

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

PRINTED: 06/27/2016
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G001 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/09/2016 |
| NAME OF PROVIDER OR SUPPLIER STOCKLEY CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 28351 PATRIOTS WAY GEORGETOWN, DE 19947 | |
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| W 000 | <p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from June 2, 2016 through June 9, 2016. 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 51. The sample totaled 16 clients.</p> <p>Abbreviations used in this report are as follows: ED- Executive Director; DON - Director of Nursing; RN - Registered Nurse; CNA - Certified Nurse's Aide; MD-Medical Director; NP- Nurse Practitioner; OT -Occupational Therapist; DORS- Director of Residential Services; RT- Respiratory Therapists; PTA- Physical Therapy Assistant; WPA - Work Program Assistant; QIDP - Qualified Intellectual Disabilities Professional; ELP- Essential Lifestyle Plan; Abduction-extremity moving toward the midline; Flexion-bending the elbow up toward your upper arm; SBAR -Situation Background Assessment Request/Recommendation; a communication note between nursing and Medical Team (Nurse Practitioner or Physician); POS - Physician Order Sheet; MAR - Medication Administration Record; PEG - percutaneous endoscopic gastrostomy tube is a method of placing a tube into the stomach percutaneous to administer medication and sources of hydration and nutrition;</p> | W 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Aden Thomas Wernke TITLE
Executive Director (X5) DATE
7/6/16

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

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| W 000 | Continued From page 1 PO - by mouth; PRN - as needed; Mg - Milligram (mg) - metric unit of weight, Cycle Fills - 2 nurses and a pharmacist review new MARs and stock new medication blister packs in the medication cart every 28 days; Blister Packs - a card-type packaging containing a 28-day supply of one medication for a client which is packaged, labeled and delivered to the facility from the pharmacy and placed in the nurse's medication cart; DRR - drug regimen review - requirement for drug regimen review; Trach- tracheostomy; Tracheostomy- an opening made in the throat to assist breathing; Decannulation - planned or accidental removal of the tracheostomy tube; Bronchoscopy- a technique for visualizing the inside of the airways for diagnostic or therapeutic purposes; Pulmonologist- a medical specialist that deals with diseases/conditions involving the respiratory tract; Stridor- a harsh vibrating sound when breathing is caused by obstruction of the windpipe; Rhonchi- a continuous low-pitched, rattling lung sounds; Expiratory Wheeze- wheezing noise heard when breathing out. | W 000 | | | |
| W 249 | 483.440(d)(1) PROGRAM IMPLEMENTATION 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 | W 249 | | | |

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| W 249 | <p>Continued From page 2 objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility staff failed to follow the Essential Lifestyle Plan (ELP) regarding the proper use of splints and hand protectors for two (C9 and C3) of 16 sampled clients. Findings include:</p> <p>1. Review of C9's clinical records, including ELP, revealed:</p> <p>3/18/13 (last revised 3/8/16) - Plan to maintain bilateral elbow range of motion and skin integrity of bilateral elbows, volar wrist creases [wrist area by palm of hand] and palms included the schedule to wear splints and palm protectors from 11:00 AM - 1:00 PM, 3:00 PM - 5:00 PM and 6:00 PM - 8:00 PM. The ELP included the following plan for applying the splints and palm protectors:</p> <ul style="list-style-type: none"> - Very slowly stretch the client's elbow [straightening out the arm] into extension (do not stretch to the point of feeling resistance). - Check elbow crease [skin in the crook of the arm opposite the elbow] for any redness. - Put splint with the middle strap over the elbow crease and fasten strap over the tip of the elbow (see pictures for details). [Pictures in the ELP show both splints in place with elbows fairly straight and no visible space between the splint/straps and the client's arm.] - Fasten lower arm strap around the forearm, the upper strap around the bicep, bringing the upper arm into as much abduction/shoulder flexion | W 249 | <p>A. E3 (DORS) spoke with the QIDPs for Chandler Suite and West Suite on 6/14/16 conveying the exit interview survey findings regarding C3 and C9 splints. The QIDPs reviewed the splint usage and positioning with the identified staff members.</p> <p>E8 (OT) completed competency checks for appropriate splint usage and splint positioning with staff members who were assigned to C3 and C9 during the survey observations of splint applications on 7/1/16.</p> <p>B. QIDPs and Administrators completed observational sweeps throughout the facility on 6/29 & 6/30/16 to document appropriate splint usage and positioning. There were a total of thirty-five (35) observations completed of which 86% were in compliance with splint usage and positioning.</p> <p>C. QIDPs will check appropriate splint usage and positioning according to service plans/instructional guidelines for a total of 14 days in July 2016, and document their findings. QIDPs will provide on the spot instructions/guidance to staff regarding splints usage and positioning for all identified concerns.</p> <p>OT staff evaluate splints for proper condition once a month, fit is checked and range of motion is evaluated once every 6 months.</p> <p>A memo was sent on 7/1/16 to all staff outlining the importance of splint usage and positioning. <i>Exhibit A</i></p> | |

