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

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Stockley Center ICF/ID

DATE SURVEY COMPLETED: March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from March 20, 2023 through March 27, 2023. The deficiencies contained in this report were based on observation, interview, review of clients' records and review of other facility documentation as indicated. The facility census on the first day of the survey was 40. The survey sample totaled 14 residents.		
3201 **3201.1.0** **3201.1.2** **3201.5.0** **3201.5.5**	**Regulations for Skilled and Intermediate Care Nursing 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.** **Personnel/Administrative** **The facility shall have written personnel policies and procedures. Personnel records**	3201... A1. The facility is unable to correct the past practice; however, to address the citation, the plan of action taken involved the Executive Director (ED) contacting the temporary staffing agency, Infojini, Inc., via telephone on 3/28/2023 to inform the agency in details of the Delaware Background Check Center (BCC) credentialing requirements to include data sources generated by the BCC (Adult Abuse Registry, State and Federal Criminal background Checks) and obtain require information for E41,E47,E48,E50,E53,E54,E55 and E56. Attachment A: Email/Memo correspondence from the Executive Director (ED) to Infojini, Inc. regarding the Delaware Background Check Center (BCC) credentialing requirements. A2. The ED sent a follow-up email to the agency, Infojini, Inc., on 3/28/2023 detailing the Delaware BCC credentialing requirements and it being imperative that the company take immediate corrective action.	05/25/2023

Provider's Signature [signature] Ed.D Title ED/NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

Executive Director / Nursing Home Administrator

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201.5.5.3 3201.5.5.5	**shall be kept current and available for each employee, and include the following:** **Results of criminal background check** **Result of Adult Abuse Registry check** **This requirement was not met as evidenced by:** Based on review of facility personnel records and interview, the facility failed to ensure that eight (E41, E47, E48, E50, E53, E54, E55 and E56) out of 19 sampled personnel records were kept current and available with the criminal background and Child and Adult Abuse Registry checks. Findings include: 3/27/23 10:45 AM – During an interview with E1 (ED), the following employee personnel records were reviewed and E1 confirmed the missing personnel records: 1. E41 (Agency CNA), was missing a criminal background check and Child and Adult Abuse Registry checks. 2. E47 (Agency CNA), was missing a criminal background check and Child and Adult Abuse Registry checks. 3. E48 (Agency CNA), was missing a criminal background check and Child and Adult Abuse Registry checks. 4. E50 (Agency CNA), was missing a criminal background check and Child and Adult Abuse Registry checks.	Attachment A: Email/Memo correspondence from the Executive Director (ED) to Infojini, Inc. regarding the Delaware Background Check Center (BCC) credentialing requirements. A3. Temporary Agency Staff that are contracted by Infojini Inc. were removed from the schedule on 3/28/2023 by the ED due to the issue with the credentialling requirements needed through the Delaware BCC. The staff were returned to the schedule by the ED on 3/30/2023 because Infojini, Inc. initiated corrective action. Attachment D: Emails stating Infojini Inc. staff were removed from the schedule on due to the issue with the credentialling requirements needed through the Delaware Background Check Center (BCC). The staff were returned to the schedule because Infojini, Inc. initiated corrective action. B1. The ED conducted a sweep of temporary all staff personnel files. Based on the results, it was concluded by the ED that temporary agency staffing both current and future staffing have the potential to be affected by the deficient practice. Attachment CC: Memo from Executive Director (ED) stating a sweep of Temporary Agency Staff personnel files were audited B2. The ED sent an email to all contract agencies that have staff at Stockley Center on 3/28/2023 and 3/29/2023 summarizing the BCC requirements of data sources generated by the BCC (Adult Abuse Registry, State and Federal Criminal background Checks) for Temporary Agency Staff that are currently working in the facility as well as future temporary agency staff.	

Provider's Signature [signature] Title ED/AHA Date 5/17/23

This version Revision#2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID

DATE SURVEY COMPLETED: March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	5. E53 (Agency RN), was missing a criminal background check. 6. E54 (Agency CNA), was missing a criminal background check and Child and Adult Abuse Registry checks. 7. E55 (Agency CNA), was missing a criminal background check and Child and Adult Abuse Registry checks. 8. E56 (Agency CNA), was missing a criminal background check and Child and Adult Abuse Registry checks. 3/27/23 2:30 PM - Findings were reviewed with E1, E2 (PA), E29 (ADON), and E4 (DRS) during the Exit Conference.	Attachment C: Emails from the Executive Director (ED) to all contract agencies that have staff at Stockley Center summarizing the Background Check Center (BCC) requirements. B3. The scope of credentialling for all staffing at Stockley Center was investigated by the ED. First, the ED contacted the Delaware Division of Human Services (DHR) via telephone on 3/28/2023, regarding the State Merit Employees. The ED was informed by DHR that all Stockley Center Merit and Seasonal Casual employees are vetted through the BCC for data sources generated by the BCC (Adult Abuse Registry, State and Federal Criminal background Checks). Second, to assess all temporary agency staffs' BCC credentialing documentation files, a second sweep audit of Temporary Agency Staff personnel files was completed on 3/31/2023, by the ED, Administrative Specialist III (ASIII) and Standards Control Specialist (SCS). These files were moved to a central location in the Executive Director's (ED) office by the ASIII and SCS. Attachment E: Memo stating a sweep of Temporary Agency Staff personnel files were audited. B5. A memo to contracting temporary staffing agencies was written by the ED regarding the requirements of criminal background checks and adult abuse registry results through of the BCC, and then memo was approved by DDDS Leadership on 4/17/2023. The ED emailed this memo to each contracting temporary staffing agency working with Stockley Center on 4/18/2023.	

Provider's Signature Kari M Jurstan, EdD Title ED/NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID

DATE SURVEY COMPLETED: March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		Attachment F: Memo to contracting temporary agencies was developed by the Executive Director (ED) and approved by DDDS Leadership and emailed to each contracting temporary agency. C1. The ED's RCA revealed the deficient practice only involved temporary staffing agency staff. It is noted that copies of Criminal Background Checks and Adult Abuse Registry Checks were part of the personnel file; however, these data points were not vetted through the BCC. The issue was the facility's new practice of hiring temporary staffing agencies did not include the specific BCC requirements as part of the credentialing and hiring processes for temporary staffing to obtain data sources generated by the BCC (Adult Abuse Registry, State and Federal Criminal background Checks). The facility's assumption of the agencies obtaining this information automatically through the BCC lead to the deficient practice. C2. The Administrative Program Administrator (APA) and the ED reviewed and will revise The Pre-Employment Screening Administrative Policy to reflect temporary agency staffing hiring with BCC credentialing requirements and start dates of new temporary employees must be after credentialing documentation is obtained which includes Adult Abuse Registry and State and Federal Criminal background Checks. C3. The Temporary Agency Staffing Hiring Checklist was revised on 4/3/2023 by the APA to reflect the credentialing requirement of the BCC and copies of necessary documentation, and a Temporary Agency	

Provider's Signature [signature] EdD Title ED/NHA Date 5/10/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		Staffing Hiring Approval form was created on 4/10/2023 by the ED and APA to reflect the credentialing requirement of the BCC and copies of necessary documentation. Attachment G: Temporary Agency Staffing Hiring Checklist Attachment H: Temporary Agency Staffing Hiring Approval form C4. The updated Pre-Employment Screening Administrative Policy will be provided to hiring manager staff by the ED for review, and a signed voucher will be completed. The APA will track completion of the is policy review. C5. Existing Temporary Staff. Obtaining required personnel documentation through the BCC for existing temporary staff is being obtained by the Administrative Specialist III (ASIII) and the Human Resources Technician/Administrative Specialist I (ASI) through email reminders and phone calls, and tracking credentialing documents until complete records are obtained. Copies of all required credentialing documentation will be filed by the ASIII or ASI in the ED office in the temporary staffing personnel files. C6. Future Temporary Staff. Prior to hiring temporary agency staffing, the ED or designee in absence of the ED is required to review and sign the Temporary Agency Staffing Hiring Approval form as well as reviewing associated credentialing BCC documentation to ensure a complete record. Copies of all required credentialing documentation will be filed in the temporary staffing personnel files in the ED office by the ASIII or ASI. The Temporary Agency Staff start date will be determined by receipt of all required documentation and	

Provider's Signature [signature] Title ED / NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		the signed Temporary Agency Staffing Hiring Approval form. Attachment G: Temporary Agency Staffing Hiring Checklist Attachment H: Temporary Agency Staffing Hiring Approval form D1. Existing Temporary Staff. The ASI and/or the ASIII will email or phone contact reminders with the current temporary staffing agencies requesting the required credentialing BCC documentation needed for temporary staff once a week until 100% compliance which will reflect a complete temporary staffing personnel record. D2. The APA and/or the SCS will complete a random sampling of 5 (five) Temporary Agency Staff personnel files 1 (one) time a week until consistency reaches 100% success (Adult Abuse Registry, State and Federal Criminal background Checks) over 3 (three) consecutive evaluations. THEN The APA and/or SCS will complete a random sampling of 5 (five) Temporary Agency Staff personnel files 2 (two) times a month until consistency reaches 100% success for 3 (three) consecutive evaluations. THEN The APA and/or SCS will complete a random sampling of 5 (five) Temporary Agency Staff personnel files 1 (one) time a month until consistency reaches 100% success for 3 (three) consecutive evaluations. FINALLY The APA and/or SCS will randomly sample 5 (five) Temporary Agency Staff personnel files 1 (one) time a quarter until consistency reaches 100% success for 3 (three) consecutive evaluations.	
16 Del. Code,	**(b) It is declared to be the public policy of this State that the interests of the resident**	16 Del. Code, 1121...	05/25/2023

Provider's Signature [signature] Title ED/NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID

DATE SURVEY COMPLETED: March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
1121. Resident Rights	**shall be protected by a declaration of a resident's rights, and by requiring that all facilities treat their residents in accordance with such rights, which shall include the following:** **(1) Each resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.** **This requirement was not met as evidenced by:** Based on random observations and interview, it was determined that the facility failed to ensure clients were treated with dignity. Findings include: 1. During a random meal observation on 3/22/23 at 9:33 AM, C14 was observed being fed by E31 (CNA). E31 was standing over the resident and not sitting down in a dignified, homelike manner. 2. During a meal observation on 3/22/23 at 11:49 AM, E32 (Activity Aide) was observed feeding C13 lunch. E32 was talking on a cell phone while feeding the resident. 11/22/23 – An interview with E16 (RN) revealed that staff do not use cell phones as part of communication on the job. E16 went on to say that if a staff person was seen using a cell phone while they were delivering care, they should be reported.	A. The facility is unable to correct the past practice of E31 and E32 related to resident rights of C13 and C14. The identified issues were presented at the survey exit so an immediate corrective action for E31 and E32 could not be taken; however, to address the citation, the plan of action taken involved the Director of Residential Services (DRS) verbally informing the residential team [Residential Program Administrators (RPA), Social Service Administrator (SSA), Qualified Intellectual Disability Professional (QIDP), and Active Treatment Supervisors (ATS)] regarding resident rights and specifics of dignity and respect, and to relay this information to staff because of observations during mealtimes revealed specific issues. All staff, including E31 and E32 received training in respect and dignity. Attachment DD: Memo from Director of Residential Services (DRS) stating a conversation was held with the Residential Services Team regarding Resident Rights, Dignity, and Mealtime Survey competencies B1. The plan of action taken involved the DRS verbally informing the residential team RPA, SSA, QIDP, and ATS regarding resident rights and specifics of dignity and respect, and to relay this information to staff because of observations during mealtimes revealed specific issues. In addition, An analysis of the identified deficient practice by the ED determined that all staff have the potential to be deficient in this cited deficient practice; therefore, the DRS and APA developed a questionnaire regarding dignity during mealtimes on 4/18/2023. A sweep regarding resident rights to dignity will be conducted among all staff assisting	

Provider's Signature [signature] Title ED/NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		residents at mealtimes by the Residential Team- RPA, SSA, QIDP, ATS. Attachment I: Mealtime Survey Attachment J: Mealtime Survey competencies B2. On 4/25/2023, the ED provided the DRS Respectful Workplace educational materials to be provided to all activity and residential staff by the Residential Team- RPA, SSA, QIDP, ATS requiring signed vouchers. Educational Flyer Topics include Mutual Respect in the Workplace; Benefits of Giving to Each Other at the Workplace; Respectful Workplace for Administrators, Managers, and Supervisors; A Respectful Trusting Workplace; RESPECT Meanings; How to be Respectful; Professional and Unprofessional Interactions. Attachment AA: Respectful Workplace educational flyers (7 (seven) flyers). C1. The ED, DRS, DON, and APA's RCA revealed the deficient practice was related to three factors; 1) lack of monitoring by management. 2) lack of education regarding dignity and respect specifically around mealtimes during meal and snack times. And 3) lack of respect among staff members. C2. The DRS and APA revised and implemented a Mealtime Survey management monitoring tool to reflect the component of dignified mealtime assistance on 4/18/2023. Attachment I: Mealtime Survey C3. The QIDP developed a flyer regarding Dignified Mealtime Assistance ("Dining with Dignity"). The DRS and designees will provide education based on the education	

Provider's Signature [signature] Title ED/WHK Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		flyer to the staff, and staff will sign an education voucher. Attachment K: "Dining with Dignity" educational flyer C4. The Speech Language Pathologist (SLP) will update the staff orientation training and any retraining to reflect the component of dignified mealtime assistance ("Dining with Dignity"). The SLP is responsible to provide specific mealtime assistance training and education for all staff who assist residents with meal and snack times. Attachment K: "Dining with Dignity" educational flyer C5. The ED's Respectful Workplace educational materials was be provided to DRS for the Residential Team – DRS, RPA, SSA, QIDP, and/or ATS to implement education among residential and activity staff members over the course of 7 weeks starting the week of May 1, 2023. Also, the ED educated the DRS on these materials on 4/26/2023. In addition, the ED sent requirements of the Education Department to the SE and RNE to incorporate the information in the Workplace Educational Materials for orientation of new staff moving forward. Attachment AA: Respectful Workplace educational flyers (7 (seven) flyers) C6. The Administration Policy - Employee Education and Training Policy will be updated by the APA to include orientation training in Respectful Workplace to include the educational material. D. Under the direction of the DRS, the Residential Team- RPA, SSA, QIDP, and/or ATS will complete a random sampling of 10 (Ten) staff a week who are assisting residents with meals across breakfast, lunch,	

