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 07/11/2019

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 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from July 8, 2019 through July 11, 2019. The facility census the first day of the survey was 49. An emergency preparedness survey was also conducted during the same time period. There were no emergency preparedness deficiencies based on observation and interviews.	E 000		
W 000	INITIAL COMMENTS An unannounced annual, complaint and emergency preparedness surveys were conducted at this facility from July 8, 2019 through July 11, 2019. 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 the first day of the survey was 49. The survey sample totaled 6 residents and 12 sub-sampled residents. Abbreviations/definitions used in this report are as follows: Aspiration Pneumonia - occurs when food, saliva, liquids, or vomit is breathed into the lungs or airways leading to lungs, instead of being swallowed into the esophagus and stomach; CNA- Certified Nursing Assistant; DON - Director of Nursing; DORS - Director of Residential Services; ED - Executive Director; narcotic - a medication that makes you sleepy and relieves pain; NHA - Nursing Home Administrator; PE - Program Evaluator;	W 000		

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

[signature] | NHA - Executive Director | 7/26/19

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

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W 000	Continued From page 1 QIDP - Qualified Intellectual Disability Professional; RN- Registered Nurse.	W 000		
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 record review, interview, review of facility policies and procedures it was determined that for two (R1 and R5) out of six sampled residents and twelve (SSR1, SSR2, SSR3, SSR4, SSR5, SSR6, SSR7, SSR8, SSR9, SSR10, SSR11, and SSR12) sub-sampled residents who were not administered ordered medications by E9 (RN), the facility failed to identify and immediately report allegations of neglect. Findings included: The facility's policy and procedure, titled Reporting and Investigation Procedure for: PM 46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, Significant Injury and Injury of Unknown Source), with a revision date of 8/8/18 indicated: "I. OBJECTIVE: To establish a process for reporting, investigating, and taking administrative action in PM46 cases for alleged or suspected abuse, neglect, mistreatment, financial exploitation, medication diversion and significant injury and injuries of unknown source to residents of Stockley Center.	W 153		

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W 153	Continued From page 2 The Eye Witness/Reporting Person is responsible to: 1. Ensures comfort and protection of the resident(s) 2. Reports the incident immediately without delay, to the nurse and the supervisor in charge/Administrator on Duty. 3. Completes an Administrative Incident Report and documentation in the resident's record. Forwards the Administrative Incident Report to the nurse and the supervisor in charge and the Administrator on Duty immediately. 4.. Immediately (within eight hours) report the Incident to the Division of Long Term Care Resident's Protection by calling the 24-hour toll free number". The Department of Health and Social Services Policy Memorandum #46, Responding to Reportable Incidents/Accidents, with a revision date of 8/22/16 documented: "Purpose. a. To identify and define reportable incidents and allegations that warrant notification and investigation. b. To identify standardized reporting and investigative procedures of reportable incidents and allegations. IV Definitions:... G. Reportable Incidents shall mean suspicion of any of the following occurrences:... Neglect shall mean: a. Lack of attention to the physical needs of an individual receiving services to include but not limited to toileting, bathing, nutrition and safety:..." 1. 2/24/19 9:10 AM - Review of a facility Medication Error Incident Report revealed that E10 (RN) notified E2 (DON) that E9 (RN) was	W 153	W153 1. A. For Residents R1 and R5, and SSR1, SSR2, SSR3, SSR4, SSR5, SSR6, SSR7, SSR8, SSR9, SSR10, SSR11, and SSR12, there are no corrective measures that can be taken at this time to address the deficient practice of not immediately reporting the identified incident. B. All residents of the Stockley Center have the potential to be impacted by this deficiency. The DHQ (DLTCRP) surveyors reviewed all Administrative Incident Reports and investigations for the facility for the time period of July 11, 2018 to July 12, 2019, during the Annual Survey. There were no other residents found to have related deficiencies. C. Changes were made to the Stockley Center Administrative Procedure "Reporting and Investigating Procedure for: PM 46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source." The Administrative Procedure now includes a statement regarding an additional avenue for reporting. The new statement is worded: "Ensures immediate (within 8 hours) reporting to the Division of Health Care Quality (Division of Long Term Care	

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W 153	Continued From page 3 found sleeping and did not administer ordered medications to 12 residents (SSR1 through SSR12). 2/24/19 - Review of a facility reported incident documented, "At 10:00 AM, on 2/24/19, it was reported by [E2 (DON)] to [E1 (ED/NHA)] that a nurse [E9 (RN)] was found sleeping on the morning of Sunday 2/24/19 in the Activities room at the MAC (medical) Center at approximately 6:45 AM. [E9] was to be on duty and act as the Facility Charge for the 11 PM to 7 AM shift. When the next shift arrived, they were unable to find [E9], and located [him/her] in the Activities department asleep in a recliner. Upon further investigation, it was discovered that [E9] had signed for narcotic medications, but had not dispensed those medications. Further, it was discovered that [E9] had missed the 5-5:30 AM and the 6:00 AM medication pass for [SSR1 through SSR12]. The medications were dispensed by the next shift at 7 AM". 2/24/19 10:00 AM - Review of a facility Summary of Findings PM 46 Investigation in the Description of Incident included, "At 10:00 AM (three hours after the incident) on 2/24/19, it was reported by [E2 (DON)] to [E1 (ED/NHA)] that a nurse, [E9 (RN)] was found sleeping on the morning of 2/24/19." 2/25/19 8:51 AM - E3 (DORS) forwarded an email to the State agency about this incident, twenty-five hours and fifty-one minutes after the facility had knowledge of the incident. 2/25/19 4:10 PM - E3 (DORS) submitted the incident electronically to the State Agency reporting system.	W 153	Residents Protection) by calling the 24-hour toll free number at 1-877-453-0012. Reporting can be completed via email by the Executive Director/Designee to ltc.residents.protection@delaware.gov and other designees then the web-based report will be filled out on the same day during the work week or next operational business day." Completed 07/18/2019. (*Attachment A*) The Executive Director/ designee knows to report these types of incidents to the State agency and will ensure all future incidents of similar nature are reported at the time of the incident. The Director of Residential Services and the Director of Nursing will ensure that Stockley Center Directors, Facility Charges, and Charge Nurses and nursing staff will complete a review and acknowledgement of the policy changes. D. The Executive Director/ Designee will continue to monitor each alleged and suspected PM46 case to ensure the Administration Procedures and PM46 policy is followed for 100% compliance. The Facility Quality Improvement staff will continue to conduct reviews of all Administrative Incident Reports and investigations on a quarterly basis for 100% compliance.	9/9/19

