

STATE SURVEY REPORT

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NAME OF FACILITY: Stockley Center ICF/ID

DATE SURVEY COMPLETED: March 27, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference	TIES	A
	and also cites the findings specified in the		
	Federal Report.		
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from March 20, 2023 through March 27, 2023. The deficiencies contained in this report were based on observation, interview, review of clients' records and review of other facility documentation as indicated. The facility census on the first day of the survey was 40. The survey sample totaled 14 residents.		
3201	Dogulations for Skilled and Intermediate	2201	05/05/0000
3201	Regulations for Skilled and Intermediate	3201	05/25/2023
	Care Nursing Facilities	A1. The facility is unable to correct the past	
0004 4 0		practice; however, to address the citation,	
3201.1.0	Scope	the plan of action taken involved the Exec-	
2004 4 2		utive Director (ED) contacting the tempo-	
3201.1.2	Nursing facilities shall be subject to all appli-	rary staffing agency, Infojini, Inc., via tele-	
	cable local, state and federal code require-	phone on 3/28/2023 to inform the agency	
	ments. The provisions of 42 CFR Ch. IV Part	in details of the Delaware Background	
	483, Subpart B, requirements for Long Term	Check Center (BCC) credentialing require-	
	Care Facilities, and any amendments or	ments to include data sources generated	
	modifications thereto, are hereby adopted	by the BCC (Adult Abuse Registry, State and	
	as the regulatory requirements for skilled	Federal Criminal background Checks) and	
	and intermediate care nursing facilities in	obtain require information for	
	Delaware. Subpart B of Part 483 is hereby	E41,E47,E48,E50,E53,E54,E55 and E56.	
	referred to, and made part of this Regula-	Attachment A: Email/Memo correspond-	
	tion, as if fully set out herein. All applicable	ence from the Executive Director (ED) to In-	
	code requirements of the State Fire Preven-	fojini, Inc. regarding the Delaware Back-	
	tion Commission are hereby adopted and in-	ground Check Center (BCC) credentialing	
	corporated by reference.	requirements.	
		A2. The ED sent a follow-up email to the	
3201.5.0	Personnel/Administrative	agency, Infojini, Inc., on 3/28/2023 detail-	
		ing the Delaware BCC credentialing re-	
3201.5.5	The facility shall have written personnel pol-	quirements and it being imperative that	
	icies and procedures. Personnel records	the company take immediate corrective ac-	
		tion.	

Provider's Signature for the further Ed. D Title ED/NHA Date 5/17/23

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

Executive Defected Norsely Home Administrator



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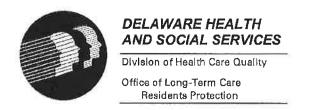
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- 10 THE HE	harden and the second		
	shall be kept current and available for each	Attachment A: Email/Memo correspond-	
	employee, and include the following:	ence from the Executive Director (ED) to In-	
3201.5.5.3		fojini, Inc. regarding the Delaware Back-	
	Results of criminal background check	ground Check Center (BCC) credentialing	
3201.5.5.5		requirements.	
	Result of Adult Abuse Registry check	A3. Temporary Agency Staff that are con-	
		tracted by Infojini Inc. were removed from	
	This requirement was not met as evidenced	the schedule on 3/28/2023 by the ED due	
	by:	to the issue with the credentialling require-	
	~1.	ments needed through the Delaware BCC.	
	Based on review of facility personnel records	The staff were returned to the schedule by	
	and interview, the facility failed to ensure	the ED on 3/30/2023 because Infojini, Inc.	
	that eight (E41, E47, E48, E50, E53, E54, E55	initiated corrective action.	
	and E56) out of 19 sampled personnel rec-	Attachment D: Emails stating Infojini Inc.	
	ords were kept current and available with the	staff were removed from the schedule on	
	criminal background and Child and Adult	due to the issue with the credentialling re-	
	_	quirements needed through the Delaware	
	Abuse Registry checks. Findings include:	Background Check Center (BCC). The staff	
	2/07/22 10 15 114 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	were returned to the schedule because In-	
	3/27/23 10:45 AM – During an interview with		
	E1 (ED), the following employee personnel	fojini, Inc. initiated corrective action.	
	records were reviewed and E1 confirmed the		
	missing personnel records:	B1. The ED conducted a sweep of tempo-	
		rary all staff personnel files. Based on the	
	1. E41 (Agency CNA), was missing a criminal	results, it was concluded by the ED that	
	background check and Child and Adult	temporary agency staffing both current	
	Abuse Registry checks.	and future staffing have the potential to be	
		affected by the deficient practice.	
	2. E47 (Agency CNA), was missing a criminal	Attachment CC: Memo from Executive Di-	
	background check and Child and Adult	rector (ED) stating a sweep of Temporary	
	Abuse Registry checks.	Agency Staff personnel files were audited	
	,	B2. The ED sent an email to all contract	
	3. E48 (Agency CNA), was missing a criminal	agencies that have staff at Stockley Center	
	background check and Child and Adult	on 3/28/2023 and 3/29/2023 summarizing	
	Abuse Registry checks.	the BCC requirements of data sources gen-	
	Linday Lindings Lauranias	erated by the BCC (Adult Abuse Registry,	
	4. E50 (Agency CNA), was missing a criminal	State and Federal Criminal background	
	background check and Child and Adult	Checks) for Temporary Agency Staff that	
	9	are currently working in the facility as well	
	Abuse Registry checks.		
1		as future temporary agency staff.	