Provider's Signature [signature] Title ED/NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID

DATE SURVEY COMPLETED: March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		and dinner using the Mealtime Survey for 1 (One) month until consistency reaches 100% success. THEN Under the direction of the DRS, the Residential Team- RPA, SSA, QIDP, and/or ATS will randomly sample 10 (Ten) staff every 2 (two) weeks who are assisting residents with meals across breakfast, lunch, and dinner using the Mealtime Survey for 2 (two) months until consistency reaches 100% success. FINALLY Under the direction of the DRS, the Residential Team- RPA, SSA, QIDP, ATS, and/or Facility Charge (FC) randomly sample 5 (Five) staff a month who are assisting residents with meals across breakfast, lunch, and dinner using the Mealtime Survey thereafter for 100% success.	
16 Del. Code, Ch. 11 Sub-Chapter III §1131	**(11) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following:** **a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for seven (C4, C5, C6, C7, C8, C12 and C15) out of seven clients sampled for abuse/neglect review, the facility failed to ensure that C12 and C15 were free from neglect when care and services were not provided for an entire shift due to failures to update staffing assignments. For C4, C5, C6, C7 and C8, the facility failed to	16 Del. Code, Ch. 11 Sub-Chapter III §1131... A. The facility is unable to correct the past practice; however, when the facility was made aware of the neglectful practices by staff in a timely matter, the facility took immediate action to secure the residents' safety, provide needed residents' care, and assess the residents' physical condition as well as staff identified as being involved were removed from the direct resident care when internal investigations were conducted. B1. To immediately address the specific deficiency with management, the ED conducted an analysis of staff assignment protocols regarding staff changes due to call outs and breaktimes with the DRS, APA, RPA, QIDP during a staff meeting on 3/29/2023, to ensure staff are providing the required resident care under various	05/25/2023

Provider's Signature Kai M. Jenkins, EdD Title EDIN/HA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	ensure they were free from neglect when care and services were not provided for approximately two or more hours when a CNA left the building and did not get coverage for the five totally dependent clients. Findings include: Review of C12's clinical record and other records revealed the following: 1. C12 was admitted to the facility in 1973 with diagnoses including, but not limited to, profound intellectual disabilities. Records show that the resident is confined to a chair for mobility, dependent on staff for activities of daily living and is dependent on a tube for feeding. 6/22/22 - Review of the record, including bowel and urinary elimination records and progress notes, lacked documentation of care being provided during the 6:00 AM to 2:00 PM shift. 3/21/23 10:52 AM - An interview with E33 (CNA) revealed that on initial rounds on the 2:00 PM to 10:00 PM shift on 6/22/22, C12 was found saturated in urine including the brief, pad, sheet, clothes and abdominal binder, there was an odor of old urine detected, the resident's eyes were gunky, face appeared unwashed and the feeding tube site looked uncared for with leakage present. E33 stated this was reported to her Supervisor E34 (Shift Building Charge), as well as E35 (Program Administrator). C12 received a full bath around 3:30 - 4:00 PM. E12 (CNA Agency) confirmed a previous statement to a DHCQ investigator that when she looked at the urinary tracker there were	staff expectations. The conclusion of the analysis revealed that failing to provide resident care leading to the deficient practices could have the potential to negatively affect all residents. During the 3/29/2023, staff meeting analysis, the ED discussed and expressed expectations of management and for management to convey the requirements to staff expectations regarding PM46 Reporting, Daily Expectations of Staff responsibilities to residents, Staff Assignments with Residents, and Management must be Checking and Correcting as necessary all staff assignments on all three shifts, at the beginning of shifts, mid shifts, and when staff changes occur during shifts. The ED followed up with an email and memo conveying the same to DRS, DON, APA, RPA, SSA, QIDP, ATS, Therapist III (TIII), Activity Therapist II (ATII), and Director of Habilitative Services/ Staff Educator (SE). Attachment L: Email/Memo from the Executive Director to the Management Staff and Facility Charge Staff regarding PM46 Reporting and Daily Documentation and Expectations of Staff B2. The APA revised the Documentation training PowerPoint to reflect the requirement of daily documentation on 3/29/2023, for orientation and reeducation conducted by the SE and Nurse Educator (RNE). Attachment M: Documentation training PowerPoint B3. To immediately address the current staff, an educational flyer will be developed by the SE and/or RNE on Daily Documentation. The staff will be educated on the information by the SE and Residential Team	

Provider's Signature [signature] Title ED/NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	no (staff) initials and the client was not assigned to anyone in the staffing book. 3/21/23 12:24 PM - An interview with E2 (Program Administrator) revealed that she was unaware of the incident until a DHCQ investigator contacted her in (June 2022). E2 stated that she did not have any specific details, but confirmed that while providing records to the DHCQ investigator, the lack of documentation of care on the shift was noted. E2 added that due to the lack of information and the investigation by the State (DHCQ), nothing further was done by the facility. 3/23/23 11:15 AM - An interview with E34 (Charge Nurse) confirmed that E33, early in the shift on 6/22/22, made her aware of the condition C12 was found in. E34 did not actually see the client before the CNA cleaned the resident up. She confirmed her statement to the DHCQ investigator that E33 reported C12's pad to be soaking wet with urine and dripping onto the floor. E34 stated that a message was left for Administration, they may have called back later that shift, but E34 could not specifically remember talking to Administration. E34 also stated that E4 (Director of Residential Services/DRS) came to the unit and was looking at the staffing books. E34 revealed that the care (communication) book appeared to have been filled out but got moved around due to a call out and they (Scheduling / Charge Staff) never updated the assignment in the book to account for C12. 3/23/23 (around 1:00 PM) - An interview with E35 (Program Administrator) revealed	– DRS, RPA, SSA, QIDP, and/or ATS, and a signed voucher will be completed. B4. Until the facility PM46 procedures are updated, the ED directed the APA (PM46 Coordinator), DRS, and DON regarding all external complaints being investigated by external entities will be reported and investigated by Stockley Center PM46 investigators just as internal complaint investigations are conducted. The ED followed up with a memo dated 3/23/2023. Attachment BB: Memo from Executive Director (ED) regarding addition of outside complaints to the PM46 Policy and Procedures B5. The APA and ED updated the PM46 Reporting Education Flyer on 3/29/2023 to include the requirement that staff members can anonymously report PM46 to Long Term Care and Resident Protection/ Division of Health Care Quality (LTCRP/DHCQ); however, the staff are obligated to report to Administration any suspected allegation of abuse, neglect, etc. immediately while still maintaining their reporting anonymity. This flyer was sent by the DRS, DON, and ED to staff overseen by these Directors to educate staff and signed education vouchers were obtained. Attachment O: PM46 Reporting Flyer B6. The Residential SSA is assigned to review and update all staff Assignments and groupings and Pick-up Lists. C1. The ED, DRS, DON, and APA's RCA revealed the deficient practice was related to several factors which includes: Lack of adequate staff documentation of resident hygiene care; Schedule changes effecting as-	

Provider's Signature [signature] Title ED/DHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	that she did not see C12 uncared for, but was aware that E33 (CNA, Agency) found the resident uncared for at the start of the shift on 6/22/22, laying in urine and feces. E35 stated that E33 should have reported it to the facility Charge or a Nurse. E35 confirmed that she did not report the incident to anyone in Administration and was told it was an issue with the Communication Book and staff assignment. 3/23/23 1:14 PM - An interview with E4 (DRS) revealed there had been a problem in the past with staffing assignments (when staff call out and the assignments need to be redistributed). E4 stated a new communication book was set up and the facility Charge must sign off on assignments. No specific details of this incident were revealed. 3/24/2023 12:02 PM - 1:12 PM - An (email) interview with E1 (NHA) identified E36 (CNA) as the Aide originally assigned to the resident group that included C12. It further revealed that it was unknown if the Aide originally assigned to R12 on 6/22/22 was interviewed about the failure to document care for the entire shift. There was no reporting or investigation by the facility about this allegation of neglect.	signments and these changes not accurately monitored my management; Lack of staff reviewing assignment changes in conjunction with lack of management monitoring; Administration's assumption based on past practices to not interfere with outside complaint investigations conducted through DHCQ/ outside entities by conducting simultaneous internal investigations; Lack guidance in the facility's PM46 procedures for conducting simultaneous investigations; Staff assumptions they had the right to anonymously report allegations of abuse, neglect, etc. to Long Term Care and Resident Protection/ DHCQ without reporting such cases to administration. Despite this right staff also have the obligation to report such cases to the administration while keeping their anonymity of direct reporting to LTCRP/DHCQ. C2. The ED updated the Performance Plans and Measures for the positions of RPA, SSA, QIDP, ATS, Certified Nursing Assistant (CNA), Active Treatment Facilitator (ATF), and Temporary Agency CNA. These performance plans and measures were reviewed by DRS, RPA, SSA, QIDP with all the staff designated by titles detailing designated staffs' duties and expectations of their job. Staff signatures were obtained designating their acknowledgement and agreement. Attachment N: Performance Plan Database C3. The SE and/or RNE will provide education on the revised Documentation training during orientation and reeducation. Attachment M: Documentation training PowerPoint C4. The APA will update the Active Treatment Supervisor's Shift Monitoring Report	

Provider's Signature [signature] Title ED/NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID

DATE SURVEY COMPLETED: March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		to include the review of staffs' documentation of hygiene care functions (Bowel and Urinary Elimination Records). The APA will also update this report to include the review of staff assignments/groupings of residents. When on duty the ATS completes this monitoring report across all shifts. C5. The APA will update the Facility Charge Shift Monitoring Report to reflect the review of staffs' documentation of hygiene care functions (Bowel and Urinary Elimination Records). The APA will also update this report to include the review of staff assignments/groupings of residents. When on duty and designated as Facility Charge, this monitoring report is completed by Facility Charge staff who consist of APA, RPA, SSA, QIDP, TIII, ATII, and/or SE across all shifts. C6. The Administrative Reporting and Investigation Procedure For: PM46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source policy was reviewed and revised on 3/28/2023, by the ED and APA to reflect facility protocol changes, that include the same LTCRP/DHCQ reporting and simultaneous internal investigations must be completed for outside complaints being investigated by external entities. The APA will create a corresponding checklist for internal investigations regarding outside complaints being investigated by external entities. C7. The updated Administrative Reporting and Investigation Procedure For: PM46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source policy will be sent by the DRS, DON,	

Provider's Signature [signature] Title ED/NHA Date 5/10/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		and ED to staff overseen by these Directors to educate staff and signed vouchers by staff will be obtained. D1. For hygiene care documentation and management monitoring (bowel and urinary elimination records), under the direction of the DRS, the RPAs (2) will each complete reviews of a random sampling of 5 (five) residents' hygiene care documentation (10 total between the two RPA) across all residential units and across three shifts for 5 (five) days a week for 1 (one) month until consistency reaches 100% success. THEN A random sampling of 5 (five) residents' hygiene care documentation (10 total between the two RPA) across all residential units and across three shifts for 5 (five) days every two weeks for 1 (one) month until consistency reaches 100% success. FINALLY A random sampling of 5 (five) residents' hygiene care documentation (10 total between the two RPA) across all residential units and across three shifts for 1 (one) time a month thereafter for 100% success. D2. For Assignments/ Grouping/ Pick-up Lists. Assignments/Groupings and management monitoring, under the direction of the DRS, the RPA and/or Facility Charge (DRS, APA, RPA, SSA, QIDP, TIII, ATII, SE) when on duty will review all assignments/groupings each Day (daily) for all residents across all residential units and across three shifts for 1 (one) month until consistency reaches 100% success. THEN 2 (two) times a week for all residents across all residential units and across three shifts	

Provider's Signature Kai-Ming Sun, EdD Title ED/AHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID

DATE SURVEY COMPLETED: March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		for 1 (one) month until consistency reaches 100% success. THEN 2 (two) weeks for all residents across all residential units and across three shifts for 1 (one) month until consistency reaches 100% success. THEN 1 (one) time every (two) weeks for all residents across all residential units and across three shifts thereafter for 100% success. FINALLY At least 1 (one) time a month for all residents across all residential units and across three shifts thereafter for 100% success. D3. For understanding of responsibilities and requirements of PM46 reporting, under the direction of the DRS and DON, the DRS, DON, Assistant Director of Nursing (ADON), APA, RPA, SSA, QIDP, TIII, ATII, ATS, RNE, and/or SE the PM46 Reporting Education Flyer will be reviewed with residential, nursing, and activity staff 1 (one) time a month for 3 (months) until consistency reaches 100% success. Staff will sign an education voucher. FINALLY 1 (one) time a quarter thereafter for 100% success. Staff will sign an education voucher. D4. For PM46 investigations and documentation compliance, under the direction of the ED, the APA and/or SCS will conduct PM46 file documentation reviews to assess that the PM46 reporting procedures were followed daily upon reporting for 1 (one) month until consistency reaches 100% success. THEN	

