

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

PRINTED: 05/19/2015  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION           |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>08G001</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>05/07/2015</b> |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>STOCKLEY CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>26351 PATRIOTS WAY<br/>GEORGETOWN, DE 19947</b>                     |   |
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE                                |
| W 000  | INITIAL COMMENTS<br><br>An unannounced annual survey was conducted at this facility from April 29, 2015 through May 7, 2015. The deficiencies contained in this report are based on observation, interviews and review of clients' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 53. The sample totaled 12 clients.<br><br>Abbreviations used in this report are as follows:<br>NHA - Nursing Home Administrator;<br>DON - Director of Nursing;<br>RN - Registered Nurse;<br>LPN - Licensed Practical Nurse;<br>CNA - Certified Nurse's Aide;<br>UM - Unit Manager;<br>MD-Medical Doctor;<br>NP- Nurse Practitioner;<br>FSD - Food Service Director;<br>POS - Physician Order Sheet;<br>MAR - Medication Administration Record;<br>OT Occupational Therapist;<br>ELP- Essential Lifestyle Plan;<br>QIDP - Qualified Intellectual Disability Professional;<br>SBAR -Situation Background Assessment Request/Recommendation; a communication note between nursing and Medical Team the Nurse Practitioner or Physician;<br>WPA - Work Program Assistant. | W 000   |   |   |
| W 331  | 483.460(c) NURSING SERVICES<br><br>The facility must provide clients with nursing services in accordance with their needs.<br><br>This STANDARD is not met as evidenced by:  | W 331   |   |   |

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

*Adelle M. Wenzel*

TITLE

*Executive Director*

(X8) DATE

*6/19/15*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| W 331   | <p>Continued From page 1</p> <p>Based on record review and interview it was determined that for one (C11) out of twelve sampled residents the facility failed to provide nursing services in accordance with the client's needs as it relates to pain management. Findings include:</p> <p>The facility policy approved by E2 DON on 10/26/12 entitled "Pain Management" identified the following objectives; to assess a client who may be experiencing discomfort/pain, to provide appropriate intervention for discomfort/pain relief, to ensure discomfort/pain has been relieved through follow up assessment for effectiveness.</p> <p>The facility policy approved by E2 on 1/11/13 entitled "Medical Team Notification" set guidelines and expectations for communications between the Nursing Staff and Medical Team. The policy indicated situations requiring prompt notification of the Medical Team as:</p> <ul style="list-style-type: none"> <li>-When a client develops increased pain;</li> <li>-When a client has a change in condition, level of consciousness, agitation, etc;</li> <li>-In the event of an urgent health issue the nurse will page the Medical Team member by calling the facility operator;</li> <li>-For routine needs the nurse will notify the Medical team using the SBAR communication book.</li> </ul> <p>Review of C11's clinical record revealed the following:</p> <p>12/6/13- C11's ELP Indicated C11 will cry and</p> | W 331  | <p>A. For resident C11, there is no corrective measure that can be taken at this time to address the deficient practice from November 21, 2014, of failure to provide residents with nursing services in accordance with their needs. The resident was evaluated by medical on November 24, 2014 and an appropriate treatment plan implemented.</p> <p>On May 13, 2015, the Director of Nursing completed the appropriate action with the staff who failed to provide timely nursing services in accordance with resident C11's needs as it related to pain management.</p> <p>A memo was sent by the Director of Nursing on May 13, 2015, to all nursing staff outlining the expectations for prompt nursing services and interventions when a change in a resident's health condition is identified.</p> <p><u>Exhibit A</u></p> <p>B. All significant injury reports and investigations for the facility for the time period May 2014 through May 7, 2015 were reviewed during the annual survey by the DLTCRP surveyors. There were no other residents found to have untimely nursing services provided.</p> |  |