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| W 249 | <p>Continued From page 3 [bringing arm upward toward the front] as needed to secure the strap.</p> <ul style="list-style-type: none"> - Then fasten the upper arm strap, ensuring the top [of the splint] is below the armpit. Refasten the middle elbow strap again for best fit. - Two fingers should be [able to get] between the strapping and skin (see pictures for details). - Very slowly stretch [upward] C9's wrist and thumb (do not stretch to the point of feeling resistance). - Check wrist and palm for any redness, sloughing skin [shedding of outer layer of skin] or open areas. - To apply the palm protectors: ensure they are applied with the roll under the fingers. Slide the thumb through the center hole and fasten the Velcro above the wrist (see pictures for details). <p>6/2/16 between 12:40 PM - 1:05 PM - Observation found C9 sitting in a wheelchair in her room wearing an elbow splint on each elbow. Each upper strap was around C9's upper arm and each lower strap was secured around the forearm. However, 1-2 inches of space was visible between the left elbow splint and C9's skin with the elbow being more bent [less extension] than pictured in the service plan. The left palm protector was in place overtop of the elbow splint's lower strap as per the service plan while the right palm protector was hanging around the client's wrist, without contact to the palm. The left elbow splint and right palm protector were not positioned correctly.</p> <p>6/3/16 between 3:55 PM - 4:15 PM - Observation of C9 sitting in the wheelchair in her room revealed the upper and lower straps were around the upper arm and forearm, respectively but the</p> | W 249 | <p>OT staff provides individual in-services for the implementation of any splint plan. The new employee orientation outlines the use of splints. The OT staff have added specific details outlining the importance of splint usage and positioning.</p> <p>D. QIDPs will monitor 100% of residents using splints for appropriate splint usage and positioning once a week at random times until 100% compliance is consistently reached over 3 consecutive evaluations.</p> <p>Then, QIDPs will monitor 100% of residents using splints for appropriate splint usage and positioning twice a month at random times until 100% compliance is consistently reached over 3 consecutive evaluations.</p> <p>Finally, QIDPs will monitor 100% of residents using splints for appropriate splint usage and positioning on a quarterly basis. <i>Exhibit B</i></p> <p>The Peer Review Committee will complete sweeps for appropriate splint usage and positioning using a random sample of residents at least once a year.</p> <p>Facility QI staff will conduct reviews to monitor splint usage to ensure compliance and will provide opportunities for immediate corrective action/education in appropriate splint usage and positioning.</p> <p style="text-align: right;"><i>Completion Date: August 8, 2016</i></p> | |

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| W 249 | <p>Continued From page 4</p> <p>splint was not flush against the skin. There was 1-2 inches of space between the splint and the left wrist and 3-4 inches of visible space between the splint and both elbows, indicating the splint was not positioned according to the service plan. Both elbows were more bent than the observation from the day prior. The right palm protector was in place while the left palm protector was on the client's lap in the wheelchair. Both elbow splints and the right palm protector were not positioned correctly.</p> <p>During an interview on 6/6/16 at 12:50 PM with E8 (OT) about C9's elbow splint placement and surveyor observations, E8 stated she will look at the Velcro on the middle strap to determine if it is preventing the splint from being held against the client's elbow area.</p> <p>During an interview with E8 on 6/7/16 at 11:20 AM E8 stated she checked out the velcro on the middle elbow strap and it was fine. However, E8 stated she spoke with staff in the activity room who said they have seen C9's splints were not always applied correctly. The OT showed the surveyor a picture she drew of how the ends of the center elbow strap should be separated to cradle the elbow, with a strap on each side of the elbow. This [picture] should help with getting the elbows extended.</p> <p>6/7/16 between 3:20 PM - 3:40 PM - Observation found the client in her bed with around 3 inches of space visible between both splints and the client's elbow. The center strap on both elbow splints were separated and secured next to the upper and lower straps, the elbow was not cradled by the straps. The right palm protector was seen on the floor.</p> | W 249 | | | |