Provider's Signature [signature] Title EDINHA Date 5/7/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		Biweekly (twice a week) upon reporting for 1 (one) month until consistency reaches 100% success. THEN 1 (one) time a week upon reporting for 1 (one) month until consistency reaches 100% success. FINALLY 1 (one) time quarterly thereafter for 100% success.	
16 Del. Code, Ch. 11 Sub-Chapter III	**Long-Term Care Facilities and Services.** **Subchapter III. Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents.** **This requirement was not met as evidenced by:** Based on interview, record review and review of facility documentation, it was determined that for seven out of (C4, C5, C6, C7, C8, C12 and C15) seven clients sampled for abuse/neglect review, the facility failed to ensure that allegations of neglect were reported immediately to State officials (DHCQ). Findings include: The facility's policy titled, "Reporting and Investigation Procedure For: PM46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source", last revised July 2019, stated that the eye witness/reporting person, "Reports incident immediately, without delay, to the nurse and the supervisor in charge/Facility Charge." The facility policy continued to state, "Immediately (within 8 hours) reports the incident to the Division of Health Care Quality	16 Del. Code, Ch. 11 Sub-Chapter III... A. The facility is unable to correct the past deficient practice; nevertheless, the ED identifies the error in timely reporting distinctions for allegations of abuse, neglect, etc. under the PM46 as defined as immediately reporting by staff to administration, and within 2 hours reporting to LTCRP/DHCQ. Subsequently, the ED and APA acted by updating the PM46 procedures as well as providing staff education using an updated PM46 Reporting Education Flyer under the direction of the ED carried out by the DRS, DON, APA, RPA to staff. Attachment O: PM46 Reporting Flyer B1. A review conducted by the ED and APA of the past year (12 months) of PM 46 investigations and outside complaints revealed that the timely reporting of allegations of abuse, neglect, etc. (PM 46 reportables) was a deficient practice of the reporting requirement of within 2 hours of the allegation. Subsequently, the ED and APA concluded that all residents have the potential to be negatively affected by the deficient practice. B2. To initially addresses the specific deficiency with Management and Facility	05/25/2023

Provider's Signature [signature] Title ED/NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID

DATE SURVEY COMPLETED: March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	(Division of Long Term Care Residents Protection) ...". 1. According to a report to the State Agency on 7/1/22, C15 was found saturated in urine and feces. Also, C15 had the same clothes on from that morning. This was reported to a Nurse that completed a skin check. There was no evidence that it was reported to Administration. 2. According to a facility investigation on 11/5/23, C4, C5, C6, C7 and C8 were neglected when E9 (Agency CNA) left the building at 1:24 AM and returned at 3:07 AM. E9 left her residents without coverage and E9 did not report to the Supervisor that she was leaving. Administration was not aware until 11/8/22 three days later and it was not reported to the State Agency until 11/8/22. 3. Statements from staff E33 (CNA), E34 (Charge Nurse) and E35 (Program Administrator) revealed their knowledge that on 6/22/22, C12 was left unassigned and unattended for the 6:00 AM to 2:00 PM shift. The client was found by the evening shift Aide to be saturated in urine, eyes gunky, face unclean and there was leakage from the feeding tube. E33 reported the same to E34 and E35. E34 stated during an interview that a message was sent to Administration, but E34 was uncertain of the communication after the initial message. The allegation was not reported to the State agency. Although a CNA (E33) identified an allegation of neglect and reported it to Supervisory staff, the facility failed to ensure that it was reported to the Administrator and the	Charge Staff regarding timely reporting of allegations of abuse, neglect, etc. under PM46, on 3/29/2023, the ED conducted a staff meeting with the DRS, APA, RPA, QIDP. During meeting, the ED discussed and expressed expectations of management and for management to convey the requirements to staff expectations regarding PM46 Reporting, The ED followed up with an email and memo conveying the same to DRS, DON, APA, RPA, SSA, QIDP, ATS, TIII, ATII, and SE. Attachment L: Email/Memo from the Executive Director to the Management Staff and Facility Charge Staff regarding PM46 Reporting and Daily Documentation and Expectations of Staff B3. The APA and ED updated the PM46 Reporting Education Flyer on 3/29/2023 to include the requirement that staff members can anonymously report PM46 to Long Term Care and Resident Protection/ Division of Health Care Quality (LTCRP/DHCQ); however, the staff are required to immediately report to Administration any suspected allegation of abuse, neglect, etc. (PM 46 reportables). This flyer was sent by the DRS, DON, and ED to staff overseen by these Directors to educate staff, and signed vouchers were obtained. Attachment O: PM46 Reporting Flyer C1 The ED and APA's RCA revealed the deficient practice was related to two factors involving: An inaccurate reporting timeframe of 8 hours written in the facility's PM46 procedures – "Administrative Reporting and Investigation Procedure For: PM46 (Abuse, Neglect, Mistreatment,	

Provider's Signature [signature], Ed.D Title ED / NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	State Agency authority. As a result of lack of reporting, no investigation was conducted. Findings were reviewed with E1 (Executive Director), E2 (PA), and E4 (DRS) on 3/27/23 during the exit conference, beginning at 2:30 PM.	Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source"; And, A misunderstandings by staff that they only needed to report allegations of PM46 reportable to LTCRP/ DHCQ without informing administration caused the failure to report and failure to timely report allegations. C2. The Administrative Reporting and Investigation Procedure For: PM46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source policy was reviewed and revised on 3/28/2023, by the ED and APA to reflect changes to the 2 (two) hour reporting requirement. C3. To immediately address the deficiency, the APA and ED's updated PM46 Reporting Education Flyer was provided to staff the DRS, DON, and ED to staff overseen by these directors to educate staff on reporting requirements and signed vouchers were obtained. In addition, the updated Administrative Reporting and Investigation Procedure For: PM46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source policy will be sent by the DRS, DON, and ED to staff overseen by these Directors to educate staff, and signed vouchers by staff will be obtained. Attachment O: PM46 Reporting Flyer D1. For understanding of responsibilities and requirements of PM46 reporting, under the direction of the DRS and DON, the DRS, DON, ADON, APA, RPA, SSA, QIDP, TIII, ATII, ATS, RNE, and/or SE, the PM46	

Provider's Signature [signature] Title ED/NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID

DATE SURVEY COMPLETED: March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		Reporting Education Flyer will be reviewed with all staff 1 (one) time a month for 3 (months) until consistency reaches 100% success. Staff will sign an education voucher. FINALLY For understanding of responsibilities and requirements of PM46 reporting, under the direction of the DRS and DON, the DRS, DON, Assistant Director of Nursing (ADON), APA, RPA, SSA, QIDP, TIII, ATII, ATS, RNE, and/or SE, the PM46 Reporting Education Flyer will be reviewed with all staff 1 (one) time a quarter thereafter for 100% success. Staff will sign an education voucher. D2. For PM46 investigations and documentation compliance, under the direction of the ED, the APA and/or SCS will conduct PM46 file documentation reviews to assess that the PM46 reporting procedures were followed daily upon reporting for 1 (one) month until consistency reaches 100% success. THEN For PM46 investigations and documentation compliance, under the direction of the ED, the APA and or SCS will conduct PM46 file documentation reviews to assess that the PM46 reporting procedures were followed biweekly (twice a week) upon reporting for 1 (one) month until consistency reaches 100% success. THEN For PM46 investigations and documentation compliance, under the direction of the ED, the APA and or SCS will conduct PM46 file documentation reviews to assess that the PM46 reporting procedures were followed 1 (one) time a week upon	

Provider's Signature [signature] Title ED/DHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		reporting for 1 (one) month until consistency reaches 100% success. FINALLY For PM46 investigations and documentation compliance, under the direction of the ED, the APA and/or SCS will conduct PM46 file documentation reviews to assess that the PM46 reporting procedures were followed 1 (one) time quarterly thereafter for 100% success.	
16 Del. Code, Ch. 11 Sub-Chapter IV §1141	**Criminal background checks.** ***(a) Purpose. —*** **The purpose of the criminal background check and drug screening requirements of this section and § 1142 of this title is the protection of the safety and well-being of residents of long-term care facilities licensed pursuant to this chapter. These sections shall be construed broadly to accomplish this purpose.** **(b) Definitions. —** **(7) "SBI" means the State Bureau of Identification.** **(c) An employer may not employ an applicant for work in a facility before obtaining a criminal history. The criminal history of any person not employed directly by the facility must be provided to the facility upon the person's commencement of work.** **(d) The requirements of subsection (c) of this section may be suspended for 60 days if the employer wishes to employ the applicant on a conditional basis.**	16 Del. Code, Ch. 11 Sub-Chapter IV §1141... A1. The facility is unable to correct the past practice; however, to address the citation, the plan of action taken involved the Executive Director (ED) contacting the temporary staffing agency, Infojini, Inc., via telephone on 3/28/2023 to inform the agency in details of the Delaware Background Check Center (BCC) credentialing requirements to include sources generated by the BCC including the State and Federal Criminal background Checks involving fingerprinting through the State Bureau of Investigation (SBI). Attachment A: Email/Memo correspondence from the Executive Director (ED) to Infojini, Inc. regarding the Delaware Background Check Center (BCC) credentialing requirements. A2. The ED sent a follow-up email to the agency, Infojini, Inc. on 3/28/2023 detailing the Delaware BCC credentialing requirements which involves fingerprinting results from the SBI, as well as it being imperative that the agency take immediate corrective action. Attachment A: Email/Memo correspondence from the Executive Director (ED) to	05/25/2023

Provider's Signature Kristy M. Dunn, EdD Title ED/NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID

DATE SURVEY COMPLETED: March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	(1) Before an employer may offer conditional employment, the employer must receive verification that the applicant has been fingerprinted by the SBI for purposes of the criminal history. **This requirement was not met as evidenced by:** Based on review of facility personnel records and interview, the facility failed to ensure that eight (E41, E47, E48, E50, E53, E54, E55 and E56) out of 19 sampled employees had fingerprinting done prior to working in the facility. Findings include: 3/27/23 10:45 AM – During an interview with E1 (ED), the following employee personnel records were reviewed and E1 confirmed the lack of fingerprinting for each employee: 1. E41 (Agency CNA) - the first day working at the facility was 12/13/22. 2. E47 (Agency CNA) – the first day working at the facility was 9/6/22. 3. E48 (Agency CNA) – the first day working at the facility was 7/26/22. 4. E50 (Agency CNA)- the first day working at the facility was 1/30/23. 5. E53 (Agency RN) – the first day working at the facility was 9/12/22. 6. E54 (Agency CNA) – the first day working at the facility was 1/9/23.	Infojini, Inc. regarding the Delaware Background Check Center (BCC) credentialing requirements. A3. Temporary Agency Staff that are contracted by Infojini Inc. were removed from the schedule on 3/28/2023 by the ED due to the issue with the credentialling requirements needed through the Delaware BCC including the fingerprinting results from the SBI. The staff were returned to the schedule by the ED on 3/30/2023 because Infojini, Inc. initiated corrective action. Attachment D: Emails stating Infojini Inc. staff were removed from the schedule on due to the issue with the credentialling requirements needed through the Delaware Background Check Center (BCC). The staff were returned to the schedule because Infojini, Inc. initiated corrective action. B1. The ED conducted a review sweep of temporary staff personnel files. Based on the results, it was concluded that by the ED that temporary agency staffing both current and future staffing have the potential to be affected by the deficient practice. Attachment CC: Memo from Executive Director (ED) stating a sweep of Temporary Agency Staff personnel files were audited B2. The ED sent an email to all contract agencies that have staff at Stockley Center on 3/28/2023 and 3/29/2023 summarizing the BCC requirements of Temporary Agency Staff that are currently working in the facility as well as future temporary agency staff. Attachment C: Emails from the Executive Director (ED) to all contract agencies that	

Provider's Signature [signature] ED Title ED/NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	7. E55 (Agency CNA) – the first day working at the facility was 10/10/22. 8. E56 (Agency CNA) – the first day working at the facility was 10/10/22. 3/27/23 2:30 PM - Findings were reviewed with E1, E2 (PA), E29 (ADON), and E4 (DRS) during the Exit Conference.	have staff at Stockley Center summarizing the Background Check Center (BCC) requirements. B3. The scope of credentialling for all staffing at Stockley Center was investigated by the ED. First, the ED contacted the Delaware Division of Human Services (DHR) via telephone on 3/28/2023, regarding the State Merit Employees. The ED was informed by DHR that all Stockley Center Merit and Seasonal Casual employees are vetted through the BCC to include fingerprinting results from the SBI. Second, to assess all temporary agency staffs' BCC credentialing documentation files, a second sweep audit of Temporary Agency Staff personnel files was completed on 3/31/2023, by the ED, Administrative Specialist III and Administrative Specialist II. These files were moved to a central location in the Executive Director's (ED) office by the Administrative Specialist III and Administrative Specialist II. Attachment E: Memo stating a sweep of Temporary Agency Staff personnel files were audited. B5. A memo to contracting temporary staffing agencies was written by the ED regarding the requirements of fingerprinting results from the SBI through of the BCC, and then memo was approved by DDDS Leadership on 4/17/2023. The ED emailed this memo to each contracting temporary staffing agency working with Stockley Center on 4/18/2023. Attachment F: Memo to contracting temporary agencies was developed by the Executive Director (ED) and approved by DDDS Leadership and emailed to each contracting temporary agency.	