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| W 331  | <p>Continued From page 2</p> <p>moan out loud if in pain or uncomfortable.</p> <p>11/21/14- At 11:12 AM E17 OT documented that C11 "was whining most of the morning ... she is experiencing discomfort. Reported to E18 NP". There was no evidence that an assessment was conducted by E18.</p> <p>11/21/14- At 12:29 PM E27 CNA documented that C11 was "having unusual behavior while during her morning care and afterward. C11 cried out throughout the care. E27 told E17 about it and to watch C11's movements."</p> <p>11/22/14-At 1:00 PM E29 RN in the nursing notes documented that C11 was "crying on and off while in wheel chair. Calms when in bed. Note left in SBAR." There is no evidence that an assessment was done for pain.</p> <p>11/22/14-1:00 PM E29 documented an SBAR note "crying on and off when in wheelchair, quiet when in bed and when left alone ". There is no evidence that the Medical team looked at the SBAR communication note.</p> <p>11/22/14- At 1:53 PM E30 CNA documented C11 "cried all 6:00 AM-2:00 PM, during lunch she only had fluids, nurse notified." There is no evidence that an assessment was done for pain.</p> <p>11/22/14 -At 8:50 PM E28 CNA documented C11 "did some crying and whining, cried the entire time she was fed dinner, cried during her shower and any other contact."</p> <p>11/23/14-At 8:15 PM E26 documented C11's "left foot ankle was swollen and warm to touch- and</p> | W 331   | <p>C. The nurse supervisors will review the facility's Nursing Procedures for Pain Management, Medical Team Notification, and Nursing Documentation with each nurse to ensure their understanding and future compliance.</p> <p>Nurse supervisor/charge nurse will review the 24-hour Nursing Service Reports each shift to ensure the nursing staff are promptly assessing, providing appropriate intervention, and notifying the medical team timely for any changes noted in a resident's health status. All concerns will be immediately reported to the Director of Nursing to determine the appropriate corrective measures. A memo was issued to all nurses on June 9, 2015. <b>Exhibit B</b></p> <p>D The nursing educator/supervisor will review the nursing documentation to ensure timely nursing services were provided, for the facility's significant/serious injury cases. This data will be reviewed by the Director of Nursing and appropriate actions taken. If after three months, 100% compliance for providing timely nursing services is achieved, reviews of 50 % of the cases will be completed.</p> |   |

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| W 331  | <p>Continued From page 3</p> <p>C11 draws it up as if she is protecting it "these findings were documented as reported to E28 RN. There is no evidence that an assessment was done for pain.</p> <p>11/23/14 -At 9:00 PM E28 documented C11 "appeared to be favoring left foot upon assessment, left foot is swollen, especially top of left foot, outer ankle is red warm to touch, no pain but C11 is quiet. A note placed in SBAR for Medical Team to evaluate in the morning."</p> <p>11/23/14- An SBAR note was written in the communication book that documented the following "left foot ankle area swollen, ankle warm and red, please assess."</p> <p>11/24/14-At 10:15AM E18 documented being notified that C11 was "crying off and on while in wheel chair and of swelling and warmth. C11 appeared mildly uncomfortable, whining at time of exam. Left shin had yellowish bruising and was slightly warm to the touch with swelling from knee to ankle, swelling on top of foot and ankle area." This notification was more than twenty four hours after the onset of pain.</p> <p>11/24/14 -At 10:30-11:20 AM E31 RN documented "left foot and ankle swollen and warm to touch, light yellow discoloration noted to shin, facial grimacing. E18 notified to examine left leg. New physician's order obtained for pain medicine to be given and x-ray of foot."</p> <p>11/24/14- 9:00 AM A facility incident report investigation began.</p> <p>11/25/14-Hospital medical record findings</p> | W 331   | <p>Again after three months, if 100% compliance continues, the provision for nursing services will be monitored every six months as part of the COR Nursing/Medical Review for each resident.</p> <p>The Office of Quality Improvement will review all significant/serious injury cases quarterly for 100% compliance of providing nursing services in accordance with the resident's needs.</p> <p><b>Completion Date: June 12, 2015</b></p> |   |