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| W 249 | <p>Continued From page 5</p> <p>The findings were discussed with E1[ED], E2[DON] , and E3 (DORS) during the exit conference on 6/9/16 at 11:30 AM.</p> <p>2. Review of C3's clinical record revealed;</p> <p>During an interview on 6/3/16 10:57 AM with the surveyor, E13 (RN) checked C3's ELP and stated that C3 was to wear the left (L) hand splint from 8:00 AM to 12:00 PM and again from 1:00 PM to 5:00 PM.</p> <p>Clinical record review 6/6/16 confirmed the above splint schedule was accurate based on the current ELP.</p> <p>6/7/16 from 10:30 AM to 11:20 AM - C3 was observed in an outside activity with facility staff and other clients without the (L)[left] hand splint on. At 11:25 AM, C3 was again observed in the activities room without the hand splint on.</p> <p>On 6/7/16 at approximately 11:27 AM, the surveyor asked E13 on Chandler Unit who was C3's caregiver. E20 (CNA) was in the break room so E13 asked E20 if the hand splint was on when the client left the unit for physical therapy (PT). E20 said yes.</p> <p>During an interview with the surveyor on 6/7/16 at 11:35 AM, E19 (PTA) stated the client did receive PT services earlier in the morning before going to the outside activity. E19 stated that he/she was working with C3 and his "leg" splints per the client's plan. When asked by the surveyor about the (L) hand splint, E19 said</p> | W 249 | | | |

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| W 249 | Continued From page 6 he/she did not notice if C3 had the hand splint on during PT services. After the brief interview, E19 did go into the activity room; looked into the client's bag on the back of the wheelchair, found the splint, and applied it to the left hand. E19 indicated that the splint would need to come off at 12 PM. | W 249 | A. For resident C5, there is no corrective measure that can be taken at this time to address the deficient practice from 9/18/15 and 10/4/15 for failure to report to nursing administration, medical, and others, or from 12/12/15, for the CNA not working within scope of practice. | |
| W 331 | The findings were discussed with E1, E2, and E3 during the exit conference on 6/9/16 at 11:30 AM. 483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on staff interviews, a clinical record review, and a review of other facility documents, it was determined that facility staff failed to communicate with Nursing Administration (DON), the physician/NP, and others regarding two incidents within 15 days where the client's trach came out during bathing/showering in order to effectively evaluate the need for any interventions to prevent recurrence for 1 (C5) of 16 sampled clients. In addition, on 12/12/15, the trach came out again, the CNA bathing/showering C5 removed gauze from around the trach and loosened the trach straps which was not within the CNAs scope of practice. Revision date approved 2/9/15 for the following Nursing Procedure document titled "Tracheostomy Stoma and Cannula Care" under Standards: Section D- The nurse/respiratory therapist should | W 331 | B. The McCabe Nurse Supervisor completed a review on June 15, 2016, of the records for all other residents at Stockley Center who have trachs. There were no further incidents of trach dislodgement identified. C. The Executive Director issued an email on June 6, 2016, directing any time a trach becomes dislodged for any reason other than a routine change, the incident must be documented on an AIR and the facility's AIR policy followed. This action will ensure that the nursing and medical team are aware of any incident. <i>Exhibit C</i> A memo was sent by the Director of Nursing on June 23, 2016, to all nursing and respiratory therapy staff outlining the expectations for prompt notification of the area nurse and charge nurse any time a trach becomes dislodged. <i>Exhibit D</i> The respiratory therapist completed training with all McCabe staff on Trach Safety in December 2015. This same training continues with all new staff on McCabe as they are hired. <i>Exhibit E</i> | |