Provider's Signature [signature] Title ED/NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		C1. The ED's RCA revealed the deficient practice only involved temporary staffing agency staff. It is noted that copies of Criminal Background Checks were part of the personnel file; however, these data points were not vetted through the BCC. The issue was the facility's new practice of hiring temporary staffing agencies did not include the specific BCC requirements as part of the credentialing and hiring processes for temporary staffing. The facility's assumption of the agencies obtaining this information automatically through the BCC lead to the deficient practice. C2. The ED and APA reviewed and will revise The Pre-Employment Screening Administrative Policy to reflect temporary agency staffing hiring with BCC credentialing requirements and start date must be after credentialing documentation is obtained which includes Criminal Background Check Fingerprinting results from the SBI vetted through the BCC. C3. The Temporary Agency Staffing Hiring Checklist was revised on 4/3/2023 by the APA to reflect the credentialing requirement of the BCC and copies of necessary documentation, and a Temporary Agency Staffing Hiring Approval form was created on 4/10/2023 by the ED and APA to reflect the credentialing requirement of the BCC and copies of necessary documentation. Attachment G: Temporary Agency Staffing Hiring Checklist Attachment H: Temporary Agency Staffing Hiring Approval form C4. The updated Pre-Employment Screening Administrative Policy will be provided to staff by the ED for review, and a signed	

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		voucher will be completed. The APA will track the completion of the is policy review. C5. Existing Temporary Staff. Obtaining required personnel documentation through the BCC for existing temporary staff is being obtained by the Administrative Specialist III (ASIII) and the Human Resources Technician/Administrative Specialist I (ASI) through email reminders and phone calls, and tracking credentialing documents until complete records are obtained. Copies of all required credentialing documentation will be filed by the ASIII or ASI in the ED office in the temporary staffing personnel files. C6. Future Temporary Staff. Prior to hiring temporary agency staffing, the ED or designee in absence of the ED is required to review and sign the Temporary Agency Staffing Hiring Approval form as well as reviewing associated credentialing BCC documentation to ensure a complete record. Copies of all required credentialing documentation will be filed in the temporary staffing personnel files in the ED office by the ASIII or ASI. The Temporary Agency Staff start date will be determined by receipt of all required documentation and the signed Temporary Agency Staffing Hiring Approval form. Attachment G: Temporary Agency Staffing Hiring Checklist Attachment H: Temporary Agency Staffing Hiring Approval form D1. Existing Temporary Staff. The ASI and/or the ASIII will email or phone contact reminders with the current temporary staff-	

Provider's Signature [signature] Title ED/NHA Date 9/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		ing agencies requesting the required credentialing BCC documentation of Criminal Background Checks Fingerprinting results from the SBI and vetted through the BCC needed for temporary staff once a week until 100% compliance which will reflect a complete temporary staffing personnel record. D2. The APA and/or SCS will complete a random sampling of 5 (five) Temporary Agency Staff personnel files 1 (one) time a week until consistency reaches 100% success (Criminal Background Checks Fingerprinting results from the SBI and vetted through the BCC) over 3 (three) consecutive evaluations. THEN The APA and/or SCS will complete a random sampling of 5 (five) Temporary Agency Staff personnel files 2 (two) times a month until consistency reaches 100% success for 3 (three) consecutive evaluations. THEN The APA and/or SCS will complete a random sampling of 5 (five) Temporary Agency Staff personnel files 1 (one) time a month until consistency reaches 100% success for 3 (three) consecutive evaluations. FINALLY The APA and/or SCS will randomly sample 5 (five) Temporary Agency Staff personnel files 1 (one) time a quarter until consistency reaches 100% success for 3 (three) consecutive evaluations.	
16 Del. Code, Ch. 11 §1144	**(a) Nursing and assisted living facilities shall annually offer, beginning no later than October 1 and extending through March 1 of a calendar year, onsite vaccinations for influenza vaccine to all employees with direct**	16 Del. Code, Ch. 11 §1144 ... A. The facility was able to correct the past practice although notably documentation was not available at the time of the survey. The corrective action included E5 E40, E41, E47, E48, E50, E52, E53, E54, and E55	05/25/2023

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	contact with patients at no cost and contingent upon availability of the vaccine. **(b) The facility shall keep on record a signed statement from each employee stating that the employee has been offered vaccination against influenza and has either accepted or declined such vaccination.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for 10 (E5, E40, E41, E47, E48, E50, E52, E53, E54 and E55) out of 19 sampled employees, the facility failed to ensure that employees were offered influenza vaccination and/or has accepted or declined such vaccination. Findings include: 3/21/23 – The facility advised the Surveyor that the following 10 employees declined the influenza vaccination during the annual influenza vaccination period beginning no later than 10/1/22 through 3/1/2023: 1. E52 (Activity Therapist I) 2. E40 (Cook) 3. E41 (Agency CNA) 4.E47 (Agency CNA) 5. E48 (Agency CNA) 6. E53 (Agency RN) 7. E5 (Program Administrator)	influenza vaccination consent/declination forms were completed through the direction of the DON. Attachment Q: E5 E40, E41, E47, E48, E50, E52, E53, E54, and E55 influenza vaccination consent/declination forms. B. Analysis of the deficient practice and review of records by the DON and ADON revealed that all staff have the potential to be negatively affected; therefore, a sweep of all staff files for influenza vaccination consent/declination was reviewed to ensure complete records were obtained by the Assistant Director of Nursing (ADON) on 3/28/2023. Attachment P: Memo stating a sweep of all staff for influenza vaccination consent/declination was reviewed C1. The DON and ADON's RCA revealed the deficient practice was an oversight by nursing because of the COVID requirements and restrictions. In so much as, the required use of facial masks despite influenza vaccination status as the requirements for employees not vaccinated for influenza is wearing a mask during the height of the flu season. Subsequently, a key factor of tracking influenza vaccination status and education is to ensure non influenza vaccinated staff wear masks, but since everyone was wearing masks, the oversight occurred. C2. The Temporary Agency Staffing Hiring Checklist was revised by the APA was completed on 4/3/2023 to reflect the requirement of obtaining influenza vaccination/declination.	

Provider's Signature Kori M. Jurkiewicz EdD Title ED/NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID

DATE SURVEY COMPLETED: March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	8. E54 (Agency CNA) 9. E50 (Agency CNA) 10. E55 (Agency CNA) Review of the facility's vaccination records documented the following employees lacked evidence of when the employee was offered the influenza vaccination and declined. Findings were reviewed with E1, E2 (PA), E29 (ADON) and E4 (DRS) during the exit conference.	Attachment G: Temporary Agency Staffing Hiring Checklist C3. A Temporary Agency Staffing Hiring Approval forms was created on 4/10/2023 by the ED and APA to reflect the requirement of maintaining influenza vaccination/declination records. Attachment H: Temporary Agency Staffing Hiring Approval form C4. The Administrative policy Influenza Vaccination was revised by the DON on 3/30/2023 to reflect facility practices and the requirements of vaccination/declination. The updated administrative policy Influenza Vaccination will be sent to staff by the ED, DRS, and DON for staff education to the staff overseen by these directors. A signed voucher will be obtained by staff. Attachment R: Administrative policy Influenza Vaccination updated. D. Beginning October 1, 2023, staff influenza consent/declination forms will be maintained in Health Services and will be monitored by the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) monthly until May 1, 2024, until consistency reaches 100% success. In addition, flu stats are reported to the State by the DON and/or the ADON as required which will continue until consistency reaches 100% success.	
16 Del. C. 11 §1162 Nursing staffing:	**Nursing Staffing:** **(a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident,**	16 Del. C. 11 §1162... A. The facility is unable to correct the past practice; however, the DRS promptly took action to address the deficiency by fixing	05/25/2023

Provider's Signature [signature] Title ED/NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID **DATE SURVEY COMPLETED:** March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	including those residents who have special needs due to dementia or a medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations. Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles. **This requirement was not met as evidenced by:** Based on observation and interview, it was determined that for all shifts, the facility failed to post the names and titles of the nursing services direct caregivers assigned to each unit including the Supervisor on duty. Findings include: 3/21/23 10:05 AM through 3/24/23 – Observations of the electronic bulletin boards on the Chandler and McCabe units failed to display the names and titles of the Nurses and Supervisor assigned for day and evening shifts. 3/23/23 10:40 AM – During an interview, E23 (RN) confirmed the daily staffing was not posted.	the visual display of staff names and titles of RNs and RN Supervisors. Attachment S: Email to the Resource Management staff instructing them of proper protocol on the electronic bulletin boards/display boards. B1. An analysis and interviews with resource management staff by the DRS regarding present and past practices of displaying staff names and titles on the electronic display boards revealed that all staff have the potential to be affected negatively by the deficient practice. B2. The DRS on 3/24/2023 instructed and emailed the Resource Management Unit staff (SSA and Operation Support Specialist [OSS]) of the necessary requirements of proper protocol regarding the electronic bulletin boards/display boards showing the Floor Nurse, Nursing Supervisor, Facility Charge, and Certified Nursing Assistants staff scheduled for shifts that must be posted daily each shift. Attachment S: Email to the Resource Management staff instructing them of proper protocol on the electronic bulletin boards/display boards. C1. The DON, DRS, and APA's RCA revealed the deficient practice was a result of two factors involving: New Resource Management staff (SSA and OSS) not fully executing their new responsibilities in the area of display board requirements; And, lack of detailed information in the Administrative policy – Identification Badges/ Passes. C2. Since the DRS addressed the current SSA and OSS staff on the requirements for	

Provider's Signature [signature] Title ED IDTA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID

DATE SURVEY COMPLETED: March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	3/23/23 3:30 PM – During an interview, E4 (DRS) confirmed that daily staffing was not posted. Findings were reviewed with E1 (ED), E2 (PA), and E4 on 3/27/23 during the exit conference, beginning at 2:30 PM.	displaying staff members on the electronic bulletin boards/display boards, the Administrative Policy Identification Badges/Passes will be revised by the APA to reflect the requirement of electronic bulletin boards/display boards to include on displays the names and titles of the Nurses and Supervisors assigned on each shift. The updated administrative policy Identification Badges/Passes will be sent to staff by the ED, DRS, and DON for staff education to the staff overseen by these directors. A signed voucher will be obtained by staff. C3. The APA will update the Facility Charge Shift Monitoring Report to reflect the review of the electronic bulletin boards/display boards for required information on staff names and titles. When on duty and designated as Facility Charge, this monitoring report is completed by Facility Charge staff who consist of APA, RPA, SSA, QIDP, TIII, ATII, and/or SE across all shifts. D. The APA and/or SCS will complete a random sampling of 10 (ten) Facility Charge Shift Monitoring Reports across all shifts to assess the Facility Charge Report documenting the accuracy of the electronic bulletin boards/display boards displaying the required information of staff names and titles for 1 (one) time a week until consistency reaches 100% success (names and titles are displayed accurately) over 3 (three) consecutive evaluations. THEN The APA and/or SCS will complete a random sampling of 5 (five) Facility Charge Shift Monitoring Reports across all shifts to assess the Facility Charge Report	

Provider's Signature [signature] Title ED INTIA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

NAME OF FACILITY: Stockley Center ICF/ID

DATE SURVEY COMPLETED: March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		documenting the accuracy of the electronic bulletin boards/display boards displaying the required information of staff names and titles for 1 (one) time a week until consistency reaches 100% success (names and titles are displayed accurately) over 3 (three) consecutive evaluations. THEN The APA and/or SCS will complete a random sampling of 5 (five) Facility Charge Shift Monitoring Reports across all shifts to assess the Facility Charge Report documenting the accuracy of the electronic bulletin boards/display boards displaying the required information of staff names and titles for 1 (one) time a month until consistency reaches 100% success (names and titles are displayed accurately) over 3 (three) consecutive evaluations. FINALLY The APA and/or SCS will complete a random sampling of 5 (five) Facility Charge Shift Monitoring Reports across all shifts to assess the Facility Charge Report documenting the accuracy of the electronic bulletin boards/display boards displaying the required information of staff names and titles for 1 (one) time a quarter until consistency reaches 100% success (names and titles are displayed accurately) over 3 (three) consecutive evaluations.	

Provider's Signature [signature] Title ED/NHA Date 5/17/23

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26361 PATRIOTS WAY GEORGETOWN, DE 19947

(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 Annual and Complaint Survey was conducted at this facility from March 20, 2023 through March 27, 2023. The facility census was 40 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, Office of Long Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, Emergency Preparedness deficiencies were cited.	E 000		
E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years,	E 037	A. The facility is unable to correct the past practice; however, to address the citation, the plan of action taken involved the Director of Habilitative Services/Staff Educator (SE) or Nurse Educator (RNE) providing training in Emergency Preparedness to E41 on 3/22/2023 and E40 on 4/11/2023. Attachment T: Emergency Preparedness training record for E40 and E41 B1. The Executive Director (ED) completed a training timeliness analysis of staff Emergency Preparedness training. The structure of orientation scheduled timing in conjunction with new hires was determined to have the potential to negatively affect all staff by the deficient practice which could impact all residents. B2. The ED directed the SE to develop and implement onboarding packets consisting of educational materials of in part the topics of Emergency Preparedness and Fire Safety among other required topics. The ED discussed and directed the SE that the SE	05/25/23

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

Kristin Jenkins EdD, Executive Director/Nursing Home Administrator 5/17/23

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.

This version Revision #2, Revision #1 sent 5/9/23, Original POC sent 04/21/23, Completion Date Revision sent on 5/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26361 PATRIOTS WAY GEORGETOWN, DE 19947

(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 037	Continued From page 1 (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037	and/or the RNE to institute onboarding education packets for all new hires to be completed on the staff start date. Attachment U: Onboarding packets C1. The Director of Nursing (DON), Director of Residential Services (DRS), and Administration Program Administrator's (APA) Root Cause Analysis (RCA) revealed the deficient practice of staff start dates of working in the facility occurring prior to the Emergency Preparedness training date was a result of two factors involving; A false assumption that new staff orientation education which involves Emergency Preparedness can be deferred until regularly scheduled orientation courses are scheduled and attended because newly hired staff are never left alone until orientation is completed; And, start dates of newly hired staff do not always correspond with Orientation Training scheduled dates. C2. The Administration Policy - Employee Education and Training Policy will be updated by the APA to include the onboarding requirements and specific topics which include Emergency Preparedness and Fire Safety. The SE and/or APA will update the Orientation Training Checklists to include the onboarding education of newly hired staff. C3. Since Staff Orientation Training is scheduled 1 (one) time a month and start dates of new staff may not correspond with orientation training classes, Onboarding Packets will be provided by the SE or RNE, or DRS or DRS designee to newly hired staff for educating the staff on various topics including include Emergency Preparedness and Fire Safety. Staff Onboarding will be scheduled to occur the first day of	

ICF 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 037	Continued From page 2 arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037	employment for all newly hired staff. Signed vouchers will be obtained from staff attending the onboarding. After each onboarding and orientation, the SE and/or RNE will instruct and obtained from each staff signed vouchers for the training education for 100% compliance. D. The APA and/or Standards Control Specialist (SCS) will complete a random sampling of 5 (five) staff orientation/ onboarding training records for 1 (one) time a month until consistency reaches 100% success (Emergency Preparedness training was completed on the staff's start date) over 3 (three) consecutive evaluations. THEN The APA and/or SCS will complete a random sampling of 5 (five) staff orientation/ onboarding training records for 1 (one) time a quarter until consistency reaches 100% success (Emergency Preparedness training was completed on the staff's start date) over 3 (three) consecutive evaluations. FINALLY The APA and/or SCS will complete a random sampling of 5 (five) staff orientation/ onboarding training records for 1 (one) time biannually until consistency reaches 100% success (Emergency Preparedness training was completed on the staff's start date) over 2 (two) consecutive evaluations.	