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| W 331  | <p>Continued From page 4</p> <p>documented C11 as having a spiral fracture involving the distal tibia shaft (broken bone in left lower leg) above the ankle.</p> <p>11/30/14 -Written Statement from E30 CNA documented that on 11/22/14 during 6:00 AM -2:00 PM shift E30 "went to look for nurse because E30 noticed C11's foot was little swollen more than the other. "E30 showed E29, C11's foot, E30 then " told that C11 was crying and whining all morning into all day".</p> <p>Review of clinical record, nursing notes, and November Medication Administration Record and physician orders indicated C11 was not medicated for signs and symptoms of pain prior to 11/24/14.</p> <p>During a telephone interview with E17 on 5/5/15 at 2:31 PM, E17 confirmed that on 11/21/14 as documented that E18 was made aware that C11 was having pain as evidenced by crying and whining in a way that was atypical of the client. E17 reiterated that C11 was exhibiting the behavior prior to C11's medical appointment out of the building and that E18 was notified of this as well.</p> <p>During an interview on 5/5/15 at 12:20 PM with E18, who was initially unable to recall a conversation with E17 on 11/21/14, then later recalled the conversation being related to C11's having pain related to myoclonic discomfort (muscles and nerves) not of new origin. E18 then stated the first time she became aware of swelling to C11's foot was on Monday, 11/24/14 morning. E18 indicated that the expectation of the nursing staff related to pain management would be for the staff to "just tell one of us. Or do an</p> | W 331   |   |   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION           |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>08G001</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>05/07/2015</b> |
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| W 331  | Continued From page 5<br>assessment or do an SBAR. Or use the ELP as a guide to the client." E18 confirmed uncontrolled pain is supposed to be reported.<br><br>During an interview on 5/5/15 at 1:03 PM with E20 RN, it was indicated that the expectation of the nursing staff is to notify the Medical Team if a client seemed to have uncontrolled pain after conducting an individualized pain assessment.<br><br>E17 was the first facility staff to have observed and documented C11 exhibiting unusual behavior consistent with signs and symptoms of pain as early as 11/21/14. C11's clinical record demonstrates pain was identified on 11/21/14 and pain medication was not administered until 11/24/14. The clinical record indicates the facility did not identify the significance of C11's crying behavior even though it was identified in C11's ELP. Consequently the facility failed to conduct assessments in a timely manner, failed to communicate with the Medical Team and failed to provide appropriate interventions to ensure C11 received the nursing services to meet the client's needs.<br><br>These findings were reviewed on 5/7/14 at 12:30 PM with E1 NHA and E2. | W 331   |   |                      |   |
| W 448  | 483.470(l)(2)(iv) EVACUATION DRILLS<br><br>The facility must investigate all problems with evacuation drills, including accidents.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and review of facility documents it was determined that the facility failed to investigate a problem with a monthly fire   | W 448   |   |                      |   |

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| W 448  | <p>Continued From page 6<br/>drill. Findings include:</p> <p>Review of fire drill reports on 5/5/15 at 12:50 PM conducted over the last year with E36, security supervisor noted the following:</p> <p>On 1/27/15 at 10:35 AM a fire drill was conducted on the McCabe unit. Under the section Problems Identified and Corrective Actions it was ' documented no nurse on the floor.</p> <p>Subsequent drills on the Chandler unit at 10:50 AM and West unit at 11 AM the same day noted the same problem of no nurse on the floor. There was no corrective action included.</p> <p>Interview with E38 during this review revealed that it is the nurses' responsibility to shut off the oxygen to the unit. During the above drills all the nurses were on break. There was no one else assigned to turn off the oxygen. He stated this personal corrective action would be to not conduct fire drills when the nurses are on break. This would have been an incorrect measure to address this problem. He revealed that he thought he had spoken to either E3, Director of Residential Services or E2, DON about this incident.</p> <p>An Interview on 5/5/15 at 1:15 PM with E1, NHA and E2 revealed that they were unaware of the incident and agreed with the surveyor that just not conducting a drill during break time would not correct the issue of the oxygen not being turned off during a fire if the nurse was not on the unit. They stated that they would need to train others to turn off the oxygen.</p> | W 448   | <p>A. There is no corrective measure that can be taken at this time to address the deficient practice of no corrective measure related to the fire drill.</p> <p>B. All Fire Drill Reports and Investigations for the facility for the time period of May 2014 through May 7, 2015, were reviewed during the Annual Survey by the DLTCRP surveyors. There were no other drills found to have deficiencies at that time.</p> <p>C. The Executive Director contacted the Maintenance Superintendent on May 13, 2015, to advise them that all Fire Drill Reports need to be submitted immediately to the Executive Director's office for review and follow-up.</p> <p>Other staff in the areas will be trained on how to turn off the medical gases. There will be specific staff assignments on each area that will be responsible for turning off medical gases during a fire drill. During a real fire, the security staff will be responsible for shutting off the main oxygen supply for the entire Mary Ann Coverdale Center.</p> <p>D. The Executive Director/designee will continue to monitor each Fire Drill for 100% compliance. The Office of Quality Assurance will continue to conduct reviews of all Fire Drill Reports on a quarterly basis for 100% compliance.</p> <p><b>Completion Date: July 6, 2015</b></p> |   |