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	5. E53 (Agency RN), was missing a criminal background check.	Attachment C: Emails from the Executive Director (ED) to all contract agencies that	
	6. E54 (Agency CNA), was missing a criminal	have staff at Stockley Center summarizing the Background Check Center (BCC) re-	
	background check and Child and Adult	quirements.	
	Abuse Registry checks.	B3. The scope of credentialling for all staff-	
	, , , , , , , , , , , , , , , , , , ,	ing at Stockley Center was investigated by	
	7. E55 (Agency CNA), was missing a criminal	the ED. First, the ED contacted the Dela-	
	background check and Child and Adult	ware Division of Human Services (DHR) via	
	Abuse Registry checks.	telephone on 3/28/2023, regarding the	
		State Merit Employees. The ED was in-	
	8. E56 (Agency CNA), was missing a criminal	formed by DHR that all Stockley Center	
	background check and Child and Adult	Merit and Seasonal Casual employees are	
	Abuse Registry checks.	vetted through the BCC for data sources	
	- / / · · · · · · · · · ·	generated by the BCC (Adult Abuse Regis-	
	3/27/23 2:30 PM - Findings were reviewed	try, State and Federal Criminal background	
	with E1, E2 (PA), E29 (ADON), and E4 (DRS)	Checks). Second, to assess all temporary	
	during the Exit Conference.	agency staffs' BCC credentialing documen-	
		tation files, a second sweep audit of Tem-	
		porary Agency Staff personnel files was completed on 3/31/2023, by the ED, Ad-	
		ministrative Specialist III (ASIII) and Stand-	
		ards Control Specialist (SCS). These files	
		were moved to a central location in the Ex-	
	_	ecutive Director's (ED) office by the ASIII	
		and SCS.	
		Attachment E: Memo stating a sweep of	
		Temporary Agency Staff personnel files	
		were audited.	
		B5. A memo to contracting temporary	
		staffing agencies was written by the ED re-	
		garding the requirements of criminal back-	
		ground checks and adult abuse registry re-	
	8	sults through of the BCC, and then memo	
		was approved by DDDS Leadership on	
		4/17/2023. The ED emailed this memo to	
		each contracting temporary staffing agency	
		working with Stockley Center on	
		4/18/2023.	