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| W 331 | <p>Continued From page 7</p> <p>familiarize themselves with the type of tracheostomy tube the person has prior to providing care. There is no mention in the document that a CNA can change or remove the gauze dressing or manipulate the trach equipment.</p> <p>A review of the clinical record from June 1, 2015 to September 17, 2015 showed no documentation that C5 had coughed out the trach tube.</p> <p>Specialty Consultation Report (Pulmonology) dated 9/17/15 had the following documentation: Respiratory therapists report intermittent stridor and occasional bleeding with tracheostomy change and inquire about possibility of a bronchoscopy. Physical Exam: expiratory wheezing and bilateral rhonchi. The Pulmonologist ordered laboratory tests and chest x-ray.</p> <p>Interdisciplinary/Progress Notes on 9/18/15 at 5:43 PM documented that C5 coughed out his trach during care with E22 [CNA]. The trach was replaced by E17 (RT). Documentation showed that C5 was in no distress and an RN was present when the trach tube was replaced. That same evening at 9:15 PM, E17 did a "follow-up check," there were no issues.</p> <p>The Nursing Service Report for all three shifts dated 9/18/15 (3-11 shift) showed documentation related to C5's trach coming out and a new trach inserted by E17.</p> <p>The Situation, Background, Assessment, Request/Recommendation (SBAR) form/Resident Care Communication Worksheet (RCCW) dated 9/18/15 showed nursing did not communicate the trach incident to the physician/nurse practitioner.</p> | W 331 | <p>D. A memo was sent by the Director of Nursing on June 14, 2016, to the Respiratory Therapy team directing them to complete the "Non-Routine Trach Change Checklist" form any time they complete a non-routine trach change. This checklist will document proper notification of all pertinent staff and indicate any unexpected dislodgement of a trach.</p> <p>Exhibit F</p> <p>This form will be monitored and reviewed to ensure proper communication and timely intervention for any trach dislodgement by the area nurse supervisor/charge nurse daily until 100% compliance is achieved for seven consecutive days.</p> <p>Then, This form will be monitored and reviewed to ensure proper communication and timely intervention for any trach dislodgement by the area nurse supervisor/charge nurse three (3) times per week until 100% compliance is achieved for three consecutive reviews.</p> <p>Then, This form will be monitored and reviewed to ensure proper communication and timely intervention for any trach dislodgement by the area nurse supervisor/charge nurse weekly until 100% compliance is achieved for three consecutive reviews.</p> | |

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| W 331 | <p>Continued From page 8</p> <p>Interdisciplinary/Progress Note from 10/4/15 at 6:00 PM documented that C5 coughed out trach tube during bath care. No distress. E18 (RT) replaced the trach tube without incident. There is no indication from the note that E18 made nursing aware of the trach incident.</p> <p>The Nursing Service Report for all three shifts dated 10/4/15 (3-11 shift) showed no documentation related to C5's trach tube coming out and a new trach tube inserted by E18.</p> <p>The SBAR form/RCCW dated 10/4/15 showed nursing did not communicate the trach incident to the physician/nurse practitioner.</p> <p>There were no facility incident reports generated for the above two trach incidents; therefore, there was no investigation or analysis of the occurrences. Both incidents occurred while staff were bathing/showering C5 on the 3:00 PM to 11 PM shift.</p> <p>The Administrative Incident Report form dated 12/12/15- Section II- Describe the Incident- documented the following: At 4:00 PM E21 [CNA] was getting C5 ready for a shower. E21 loosened the trach strap around neck to change the gauze because it was dirty. After pulling the gauze away C5 began coughing and the trach tube came out. "I immediately called for a nurse" and the nurse called for respiratory staff.</p> <p>Interdisciplinary/Progress Notes from 12/12/15 at 4:40 PM completed by the RT documented the following: C5 had his trach "disengaged and coughed out"</p> | W 331 | <p>Finally, This form will be monitored and reviewed to ensure proper communication and timely intervention for any trach dislodgement by the area nurse supervisor/charge nurse one more time a month later. If 100% compliance is again noted, the deficient practices of lack of communication to nursing administration, medical and others and CNAs working out of their scope of practice by removing gauze or loosening the Velcro trach collar will be considered successfully addressed.</p> <p>The Director of Nursing will review and sign these forms monthly. The Executive Director and Director of Nursing will review all AIRs concerning trach dislodgement as they occur and take appropriate actions.</p> <p>The assigned facility Quality Improvement staff will review all AIR's quarterly for 100% compliance of providing immediate corrective actions for any trach dislodgments.</p> <p style="text-align: right;"><i>Completion Date: August 1, 2016</i></p> | | |