**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-6661

**STATE SURVEY REPORT**

NAME OF FACILITY: Stockley Center

DATE SURVEY COMPLETED: May 7, 2015

| SECTION | STATEMENT OF DEFICIENCIES<br>Specific Deficiencies  | ADMINISTRATOR'S PLAN FOR<br>CORRECTION<br>OF DEFICIENCIES | COMPLETION<br>DATE |
|---------|---|---|--------------------|
|         | <p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced annual survey was conducted at this facility from April 29, 2015 through May 7, 2015. The deficiencies contained in this report are based on observation, interviews and review of clients' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 53. The sample totaled 12 clients.</p> <p>Abbreviations used in this report are as follows:<br/> NHA - Nursing Home Administrator;<br/> DON - Director of Nursing;<br/> RN - Registered Nurse;<br/> LPN - Licensed Practical Nurse;<br/> CNA - Certified Nurse's Aide;<br/> UM - Unit Manager;<br/> MD-Medical Doctor;<br/> NP- Nurse Practitioner;<br/> FSD - Food Service Director;<br/> POS - Physician Order Sheet;<br/> MAR - Medication Administration Record;<br/> OT Occupational Therapist;<br/> ELP- Essential Lifestyle Plan;<br/> QIDP - Qualified Intellectual Disability Professional;<br/> SBAR -Situation Background Assessment Request/Recommendation; a communication note between nursing and Medical Team the Nurse Practitioner or Physician;<br/> WPA - Work Program Assistant.</p> |   |                    |

Provider's Signature Aileen Wenzel Title Executive Director Date 6/9/15



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| 3201     | <b>Regulations for Skilled and Intermediate Care Facilities</b>  |   |                    |
| 3201.1.0 | <b>Scope</b>   |   |                    |
| 3201.1.2 | <p>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.</p> <p>This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey date completed May 7, 2015, W331 and W448.</p> | <p><b>3201.1.2</b></p> <p>Cross refer to the CMS 2567-L survey ending May 7, 2015, W331 and W448</p>  |                    |
| 3201.7.5 | <p><b>Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.</b></p> <p>Based on observation during a kitchen tour with a Public Health Inspector on 5/5/15 from 9 – 10:30 AM it was determined that the facility failed to be in compliance with the Delaware Food Code. Findings include:</p> <p><b>3-501.13 Thawing</b><br/><b>(B) Completely submerged under running water:</b><br/><b>(1) At a water temperature of 70 degrees Fahrenheit (F) or below,</b></p>   | <p><b>3201.7.5</b></p> <p>A. On May 5, 2015, the senior cook discarded the luncheon turkey meat that was thawed improperly and an irreversible registering temperature indicator was located and implemented for monitoring of the manual and mechanical ware washing. Also, the chemical container for the self-cleaning oven was labeled.</p> |                    |