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W 153	Continued From page 4 7/10/19 12:00 PM - During an interview E2 (DON) confirmed that the facility had knowledge of the incident at approximately 7:00 AM on 2/24/19. E2 confirmed that the incident was reported to the State Agency late. 7/10/19 12:15 PM - During an interview E1 (ED/NHA) and E2 (DON) explained that the incident was not reported on 2/24/19 because facility staff did not know the extent of the information and the scope of how many people were involved. E1 and E2 added that the facility wanted to do more investigating to have all of the information to report to the State Agency. The facility failed to identify R9 (RN) not administering the ordered medications to 12 residents as an allegation of neglect, which resulted in not immediately reporting the incident to the State Agency. 2. The following was reviewed in R1's clinical record: Undated - Physician's Order for R1's diet which included honey thick liquids. 1/8/19 - R1's plan of care documented "I also must have visual supervision at all times (unless in my bed) as I may eat food that does not belong to me or drink liquids that are (not) beverages (i.e. hand sanitizer or paint)." 6/21/19 at approximately 11:00 AM - A facility Disciplinary Investigative Report revealed that "[E11 (Activity Aide)] accompanied [R1] to the West Game room. When [he/she] entered the room with [R1, he/she] turned away to get a	W 153	2. A. For resident R1 there is no corrective measure to be taken at this time to address the deficient practice of not reporting to the State agency. B. All residents of the Stockley Center have the potential to be impacted by this deficiency. The DHQ (DLTCRP) surveyors reviewed all Administrative Incident Reports and investigations for the facility for the time period of July 11, 2018 to July 12, 2019, during the Annual Survey. There was one other resident found to have the same deficiency. The remaining residents' records revealed no deficiencies of this kind in those records at that time. C. Changes were made to the Stockley Center Administrative Procedure "Reporting and Investigating Procedure for: PM 46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source." The Administrative Procedure now includes an expanded objective to include potential impact. The new objective is worded: "To establish a process for reporting, investigating, and taking administrative	

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W 153	Continued From page 5 blanket from the mat table so [R1] could lay [his/her] head down on the table with a rolled up blanket. When [E11] turned around, [he/she] observed [R1] drinking water from a [brand name] water bottle. [E11] immediately took the bottle from [R1] and threw it in the sink". It was documented in [E11's] statement that [R1] "drank probably six ounces (of water) before I grabbed it." The facility failed to identify the incident as an allegation of neglect and immediately report the incident to the State Agency. 3. The following was reviewed in R5's clinical record: 8/8/16 - The Instructional Guidelines (IG) for toileting back support with buckle and grab bar documented that R5 required two person assistance at all times when standing throughout the toileting process and one staff providing visual supervision when seated and seatbelt is fastened on the toilet back support. Steps in the procedure included: "...4...Seatbelt should remain on [R5] throughout the entire toileting procedure until [he/she] is transferred off the commode as [he/she] will stand up fast on [his/her] own...6. After toileting, unbuckle seat belt and transfer..." 4/22/19 8:30 PM - An Incident Report documented that E6 (CNA) was toileting R5 in the bathroom and unbuckled the seat belt to have R5 stand but R5 jumped up once the seatbelt was unbuckled and tripped over his/her own shoes. E6 documented, "Was only trying to clean [R5] until someone came to assist. I assisted [R5] to the floor and [R5] assisted [E6] by grabbing the handle on the cart to help get up off the floor." R5	W 153	action in PM46 cases for alleged or suspected abuse, neglect with known or potential negative impact, mistreatment, financial exploitation, medication diversion and significant injury and injuries of unknown source to residents of Stockley Center." Completed 07/18/2019. (Attachment A) The Executive Director/ designee knows to report these types of incidents to the State agency and will ensure all future incidents of similar nature are reported at the time of the incident. The Director of Residential Services and the Director of Nursing will ensure that Stockley Center Directors, Facility Charges, and Charge Nurses and nursing staff will complete a review and acknowledgement of the policy changes. D. The Executive Director/designee will continue to monitor each Administrative Incident Report and investigation for 100% compliance. The Facility Quality Improvement staff will continue to conduct reviews of all Administrative Incident Reports and investigations on a quarterly basis for 100% compliance. 3. A. For resident R5 there is no corrective measure to be taken at this time to address the deficient practice of not reporting to the State agency. B. All residents of the Stockley Center have the potential to be impacted by this	9/9/19