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		F. M	
		Attachment F: Memo to contracting tem-	
		porary agencies was developed by the Ex-	
		ecutive Director (ED) and approved by	
		DDDS Leadership and emailed to each con-	
		tracting temporary agency.	
		C1. The ED's RCA revealed the deficient	
		practice only involved temporary staffing	
		agency staff. It is noted that copies of Crim-	
		inal Background Checks and Adult Abuse	
		Registry Checks were part of the personnel	
		file; however, these data points were not	
		vetted through the BCC. The issue was the	
		facility's new practice of hiring temporary	
		staffing agencies did not include the spe-	
		cific BCC requirements as part of the cre-	
		dentialing and hiring processes for tempo-	
		rary staffing to obtain data sources gener-	
		ated by the BCC (Adult Abuse Registry,	
i i		State and Federal Criminal background	
		Checks). The facility's assumption of the	
		agencies obtaining this information auto-	
		matically through the BCC lead to the defi-	
		cient practice.	
		C2. The Administrative Program Adminis-	
		trator (APA) and the ED reviewed and will	
		revise The Pre-Employment Screening Ad-	
		ministrative Policy to reflect temporary	
		agency staffing hiring with BCC credential-	
-		ing requirements and start dates of new	
		temporary employees must be after cre-	
		dentialing documentation is obtained	
		which includes Adult Abuse Registry and	
		State and Federal Criminal background	
		Checks.	
		C3. The Temporary Agency Staffing Hiring	
		Checklist was revised on 4/3/2023 by the	
		APA to reflect the credentialing require-	
		ment of the BCC and copies of necessary	
		documentation, and a Temporary Agency	

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	-	Staffing Hiring Approval form was created	
		on 4/10/2023 by the ED and APA to reflect	
		the credentialing requirement of the BCC	
		and copies of necessary documentation.	
		Attachment G: Temporary Agency Staffing	
		Hiring Checklist	
		Attachment H: Temporary Agency Staffing	
		Hiring Approval form	
		C4. The updated Pre-Employment Screen-	
	¥	ing Administrative Policy will be provided	
		to hiring manager staff by the ED for re-	
		view, and a signed voucher will be com-	
		pleted. The APA will track completion of	
		the is policy review.	
		C5. Existing Temporary Staff. Obtaining re-	
		quired personnel documentation through	
		the BCC for existing temporary staff is be-	
1		ing obtained by the Administrative Special-	
Ì		ist III (ASIII) and the Human Resources	
		Technician/Administrative Specialist I (ASI)	
	*	through email reminders and phone calls,	
		and tracking credentialing documents until	
		complete records are obtained. Copies of	
1		all required credentialing documentation	
		will be filed by the ASIII or ASI in the ED of-	
		fice in the temporary staffing personnel	
		files.	
		C6. Future Temporary Staff. Prior to hiring	
		temporary agency staffing, the ED or de-	
		signee in absence of the ED is required to	
		review and sign the Temporary Agency	
		Staffing Hiring Approval form as well as re-	
		viewing associated credentialing BCC docu-	
	*	mentation to ensure a complete record.	
		Copies of all required credentialing docu-	
		mentation will be filed in the temporary	55
		staffing personnel files in the ED office by	
		the ASIII or ASI. The Temporary Agency	
		Staff start date will be determined by re-	
		ceipt of all required documentation and	

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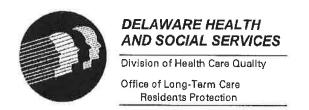
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SECTION	SPECIFIC DEFICIENCIES	the signed Temporary Agency Staffing Hiring Approval form. Attachment G: Temporary Agency Staffing Hiring Checklist Attachment H: Temporary Agency Staffing Hiring Approval form D1. Existing Temporary Staff. The ASI and/or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