Provider's Signature Adelle M. Wilson Title Executive Director Date 6/9/15



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STATE SURVEY REPORT

NAME OF FACILITY: Stockley Center

DATE SURVEY COMPLETED: May 7, 2015

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| <p>3201.9.8</p> <p>3201.9.8.4</p> <p>3201.9.8.4.2</p> | <p>Luncheon turkey meat was observed being thawed under running water at 72 degrees F.</p> <p><b>4-302.13 Temperature Measuring Devices, Manual and Mechanical Warewashing (B) In hot water mechanical warewashing operations, an irreversible registering temperature indicator shall be provided and readily accessible for measuring the utensil surface temperature.</b></p> <p>The food service staff did not have an irreversible registering temperature indicator.</p> <p><b>7-102.11 Identifying Information, Prominence Containers of poisonous or toxic materials and personal care items shall bear a legible manufacturer's label.</b></p> <p>The self-cleaning oven had a container of green liquid chemical that was not labeled.</p> <p><b>Reportable incidents are as follows:</b></p> <p><b>Significant injuries</b></p> <p><b>Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.</b></p> <p>Based on facility document review and interview it was determined that for one (C12) out of 12 sampled residents the facility failed to report a significant injury that resulted in hospital treatment. Findings include:</p> <p>Review of the facility's Incident Reporting</p> | <p>B. The Delaware Food Code was reviewed by the Dietary Manager on May 12, 2015, and no other deficient food handling practices were identified in the facility's dietary department.</p> <p>C. A memo was sent on May 13, 2015, by the Dietary Manager to all Food Service staff outlining the proper thawing procedures, and water temperature monitoring requirements.</p> <p><u>Exhibit A</u><br/>A memo was sent on May 21, 2015, by the Dietary Manager to all Food Service staff reminding them of the proper labeling of all containers of poisonous or toxic materials.</p> <p><u>Exhibit B</u><br/>The facility's Food Handling Manual will be revised to include the proper thawing processes for frozen foods, water temperature monitoring for manual and mechanical ware washing, and the proper labeling of all containers of poisonous or toxic materials. All Food Service staff will read and sign the revised Food Handling Manual.</p> <p>D. The Dietary Manager will monitor compliance for the identified deficient practices weekly using the Food Service Safety Inspection form. <u>Exhibit C</u> This data will be reviewed by the Director of Nursing and appropriate actions taken. If after 6 weeks, 100% compliance is noted the inspections will continue monthly. The Office of Quality Improvement will conduct quarterly Food Service Inspections for 100% compliance of safe food handling practices.</p> <p style="text-align: right;"><b>Completion Date: June 26, 2015</b></p> |
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Provider's Signature Debra M. Wenzel Title Quality Director Date 6/19/15



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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Wilmington, Delaware 19806  
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**STATE SURVEY REPORT**

NAME OF FACILITY: Stockley Center

DATE SURVEY COMPLETED: May 7, 2015

| SECTION | STATEMENT OF DEFICIENCIES<br>Specific Deficiencies | ADMINISTRATOR'S PLAN FOR<br>CORRECTION<br>OF DEFICIENCIES | COMPLETION<br>DATE |
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|  | <p>policy included the reporting of any significant event that warrants administrative reporting and/or documentation but failed to include broken bones needing medical treatment in the list of examples.</p> <p>Review of a facility incident report dated 11/17/14 documented; while replacing (C12's name) adult brief I attempted to spread her legs and heard a loud pop/crack noise. I immediately notified (staff name) what had happened. The resident was taken to the hospital and found to have a broken left upper leg bone (femur).</p> <p>An interview on 5/5/15 at 1:15 PM with E1, NHA confirmed that this incident was not reported to the State agency.</p> <p><b>§ 1108. Posting of inspection summary and other information and public meetings.</b><br/> <b>(a) Each facility shall prominently and conspicuously post for display in a public area of the facility that is readily available to residents, employees and visitors the following:</b></p> <p><b>(3) The most recent state survey report prepared by the Department of the most recent inspection report for the facility.</b></p> <p>Based on observation and interview it was determined that the facility failed to post the survey inspections results in a public area. Findings include:</p> <p>Observations each day during the survey 4/29 – 5/1/15 the survey results were not found in the public areas.</p> <p>During an interview on 5/1/15 at 9:45 AM with</p> | <p><b>3201.9.8.4.2</b></p> <p>A. For resident C12, there is no corrective measure that can be taken at this time to address the deficient practice of not reporting to the State agency.</p> <p>B. All Administrative Incident Reports and investigations for the facility for the time period of May 2014 through May 7, 2015, were reviewed during the Annual Survey by the DLTCRP surveyors. There were no other residents found to have deficiencies at that time.</p> <p>C. The Executive Director/designee knows to report these types of incidents to the State agency and will ensure all future incidents of a similar nature are reported at the time of the incident.</p> <p>D. The Executive Director/designee will continue to monitor each Administrative Incident Reports and investigations for 100% compliance. The Office of Quality Improvement will continue to conduct reviews of all Administrative Incident Reports and investigations on a quarterly basis for 100% compliance.</p> <p style="text-align: right;"><b>Completion Date: May 5, 2015</b></p> |  |
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Provider's Signature Aileen Williams Title Executive Director Date 6/9/15