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W 153	Continued From page 6 was assessed by E5 (RN) with no significant injury from the fall. 7/9/19 11:00 AM - During an interview E3 (RSM) revealed that E3 had investigated the above fall on 4/22/19 and determined that the above IG dated 8/8/16 was unclear for the staff, thus, additional comment of "Do not unbuckle seatbelt until 2nd staff has arrived" was included on 4/23/19 after the fall. 7/11/19 9:45 AM - During an interview E5 (RN), who assessed R5 following the 4/22/19 fall confirmed that R5 required two person assistance at all times when standing throughout the toileting process and provided verbal counseling to E6 (CNA) after the incident. 7/11/19 10:45 AM - During an interview E1 (ED/NHA) revealed that a "mistake was made, R5's seatbelt was unbuckled" and confirmed that the facility failed to follow R5's IG, by failing to have two staff assistance at all times when standing throughout the toileting process. Although the above IG dated 8/8/16 documented for toileting that R5 required two person assistance at all times when standing throughout the toileting process and the seatbelt should remain on throughout the entire toileting procedure until R5 was transferred off the commode, the facility failed to identify this incident as an allegation of neglect, in which there was lack of attention to the safety needs of R5. This failure resulted in lack of immediate reporting. The findings were reviewed on 7/11/19 beginning at approximately 11:15 AM, during an exit	W 153	deficiency. The DHQ (DLTCRP) surveyors reviewed all Administrative Incident Reports and investigations for the facility for the time period of July 11, 2018 to July 12, 2019, during the Annual Survey. There was one other resident found to have the same deficiency. The remaining residents' records revealed no deficiencies of this kind in those records at that time. C. Changes were made to the Stockley Center Administrative Procedure "Reporting and Investigating Procedure for: PM 46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source." The Administrative Procedure now includes an expanded objective to include potential impact. The new objective is worded: "To establish a process for reporting, investigating, and taking administrative action in PM46 cases for alleged or suspected abuse, neglect with known or potential negative impact, mistreatment, financial exploitation, medication diversion and significant injury and injuries of unknown source to residents of Stockley Center." Completed 07/18/2019. (Attachment A) The Executive Director/ designee knows to report these types of incidents to the State agency and will ensure all future incidents of similar nature are reported at the time of the incident. The Director of Residential Services and the Director of Nursing will ensure that Stockley Center	

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W 153	Continued From page 7 meeting with E1(ED/ NHA), E2(DON), and E3(RSM).	W 153	Directors, Facility Charges, and Charge Nurses and nursing staff will complete a review and acknowledgement of the policy changes.	
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 record review and interview it was determined that for one (R6) out of six sampled residents the facility failed to implement an active treatment program for dental desensitization. Findings include: The following was reviewed in R6's clinical record: 12/13/18 - A learning plan was initiated for "[R6] will visit the dental clinic monthly to work on desensitization exercises. [R6] will tolerate 10 minutes of positive interaction while in the dental clinic for 12 consecutive months by 12/31/19". The data collection plan documented "Implement 1 (one) time a month. Collect date 1 (one) time a month. BA (behavior analyst) will document the desensitization exercise, length of positive interaction, and the response in an ID (Interdisciplinary) Note in the COR (clinical record)".	W 249	D. The Executive Director/designee will continue to monitor each Administrative Incident Report and investigation for 100% compliance. The Facility Quality Improvement staff will continue to conduct reviews of all Administrative Incident Reports and investigations on a quarterly basis for 100% compliance. W249 A. For resident R6 there are no corrective measures that can be taken at this time to address the deficient practice of not implementing the plan for dental desensitization in a timely manner. B. All residents of the Stockley Center who have a dental desensitization plan have the potential to be impacted by this deficiency. A review of all the Behavior Analyst's behavior supports learning plans will be completed by the Program Administrator. C. The Behavior Analyst will complete monthly implementation reviews of behavior supports learning plans then report all data to the QIDP for the QIDP's monthly reports. The Behavior Analyst will document this information exchange in emails and provide this documentation to the QIDP and Director of Residential Services.	9/9/19

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W 249	Continued From page 8 Review of R6's 2019 monthly summaries revealed: January - new plan implemented by BA; February - no visit; March - no visit to clinic; April - no visit to clinic; May - in hospital. Review of ID notes documented: 5/10/19 - The ID note documented that staff took R6 to the clinic and he/she turned around and left in less than a minute. 5/30/19 - The ID note documented that the resident was in hospital and the BA could not implement the plan. 6/21/19 - The ID note documented a visit to the dental clinic with the BA and R6 tolerated two minutes. 7/10/19 2:15 PM - During an interview with E8 (QIDP) it was revealed that in February, March and April R6's dental desensitization plan was not conducted. It was further revealed that E8 (QIDP) must have missed the 5/10/19 ID note about the plan when he/she documented that there was no plan implemented in May. 7/10/19 2:31 PM - During an interview with E12 (former BA) it was revealed that he/she had an email that was sent to E8 (QIDP) documenting that the plan was implemented on 4/23/19 but the plan implementation was not documented in the record. It was further revealed that when E12 was the BA he/she established the dental desensitization plan but failed to implement it until 4/23/19.	W 249	D. A review sweep of all behavior supports learning plans including R6 was completed on July 15, 2019 for the quarter of April 2019 through June 2019. The review sweep, of these types of learning plans, revealed that the plans were implemented unless medically contraindicated, continue, and have been monitored by the Behavior Analyst monthly. (Attachment B) THEN, all of the Behavior Analyst's behavior supports learning plans implementation data will be reviewed for 1 time a month by the Program Administrator to ensure 100% compliance is achieved over three consecutive evaluations. FINALLY, all of the behavior supports learning plans implementation data will be reviewed biannually by the Peer Review Committee.	9/9/19

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W 249	Continued From page 9 The findings were reviewed on 7/11/19 beginning at approximately 11:15 AM, during an exit meeting with E1(ED/ NHA), E2(DON), and E3(RSM).	W 249	W331 1. A. For resident R5 there are no corrective measures that can be taken at this time to address the deficient practice of staff not following the instructional guidelines resulting in R5's fall. It is noted that the facility did complete a body check and physician evaluation to ensure assess for injury for which no injury was noted at that time nor later. B. All residents of the Stockley Center who have similar IGs as R5 have the potential to be impacted by this deficiency. A review of all similar IGs as R5 will be completed by the Occupational Therapist and revisions made as necessary. C. The day after the incident, 04/23/2019, a review of the Instructional Guidelines (IG) for R5 resulted in a clarification to the IG to communicate the necessity to not unbuckle the seatbelt until a second staff member is present. (Attachment C). D. A review sweep of the other IGs for residents with similar supports were reviewed and updated as necessary to ensure clarity of the supports. The Occupational Therapist updated and revised any IGs that require clarity relative to unbuckling a seatbelt if two staff members are required to assist the individual. Completed 07/25/2019 (Attachment D).	
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: Based on record review and interview it was determined for two (R1 and R5) out of six sampled residents the facility failed to ensure adequate staff assistance and/or assistive devices. The facility failed to provide two person assistance during toileting and assistive devices for R5, which resulted in a fall. For R1, the facility failed to provide care and services to ensure visual supervision to prevent accidental ingestion of unsafe liquids. Findings include: 1. The following was reviewed in R5's clinical record: 8/8/16 - The Instructional Guidelines (IG) for toileting back support with buckle and grab bar documented that R5 required two person assistance at all times when standing throughout the toileting process and one staff providing visual supervision when seated and seatbelt is fastened on the toilet back support. The steps in the procedure included: "...4...Seatbelt should remain on [R5] throughout the entire toileting procedure until [he/she] transferred off the commode as [he/she] will stand up fast on [his/her] own...6. After toileting, unbuckle seat	W 331		