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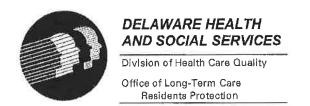
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1121. Res-	shall be protected by a declaration of a res-	A The facility is such that the second state of the second state o	
ident	ident's rights, and by requiring that all facil-	A. The facility is unable to correct the past	
Rights	ities treat their residents in accordance	practice of E31 and E32 related to resident	
Mights	with such rights, which shall include the fol-	rights of C13 and C14. The identified issues	
	lowing:	were presented at the survey exit so an im-	
	lowing:	mediate corrective action for E31 and E32	
	(1) Each varidous shall have the wight to up	could not be taken; however, to address	
	(1) Each resident shall have the right to re-	the citation, the plan of action taken in-	
	ceive considerate, respectful, and appropri-	volved the Director of Residential Services	
	ate care, treatment and services, in compli- ance with relevant federal and state law	(DRS) verbally informing the residential	
		team [Residential Program Administrators	
	and regulations, recognizing each person's	(RPA), Social Service Administrator (SSA),	
	basic personal and property rights which in-	Qualified Intellectual Disability Profes-	
	clude dignity and individuality.	sional (QIDP), and Active Treatment Super-	
	This requirement was not used as suiden and	visors (ATS)] regarding resident rights and	
	This requirement was not met as evidenced	specifics of dignity and respect, and to relay	12
	by:	this information to staff because of obser-	1
31	Donal on remiens about the conditions	vations during mealtimes revealed specific	
	Based on random observations and inter-	issues. All staff, including E31 and E32 re-	
	view, it was determined that the facility	ceived training in respect and dignity.	
	failed to ensure clients were treated with	Attachment DD: Memo from Director of	
	dignity. Findings include:	Residential Services (DRS) stating a conver-	
	1 During a random manifely and	sation was held with the Residential Ser-	
	1. During a random meal observation on	vices Team regarding Resident Rights, Dig-	
	3/22/23 at 9:33 AM, C14 was observed be-	nity, and Mealtime Survey competencies	
	ing fed by E31 (CNA). E31 was standing over	D4 The where of the state of th	
	the resident and not sitting down in a dignified, homelike manner.	B1. The plan of action taken involved the	
1	ned, nomenke manner.	DRS verbally informing the residential team	
	2 During a model observation on 2/22/23 at	RPA, SSA, QIDP, and ATS regarding resident	
	2. During a meal observation on 3/22/23 at	rights and specifics of dignity and respect,	15
	11:49 AM, E32 (Activity Aide) was observed	and to relay this information to staff be-	
	feeding C13 lunch. E32 was talking on a cell	cause of observations during mealtimes re-	
İ	phone while feeding the resident.	vealed specific issues. In addition, An anal-	
	11/33/33 An internation with 545 (55)	ysis of the identified deficient practice by	
	11/22/23 – An interview with E16 (RN) re-	the ED determined that all staff have the	
	vealed that staff do not use cell phones as	potential to be deficient in this cited defi-	
	part of communication on the job. E16 went	cient practice; therefore, the DRS and APA	
	on to say that if a staff person was seen us-	developed a questionnaire regarding dig-	
	ing a cell phone while they were delivering	nity during mealtimes on 4/18/2023. A	
	care, they should be reported.	sweep regarding resident rights to dignity	
		will be conducted among all staff assisting	

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

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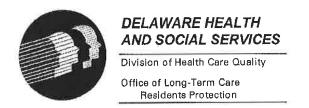
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SECTION			
		C6. The Administration Policy - Employee Education and Training Policy will be updated by the APA to include orientation training in Respectful Workplace to include the educational material.	
		D. Under the direction of the DRS, the Residential Team-RPA, SSA, QIDP, and/or ATS will complete a random sampling of 10 (Ten) staff a week who are assisting residents with meals across breakfast, lunch,	

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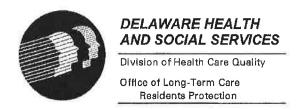
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		and dinner using the Mealtime Survey for 1 (One) month until consistency reaches 100% success. THEN Under the direction of the DRS, the Residential Team- RPA, SSA, QIDP, and/or ATS will randomly sample 10 (Ten) staff every 2 (two) weeks who are assisting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