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| W 331 | <p>Continued From page 9</p> <p>during a bath. C5 was in no distress from the dislodgement of the trach tube. A new trach tube was "introduced and secured safely." A nurse was present when a new tube was inserted. E21 "was admonished to not manipulate any part of trach tube henceforth." Nursing Supervisor was made aware of the incident.</p> <p>The Nursing Service Report for all three shifts dated 12/12/15 (3-11 shift) showed documentation related to C5's trach tube coming out and a new trach tube inserted by E17.</p> <p>The SBAR form/RCCW dated 12/12/15 showed that nursing did communicate this trach incident to the physician/nurse practitioner.</p> <p>An RT note dated 12/12/15 from E17 was in the CNA communication book documented the following: "Absolutely under no circumstances should Direct care staff remove split gauze, change split gauze, unfasten Velcro ties on trach holders and or manipulate any tracheostomy client's trach for any reason. This causes a High Risk of Decannulization and could do Harm."</p> <p>The Administrative Incident Report from 12/12/15 had documents attached. One email dated 12/14/15 from E2 (DON) to various staff documented that this was the first time E2 was hearing about the trach incidents.</p> <p>There were two trach incidents involving C5 within 15 days of each other and the third incident occurred approximately 2 months later. All occurred while staff were bathing and/or showering C5.</p> | W 331 | | | |

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G001 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/09/2016 |
| NAME OF PROVIDER OR SUPPLIER STOCKLEY CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 28351 PATRIOTS WAY GEORGETOWN, DE 19947 | | |
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| W 331 | <p>Continued From page 10</p> <p>The facility initiated their own plan of correction on 12/16/15 which included inservicing all staff on the McCabe Unit and two Active Treatment Supervisors on trach safety; newly hired staff assigned to the unit will receive specific orientation training and trach safety inservice prior to working alone with a client that has a trach. Trach safety document dated 12/15/15 included but was not limited to the following:</p> <p>Make sure trach holder is secure (not loose or floppy) before performing personal care. Notify the nurse/respiratory therapist immediately if the trach cannula comes out or if the trach holder is too loose.</p> <p>6/6/16 -9:10 AM- The surveyor interviewed E2 regarding the role of CNAs in trach care. E2 stated the CNAs do not have a direct role in trach care. The RTs are responsible and are on 6:00 AM to 10:00 AM, when they are not available it's the nurse's responsibility. The lead RT did inservice CNAs and others regarding do's and don'ts related to personal care for clients with a trach.</p> <p>Interview on 6/6/16 at 2:00 PM with the surveyor in the presence of E2 (DON) at 2 PM, E18 (RT) stated that he/she was not sure who was bathing C5 on 10/4/15 when notified C5 coughed out his trach. A new tube was inserted by E18. C5 was in no distress during the incident or after the incident. " When asked what can a CNA do related to trach care, E18 stated if the " filter falls off can put it back on " and if the collar slides to the side can put it back in place.</p> <p>E12 (Nursing Supervisor) was interviewed on 6/7/16 at 12:38 PM- he/she reported that the 10/4/15 trach incident was not on the 24 hour</p> | W 331 | | | |

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| W 331 | <p>Continued From page 11</p> <p>report and if a trach came out E12 would expect staff to report the occurrence. E12 did indicate that nursing may have not been informed of the incident. The nursing supervisor was aware of the first incident on 9/18/15 but not the incident that occurred 15 days later. If it was on the 24 hour report E12 may have looked into it further since he/she was aware of the 9/18/15 incident.</p> <p>E23 (NP) was interviewed on 6/7/2016 at 2:35 PM regarding the three incidents with C5's trach tube coming out. E23 stated that nursing staff had not notified E23 of the first two incidents (9/18/15 & 10/4/15) involving C5's trach tube coming out but was made aware of the 12/12/15 incident. Nursing staff generally communicate by documenting issues on the SBAR form.</p> <p>During an interview with the surveyor on 8/7/16 at 3:10 PM E18 stated he/she did not know who he/she notified on 10/4/15 that the trach tube had been out and it was replaced. It was such a "small thing." If it was something serious that I could not fix then definitely the staff would "all be there" and the physician would have been notified. E18 indicated that there is a core group that work regularly together and everyone knows what is generally going on.</p> <p>6/9/16 9:45 AM - Interview with E1 (ED) and E2 revealed that a new communication form had also been implemented. It was to be used by RTs and nursing to document any trach issues. E2 stated that he/she could not find any information that the 10/4/15 incident was reported to nursing. E1 did implement a new procedure on 6/8/16 that any trach that becomes dislodged for any reason, other than routine changes must be documented on an Administrative Incident Report. These two</p> | W 331 | | | |

