</b></p> <p>Hand Hygiene Techniques Signs will be posted on paper towel dispensers. The procedure includes turning faucet off with paper towel. <b>12/30/09 and ongoing</b></p> <p>Develop monitoring tool and educate all nurses on hand hygiene policy and how to use monitoring tool. All nurses will be trained. <b>12/30/09 and ongoing</b></p> <p>Implement new observational monitoring tool of hand hygiene practices among all staff. <b>1/30/2010 and ongoing</b></p> <p>Monitoring tools will identify staff requiring additional in-service. <b>12/30/09 and ongoing</b></p>	
W 475	<p><b>483.480(b)(2)(iv) MEAL SERVICES</b></p> <p>Food must be served with appropriate utensils.</p> <p>This STANDARD is not met as evidenced by: Based on observations made in the kitchen on 11/02/09, it was determined that the facility failed</p>	W 475	<p>All nurses will be assigned monitoring observations. Review of Hand Hygiene Policy, Medication Administration Policy, and additional information on proper procedure (going from clean site to dirty site). <b>12/30/09 and ongoing</b></p> <p>Information from monitoring observations will be reported to Infection Prevention Committee who will prepare monthly compliance notes. <b>12/30/09 and ongoing</b></p>	

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

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OMB NO. 0938-0391

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W 475	Continued From page 9 to provide food preparation ware items in clean condition for food preparation and service. Findings include:  1. Four out of sixteen steam table pans sampled were observed with food debris on the food contact surfaces. These pans were stored under the food preparation table in ready-to-use status.	W 475	<p><b>W475</b> The issues were discussed with Ecolab who corrected the dish machine problem on 11/17/09. Recommendation to face racks into machine. An in-service by Ecolab will be held on 12/10/09 regarding proper procedure for hand washing and clearing food from dishes. All staff will be in-serviced. <b>11/17/09, 12/10/09 and ongoing</b></p> <p>All pots, pans and dishes were inspected on 11/12/09 for food debris and all items were clean. <b>11/12/09 and ongoing</b></p> <p>The supervisors are assigned to daily inspect pots, pans and dishes for cleanliness. <b>11/25/09 and ongoing</b></p> <p>Dish washing procedure written and all staff in-serviced by 12/30/09. <b>Exhibit C 12/30/09 and ongoing</b></p> <p>Cook Supervisors will inspect daily to ensure all pots, pans and dishes are thoroughly cleaned. <b>11/25/09 and ongoing</b></p> <p>The Office of Quality Management will inspect cleanliness of pots, pans and dishes during their quarterly environmental reviews. <b>12/15/09 and ongoing</b></p>	
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**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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**STATE SURVEY REPORT**

**LTC Residents Protection**  
**DEC 07 2009**  
**Director's Office**

**NAME OF FACILITY: The Stockley Center**

**DATE SURVEY COMPLETED: November 10, 2009**

**ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED**

**SECTION**      **STATEMENT OF DEFICIENCIES Specific Deficiencies**

	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced annual survey and complaint visit was conducted at this facility from November 02, 2009 through November 10, 2009. The deficiencies contained in this report are based on observations, staff interviews, review of residents' clinical records, and review of other facility documentation as indicated.</p>
3201	<p><b>Nursing Home Regulations for Skilled and Intermediate Care Nursing Facilities</b></p>
3201.6.0	<p><b>Services To Residents</b></p>
3201.6.5.8	<p><b>The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</b></p> <p><b>When the use of restraints has been implemented, the facility shall initiate a systematic process, on an ongoing basis, documented in the care plan, in an effort to</b></p>

Provider's Signature: Edleen W. Wampler Title: Executive Director Date: December 2, 2009



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>employ the least restrictive restraint.</p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Cross-refer to CMS 2567-L survey date completed 11/10/09, W128, W297 and W312.</p> <p><b>Communicable Diseases</b></p> <p><b>General Requirements</b></p> <p>The facility shall follow Division of Public Health regulations for the Control of Communicable and Other Disease Conditions and Centers for Disease Control guidelines for communicable diseases.</p> <p>The facility shall establish written policies and procedures implementing the Division of Public Health regulations and Centers for Disease Control guidelines for communicable diseases.</p> <p>The nursing facility shall ensure that the necessary precautions stated in the policies and procedures are followed.</p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Cross-refer to CMS 2567-L survey date completed</p>	<p>Cross reference CMS-2567 Plan of Correction responses for W128, W297 and W312.</p> <p>Cross reference CMS2567 Plan of Correction responses for W455.</p>



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3201.7.5	11/10/09, W455.  Kitchen and Food Storage Areas	
3201.7.5.1	Facilities shall comply with the Delaware Food Code.  4-6 Cleaning of equipment and utensils  4-6011.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.* (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The good-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.	
	This requirement was not met as evidenced by:  Cross refer to the CMS 2567-L survey report date completed 11/10/09, W475.	
	5-2 Plumbing System  5-202.13 Backflow Prevention, Air Gap.*  An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment,	Cross reference CMS 2567 Plan of Correction responses for W475.



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	<p>or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch).</p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Based on observation of the ice machine in the All-Star building, it was determined that the facility failed to provide adequate backflow prevention for potable ice utilized by the residents. Findings include:</p>	
3201.10.0	<ol style="list-style-type: none"> <li>The ice machine waste line elbow was observed to be lying on the collar surrounding the drain plate. There was not an air gap provided between the ice bin and flood level rim of the floor drain.</li> </ol>	<p>This was corrected on 11/12/09. All other ice machines checked with no issues found. The Facility Operations staff will check machine during preventative maintenance schedules. The Office of Quality Management will check during quarterly environmental surveys.</p> <p><b>11/12/09 and ongoing</b></p>
3201.10.5	<p><b>Records and Reports</b></p> <p><b>Incident reports, with adequate documentation, shall be completed for each incident.</b></p> <p><b>Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident's</b></p>	



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<p><b>representative or family, attending physician and licensing or law enforcement authorities, when appropriate.</b></p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Cross refer to the CMS 2567-L survey report date completed 11/10/09, W154 W157 and W149.</p> <p><b>Reportable incidents are as follows:</b></p> <p>Areas of contusions or bruises caused by staff to a dependent resident during ambulation, transport, transfer or bathing.</p> <p>Cross refer to the CMS 2567-L survey report date completed 11/10/09, W153.</p>	<p>Cross reference CMS2567 Plan of Correction for W154, W157, and W149.</p> <p>Cross reference CMS 2567 Plan of Correction for W153.</p>	