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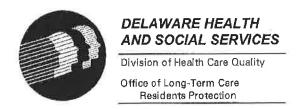
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	ensure they were free from neglect when	staff expectations. The conclusion of the	
	care and services were not provided for ap-	analysis revealed that failing to provide res-	
	proximately two or more hours when a CNA	ident care leading to the deficient practices	
	left the building and did not get coverage for	could have the potential to negatively af-	
	the five totally dependent clients. Findings	fect all residents. During the 3/29/2023,	
	include:	staff meeting analysis, the ED discussed	
		and expressed expectations of manage-	
	Review of C12's clinical record and other	ment and for management to convey the	
	records revealed the following:	requirements to staff expectations regard-	
	_	ing PM46 Reporting, Daily Expectations of	
	1. C12 was admitted to the facility in 1973	Staff responsibilities to residents, Staff As-	
	with diagnoses including, but not limited to,	signments with Residents, and Manage-	
	profound intellectual disabilities. Records	ment must be Checking and Correcting as	
	show that the resident is confined to a chair	necessary all staff assignments on all three	
	for mobility, dependent on staff for activities	shifts, at the beginning of shifts, mid shifts,	
	of daily living and is dependent on a tube for	and when staff changes occur during shifts.	
	feeding.	The ED followed up with an email and	
	0	memo conveying the same to DRS, DON,	
	6/22/22 - Review of the record, including	APA, RPA, SSA, QIDP, ATS, Therapist III	
	bowel and urinary elimination records and	(TIII), Activity Therapist II (ATII), and Direc-	
	progress notes, lacked documentation of	tor of Habilitative Services/ Staff Educator	
	care being provided during the 6:00 AM to	(SE).	
	2:00 PM shift.	Attachment L: Email/Memo from the Exec-	
	2.50 (14) 5111(.	utive Director to the Management Staff	
	3/21/23 10:52 AM - An interview with E33	and Facility Charge Staff regarding PM46	
	(CNA) revealed that on initial rounds on the	Reporting and Daily Documentation and	
	2:00 PM to 10:00 PM shift on 6/22/22, C12	Expectations of Staff	
	was found saturated in urine including the	B2. The APA revised the Documentation	
	- I		
	brief, pad, sheet, clothes and abdominal	training PowerPoint to reflect the require-	
	binder, there was an odor of old urine de-	ment of daily documentation on	
	tected, the resident's eyes were gunky, face	3/29/2023, for orientation and reeducation	
	appeared unwashed and the feeding tube	conducted by the SE and Nurse Educator	
	site looked uncared for with leakage pre-	(RNE).	
	sent. E33 stated this was reported to her Su-	Attachment M: Documentation training	
	pervisor E34 (Shift Building Charge), as well	PowerPoint	
	as E35 (Program Administrator). C12 re-	B3. To immediately address the current	
	ceived a full bath around 3:30 - 4:00 PM.	staff, an educational flyer will be developed	
	E12 (CNA Agency) confirmed a previous	by the SE and/or RNE on Daily Documenta-	
	statement to a DHCQ investigator that when	tion. The staff will be educated on the in-	

Provider's Signature

Title **ED (NHA** Date <u>5/17/23</u>

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

she looked at the urinary tracker there were | formation by the SE and Residential Team



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

Provider's Signature 4

Thuyld

3/23/23 (around 1:00 PM) - An interview with E35 (Program Administrator) revealed

Title ED (NHA-

giene care; Schedule changes effecting as-

Date 5/17/23



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NAME OF FACILITY: Stockley Center ICF/ID

SECTION

DATE SURVEY COMPLETED: March 27, 2023 COMPLETION ADMINISTRATOR'S PLAN FOR **CORRECTION OF DEFICIENCIES** DATE

that she did not see C12 uncared for, but was aware that E33 (CNA, Agency) found the resident uncared for at the start of the shift on 6/22/22, laying in urine and feces. E35 stated that E33 should have reported it to the facility Charge or a Nurse. E35 confirmed that she did not report the incident to anyone in Administration and was told it was an issue with the Communication Book and staff assignment.

STATEMENT OF DEFICIENCIES

SPECIFIC DEFICIENCIES

3/23/23 1:14 PM - An interview with E4 (DRS) revealed there had been a problem in the past with staffing assignments (when staff call out and the assignments need to be redistributed). E4 stated a new communication book was set up and the facility Charge must sign off on assignments. No specific details of this incident were revealed.