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W 331	Continued From page 10 belt and transfer..." 4/22/19 8:30 PM - The Incident Report documented that E6 (CNA) was toileting R5 in the bathroom and unbuckled the seat belt to have R5 stand but R5 jumped up once seatbelt was unbuckled and tripped over his/her own shoes. E6 documented, "Was only trying to clean [R5] until someone came to assist. I assisted [him/her] to the floor and [R5] assisted [E6] by grabbing the handle on the cart to help get up off the floor." R5 was assessed by E5 (RN) with no significant injury from the fall. 4/23/19- The IG for toileting back support with buckle and grab bar was revised on 4/23/19 following the above fall on 4/22/19 at 8:30 PM. An additional sentence was added "Do not unbuckle seatbelt until the 2nd staff have arrived." 7/11/19 9:45 AM - An interview with E5 (RN), who assessed R5 following the 4/22/19 fall confirmed that R5 required two person assistance at all times when standing throughout the toileting process and provided verbal counseling to E6 after the incident. 7/11/19 10:45 AM - An interview with E1 (ED/NHA) confirmed that the facility failed to follow the R5's IG, by failing to have two staff assistance at all times when standing throughout the toileting process. In addition, failed to ensure that the seatbelt remained buckled until R5 was transferred off the commode. 2. The following was reviewed in R1's clinical record: Undated - A physician's order for R1's diet	W 331	THEN, The Peer Review Committee will review a sampling of all IGs for 2 residents on each area for 100% clarity for 3 consecutive months. FINALLY, The Peer Review Committee will review a sampling of all IGs for 2 residents on each area for 100% clarity for 3 quarters. 2. A. For resident R1 there are no corrective measures that can be taken at this time to address the deficient practice of staff not following the visual supervision requirements when staff turned around to get a blanket in the same room resulting in R1 grabbing a bottle of water and wrongfully ingesting the liquid. It is noted that the staff member immediately stopped the action of the resident and the facility completed a body check and physician evaluation for which no injury was noted at that time. It is also noted that on 06/20/2019, R1 returned from a hospitalization with a diagnosis of aspiration pneumonia and R1 was actively being treated with antibiotics. Since the 06/21/2019 incident, there were follow up vital signs and respiratory assessment by the respiratory therapist. B. A review of residents revealed that R1 is the only resident with active PICA who is able to independently move toward, reach out, and grab liquids not belonging to the resident. A review sweep of R1's residential and activity areas will be completed.	9/9/19

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 07/11/2019

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 11 included honey thick liquids. 1/8/19 - R1's plan of care documented, "I also must have visual supervision at all times (unless in my bed) as I may eat food that does not belong to me or drink liquids that are (not) beverages (i.e. hand sanitizer or paint)." 6/21/19 at approximately 11:00 AM - A facility Disciplinary Investigative Report revealed that "[E11 (Activity Aide)] accompanied [R1] to the West Game room. When [he/she] entered the room with [R1, he/she] turned away to get a blanket from the mat table so [R1] could lay [his/her] head down on the table with a rolled up blanket. When [E11] turned around, [he/she] observed [R1] drinking water from a water bottle. [E11] immediately took the bottle from [R1] and threw it in the sink". It was documented in E11's statement that R1 "drank probably six ounces (of water) before I grabbed it." 6/26/19 - R1 was admitted to the hospital with a diagnosis of aspiration pneumonia. The facility failed to provide adequate supervision to prevent an accident. R1 was unsupervised in the presence of a thin liquid beverage. The findings were reviewed on 7/11/19 beginning at approximately 11:15 AM, during an exit meeting with E1(ED/ NHA), E2(DON), and E3(RSM).	W 331	C. The Executive Director sent out a clarification directive to staff members regarding a previous memorandum detailing the need of not bringing food or drinks in areas where residents could accidently ingest such items. Completed 7/10/2019 (Attachment E). D. A review sweep was completed of areas relating to R1 on the date of the incident to ensure other liquid containers were not in areas the resident could have accidental access. Complete 06/21/2019. THEN, The designated Facility Charge will check for 100% compliance to the email directive issued 7/10/2019 by surveying R1's residential and activity areas 3 times a week until 100% compliance is consistently reached over 4 consecutive surveys. THEN, The designated Facility Charge will check for 100% compliance to the email directive issued 7/10/2019 by surveying R1's residential and activity areas 2 times a week until 100% compliance is consistently reached over 2 consecutive surveys. FINALLY,The designated Facility Charge will check for 100% compliance to the email directive issued 7/10/2019 by surveying R1's residential and activity areas once a week thereafter. (Attachment F)	9/9/19