KS 5/07/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 037	Continued From page 3 arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients,	E 037		

KS7
5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 037	Continued From page 4 personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, Individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on review of documents, it was determined that for two (E40 and E41) out of ten (10) sampled staff members, the facility failed to ensure that new staff received the required initial Emergency Preparedness training upon hire. Findings include: 1. The first day in the facility for E40 was 1/17/23, and as of the exit date of this survey, the facility has failed to provide the initial Emergency Preparedness training.	E 037		

KS7
5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 037	Continued From page 5 2. The first day in the facility for E41 was 12/13/22, and as of the exit date of this survey, the facility has failed to provide the initial Emergency Preparedness training.	E 037		
W 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from March 20, 2023 through March 27, 2023. The deficiencies contained in this report were based on observation, interview, review of clients' records and review of other facility documentation as indicated. The facility census on the first day of the survey was 40. The survey sample totaled 14 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nursing Assistant; DHCQ - Division of Health Care Quality; DON - Director of Nursing; DRS - Director of Residential Services; ED - Executive Director; IPP - Individual Program Plan; NHA - Nursing Home Administrator; PA - Program Administrator; QIDP - Qualified Intellectual Disability Professional; RN - Registered Nurse.	W 000		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	W 149	A. The facility is unable to correct the past practice for C4,C5,C6,C7,C8,C12,C15; however, when the facility was made aware of the neglectful practices by staff in a timely matter, the facility took immediate action to secure the residents' safety, provide needed	05/25/23

1157 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 149	Continued From page 6 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that for seven (C4, C5, C6, C7, C8, C12 and C15) out of seven clients sampled for abuse/neglect review, the facility failed to ensure that C12 and C15 were free from neglect when care and services were not provided for an entire shift due to failures to update staffing assignments. For C4, C5, C6, C7 and C8, the facility failed to ensure they were free from neglect when care and services were not provided for approximately two or more hours when a CNA left the building and did not get coverage for the five totally dependent clients. Findings include: Review of C12's clinical record and other records revealed the following: 1. C12 was admitted to the facility in 1973 with diagnoses including, but not limited to profound intellectual disabilities. Records show that the resident is confined to a chair for mobility, dependent on staff for activities of daily living and is dependent on a tube for feeding. 6/22/22 - Review of the record, including bowel and urinary elimination records and progress notes, lacked documentation of care being provided during the 6:00 AM to 2:00 PM shift. 3/21/23 10:52 AM - An interview with E33 (CNA) revealed that on initial rounds on the 2:00 PM to 10:00 PM shift on 6/22/22, C12 was found saturated in urine including the brief, pad, sheet, clothes and abdominal binder, there was an odor of old urine detected, the resident's eyes were gunky, face appeared unwashed, and the feeding tube site looked uncared for with leakage present.	W 149	residents' care, and assess the residents' physical condition as well as staff identified as being involved were removed from the direct resident care when internal investigations were conducted. Attachment L: Email/Memo from the Executive Director to the Management Staff and Facility Charge Staff regarding PM46 Reporting and Daily Documentation and Expectations of Staff B1. To immediately address the specific deficiency with management, the ED conducted an analysis of staff assignment protocols regarding staff changes due to call outs and breaktimes with the DRS, APA, Residential Program Administrator (RPA), Qualified Intellectual Disabilities Professional (QIDP) during a staff meeting on 3/29/2023, to ensure staff are providing the required resident care under various staff expectations. The conclusion of the analysis revealed that failing to provide resident care leading to the deficient practices could have the potential to negatively affect all residents. During the 3/29/2023, staff meeting analysis, the ED discussed and expressed expectations of management and for management to convey the requirements to staff expectations regarding Delaware Policy Memorandum (PM46) Reporting, Daily Expectations of Staff responsibilities to residents, Staff Assignments with Residents, and Management must be Checking and Correcting as necessary all staff assignments on all three shifts, at the beginning of shifts, mid shifts, and when staff changes occur during shifts. The ED followed up with an email and memo conveying the same to DRS, DON, APA, RPA, Social Services Administrator (SSA), QIDP, Active Treatment	

KST 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 149	Continued From page 7 E33 stated this was reported to her Supervisor E34 (Shift Building Charge), as well as E35 (Program Administrator). C12 received a full bath around 3:30 - 4:00 PM. E12 (Agency CNA) confirmed a previous statement to a DHCQ investigator that when she looked at the urinary tracker, there were no (staff) initials and the client was not assigned to anyone in the staffing book. 3/21/23 12:24 PM - An Interview with E2 (Program Administrator) revealed that she was unaware of the incident until a DHCQ investigator contacted her in (June 2022). E2 stated that she did not have any specific details, but confirmed that while providing records to the DHCQ investigator, the lack of documentation of care on the shift was noted. E2 added that due to the lack of information and the investigation by the State (DHCQ) nothing further was done by the facility. 3/23/23 11:15 AM - An interview with E34 (Charge Nurse), confirmed that E33 (CNA), early in the shift on 6/22/22 made her aware of the condition C12 was found in. E34 did not actually see the client before the CNA cleaned the resident up. She confirmed her statement to the DHCQ investigator that E33 reported C12's pad to be soaking wet with urine and dripping onto the floor. E34 stated that a message was left for Administration, they may have called back later that shift, but E34 could not specifically remember talking to Administration. E34 also stated that E4 (Director of Residential Services/DRS) came to the unit and was looking at the staffing books for the unit. E34 revealed that the care (communication) book appeared to have been filled out, but assignments got moved around due to a call out and they (Scheduling/Charge Staff) never updated the assignment in the book to	W 149	Specialist (ATS), Therapist III (TIII), Activity Therapist II (ATII), and SE. Attachment L: Email/Memo from the Executive Director to the Management Staff and Facility Charge Staff regarding PM46 Reporting and Daily Documentation and Expectations of Staff B2. The APA revised the Documentation training PowerPoint to reflect the requirement of daily documentation and not falsifying documentation on 3/29/2023, for orientation and reeducation conducted by the SE and RNE. Attachment M: Documentation training PowerPoint B3. To immediately address the current staff, an educational flyer will be developed by the SE and/or RNE on Daily Documentation. The staff will be educated on the information by the SE and Residential Team – DRS, RPA, SSA, QIDP, and/or ATS, and a signed voucher will be completed. B4. Until the facility PM46 procedures are updated, the ED directed the APA (PM46 Coordinator), DRS, and DON regarding all external complaints being investigated by external entities will be reported and investigated by Stockley Center PM46 investigators just as internal complaint investigations are conducted. The ED followed up with a memo dated 3/23/2023. Attachment BB: Memo from Executive Director (ED) regarding addition of outside complaints to the PM46 Policy and Procedures B5. The APA and ED updated the PM46 Reporting Education Flyer on 3/29/2023 to include the requirement that staff members can anonymously report PM46 to Long Term Care and Resident Protection/ Division of Health Care Quality (LTCRP/DHCQ); however, the staff are obligated to report to Administration any suspected allegation of abuse, neglect, etc. immediately while still	

157
5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 149	Continued From page 8 account for C12. 3/23/23 (around 1:00 PM) - An interview with E35 (retired Program Administrator) revealed that she did not see C12 uncared for, but was aware that E33 (CNA) found the resident uncared for at the start of the shift on 6/22/22, laying in urine and feces. E35 stated that E33 should have reported it to the facility Charge or a Nurse. E35 confirmed that she did not report the incident to anyone in Administration and heard it was an issue with the Communication Book and staff assignment. 3/23/23 1:14 PM - An interview with E4 (DRS) revealed there had been a problem in the past with staffing assignments (when staff call out and the assignments need to be redistributed). E4 stated a new communication book was set up and the facility Charge must sign off on assignments. No specific details of this incident were revealed. 3/24/2023 12:02 PM - 1:12 PM - An (email) interview with E1 (NHA) identified E36 (CNA) as the Aide originally assigned to the resident group that included C12. It further revealed that it was unknown if the Aide originally assigned to R12 on 6/22/22 was interviewed about the failure to document care for the entire shift. There was no reporting or investigation by the facility about this allegation of neglect. 2. Review of C15's clinical record and other records revealed the following: 7/1/22 - The communication book (a tool used to assign CNA's to clients) did not include C15 for the 2:00 PM to 10:00 PM shift.	W 149	maintaining their reporting anonymity. This flyer was sent by the DRS, DON, and ED to staff overseen by these Directors to educate staff and signed education vouchers were obtained. Attachment O: PM46 Reporting Flyer B6. The Residential SSA is assigned to review and update all staff Assignments and groupings and Pick-up Lists. C1. The ED, DRS, DON, and APA's RCA revealed the deficient practice was related to several factors which includes: Lack of adequate staff documentation of resident hygiene care, lack of follow up by therapies on lifts/transfers; Schedule changes effecting assignments and these changes not accurately monitored my management; Lack of staff reviewing assignment changes in conjunction with lack of management monitoring; Administration's assumption based on past practices to not interfere with outside complaint investigations conducted through DHCQ/outside entities by conducting simultaneous internal investigations; Lack guidance in the facility's PM46 procedures for conducting simultaneous investigations; Staff assumptions they had the right to anonymously report allegations of abuse, neglect, etc. to Long Term Care and Resident Protection/ DHCQ without reporting such cases to administration. Despite this right staff also have the obligation to report such cases to the administration while keeping their anonymity of direct reporting to LTCRP/ DHCQ. C2. The ED updated the Performance Plans and Measures for the positions of RPA, SSA, QIDP, ATS, Certified Nursing Assistant (CNA), Active Treatment Facilitator (ATF), and Temporary Agency CNA. These performance plans and measures were reviewed by DRS, RPA, SSA, QIDP with all the staff designated	

KST 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 149	Continued From page 9 7/1/22 - Review of the record including bowel and urinary elimination records and progress notes lacked documentation of care being provided during the 2:00 PM to 10:00 PM shift. 3/23/23 2:00 PM - During an interview, E7 (CNA) reviewed and confirmed that the assignment for 7/1/23 did not include C15. Furthermore, E7 stated that E37 (CNA) would not have known that C15 was assigned to their group. 3/24/23 1:36 PM - During an interview, E37 revealed that the process was to read the communication book for assignment of clients. E37 was unaware that C15 was in E37's assignment and stated that no care was delivered on that shift. 3/27/23 10:00 AM - During an interview with E11 (CNA), E11 revealed that on 7/1/22 C15 was found by the oncoming 10:00 PM shift soiled, unchanged and still dressed in the same clothes from morning. E11 further revealed that an incident report was completed and a Nurse was notified. E10 (RN) was notified and did a skin check. The Facility Charge was unsure of how to report the incident. 3/27/23 11:45 AM - During an interview, E10 (RN) was unable to recall all the details of R15's incident, but remembered that it happened. The facility failed to report an allegation of neglect when C15 was not assigned to a CNA and went eight hours without care. 3/27/23 9:15 AM - During an interview, E2 (Program Administrator) revealed that because of C15 not receiving care on 7/1/22 a correction was	W 149	by titles detailing designated staffs' duties and expectations of their job. Staff signatures were obtained designating their acknowledgement and agreement. Attachment N: Performance Plan Database C3. The SE and/or RNE will provide education on the updated Documentation training during orientation and reeducation. Attachment M: Documentation training PowerPoint C4. The APA will update the Active Treatment Supervisor's Shift Monitoring Report to include the review of staffs' documentation of hygiene care functions (Bowel and Urinary Elimination Records). The APA will also update this report to include the review of staff assignments/ groupings of residents. When on duty the ATS completes this monitoring report across all shifts. C5. The APA will update the Facility Charge Shift Monitoring Report to reflect the review of staffs' documentation of hygiene care functions (Bowel and Urinary Elimination Records). The APA will also update this report to include the review of staff assignments/ groupings of residents. When on duty and designated as Facility Charge, this monitoring report is completed by Facility Charge staff who consist of APA, RPA, SSA, QIDP, TIII, ATII, and/or SE across all shifts. C6. The Administrative Reporting and Investigation Procedure For: PM46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source policy was reviewed and revised on 3/28/2023, by the ED and APA to reflect facility protocol changes, that include the same LTCRP/DHCQ reporting and simultaneous internal investigations must be completed for outside complaints being investigated by external entities. The APA will	

157
3/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 149	Continued From page 10 made for how assignments were made. 3. Review of C4, C5, C6, C7 and C8's clinical and other records revealed the following: 11/4/22 10:00 to 6:00 - E9 (Agency CNA) was assigned to C4, C5, C6, C7 and C8. 11/4/22 to 11/5/22 The facility investigation reported that E9 left the facility at 1:24 AM and returned to the facility at 3:04 AM. 3:17 AM to 3:37 AM - E9 completed rounds on C6 and C7 documented that both received incontinence care. According to the record, C6 was a two person for bed mobility, however, E9 provided care to C6 without a second person. 3:37 AM to 3:37 AM - E9 entered C8's room and documented that C8 voided. C8 was a two person for bed mobility, however, E9 provided care to C8 without a second person. 11/5/22 5:08 AM to 5:08 AM - E9 entered C6's room completed rounds and documented that C6 had voided. C6 is a two person for bed mobility and less than a minute would not be adequate time to change a totally dependent client requiring two persons for bed mobility. E9 falsified C6's documentation on the urinary elimination record and changed C6 without a second person. 5:23 AM to 5:28 AM - E9 entered C8's room, completed rounds and documented that C8 voided. E9 provided incontinence care alone to C8 who required two persons for bed mobility. According to a timeline provided by the facility for the night of 11/5/22 from 10:00 PM to 6:00 AM,	W 149	create a corresponding checklist for internal investigations regarding outside complaints being investigated by external entities. C7. The updated Administrative Reporting and Investigation Procedure For: PM46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source policy will be sent by the DRS, DON, and ED to staff overseen by these Directors to educate staff and signed vouchers by staff will be obtained. D1. For hygiene care documentation and management monitoring (bowel and urinary elimination records), under the direction of the DRS, the RPAs (2) will each complete reviews of a random sampling of 5 (five) residents' hygiene care documentation (10 total between the two RPA) across all residential units and across three shifts for 5 (five) days a week for 1 (one) month until consistency reaches 100% success. THEN A random sampling of 5 (five) residents' hygiene care documentation (10 total between the two RPA) across all residential units and across three shifts for 5 (five) days every two weeks for 1 (one) month until consistency reaches 100% success. FINALLY A random sampling of 5 (five) residents' hygiene care documentation (10 total between the two RPA) across all residential units and across three shifts for 1 (one) time a month thereafter for 100% success. D2. For Assignments/ Grouping/ Pick-up Lists. Assignments/Groupings and management monitoring, under the direction of the DRS, the RPA and/or Facility Charge (DRS, APA, RPA, SSA, QIDP, TIII, ATII, SE) when on duty will review all assignments	