3/24/2023 12:02 PM - 1:12 PM - An (email) interview with E1 (NHA) identified E36 (CNA) as the Aide originally assigned to the resident group that included C12. It further revealed that it was unknown if the Aide originally assigned to R12 on 6/22/22 was interviewed about the failure to document care for the entire shift. There was no reporting or investigation by the facility about this allegation of neglect.

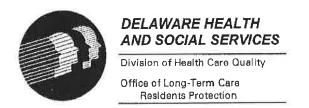
signments and these changes not accurately monitored my management; Lack of staff reviewing assignment changes in conjunction with lack of management monitoring; Administration's assumption based on past practices to not interfere with outside complaint investigations conducted through DHCQ/ outside entities by conducting simultaneous internal investigations; Lack guidance in the facility's PM46 procedures for conducting simultaneous investigations; Staff assumptions they had the right to anonymously report allegations of abuse, neglect, etc. to Long Term Care and Resident Protection/ DHCQ without reporting such cases to administration. Despite this right staff also have the obligation to report such cases to the administration while keeping their anonymity of direct reporting to LTCRP/DHCQ.

C2. The ED updated the Performance Plans and Measures for the positions of RPA, SSA, QIDP, ATS, Certified Nursing Assistant (CNA), Active Treatment Facilitator (ATF), and Temporary Agency CNA. These performance plans and measures were reviewed by DRS, RPA, SSA, QIDP with all the staff designated by titles detailing designated staffs' duties and expectations of their job. Staff signatures were obtained designating their acknowledgement and agreement. Attachment N: Performance Plan Database C3. The SE and/or RNE will provide education on the revised Documentation training during orientation and reeducation. Attachment M: Documentation training

PowerPoint

C4. The APA will update the Active Treatment Supervisor's Shift Monitoring Report

ESO Title ED/NHA Date 9/7/23 Provider's Signature / aq



STATE SURVEY REPORT

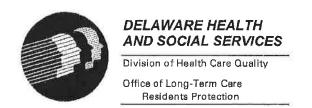
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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The second secon	to include the review of staffs' documenta-	
		tion of hygiene care functions (Bowel and	
		Urinary Elimination Records). The APA will	
		also update this report to include the re-	
		view of staff assignments/groupings of res-	
1		idents. When on duty the ATS completes	
		this monitoring report across all shifts.	
		C5. The APA will update the Facility Charge	
		Shift Monitoring Report to reflect the re-	
1		view of staffs' documentation of hygiene	
		care functions (Bowel and Urinary Elimina-	
		tion Records). The APA will also update this	
		report to include the review of staff assign-	
		ments/groupings of residents. When on	
		duty and designated as Facility Charge, this	
1		monitoring report is completed by Facility	
		Charge staff who consist of APA, RPA, SSA,	
		QIDP, TIII, ATII, and/or SE across all shifts.	
		C6. The Administrative Reporting and In-	
		vestigation Procedure For: PM46 (Abuse,	
t		Neglect, Mistreatment, Financial Exploita-	
		tion, Medication Diversion, and Significant	
		Injury) and Injuries of Unknown Source pol-	
		icy was reviewed and revised on	
1		3/28/2023, by the ED and APA to reflect fa-	
		cility protocol changes, that include the	
		same LTCRP/DHCQ reporting and simulta-	
1		neous internal investigations must be com-	
1		pleted for outside complaints being inves-	
		tigated by external entities. The APA will	
		create a corresponding checklist for inter-	
		nal investigations regarding outside com-	
		plaints being investigated by external enti-	
		ties.	
		C7. The updated Administrative Reporting	
		and Investigation Procedure For: PM46	
		(Abuse, Neglect, Mistreatment, Financial	
		Exploitation, Medication Diversion, and	
		Significant Injury) and Injuries of Unknown	
		Source policy will be sent by the DRS, DON,	