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Stockley Center

DATE SURVEY COMPLETED: July 11, 2019

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 surveys were conducted at this facility from July 8, 2019 through July 11, 2019. The facility census the first day of the survey was 49. The survey sample totaled 6 residents and 12 sub-samples residents. For the Emergency Preparedness survey, no deficiencies were cited. **Regulations for Skilled and Intermediate Care 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.** **This requirement is not met as evidenced by:** Based on record review and interview it was determined for two (R1 and R5) out of six sampled residents the facility failed to ensure adequate staff assistance and/or assistive devices. The facility failed to provide two person assistance during toileting and assistive devices for R5, which resulted in a fall. For R1, the facility failed to provide care and services to ensure visual supervision to prevent accidental ingestion		
3201 3201.1.0 3201.1.2			

Provider's Signature Jay Stephen Jawkins Title Executive Director Date 7/26/19

NAME OF FACILITY: Stockley Center

DATE SURVEY COMPLETED: July 11, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	of unsafe liquids. Findings include: 1. The following was reviewed in R5's clinical record: 8/8/16 - The Instructional Guidelines (IG) for toileting back support with buckle and grab bar documented that R5 required two person assistance at all times when standing throughout the toileting process and one staff providing visual supervision when seated and seatbelt is fastened on the toilet back support. The steps in the procedure included: "...4...Seatbelt should remain on (Name of R5) throughout the entire toileting procedure until (he/she) transferred off the commode as (he/she) will stand up fast on (his/her) own...6. After toileting, unbuckle seat belt and transfer..." 4/22/19 8:30 PM - The Incident Report documented that E6 (CNA) was toileting R5 in the bathroom and unbuckled the seat belt to have R5 stand but R5 jumped up once seatbelt was unbuckled and tripped over his/her own shoes. E6 documented, "Was only trying to clean (R5) until someone came to assist. I assisted (him/her) to the floor and (R5) assisted (E6) by grabbing the handle on the cart to help get up off the floor." R5 was assessed by E5 (RN) with no significant injury from the fall. 4/23/19- The IG for toileting back support with buckle and grab bar was revised on 4/23/19 following the above fall on 4/22/19 at 8:30 PM. An additional sentence was added "Do not unbuckle seatbelt until the 2nd staff have arrived." 7/11/19 9:45 AM - An interview with E5 (RN), who assessed R5 following the 4/22/19 fall confirmed that R5 required two person assistance at all times when standing throughout the toileting process and provided verbal counseling to E6 after the incident.	3201 1. A. For resident R5 there are no corrective measures that can be taken at this time to address the deficient practice of staff not following the instructional guidelines resulting in R5's fall. It is noted that the facility did complete a body check and physician evaluation to ensure assess for injury for which no injury was noted at that time nor later. B. All residents of the Stockley Center who have similar IGs as R5 have the potential to be impacted by this deficiency. A review of all similar IGs as R5 will be completed by the Occupational Therapist and revisions made as necessary. C. The day after the incident, 04/23/2019, a review of the Instructional Guidelines (IG) for R5 resulted in a clarification to the IG to communicate the necessity to not unbuckle the seatbelt until a second staff member is present. (*Attachment C*). D. A review sweep of the other IGs for residents with similar supports were reviewed and updated as necessary to ensure clarity of the supports. The Occupational Therapist updated and revised any IGs that require clarity relative to unbuckling a seatbelt if two staff members are required to assist the individual. Completed 07/25/2019 (*Attachment D*).	

Provider's Signature _____ Title Executive Director Date 7/26/19

NAME OF FACILITY: Stockley Center

DATE SURVEY COMPLETED: July 11, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	7/11/19 10:45 AM - An interview with E1 (ED, NHA) confirmed that the facility failed to follow the R5's IG, by failing to have two staff assistance at all times when standing throughout the toileting process. In addition, failed to ensure that the seatbelt remained buckled until R5 was transferred off the commode. 2. The following was reviewed in R1's clinical record: Undated - A physician's order for R1's diet included honey thick liquids. 1/8/19 - R1's plan of care documented, "I also must have visual supervision at all times (unless in my bed) as I may eat food that does not belong to me or drink liquids that are (not) beverages (i.e. hand sanitizer or paint)." 6/21/19 at approximately 11:00 AM - A facility Disciplinary Investigative Report revealed that "(E11 Activity Aide) accompanied (R1) to the West Game room. When (he/she) entered the room with (R1), (he/she) turned away to get a blanket from the mat table so (R1) could lay (his/her) head down on the table with a rolled up blanket. When (E11) turned around, (he/she) observed (R1) drinking water from a water bottle. (E11) immediately took the bottle from (R1) and threw it in the sink". It was documented in E11's statement that R1 "drank probably six ounces (of water) before I grabbed it." 6/26/19 - R1 was admitted to the hospital with a diagnosis of aspiration pneumonia. The facility failed to provide adequate supervision to prevent an accident. R1 was unsupervised in the presence of a thin liquid beverage. The above findings were reviewed on 7/11/19 beginning at approximately 11:15 AM, during an	THEN, The Peer Review Committee will review a sampling of all IGs for 2 residents on each area for 100% clarity for 3 consecutive months. FINALLY, The Peer Review Committee will review a sampling of all IGs for 2 residents on each area for 100% clarity for 3 quarters. 2. A. For resident R1 there are no corrective measures that can be taken at this time to address the deficient practice of staff not following the visual supervision requirements when staff turned around to get a blanket in the same room resulting in R1 grabbing a bottle of water and wrongfully ingesting the liquid. It is noted that the staff member immediately stopped the action of the resident and the facility completed a body check and physician evaluation for which no injury was noted at that time. It is also noted that on 06/20/2019, R1 returned from a hospitalization with a diagnosis of aspiration pneumonia and R1 was actively being treated with antibiotics. Since the 06/21/2019 incident, there were follow up vital signs and respiratory assessment by the respiratory therapist. B. A review of residents revealed that R1 is the only resident with active PICA who is able to independently move toward, reach out, and grab liquids not belonging to the resident. A review sweep of R1's residential and activity areas will be completed. C. The Executive Director sent out a	9/9/19