KS7
5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 149	Continued From page 11 E9 spent one hour and 23 minutes providing care to five clients (C4, C5, C6, C7 and C8). E9 and spent 19 minutes helping E43 (CNA) provide care to C1. 3/22/23 10:10 PM - During an interview with E43 revealed that by the time it was realized that E9 (CNA) was gone, E9 returned a little bit later. Also, E43 provided confirmation that residents were not reassigned to another CNA for care in E9's absence. 3/22/23 10:10 PM - During an interview with E44 (RN Supervisor), E44 revealed that the Charge Nurse (E46, RN) reported that they were looking for and could not find E9. E44 sent a staff person to look for E9 and was unable to locate E9. It was reported to E44 by a CNA from another unit that E9 was supposed to go to pick up food, but E9 never returned. E44 sent staff to look outside the building and check E9's car which was in the parking lot, but E9 was not found. E44 revealed that around 3:00 AM E9 returned into the facility. It was further revealed that E44 had communication with E2 (DON) and discussed if this was neglect or discipline; an email was forwarded to E4 (Director of Residential Services-DRS). 3/23/23 1:14 PM - During an interview, E4 (DRS) was unable to recall any specific details. Review of the facility investigation determined that neglect was unfounded. C4, C5, C6, C7 and C8 were checked over and there were no concerns. The facility failed to identify neglect for the above residents, when E9 left the facility, falsified documentation and used an unsafe transfer method on totally dependent clients	W 149	groupings each Day (daily) for all residents across all residential units and across three shifts for 1 (one) month until consistency reaches 100% success. THEN 2 (two) times a week for all residents across all residential units and across three shifts for 1 (one) month until consistency reaches 100% success. THEN 1 (one) time every 2 (two) weeks for all residents across all residential units and across three shifts for 1 (one) month until consistency reaches 100% success. FINALLY At least 1 (one) time a month for all residents across all residential units and across three shifts thereafter for 100% success. D3. For understanding of responsibilities and requirements of PM46 reporting, under the direction of the DRS and DON, the DRS, DON, Assistant Director of Nursing (ADON), APA, RPA, SSA, QIDP, TIII, ATII, ATS, RNE, and/or SE the PM46 Reporting Education Flyer will be reviewed with residential, nursing, and activity staff 1 (one) time a month for 3 (months) until consistency reaches 100% success. Staff will sign an education voucher. FINALLY 1 (one) time a quarter thereafter for 100% success. Staff will sign an education voucher. D4. For PM46 investigations and documentation compliance, under the direction of the ED, the APA and/or SCS will conduct PM46 file documentation reviews to assess that the PM46 reporting procedures were followed daily upon reporting for 1 (one) month until consistency reaches 100% success. THEN Biweekly (twice a week) upon reporting for 1 (one) month until consistency reaches 100% success. THEN	

RS7 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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
			1 (one) time a week upon reporting for 1 (one) month until consistency reaches 100% success. FINALLY 1 (one) time quarterly thereafter for 100% success. D5. The Therapy Department (PT) and Residential Management Team – each RPA and QIDP will complete a random sampling of 5 (five) residents each (5 residents each per reviewer) on each residential unit on various shifts and with various staff, utilizing the Lift, Gait Belt, and Transfer Competencies tool for 1 (one) time a week for 2 (two) months until consistency reaches 100% success (correct application of lift/ transfer) over 3 (three) consecutive evaluations. THEN A random sampling of 5 (five) residents each (5 residents each per reviewer) on each residential unit on various shifts and with various staff, utilizing the Lift, Gait Belt, and Transfer Competencies tool for 2 (two) times a month until consistency reaches 100% success (correct application of lift/transfer) over 3 (three) consecutive evaluations. FINALLY A random sampling of 5 (five) residents each (5 residents each per reviewer) on each residential unit on various shifts and with various staff, utilizing the Lift, Gait Belt, and Transfer Competencies tool for 1 (one) time a month until consistency reaches 100% success (correct application of lift/transfer) over 3 (three) consecutive evaluations.	

K57
5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 149	Continued From page 12 requiring 24-hour care. Findings were reviewed with E1 (Executive Director), E2 (PA), and E4 (DRS) on 3/27/23 during the exit conference, beginning at 2:30 PM.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) 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 interview, record review and review of facility documentation, it was determined that for seven out of (C4, C5, C6, C7, C8, C12 and C15) seven clients sampled for abuse/neglect review, the facility failed to ensure allegations of neglect were reported immediately to State officials (DHCQ). Findings include: The facility's policy titled, "Reporting and Investigation Procedure For: PM46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source", last revised July 2019, stated that the eye witness/reporting person, "Reports incident immediately, without delay, to the nurse and the supervisor in charge/Facility Charge." The facility policy continued to state, "Immediately (within 8 hours) reports the incident to the Division of Health Care Quality (Division of Long Term Care Residents Protection) ...". 1. According to a report to the State Agency on	W 153	A1. The facility is unable to correct the past deficient practice for C4,C5,C6,C7,C8, C12,C15; nevertheless, the ED identifies the error in timely reporting distinctions for allegations of abuse, neglect, etc. under the PM46 as defined as immediately reporting by staff to administration, and within 2 hours reporting to LTCRP/DHCQ. Subsequently, the ED and APA acted by updating the PM46 procedures as well as providing staff education using an updated PM46 Reporting Education Flyer under the direction of the ED carried out by the DRS, DON, APA, RPA to staff. Attachment L: Email/Memo from the Executive Director to the Management Staff and Facility Charge Staff regarding PM46 Reporting and Daily Documentation and Expectations of Staff B1. A review conducted by the ED and APA of the past year (12 months) of PM 46 investigations and outside complaints revealed that the timely reporting of allegations of abuse, neglect, etc. (PM 46 reportables) was a deficient practice of the reporting requirement of within 2 hours of the allegation. Subsequently, the ED and APA concluded that all residents have the potential to be negatively affected by the deficient practice. B2. To initially addresses the specific deficiency with Management and Facility Charge Staff regarding timely reporting of allegations of abuse, neglect, etc. under PM46, on 3/29/2023, the ED conducted a staff meeting with the DRS, APA, RPA, QIDP.	05/25/23

KST 5/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 153	Continued From page 13 7/1/22, C15 was found saturated in urine and feces. Also, C15 had the same clothes on from that morning. This was reported to a Nurse that completed a skin check. There was no evidence that it was reported to Administration. 2. According to a facility investigation on 11/5/23, C4, C5, C6, C7 and C8 were neglected when E9 (Agency CNA) left the building at 1:24 AM and returned at 3:07 AM. E9 left her residents without coverage and E9 did not report to the Supervisor that she was leaving. Administration was not aware until 11/8/22, three days later and it was not reported to the State Agency until 8/11/22. 3. Statements from staff E33 (CNA), E34 (retired Charge Nurse), and E35 (retired Program Administrator) revealed that on 6/22/22, C12 was left unassigned and unattended for the 6:00 AM to 2:00 PM shift. The client was found by the evening shift Alde to be saturated in urine, eyes gunky, face unclean and there was leakage from the feeding tube. E33 reported the same to E34 and E35. E34 stated during an interview that a message was sent to Administration, but E34 was uncertain of the communication after the initial message. The allegation was not reported to the State Agency. Although a CNA (E33) identified an allegation of neglect and reported it to Supervisory staff, the facility failed to ensure that it was reported to the Administrator and the State Agency authority. As a result of lack of reporting, no investigation was conducted. Findings were reviewed with E1 (Executive Director), E2 (PA), and E4 (DRS) on 3/27/23 during the exit conference, beginning at 2:30 PM.	W 153	During meeting, the ED discussed and expressed expectations of management and for management to convey the requirements to staff expectations regarding PM46 Reporting, The ED followed up with an email and memo conveying the same to DRS, DON, APA, RPA, SSA, QIDP, ATS, TIII, ATII, and SE. B3. The APA and ED updated the PM46 Reporting Education Flyer on 3/29/2023 to include the requirement that staff members can anonymously report PM46 to Long Term Care and Resident Protection/ Division of Health Care Quality (LTCRP/DHCQ); however, the staff are required to immediately report to Administration any suspected allegation of abuse, neglect, etc. (PM 46 reportables). This flyer was sent by the DRS, DON, and ED to staff overseen by these Directors to educate staff, and signed vouchers were obtained. C1 The ED and APA's RCA revealed the deficient practice was related to two factors involving: An inaccurate reporting timeframe of 8 hours written in the facility's PM46 procedures – "Administrative Reporting and Investigation Procedure For: PM46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source"; And, A misunderstandings by staff that they only needed to report allegations of PM46 reportable to LTCRP/ DHCQ without informing administration caused the failure to report and failure to timely report allegations. C2. The Administrative Reporting and Investigation Procedure For: PM46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source policy was reviewed and revised on 3/28/2023, by the ED and APA to reflect changes to the 2 (two) hour reporting requirement.	

1657 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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
			C3. To immediately address the deficiency, the APA and ED's updated PM46 Reporting Education Flyer was provided to staff the DRS, DON, and ED to staff overseen by these directors to educate staff on reporting requirements and signed vouchers were obtained. In addition, the updated Administrative Reporting and Investigation Procedure For: PM46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source policy will be sent by the DRS, DON, and ED to staff overseen by these Directors to educate staff and signed vouchers by staff will be obtained. Attachment O: PM46 Reporting Flyer D1. For understanding of responsibilities and requirements of PM46 reporting, under the direction of the DRS and DON, the DRS, DON, ADON, APA, RPA, SSA, QIDP, TIII, ATII, ATS, RNE, and/or SE, the PM46 Reporting Education Flyer will be reviewed with all staff 1 (one) time a month for 3 (months) until consistency reaches 100% success. Staff will sign an education voucher. FINALLY For understanding of responsibilities and requirements of PM46 reporting, under the direction of the DRS and DON, the DRS, DON, ADON, APA, RPA, SSA, QIDP, TIII, ATII, ATS, RNE, and/or SE, the PM46 Reporting Education Flyer will be reviewed with all staff 1 (one) time a quarter thereafter for 100% success. Staff will sign an education voucher. D2. For PM46 investigations and documentation compliance, under the direction of the ED, the APA and/or SCS will conduct PM46 file documentation reviews to assess that the PM46 reporting procedures were followed daily upon reporting for 1 (one) month until consistency reaches 100% success.	

KSF 3/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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
			THEN For PM46 investigations and documentation compliance, under the direction of the ED, the APA and or SCS will conduct PM46 file documentation reviews to assess that the PM46 reporting procedures were followed biweekly (twice a week) upon reporting for 1 (one) month until consistency reaches 100% success. THEN For PM46 investigations and documentation compliance, under the direction of the ED, the APA and or SCS will conduct PM46 file documentation reviews to assess that the PM46 reporting procedures were followed 1 (one) time a week upon reporting for 1 (one) month until consistency reaches 100% success. FINALLY For PM46 investigations and documentation compliance, under the direction of the ED, the APA and/or SCS will conduct PM46 file documentation reviews to assess that the PM46 reporting procedures were followed 1 (one) time quarterly thereafter for 100% success.	

RST 5/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that for five out of 19 sampled staff members, the facility failed to ensure that new staff received timely Abuse Prohibition training during their orientation to the facility. Findings include: Review of the facility's training records revealed the following: 1) E40's (Cook) first date in the facility was 1/17/23. There was lack of evidence that E40 was provided new staff Abuse Prohibition Training. E40 was scheduled for this training on 4/10/23. 2) E41's (Agency CNA) first date in the facility was 12/13/22. There was lack of evidence that E41 was provided new staff Abuse Prohibition Training. E41 was scheduled for this training on 4/10/23. 3) E48's (Agency CNA) first date in the facility was 7/26/22 and E48 was provided new staff Abuse Prohibition Training on 8/11/22. 4) E5's (Program Administrator) first date in the facility was 12/5/22 and E5 was provided new staff Abuse Prohibition Training on 12/12/22. 5) E50's (Agency CNA) first date in the facility was 1/3/23 and E50 was provided new staff	W 189	A. The facility is unable to correct the past practice E5, E40, E41, E48, and E50; however, to address the citation, the plan of action taken involved the SE or RNE providing training in Abuse Prohibition to E5 on 12/12/2022, E40 on 4/11/2023, E41 on 3/22/2023, E48 on 8/11/2022, and E50 on 1/9/2023. Attachment V: Abuse Prohibition training records for E5, E40, E41, E48, and E50 B1. A sweep was conducted by SE of the Abuse Prohibition training records - 100% of staff received the Abuse Prohibition training in orientation,and the ED completed an analysis of the timing of staff Abuse Prohibition training. The structure of orientation scheduled timing in conjunction with new hires was determined to have the potential to negatively affect all staff by the deficient practice which could impact all residents. B2. The ED directed the SE to develop and implement onboarding packets consisting of educational materials of in part the topics of Abuse Prohibition – Abuse/Neglect and Client Rights among other required topics. The ED discussed and directed the SE that the SE and/or the RNE to institute onboarding education packets for all new hires to be completed on the staff start date. Attachment U: Onboarding packet C1. The DON, DRS, and APA's RCA revealed the deficient practice of staff start dates of working in the facility occurring prior to the Abuse Prohibition training date was a result of two factors involving; A false assumption that new staff orientation education which involves education in Abuse Prohibition – Abuse/Neglect and Client Rights can be deferred until regularly scheduled orientation courses are scheduled and	05/25/23