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**STATE SURVEY REPORT**

NAME OF FACILITY: Stockley Center

DATE SURVEY COMPLETED: May 7, 2015

| SECTION | STATEMENT OF DEFICIENCIES<br>Specific Deficiencies | ADMINISTRATOR'S PLAN FOR<br>CORRECTION<br>OF DEFICIENCIES | COMPLETION<br>DATE |
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|  | <p>CG1 it was revealed that the state report was not readily accessible for family members of clients. CG1 stated "If there is a report then I have not been told of it" and confirmed that he has not seen a sign posting survey results in the facility.</p> <p>During an interview on 5/1/15 at 1:00 PM with E1 NHA, it was reported that the State survey results are kept in her office. E1 further explained that the survey results are reviewed twice a year at the facility family meetings and that at that time clients and families are encouraged to ask questions.</p> <p><b>1108 Nurse Staffing</b><br/><b>(a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, 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.</b></p> <p>Based on observation, policy review and interview, it was determined that 14 employees were not visibly wearing name tags. Findings include:</p> | <p><b>1108</b></p> <p>A. There is no corrective measure that can be taken at this time to address the deficient practice of not publically posting the survey results.</p> <p>B. This is a specific deficiency and there are no other areas that are affected.</p> <p>C. The last 3 surveys are publically posted in the main lobby of the Mary Ann Coverdale Center in a notebook labeled as such. The survey results and corresponding plan of correction will continue to be reviewed during the two Family Day meetings with subsequent minutes being sent to all families/guardians of Stockley residents.</p> <p>D. The notebook will be updated annually after each subsequent survey by Executive Director/Designee to ensure the last 3 annual surveys are available to the public 100% of the time.</p> <p style="text-align: right;"><b>Completion Date: 5/21/15</b></p> <p><b>1108</b></p> <p>A. There is no corrective measure that can be taken at this time to address the deficient practice of staff not prominently having their ID badges displayed at the time of the survey.</p> <p>B. Supervisors and managers conducted 4 sweeps which was completed on 5/21/15. There were several staff found to be out of compliance and were counseled on the spot.</p> |  |
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Provider's Signature Adrian Wemlinger Title Executive Director Date 6/9/15



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**STATE SURVEY REPORT**

NAME OF FACILITY: Stockley Center

DATE SURVEY COMPLETED: May 7, 2015

| SECTION | STATEMENT OF DEFICIENCIES<br>Specific Deficiencies | ADMINISTRATOR'S PLAN FOR<br>CORRECTION<br>OF DEFICIENCIES | COMPLETION<br>DATE |
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|  | <p>Facility Policy and Procedure: Delaware Health and Social Services Division of Developmental Disabilities Services Stockley Center Administrative Procedure: Identification Badges/Passes Section IV, page 2, Item H: "All on duty employees/contractors will prominently display their I.D. Badges while on Stockley Center grounds."</p> <p>Observations during the survey revealed that numerous staff members in various positions and work areas that were observed not wearing or did not have their name tags displayed, including:</p> <p>-On 4/30/15 - E4 -Active Treatment Supervisor; E5- Social Worker; E6- Work Program Assistant; E7- CNA; E8- CNA; E9- CNA; E10- CNA; E11- CNA; E12- RN II; E13- CNA; E14- Nurse Supervisor; E15 - Janitorial Service</p> <p>-On 5/1/15- E16- CNA</p> <p>-On 5/4/15 -E24 – Cosmetologist and E16- CNA</p> <p>An interview on 5/5/15 at 1:15 PM with E1, NHA confirmed that at times the facility has had problems with staff compliance with displaying name badges.</p> | <p>C. A memo was issued on May 21, 2015, to all staff to remind them of the law and Stockley Center policy regarding prominently displaying ID badges at all times. Staff will initial that they have read and will comply with the law and Stockley Center Policy.</p> <p><u>Exhibit D</u></p> <p>D. Supervisors and managers will observe on an ongoing basis that all staff are wearing their ID badges. The Office of Quality Improvement will continue to conduct reviews of compliance on a quarterly basis for 100% compliance.</p> <p><b>Completion Date: 6/20/15</b></p> |  |
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Provider's Signature Adelene Wernberg Title Executive Director Date 6/19/15