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| W 331 | Continued From page 12 new procedures were implemented after the survey began. | W 331 | | |
| W 369 | <p>These findings were reviewed with E1, E2, and E3 (DORS) at the exit conference on 6/9/16 at 11:30 AM.</p> <p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview It was determined that the facility failed to ensure medications were administered without error for 1 (C16) of 16 sampled clients. Findings include:</p> <p>During the medication administration observation on 6/3/16 at 4:15 PM, E6 (RN) administered Keflex (250 mg every pm), an antibiotic, to C16 via the PEG tube. Prior to administration, the surveyor confirmed this Keflex order was on the MAR (hand written to give Keflex 250 mg po every pm) and on the pre-labeled blister pack that contains a month's supply of Keflex which is sent from the pharmacy.</p> <p>Review of C16's chart on 6/3/16 at 4:30 PM, revealed that the May 2016 POS and current hand written orders in C16's chart showed there was no order for the above medication. The May 2016 POS was printed on 5/3/16, reviewed by E8 (RN) on 5/11/16 and signed by E5 (physician) on 5/17/16. The last order for Keflex was written on 3/28/16 (Keflex 250 mg po every pm). Review of</p> | W 369 | <p>A. The area nurse supervisor contacted the medical team on 6/4/16, and obtained a verbal order for the Keflex for resident C16. The facility's medication error procedure was followed and appropriate actions were taken with the nurses involved. Exhibit G</p> <p>B. The assigned nurses, facility's pharmacist, and Director of Nursing completed a medication reconciliation of all current medical teams' orders and MARs on June 24, 2016. No further deficient practices were identified.</p> <p>C. The Noting and Transcribing an Order Nursing Procedure was revised and approved by the Director of Nursing on June 16, 2016. The revisions reflect a reconciliation of the 60 day POSs by the 11-7 nurse and expands the nurse supervisor/designee's role in reviewing/preparing the preprinted POSs. Exhibit H</p> <p>The nurse educator will in-service the nursing staff on medication reconciliation as outlined in the facility's procedure.</p> | |

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| W 369 | <p>Continued From page 13</p> <p>the MARs showed C16 had received Keflex 250 mg every pm since 3/28/16.</p> <p>In an interview at 5:00 PM on 6/3/16, E7 (RN supervisor) reviewed the chart and confirmed that there was no current order for the Keflex. E7 confirmed that current medication orders need to be on the POS when it is updated and signed by the physician every 60 days.</p> <p>In an interview at 9:30 AM on 6/6/16, E5 stated that C16 was to receive the Keflex as given since 3/28/16. E5 signed the May 2016 POS without realizing it did not include the Keflex order. E6 confirmed there is now a new signed Keflex order that is current and correct on C16's chart.</p> <p>An interview with E2 (DON) and E4 (MD) on 6/6/16 at 10:50 AM confirmed that this medication error had occurred during the review of the May pre-printed POS when the 3/28/16 Keflex order was not added to the POS and when E5 signed the May POS without noticing it did not include Keflex. During the April and May cycle fills, staff continued to hand write the Keflex order on the MAR and to load the Medication Cart with C16's blister pack of Keflex capsules monthly. E2 confirmed that the facility policy states that current medication orders need to be on the POS when it is updated and signed by the physician every 60 days.</p> <p>Review on 6/7/16 at 3:30 PM of the April and May 2016 DRR for C16 and the Chandler Unit cycle fill / pharmacy audits, E10 (Pharmacist) did not mention Keflex. E10 checked the DDR form indicating "n" (nothing inappropriate) and wrote no comments. C16's monthly supply of Keflex blister pack was put into the medication cart</p> | W 369 | <p>D. The pharmacist/nurse supervisor will complete medication reconciliations on a 20% sample weekly until 100% compliance is achieved for four (4) consecutive weeks. Any discrepancies with the medical team's orders and MARs not coinciding will be reported to the DON and appropriate actions taken.</p> <p>Then, The pharmacist/nurse supervisor will complete medication reconciliations on a 20% sample monthly until 100% compliance is achieved for three (3) consecutive months. Any discrepancies with the medical team's orders and MARs not coinciding will be reported to the DON and appropriate actions taken.</p> <p>Finally, During the pharmacist's Unit Inspections he/she will complete medication reconciliation on a minimum of 2 residents in each area (10% sampling). Any discrepancies with the medical team's orders and MARs not coinciding will be reported to the DON and appropriate actions taken. If 100% compliance continues for one (1) more month it will conclude that reconciliation of current medical team orders and MARs has been addressed successfully.</p> <p style="text-align: right;"><i>Completion Date: August 1, 2016</i></p> | |