Provider's Signature _____ Title Executive Director Date 7/26/19

NAME OF FACILITY: Stockley Center

DATE SURVEY COMPLETED: July 11, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Exit Meeting with E1 (ED, NHA), E2 (DON), and E3 (RSM).	clarification directive to staff members regarding a previous memorandum detailing the need of not bringing food or drinks in areas where residents could accidently ingest such items. Completed 7/10/2019 (*Attachment E*).	
9.6	**All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection. The method of reporting shall be as directed by the Division.**	D. A review sweep was completed of areas relating to R1 on the date of the incident to ensure other liquid containers were not in areas the resident could have accidental access. Complete 06/21/2019.	
9.8	**Reportable incidents are as follows:**	THEN, The designated Facility Charge will check for 100% compliance to the email directive issued 7/10/2019 by surveying R1's residential and activity areas 3 times a week until 100% compliance is consistently reached over 4 consecutive surveys.	
9.8.2	**Neglect, mistreatment or financial exploitation as defined in 16 Delaware Code, §1131.** Based on record review, interview, review of facility policies and procedures it was determined that for two (R1 and R5) out of six residents sampled and twelve (SSR1, SSR2, SSR3, SSR4, SSR5, SSR6, SSR7, SSR8, SSR9, SSR10, SSR11, and SSR12) sub-sampled residents who were not administered medications by E9 (RN), the facility failed to identify and immediately report allegations of neglect. Findings included: The facility's policy and procedure, titled Reporting and Investigation Procedure for: PM 46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, Significant Injury and Injury of Unknown Source), with a revision date of 8/8/18 indicated: "I. OBJECTIVE: To establish a process for reporting, investigating, and taking administrative action in PM46 cases for alleged or suspected abuse, neglect, mistreatment, financial exploitation, medication diversion and significant injury and injuries of unknown source to residents of Stockley Center. The Eye Witness/Reporting Person is responsible to: 1. Ensures comfort and protection of the resident(s) 2. Reports the incident immediately without delay,	THEN, The designated Facility Charge will check for 100% compliance to the email directive issued 7/10/2019 by surveying R1's residential and activity areas 2 times a week until 100% compliance is consistently reached over 2 consecutive surveys. FINALLY,The designated Facility Charge will check for 100% compliance to the email directive issued 7/10/2019 by surveying R1's residential and activity areas once a week thereafter. (*Attachment F*) 9.8 1. A. For Residents R1 and R5, and SSR1, SSR2, SSR3, SSR4, SSR5, SSR6, SSR7, SSR8, SSR9, SSR10, SSR11, and SSR12, there are no corrective measures that can be taken at this time to address the deficient practice of not immediately reporting the identified incident. B. All residents of the Stockley Center	9/9/19

Provider's Signature [signature] Title Executive Director Date 7/26/19

NAME OF FACILITY: Stockley Center

DATE SURVEY COMPLETED: July 11, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	to the nurse and the supervisor in charge/Administrator on Duty. 3. Completes an Administrative Incident Report and documentation in the resident's record. Forwards the Administrative Incident Report to the nurse and the supervisor in charge and the Administrator on Duty immediately. 4. Immediately (within eight hours) report the incident to the Division of Long Term Care Resident's Protection by calling the 24-hour toll free number". The Department of Health and Social Services Policy Memorandum #46, Responding to Reportable Incidents/Accidents, with a revision date of 8/22/16 documented: "Purpose. a. To identify and define reportable incidents and allegations that warrant notification and investigation. b. To identify standardized reporting and investigative procedures of reportable incidents and allegations. IV Definitions:... G. Reportable Incidents shall mean suspicion of any of the following occurrences:... Neglect shall mean: a. Lack of attention to the physical needs of an individual receiving services to include but not limited to toileting, bathing, nutrition and safety:..." 1. 2/24/19 9:10 AM - Review of a facility Medication Error Incident Report revealed that E10 (RN) notified E2 (DON) that E9 (RN) was found sleeping and did not administer medications to 12 residents (SSR1 through SSR12). 2/24/19 - Review of a facility reported incident documented, "At 10:00 AM, on 2/24/19, it was reported by (E2 DON) to (E1 ED/NHA) that a nurse (E9 RN) was found sleeping on the morning of Sunday 2/24/19 in the Activities room at the MAC (medical) Center at approximately 6:45 AM. (E9) was to be on duty and act as the Facility Charge for the 11 PM to 7 AM shift. When the next shift arrived, they were unable to find (E9),	have the potential to be impacted by this deficiency. The DHQ (DLTCRP) surveyors reviewed all Administrative Incident Reports and investigations for the facility for the time period of July 11, 2018 to July 12, 2019, during the Annual Survey. There were no other residents found to have related deficiencies. C. Changes were made to the Stockley Center Administrative Procedure "Reporting and Investigating Procedure for: PM 46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source." The Administrative Procedure now includes a statement regarding an additional avenue for reporting. The new statement is worded: "Ensures immediate (within 8 hours) reporting to the Division of Health Care Quality (Division of Long Term Care Residents Protection) by calling the 24-hour toll free number at 1-877-453-0012. Reporting can be completed via email by the Executive Director/Designee to ltc.residents.protection@delaware.gov and other designees then the web-based report will be filled out on the same day during the work week or next operational business day." Completed 07/18/2019. (*Attachment A*) The Executive Director/ designee knows to report these types of incidents to the State agency and will ensure all future incidents of similar nature are reported at the time of the incident. The Director of Residential Services and the Director of Nursing will ensure that Stockley Center Directors, Facility Charges, and Charge Nurses and nursing staff will complete a review and acknowledgement of the policy	