5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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
			attended because newly hired staff are never left alone until orientation is completed; And, start dates of newly hired staff do not always correspond with Orientation Training scheduled dates. C2. The Administration Policy - Employee Education and Training Policy will be updated by the APA to include the onboarding requirements and specific topics which include Abuse Prohibition – Abuse/Neglect and Client Rights. The SE and/or APA will update the Orientation Training Checklists to include the onboarding education of newly hired staff. C3. Since Staff Orientation Training is scheduled 1 (one) time a month and start dates of new staff may not correspond with orientation training classes, Onboarding Packets will be provided by the SE or RNE, or DRS or DRS designee to newly hired staff for educating the staff on various topics including include Abuse Prohibition – Abuse/Neglect and Client Rights. Staff Onboarding will be scheduled to occur the first day of employment for all newly hired staff. Signed vouchers will be obtained from staff attending the onboarding. After each onboarding and orientation, the SE and/or RNE will instruct and obtained from each staff signed vouchers for the training education for 100% compliance. D. The APA and/or SCS will complete a random sampling of 5 (five) staff orientation/ onboarding training records for 1 (one) time a month until consistency reaches 100% success (Abuse Prohibition – Abuse/Neglect and Client Rights training was completed on the staff's start date) over 3 (three) consecutive evaluations. THEN The APA and/or SCS will complete a random sampling of 5 (five) staff orientation/	

IC57 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 189	Continued From page 15 Abuse Prohibition Training on 2/13/23. 3/27/23 9:35 AM - An interview with E29 (ADON) revealed that new employee orientation for all staff was four days in length and during this time, the new employees were provided Abuse Prohibition Training. 3/27/23 2:30 PM - Findings were reviewed with E1 (ED), E2 (PA), E29 and E4 (DRS) during the Exit Conference.	W 189	onboarding training records for 1 (one) time a quarter until consistency reaches 100% success (Abuse Prohibition – Abuse/Neglect and Client Rights training was completed on the staff's start date) over 3 (three) consecutive evaluations. FINALLY The APA and/or SCS will complete a random sampling of 5 (five) staff orientation/ onboarding training records for 1 (one) time biannually until consistency reaches 100% success (Abuse Prohibition – Abuse/Neglect and Client Rights training was completed on the staff's start date) over 2 (two) consecutive evaluations.	
W 191	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that for four (E47, E48, E49 and E50) out five CNA's, the facility failed to ensure training for guidelines on behavior plans were completed for nine clients (C5, C7, C9, C17, C18, C19, C20, C22 and C23). Findings include: A training review voucher was last updated 4/29/22 for the following clients: C5, C7, C9, C17, C18, C19, C20, C22 and C23. The material included: Target Symptoms/Responses to Behaviors; How to prevent Self Injurious Behaviors; and Response to Self Injurious Behaviors. CNAs E47, E48, E49 and E50 are still employed with the facility and have not completed the training. 3/24/23 10:42 - During an interview, E2 (Program	W 191	A. The facility is unable to correct the past practice resulting in lack of training for E47, E48, E49,E50 related to behavior supports/plans for C5,C7,C9,C17,C18,C19,C20,C22,C23); however, the APA will develop an educational flyer regarding behavior supports/plans for current staff, and the APA will update the Behavioral Services training PowerPoint for new staff to be completed in staff orientation and reeducation. Attachment W: Behavioral Services training PowerPoint B1. The APA conducted an academic analysis of behavior supports/plans training of implementing plans for all staff and determined that all residents have the potential to be negatively affected by the deficient practice. B2. The APA will develop an educational flyer regarding behavior supports/plans for current staff, and the APA will update the Behavioral Services training PowerPoint for new staff to be completed in staff orientation and reeducation to be conducted by the APA and/or Behavior Analyst (BA) C1. The APA's RCA revealed the deficient practice was related to two factors including: inadequate and informal orientation training in the	05/25/23

KST
5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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
			areas of Behavior Supports/Plans; and, lack of tracking of behavior supports/plans training of staff. C2. The APA will update the Behavior Services training PowerPoint for orientation. The Behavior Services and Supports training will be added to the staff orientation training schedule by the SE and/or RNE. The BA, APA, and/or the SE or RNE will provide the training during orientation classes as scheduled. Attachment W: Behavioral Services training PowerPoint C3. To immediately address the deficiency with current staff an educational flyer will be developed by the APA and/or BA on Behavior Supports/Plans. The staff will be educated on the information by the APA, BA, SE, DRS, RPA, and/or QIDP, and a signed voucher will be completed. C4. The Administration Policy - Employee Education and Training Policy will be updated by the APA to include orientation training in Behavior Supports/Plans. D. The APA and/or SCS will complete a random sampling of 5 (five) staff orientation/ onboarding training records for 1 (one) time a month until consistency reaches 100% success (Behavior Supports/Plans training was completed during orientation) over 3 (three) consecutive evaluations. THEN The APA and/or SCS will complete a random sampling of 5 (five) staff orientation/ onboarding training records for 1 (one) time a quarter until consistency reaches 100% success (Behavior Supports/Plans training was completed during orientation) over 3 (three) consecutive evaluations. FINALLY The APA and/or SCS will complete a random sampling of 5 (five) staff orientation/ onboarding training records for 1 (one) time	

KSF 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 191	Continued From page 16 Administrator) confirmed that the aforementioned CNA's should have signed off on the training for the nine (C5, C7, C9, C17, C18, C19, C20, C22 and C23) clients. Findings were reviewed with E1 (Executive Director), E2 (PA) and E4 (DRS) on 3/27/23 during the exit conference, beginning at 2:30 PM.	W 191	biannually until consistency reaches 100% success (Behavior Supports/Plans training was completed during orientation) over 2 (two) consecutive evaluations.	
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to consistently implement interventions identified on the individual program plan (IPP) for two (C6 and C8) out of 10 sampled clients. The facility failed to implement an arm splint to C6 as specified in the individual program plan. The facility failed to provide a recliner for C8 as specified in the individual program plan. Findings include: 1. Review of C6's clinical records revealed; 4/12/2021 - C6 was admitted to the facility.	W 249	A. The facility is unable to correct the past deficient practice regarding the missed splint application for C6 and missed recliner positioning time for C8. DON sent COTA to C6 to apply the splint on the 03/24/2023. The missed reliner time positioning for C8 could not be corrected at the time of the survey as this information was presented on the day of the survey exit interview; however, to address the immediate need of C8 the DRS checked the recliner location to ensure the C8 recliner is in the proper location(s) needed to implement the program plan 03/27/2023. Attachment X: Email from the Certified Occupational Therapist Assistant (COTA) regarding a sweep of splint compliance. B1. The ED held a staff meeting on 3/29/2023, as well as sent a follow up email and memo to DRS, DON, APA, RPA, SSA, QIDP, ATS, TIII, ATII, and SE regarding expectations of staff (Positioning and implementation of Program Plans which contain splint applications and resident recliner positioning use time). During this staff meeting with the DRS, APA, RPA, QIDP, the ED completed an academic analysis of splint use and recliner positioning related to staff following program plans (IPPs), and securing needed equipment. The analysis	05/25/23

KS 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 249	Continued From page 17 3/28/07 - C6's IPP stated that the restorative splint plan was to be implemented by Activities staff and direct care staff (CNA) per the plan's wearing schedule 9:00 AM to 1:00 PM; four hours per day. 3/20/23 10:55 AM - C6 was observed out of bed in his wheelchair with no left arm splint. 3/21/23 11:55 AM - C6 was observed without a left arm splint in place. An interview with E26 (RN), confirmed that C6 did not have an arm splint in place per the IPP. Additionally, E26 stated that the QIDP (Qualified Intellectual Disabilities Professional) was responsible to ensure placement of the splint. 3/21/23 1:53 PM - C6 was observed in bed without an arm splint. 3/22/23 1:16 PM - An interview with E27 (CNA) confirmed that she forgot to apply the splint to C6 on 3/21/23 from 9:00 AM to 1:00 PM. CNA (C6) confirmed that the CNA or Activities staff were responsible for applying the splint per the IPP. 3/22/23 1:33 PM - An interview with E28 (QIDP), confirmed that he was responsible to ensure that C6 has his splints in place by staff and to ensure the IPP is being followed. E28 stated that he was unaware that C6 did not have his splint applied on 3/21/23 and it would have been corrected during rounds if they were completed. 2. Review of C8's clinical records revealed; 3/24/60 - C8 was admitted to the facility. 2/29/22 - C8's individual program plan (IPP)	W 249	concluded that failing to provide required care through the use of and following program plans has the potential to negatively affect all residents who use splints, and recliners for positioning time. Under the direction of DON, checking of all splints was conducted by the COTA regarding splints locations and splint use for all residents, on 03/24/2023, and the DON informed the therapy department of their responsibilities regarding splint applications, 100% of splints were in locations for application and use. The DRS checked on the facility's/ residents' recliners, 100% of recliners were in locations for residents' use for positioning 03/27/2023. Attachment L: Email/Memo from the Executive Director to the Management Staff and Facility Charge Staff regarding PM46 Reporting and Daily Documentation and Expectations of Staff B2. The DON directed the Certified Occupational Therapist Assistant (COTA) to complete a sweep of splint compliance, which was completed on 3/24/2023. Attachment X: Email from the Certified Occupational Therapist Assistant (COTA) regarding a sweep of splint compliance B3. The DON informed the therapy department staff of their responsibilities to ensure that all splints are being applied per guidelines and monitored by the Therapy Department-Occupational Therapists (OT). Attachment Y: Email from the Director of Nursing (DON) to the Therapy Department reminding them that they are to ensure that all splints are being applied per guidelines and monitored by the Therapy Department C1. The DRS, DON, APA, and ED's RCA revealed that the deficient practice was related to two factors that involved confusion	

ICS 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 249	Continued From page 18 stated that "C8 may be positioned in a recliner as tolerated as an alternative to out of bed or wheelchair position to assist with chronic foot edema (swelling of feet). The chair should be reclined, utilizing a push button seat belt fastened in the front. On 6/14/22 Configure Chair IG (recliner) completed (was approved) for this client for use in Residential and Activity areas. Configure chair is also an alternate out of wheelchair positioning like recliner." 3/20/23 11:16 AM - C8 was observed out of bed, sitting in wheelchair in his room. C8 was observed holding a rainstick and watching television. 3/21/23 12:05 PM - C8 was observed sitting in his wheelchair watching television and no recliner was observed in his room. 3/22/23 9:58 AM - C8 was observed sitting in his wheelchair in his room watching television and no recliner observed. 3/24/23 11:16 AM - An interview with E30 (CNA) confirmed that C8 had a recliner in his room on the West Wing. She confirmed that C8 does not have a recliner in his room on the McCabe unit. 3/27/23 2:30 PM - Findings were discussed with E1 (ED), E2 (PA), E29 (ADON) and E4 (DRS) during the exit conference.	W 249	and/or lack of understanding among the roles and responsibilities of the Residential Management Staff leading to the lack of monitoring by management; And, this lack of management monitoring led to staffs' indolent approach at times with implementing program plans for which splint application and recliner time positioning protocols are detailed. C2. Regarding expectations of roles and duties. The ED updated the Performance Plans and Measures for the positions of RPA, SSA, QIDP, ATS, CNA, ATF, and Temporary Agency CNA. These performance plans and measures were reviewed by DRS, RPA, SSA, QIDP with all the staff designated by titles detailing designated staffs' duties and expectations of their job. Staff signatures were obtained designating their acknowledgment and agreement. Attachment N: Performance Plan Database C3. The facility will utilize an existing Splint Competencies and Compliance tool for monitoring splint use by the Therapy Department (OT). C4. The APA, DON, and DRS will create a Rotational Positioning (recliner use time is part of positioning) Checklist monitoring tool to be implemented by RPA and QIDP. D1. For splint application, the Therapy Department (OT) will complete a random sampling of 5 (five) residents on each residential unit on various shifts and with various staff, utilizing the Splint Competencies and Compliance tool for 1 (one) time a week for 2 (two) months until consistency reaches 100% success (correct application of splints) over 3 (three) consecutive evaluations. THEN For splint application, the Therapy Department (OT) will complete a random sampling of 5 (five) residents on each residential unit on various shifts and with	

KST 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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
			various staff utilizing the Splint Competencies and Compliance tool for 2 (two) times a month until consistency reaches 100% success (correct application of splints) over 3 (three) consecutive evaluations. FINALLY For splint application, the Therapy Department (OT) will complete a random sampling of 5 (five) residents on each residential unit on various shifts and with various staff utilizing the Splint Competencies and Compliance tool for 1 (one) time a month until consistency reaches 100% success (correct application of splints) over 3(three) consecutive evaluations. D2. For Rotational Positioning, each RPA and QIDP will complete a random sampling of 5 (five) residents on each residential unit on various shifts and with various staff utilizing the Rotational Positioning Checklist Tool for 1 (one) time weekly for 3 (three) months until consistency reaches 100% success (correct position according to the program plans) over 3 (three) consecutive evaluations. THEN For Rotational Positioning, each RPA and QIDP will complete a random sampling of 5 (five) residents on each residential unit on various shifts and with various staff utilizing the Rotational Positioning Checklist Tool for every 2 (two) weeks for 2 (two) months until consistency reaches 100% success (correct position according to the program plans) over 3 (three) consecutive evaluations. FINALLY For Rotational Positioning, each RPA and QIDP will complete a random sampling of 5 (five) residents on each residential unit on various shifts and with various staff utilizing the Rotational Positioning Checklist Tool for 1 (one) time a month until consistency reaches 100% success (correct position according to the program plans) over 3 (three) consecutive evaluations.	