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| W 369 | Continued From page 14 during the April and May cycle fill. During an interview on 6/7/16 at 3:15 PM, E10 stated that the POS is reviewed and updated only every 60 days and the cycle fill is done every 28 days. E10 stated the Keflex discrepancy would have been identified when the Chandler Unit's June cycle fill and pharmacy audits are done, but acknowledged that there was not a current order for Keflex since the May POS was signed by E5 on 5/17/16 and that C16 has been receiving 250 mg every pm. Findings reviewed with E1 (ED), E2, and E3 (DORS) on 6/9/16 at 11:30 AM during the exit conference. | W 369 | | | |



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: June 9, 2016

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
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| <p>3201.9.8.4.3</p> <p>3201.9.8.4.4</p> | <p>evaluation supports the conclusion that the injury is suspicious. Circumstances which may cause an injury to be suspicious are: the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time, or the incidence of injuries over time.</p> <p>Areas of contusion or bruises causes by staff to a dependent resident during ambulation, transport, transfer or bathing.</p> <p>Significant error or omission in medication/treatment, including drug diversion, which causes the resident discomfort, jeopardizes the residents' health and safety or requires periodic monitoring for up to 48 hours.</p> <p>Based on review of other facility documentation, review of reported incidents to the State and interview it was determined that the facility failed to report 5 incidents involving six (C5, C11, C12, C13, C14, and C15) out of 16 sampled clients to the State reporting agency. Findings include:</p> <p>Review of facility incident reports from May 2015 through May 2016 discovered the following:</p> <p>5/14/15 – C14 sustained left foot bruising and swelling during transfer to the shower trolley.</p> <p>7/23/15 - C12 hit own face with a metal airplane toy causing laceration needing 5 stitches at a local emergency department.</p> <p>9/5/15 - C13 fell and sustained minor face lacerations but needed neurological assessments at the facility.</p> <p>9/7/15 - C15's water flush was connected to the balloon port of feeding tube causing the</p> | <p>3201.9.8.4</p> <p>A. For residents C5, C11, C12, C13, C14 & C15 there are no corrective measures 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 1, 2015, through June 2, 2016, 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 similar nature</p> | |
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Provider's Signature Aileen M. Wilmington Title Executive Director Date 7/6/16



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
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| | <p>balloon to burst and the feeding tube was replaced at a local emergency department.</p> <p>9/20/15 - C11 held onto a grab bar and twisted own hand causing a laceration needing 8 stiches at a local emergency department.</p> <p>12/12/15 - C5's CNA loosened the trach strap and removed the gauze around trach. The resident coughed out the trach tube. RT had to reinsert a new tube. Trach care is only provided by a respiratory therapist or nurse as documented in the facility's "Tracheostomy Stoma and Cannula Care" Policy/Procedure with a revision approved date of 2/9/15. There was no evidence that this incident was reported to the State agency.</p> <p>During an interview with E1 (ED) on 6/7/16 at 2:30 PM E1 confirmed the incidents for C11, C12, C13, C14 and C15 were not reported to the State.</p> <p>These findings were reviewed with E1, E2 (DON) and E3 (Director of Residential Services) on 6/9/16 at 11:30 AM.</p> | <p>are reported at the time of the incident.</p> <p>D. The Executive Director/designee will continue to monitor each Administrative Incident Report and investigation for 100% compliance. The Facility QI staff will continue to conduct reviews of all Administrative Incident Reports and investigations on a quarterly basis for 100% compliance.</p> | <p>June 9, 2016</p> |

Provider's Signature *Adam M. Wenzel* Title *Executive Director* Date *7/6/16*