Provider's Signature [signature] Title Executive Director Date 7/26/19

NAME OF FACILITY: Stockley Center **DATE SURVEY COMPLETED: July 11, 2019**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	and located him/her in the Activities department asleep in a recliner. Upon further investigation, it was discovered that (E9) had signed for narcotic medications, but had not dispensed those medications. Further, it was discovered that (E9) had missed the 5-5:30 AM and the 6:00 AM medication pass for (SSR1 through SSR12). The medications were dispensed by the next shift at 7 AM". 2/24/19 10:00 AM - Review of a facility Summary of Findings PM 46 Investigation in the Description of Incident included, "At 10:00 AM (three hours after the incident) on 2/24/19, it was reported by (E2 DON) to (E1 ED/NHA) that a nurse, (E9 RN) was found sleeping on the morning of 2/24/19." 2/25/19 8:51 AM - E3 (DORS) forwarded an email to the State agency about this incident, twenty-five hours and fifty-one minutes after the facility had knowledge of the incident. 2/25/19 4:10 PM - E3 (DORS) submitted the incident electronically to the State Agency reporting system. 7/10/19 12:00 PM - In an interview with E2 (DON) it was confirmed that the facility had knowledge of the incident at approximately 7:00 AM on 2/24/19. E2 confirmed that the incident was reported to the State Agency late. 7/10/19 12:15 PM - In an interview with E1 (ED/NHA) and E2 (DON) it was explained that the incident was not reported on 2/24/19 because facility staff did not know the extent of the information and the scope of how many people were involved. E1 and E2 added that the facility wanted to do more investigating to have all of the information to report to the State Agency. The facility failed to identify R9 (RN) sleeping on his/her shift and not administering the resident's medications to 12 residents as an allegation of neglect, which resulted in not immediately reporting the incident to the State Agency.	changes. D. The Executive Director/ Designee will continue to monitor each alleged and suspected PM46 case to ensure the Administration Procedures and PM46 policy is followed for 100% compliance. The Facility Quality Improvement staff will continue to conduct reviews of all Administrative Incident Reports and investigations on a quarterly basis for 100% compliance.	9/9/19

Provider's Signature [signature] Title Executive Director Date 7/26/19

NAME OF FACILITY: Stockley Center

DATE SURVEY COMPLETED: July 11, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	2. The following was reviewed in R1's clinical record: Undated - Physician's Order for R1's diet which included honey thick liquids. 1/8/19 - R1's plan of care documented "I also must have visual supervision at all times (unless in my bed) as I may eat food that does not belong to me or drink liquids that are (not) beverages (i.e. hand sanitizer or paint)." 6/21/19 at approximately 11:00 AM - A facility Disciplinary Investigative Report revealed that "(E11 Activity Aide) accompanied (R1) to the West Game room. When he/she entered the room with (R1), he/she turned away to get a blanket from the mat table so (R1) could lay his/her head down on the table with a rolled up blanket. When (E11) turned around, he/she observed (R1) drinking water from a (brand name) water bottle. (E11) immediately took the bottle from (R1) and threw it in the sink". It was documented in E11's statement that R1 "drank probably six ounces (of water) before I grabbed it." The facility failed to identify the incident as an allegation of neglect and immediately report the incident to the State Agency. 3. The following was reviewed in R5's clinical record: 8/8/16 - The Instructional Guidelines (IG) for toileting back support with buckle and grab bar documented that R5 required two person assistance at all times when standing throughout the toileting process and one staff providing visual supervision when seated and seatbelt is fastened on the toilet back support. Steps in the procedure included: "...4...Seatbelt should remain on (Name of R5) throughout the entire toileting procedure until (he/she) is transferred off the commode as (he/she) will stand up fast on (his/her) own...6. After toileting, unbuckle seat belt and transfer..."	2. A. For resident R1 there is no corrective measure to be taken at this time to address the deficient practice of not reporting to the State agency. B. All residents of the Stockley Center have the potential to be impacted by this deficiency. The DHQ (DLTCRP) surveyors reviewed all Administrative Incident Reports and investigations for the facility for the time period of July 11, 2018 to July 12, 2019, during the Annual Survey. There was one other resident found to have the same deficiency. The remaining residents' records revealed no deficiencies of this kind in those records at that time. C. Changes were made to the Stockley Center Administrative Procedure "Reporting and Investigating Procedure for: PM 46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source." The Administrative Procedure now includes an expanded objective to include potential impact. The new objective is worded: "To establish a process for reporting, investigating, and taking administrative action in PM46 cases for alleged or suspected abuse, neglect with known or potential negative impact, mistreatment, financial exploitation, medication diversion and significant injury and injuries of unknown source to residents of Stockley Center." Completed 07/18/2019. (*Attachment A*) The Executive Director/ designee knows to report these types of incidents to the State agency and will ensure all future incidents of similar nature are reported at the time of the	

Provider's Signature _____ Title Executive Director Date 7/26/19

NAME OF FACILITY: Stockley Center

DATE SURVEY COMPLETED: July 11, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	4/22/19 8:30 PM - An Incident Report documented that E6 (CNA) was toileting R5 in the bathroom and unbuckled the seat belt to have R5 stand but R5 jumped up once the seatbelt was unbuckled and tripped over his/her own shoes. E6 documented, "Was only trying to clean (R5) until someone came to assist. I assisted R5 to the floor and (R5) assisted (E6) by grabbing the handle on the cart to help get up off the floor." R5 was assessed by E5 (RN) with no significant injury from the fall. 7/9/19 11:00 AM - An interview with E3 (RSM) revealed that E3 had investigated the above fall on 4/22/19 and determined that the above IG dated 8/8/16 was unclear for the staff, thus, additional comment of "Do not unbuckle seatbelt until 2nd staff has arrived" was included on 4/23/19 after the fall. 7/11/19 9:45 AM - An interview with E5 (RN), who assessed R5 following the 4/22/19 fall confirmed that R5 required two person assistance at all times when standing throughout the toileting process and provided verbal counseling to E6 (CNA) after the incident. 7/11/19 10:45 AM - An interview with E1 (ED, NHA) verbalized a "mistake was made, R5's seatbelt was unbuckled" and confirmed that the facility failed to follow the R5's IG, by failing to have two staff assistance at all times when standing throughout the toileting process. Although the above IG dated 8/8/16 documented for toileting that R5 required two person assistance at all times when standing throughout the toileting process and the seatbelt should remain on throughout the entire toileting procedure until R5 was transferred off the commode, the facility failed to identify this incident as an allegation of neglect, in which there was lack of attention to the safety needs of R5. This failure resulted in lack of immediate reporting.	incident. The Director of Residential Services and the Director of Nursing will ensure that Stockley Center Directors, Facility Charges, and Charge Nurses and nursing staff will complete a review and acknowledgement of the policy changes. D. The Executive Director/designee will continue to monitor each Administrative Incident Report and investigation for 100% compliance. The Facility Quality Improvement staff will continue to conduct reviews of all Administrative Incident Reports and investigations on a quarterly basis for 100% compliance. 3. A. For resident R5 there is no corrective measure to be taken at this time to address the deficient practice of not reporting to the State agency. B. All residents of the Stockley Center have the potential to be impacted by this deficiency. The DHQ (DLTCRP) surveyors reviewed all Administrative Incident Reports and investigations for the facility for the time period of July 11, 2018 to July 12, 2019, during the Annual Survey. There was one other resident found to have the same deficiency. The remaining residents' records revealed no deficiencies of this kind in those records at that time. C. Changes were made to the Stockley Center Administrative Procedure "Reporting and Investigating Procedure for: PM 46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unknown Source." The Administrative Procedure	9/9/19