KS7 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by:	W 331	A. The facility is unable to correct the past deficient practice regarding the staff E38 not following the program plan for C2 specific to lifts and transfers resulting in the injury of C2; however, during the time of the injury, C2 received medical care at the facility as well as at the hospital, the incident was reported as a reportable incident of significant injury (PM46), and the lift system was inspected for proper function for which it was deemed to be properly function. The incident was reported to State Officials through the proper reporting and investigation procedures, E38 was removed from client care and removed from the building. E38 no longer works for the facility as well. B. At the time of the investigation E38 was removed from patient care pending the outcome of the investigation. To address the issue, the ED held a staff meeting on 3/29/2023, as well as sent a follow up email and memo to DRS, DON, APA, RPA, SSA, QIDP, ATS, TIII, ATII, and SE regarding expectations of staff (following Program Plans which contain lift and transfer guidelines). During this staff meeting with the DRS, APA, RPA, QIDP, the ED completed an academic analysis of lifts and transfers related to staff following program plans. The analysis concluded that failing to provide required care through the use of and following program plans has the potential to negatively affect all residents. Attachment L: Email/Memo from the Executive	05/25/23

KSZ 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26361 PATRIOTS WAY GEORGETOWN, DE 19947

(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 331	Continued From page 19 Based on record review and interview, it was determined that for one (C2) out of two sampled residents reviewed for accidents, the facility failed to ensure adequate staff assistance and/or assistive devices. The facility failed to provide two person assistance during a transfer using the overhead lift. The lift hit R2 in the face which resulted in bruising, a laceration under the right eye and a fractured nose. Findings include: Review of C2's clinical record revealed: 12/25/22 1:30 PM - The Incident Report documented that E38 (Agency CNA) was attempting to transfer R2 from a wheelchair to his bed. E38 documented, "I was attempting to put his sling under him, got it under him. Then I took the lift and swung it to get to resident, I swung it too hard and it hit him on his right eye." 12/25/22 4:26 PM - An email correspondence from E39 (Adaptive Equipment Tech II) documented that the overhead lift in R2's room was checked and it was working correctly. 12/25/22 2:55 PM - Review of hospital ED (Emergency Department) records documented, "Patient presents with swelling and bruising to right eye... 1.5 cm (centimeter) laceration (cut) repair method: tissue adhesive (liquid glue)...no dressing." X-rays of R2's nose showed "bone fractures." C2 was discharged the same day and returned to the facility. 3/22/23 (approximately 11:45) - A QIDP monthly review of 6/22/22 through 3/23/23 documented that C2 must be a two person assist at all times. 3/22/23 1:45 PM - During an interview, E17 (RN)	W 331	Director to the Management Staff and Facility Charge Staff regarding PM46 Reporting and Daily Documentation and Expectations of Staff C1. The DRS, DON, APA, and ED's RCA revealed that the deficient practice was related to factors involving unclear expectations and/or insufficiency understanding of roles and responsibilities of the Residential Management Staff leading to the lack of monitoring by management; a lack of management monitoring staffs' work can cause staff to become apathetic in their approach to duties with implementing program plans in which lifts and transfer guidelines are detailed; And, E38 who was trained in lifts and transfers both 1 person and 2 person, and trained in following instructional guidelines in program plans took it upon E38's self to conduct the lift transfer on her own without the assistance of another staff person, which led to C2 injury. C2. Regarding expectations of roles and duties. The ED updated the Performance Plans and Measures for the positions of RPA, SSA, QIDP, ATS, CNA, ATF, and Temporary Agency CNA. These performance plans and measures were reviewed by DRS, RPA, SSA, QIDP with all the staff designated by titles detailing designated staffs' duties and expectations of their job. Staff signatures were obtained designating their acknowledgment and agreement. Attachment N: Performance Plan Database C3. The facility will utilize an existing Lift, Gait Belt, and Transfer Competencies tool for monitoring splint use by the Therapy Department (PT) and the Residential Management Team - RPA and QIDP. D1. The Therapy Department (PT) and Residential Management Team – each RPA and	

5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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
			QIDP will complete a random sampling of 5 (five) residents each (5 residents each per reviewer) on each residential unit on various shifts and with various staff, utilizing the Lift, Gait Belt, and Transfer Competencies tool for 1 (one) time a week for 2 (two) months until consistency reaches 100% success (correct application of lift/transfer) over 3 (three) consecutive evaluations. THEN The Therapy Department (PT) and Residential Management Team – each RPA and QIDP will complete a random sampling of 5 (five) residents each (5 residents each per reviewer) on each residential unit on various shifts and with various staff, utilizing the Lift, Gait Belt, and Transfer Competencies tool for 2 (two) times a month until consistency reaches 100% success (correct application of lift/transfer) over 3 (three) consecutive evaluations. FINALLY The Therapy Department (PT) and Residential Management Team – each RPA and QIDP will complete a random sampling of 5 (five) residents each (5 residents each per reviewer) on each residential unit on various shifts and with various staff, utilizing the Lift, Gait Belt, and Transfer Competencies tool for 1 (one) time a month until consistency reaches 100% success (correct application of lift/transfer) over 3 (three) consecutive evaluations.	

KS7 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 331	Continued From page 20 stated she was working the day of the incident on the McCabe unit. E17 stated she received a phone call from E42 (RN) asking for her help as C2 was "hit in the face with the lift." Upon entering C2's room E17 immediately saw C2 had swelling and a laceration just under the right eye. E17 applied pressure to the area. E38 (agency CNA) confirmed she was attempting to transfer C2 by herself, despite knowing that C2's transfer status was two person assist at all times. Findings were reviewed with E1 (Executive Director), E2 (PA) and E4 (DRS) on 3/27/23 during the exit conference, beginning at 2:30 PM.	W 331		
W 339	NURSING SERVICES CFR(s): 483.460(c)(4) Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined that for five out of five clients reviewed for non-medication treatments, the facility failed to ensure that the CNAs were providing care and consistently signing off their treatments in the designated treatment binder on the Chandler and McCabe units. Findings include: 1. Review of C2's treatment record revealed; 3/22/23 10:05 AM - Review of the treatment record dated 3/8/23 included the following non-medication treatments: - Apply extra thick antifungal to bilateral (both sides) groin, after bath and after hygiene;	W 339	A. The facility is unable to correct the past practice resulting in the deficiency regarding the application of treatments not being documented in the Treatment Administration Records (TAR) for C2,C3,C4,C6,C7. A sweep of treatment products was conducted by the DON and ADON on 3/27/23, 100% of the over the counter treatment products were available for use for C2,C3,C4,C6,C7. B1. To immediately address the specific deficiency with management, the ED conducted an analysis with the DRS, APA, RPA, QIDP during a staff meeting on 3/29/2023, regarding the lack of staff documentation of application of resident treatments and documentation in the TARs to ensure staff are providing the required resident care. The conclusion of the analysis revealed that other residents' TARs did not have staff initials indicating application of treatments which leads to failing to document applied treatments in the TAR does not confirm that the treatments were in fact applied, which is essential in providing resident care. The failure of not documenting the application of treatment	05/25/23

IES 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 339	Continued From page 21 - Acne face wash to back twice a day; - Hibiclens liquid 4%, bath weekly on Saturday 2:00 PM -10:00 PM shift; - Apply Abreva cream to lips five times a day or until healed; - Coal tar shampoo three times a week on Monday, Wednesday, Friday, 2:00 PM -10:00 PM shift. None of the abovementioned treatments were signed off as being done by the CNAs. 3/22/23 11:30 AM - During an interview, E13 (CNA) confirmed that the binder located at the nurses' station is where the CNAs check their assignments. In addition, the treatment record addresses the treatments that are to be done for each resident and are signed off when completed. 3/23/23 10:05 AM - During an interview, E20 (CNA) confirmed that if a residents gets bathed, uses any special shampoo or cream it is documented in the treatment record. 3/23/23 10:12 AM - During an interview, E11 (CNA) confirmed that the treatment record is where the CNAs sign off their treatments and tasks. 3/23/23 11:04 AM - During an interview, E22 (RN) confirmed there were multiple blank and incomplete documents in the binder. E22 stated that Administrative staff are supposed to be doing audits to ensure they are being done. 2. Review of C3's treatment record revealed: 3/22/23 10:05 AM - Review of the treatment	W 339	leading to deficient practices could have the potential to negatively affect all residents. In addition, the DON and ADON conducted a sweep of all residents Over the Counter Treatment products and found that 100% of the products were available for use for all residents. Attachment L: Email/Memo from the Executive Director to the Management Staff and Facility Charge Staff regarding PM46 Reporting and Daily Documentation and Expectations of Staff B2. During the 3/29/2023, staff meeting analysis, the ED discussed and expressed expectations of management and for management to convey the requirements to staff expectations regarding Completion and Documentation of various needs and treatments and Management must be Checking and Correcting TARs across all shifts. The ED followed up with an email and memo conveying the same to DRS, DON, APA, RPA, SSA, QIDP, ATS, TIII, ATII, and SE. Attachment L: Email/Memo from the Executive Director to the Management Staff and Facility Charge Staff regarding PM46 Reporting and Daily Documentation and Expectations of Staff B3. A sweep conducted by the APA revealed the need for documentation training for all staff; therefore, the APA revised the Documentation training PowerPoint to reflect the requirement of daily documentation on 3/29/2023, for orientation and reeducation conducted by the SE and RNE. Attachment M: Documentation training PowerPoint B4. To immediately address the current staff, an educational flyer will be developed by the SE and/or RNE on Daily Documentation. The Direct Care Staff (CNAs, ATFs, and Temp	

KS 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 339	Continued From page 22 record dated 3/8/23 included the following non-medication treatments: - Ted hose stockings (help prevent blood clots and swelling in the legs) apply in the morning and remove at bedtime; - Coal tar shampoo three times a week on Monday, Wednesday, Friday, 2:00 PM -10:00 PM shift; - Apply Selsun blue (shampoo) four times a week on Sunday, Tuesday, Thursday, Saturday; - Elevate both legs in recliner chair one hour during the day and one hour in the evening. None of the abovementioned treatments were signed off as being done by the CNAs. 3/23/23 10:45 AM - During an interview, E23 (RN) confirmed the treatments were not signed off by the CNAs. 3/24/23 10:00 AM - During an interview, E24 (RN Supervisor) confirmed there were multiple blank and incomplete documents. E24 stated that she brought it to the attention of Administration several times. 3. Review of C6's treatment record, dated 3/15/23, revealed: -Ketoconazole shampoo on Monday, Wednesday, Friday; -Calmoseptine ointment during hygiene care; -Burts Bees soap for bathing. 4. Review of C7's treatment record, dated 3/15/23, revealed: -Acne face wash twice daily;	W 339	Agency CNAs) will be educated on documentation training by the SE and Residential Team – DRS, RPA, SSA, QIDP, and/or ATS, and a signed voucher will be completed. C1. The ED, DRS, DON, and APA's RCA revealed the deficient practice was related to four factors which includes: lack of adequate staff documentation of resident treatments on the TAR; confusion and/or lack of understanding among the roles and responsibilities of the residential management staff leading to the lack of monitoring by management; some ambiguities written in the TAR policy, The staffs' lackadaisical approach to the important of documentation despite staffs' knowledge regarding documenting in the TAR. C2. The Medication Administration Nursing policy, Treatment Administration Record (TAR), and Orientation/In-service was reviewed and revised by the DON on 4/14/2023. Attachment Z: Medication Administration Nursing policy and Treatment Administration Record (TAR) In-service update C3. Regarding expectations of roles and duties. The ED updated the Performance Plans and Measures for the positions of RPA, SSA, QIDP, ATS, Certified Nursing Assistant (CNA), Active Treatment Facilitator (ATF), and Temporary Agency CNA. These performance plans and measures were reviewed by DRS, RPA, SSA, QIDP with all the staff designated by titles detailing designated staffs' duties and expectations of their job. Staff signatures were obtained designating their acknowledgement and agreement. Attachment N: Performance Plan Database	

KSZ 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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 339	Continued From page 23 - WeeklyWeights; -Desitin during hygiene care until resolved. 5. Review of C4's treatment record, dated 3/15/23, revealed: - Botene for oral hygiene twice daily; - Ammonium lactate lotion to dry skin areas twice daily; -Vitamin E oil to lips twice daily; -Use of insert in brief with incontinent care. 3/23/23 approximately 11:30 AM - During an interview, E8 (CNA) revealed that when treatments are completed on clients the CNA is expected to record in the treatment book. 3/23/23 around 12:00 PM - During an interview, E28 (QIDP) confirmed there were multiple blank and incomplete documents. E28 stated that he does not monitor these documents for completion. 3/23/23 around 12:00 PM - During an interview, E5 (PA) confirmed that monitoring these documents was not part of his responsibilities, E4 (DRS) provided the oversight. 3/23/23 1:14 PM - An interview with E4 (DRS) revealed that the Q's (QIDP) were responsible for monitoring the CNA's work. Findings were reviewed with E1 (Executive Director), E2 (PA) and E4 (DRS) on 3/27/23 during the exit conference, beginning at 2:30 PM.	W 339	C4. The SE and/or RNE will provide education on the revised Documentation training during orientation and reeducation. C5. The APA will update the Active Treatment Supervisor's Shift Monitoring Report to include the review of staffs' documentation on TARs. When on duty the ATS completes this monitoring report across all shifts. C6. The APA will update the Facility Charge Shift Monitoring Report to reflect the review of staffs' documentation on TARs. When on duty and designated as Facility Charge, this monitoring report is completed by Facility Charge staff who consist of APA, RPA, SSA, QIDP, TIII, ATII, and/or SE across all shifts. D. The ATS will review TARs on each shift across residential units for each resident 5 times a week for 1 (one) month until consistency reaches 100% success (all TARs are documented) over three (three) consecutive evaluations. The ATS will document on the Active Treatment Supervisor's Report. THEN The ATS will review TARs on each shift for 5 randomly selected residents on each residential unit every 2 (two) weeks for 1 (one) month until consistency reaches 100% success (all TARs are documented) over three (three) consecutive evaluations. The ATS will document on the Active Treatment Supervisor's Report. THEN The ATS will review TARs on each shift for 5 randomly selected residents on each residential unit once a month for 2 (two) months until consistency reaches 100% success (all TARs are documented) over three (three) consecutive evaluations. The	

KST 5/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(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
			ATS will document on the Active Treatment Supervisor's Report. FINALLY The ATS will continue to review TAR documentation for each scheduled shift across residential units, and document on the Active Treatment Supervisor's Report. The APA or SCS will review the Active Treatment Supervisor's Report for compliance with the monitoring. A monthly report of the findings will be completed and reported to the Residential Management Team (DRS, RPA, SSA, QIDP, and ATS).	

KST 5/17/23