Provider's Signature Kai-Stephen Jamison Title Executive Director Date 7/26/19

NAME OF FACILITY: Stockley Center

DATE SURVEY COMPLETED: July 11, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The above findings were reviewed on 7/11/19 beginning at approximately 11:15 AM, during an Exit Meeting with E1 (ED, NHA), E2 (DON), and E3 (RSM). Based on record review and interview it was determined that for one (R6) out of six sampled residents the facility failed to implement an active treatment program for dental desensitization. Findings include: The following was reviewed in R6's clinical record: 12/13/18 - A learning plan was initiated for "(R6) will visit the dental clinic monthly to work on desensitization exercises. (R6) will tolerate 10 (ten) minutes of positive interaction while in the dental clinic for 12 (twelve) consecutive months by 12/31/19". The data collection plan documented "Implement 1 (one) time a month. Collect date 1 (one) time a month. BA (behavior analyst) will document the desensitization exercise, length of positive interaction, and the response in an ID (interdisciplinary) Note in the COR (clinical record)". Review of R6's 2019 monthly summaries revealed: January - new plan implemented by BA; February - no visit; March - no visit to clinic; April - no visit to clinic; May - in hospital. Review of ID notes documented: 5/10/19 - The ID note documented that staff took R6 to the clinic and he/she turned around and left in less than a minute. 5/30/19 - The ID note documented that the resident was in hospital and the BA could not implement the plan. 6/21/19 - The ID note documented a visit to the dental clinic with the BA and R6 tolerated two minutes.	now includes an expanded objective to include potential impact. The new objective is worded: "To establish a process for reporting, investigating, and taking administrative action in PM46 cases for alleged or suspected abuse, neglect with known or potential negative impact, mistreatment, financial exploitation, medication diversion and significant injury and injuries of unknown source to residents of Stockley Center." Completed 07/18/2019. (*Attachment A*) The Executive Director/ designee knows to report these types of incidents to the State agency and will ensure all future incidents of similar nature are reported at the time of the incident. The Director of Residential Services and the Director of Nursing will ensure that Stockley Center Directors, Facility Charges, and Charge Nurses and nursing staff will complete a review and acknowledgement of the policy changes. D. The Executive Director/designee will continue to monitor each Administrative Incident Report and investigation for 100% compliance. The Facility Quality Improvement staff will continue to conduct reviews of all Administrative Incident Reports and investigations on a quarterly basis for 100% compliance. A. For resident R6 there are no corrective measures that can be taken at this time to address the deficient practice of not implementing the plan for dental desensitization in a timely manner. B. All residents of the Stockley Center	9/9/19

Provider's Signature Kai-Ayre Fontain Title Executive Director Date 7/26/19

NAME OF FACILITY: Stockley Center

DATE SURVEY COMPLETED: July 11, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	7/10/19 2:15 PM - During an interview with E8 (QIDP) it was revealed that in February, March and April the dental desensitization plan was not conducted. It was further revealed that E8 (QIDP) must have missed the 5/10/19 ID note about the plan when he/she documented that there was no plan implemented in May. 7/10/19 2:31 PM - During an interview with E12 (former BA) it was revealed that he/she had an email that was sent to E8 (QIDP) documenting that the plan was implemented on 4/23/19 but the plan implementation was not documented in the record. It was further revealed that when E12 was the BA he/she established the dental desensitization plan but failed to implement it until 4/23/19. The above findings were reviewed on 7/11/19 beginning at approximately 11:15 AM, during an Exit Meeting with E1 (ED, NHA), E2 (DON), and E3 (RSM).	who have a dental desensitization plan have the potential to be impacted by this deficiency. A review of all the Behavior Analyst's behavior supports learning plans will be completed by the Program Administrator. C. The Behavior Analyst will complete monthly implementation reviews of behavior supports learning plans then report all data to the QIDP for the QIDP's monthly reports. The Behavior Analyst will document this information exchange in emails and provide this documentation to the QIDP and Director of Residential Services. D. A review sweep of all behavior supports learning plans including R6 was completed on July 15, 2019 for the quarter of April 2019 through June 2019. The review sweep, of these types of learning plans, revealed that the plans were implemented unless medically contraindicated, continue, and have been monitored by the Behavior Analyst monthly. (*Attachment B*) THEN, all of the Behavior Analyst's behavior supports learning plans implementation data will be reviewed for 1 time a month by the Program Administrator to ensure 100% compliance is achieved over three consecutive evaluations. FINALLY, all of the behavior supports learning plans implementation data will be reviewed biannually by the Peer Review Committee.	9/9/19

Provider's Signature [signature] Title Executive Director Date 7/26/19