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		and ED to staff aversage by these Directors	
		and ED to staff overseen by these Directors to educate staff and signed vouchers by	
		staff will be obtained.	
		Staff will be obtained.	
		D1. For hygiene care documentation and	
		management monitoring (bowel and uri-	
		nary elimination records), under the direc-	
		tion of the DRS, the RPAs (2) will each com-	
		plete reviews of a random sampling of 5	
×		1	
		(five) residents' hygiene care documenta- tion (10 total between the two RPA) across	
		all residential units and across three shifts	
		for 5 (five) days a week for 1 (one) month	
1		until consistency reaches 100% success.	
		THEN	
		A random sampling of 5 (five) residents' hy-	
l)		giene care documentation (10 total be-	
		tween the two RPA) across all residential	
[]		units and across three shifts for 5 (five)	
		days every two weeks for 1 (one) month	
		until consistency reaches 100% success.	
		FINALLY	
J.		A random sampling of 5 (five) residents' hy-	
- 1		giene care documentation (10 total be-	
		tween the two RPA) across all residential	
		units and across three shifts for 1 (one)	
		time a month thereafter for 100% success.	
		D2. For Assignments/ Grouping/ Pick-up	
		Lists. Assignments/Groupings and manage-	
		ment monitoring, under the direction of	
		the DRS, the RPA and/or Facility Charge (DRS, APA, RPA, SSA, QIDP, TIII, ATII, SE)	
		when on duty will review all assign- ments/groupings each Day (daily) for all	
		residents across all residential units and	
		across three shifts for 1 (one) month until	
		·	
		consistency reaches 100% success. THEN	
1	12		
	-	2 (two) times a week for all residents across	
		all residential units and across three shifts	

Provider's Signature Mai

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

EDINHA Date 5/17/23 Provider's Signature Man



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

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STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES

ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES

COMPLETION DATE

(Division of Long Term Care Residents Protection) ...".

- 1. According to a report to the State Agency on 7/1/22, C15 was found saturated in urine and feces. Also, C15 had the same clothes on from that morning. This was reported to a Nurse that completed a skin check. There was no evidence that it was reported to Administration.
- 2. According to a facility investigation on 11/5/23, C4, C5, C6, C7 and C8 were neglected when E9 (Agency CNA) left the building at 1:24 AM and returned at 3:07 AM. E9 left her residents without coverage and E9 did not report to the Supervisor that she was leaving. Administration was not aware until 11/8/22 three days later and it was not reported to the State Agency until 11/8/22.
- 3. Statements from staff E33 (CNA), E34 (Charge Nurse) and E35 (Program Administrator) revealed their knowledge that on 6/22/22, C12 was left unassigned and unattended for the 6:00 AM to 2:00 PM shift. The client was found by the evening shift Aide to be saturated in urine, eyes gunky, face unclean and there was leakage from the feeding tube. E33 reported the same to E34 and E35. E34 stated during an interview that a message was sent to Administration, but E34 was uncertain of the communication after the initial message. The allegation was not reported to the State agency.

Although a CNA (E33) identified an allegation of neglect and reported it to Supervisory staff, the facility failed to ensure that it was reported to the Administrator and the Charge Staff regarding timely reporting of allegations of abuse, neglect, etc. under PM46, on 3/29/2023, the ED conducted a staff meeting with the DRS, APA, RPA, QIDP. During meeting, the ED discussed and expressed expectations of management and for management to convey the requirements to staff expectations regarding PM46 Reporting, The ED followed up with an email and memo conveying the same to DRS, DON, APA, RPA, SSA, QIDP, ATS, TIII, ATII, and SE.

Attachment L: Email/Memo from the Executive Director to the Management Staff and Facility Charge Staff regarding PM46 Reporting and Daily Documentation and Expectations of Staff

B3. The APA and ED updated the PM46 Reporting Education Flyer on 3/29/2023 to include the requirement that staff members can anonymously report PM46 to Long Term Care and Resident Protection/ Division of Health Care Quality (LTCRP/DHCQ); however, the staff are required to immediately report to Administration any suspected allegation of abuse, neglect, etc. (PM 46 reportables). This flyer was sent by the DRS, DON, and ED to staff overseen by these Directors to educate staff, and signed vouchers were obtained.

Attachment O: PM46 Reporting Flyer

C1 The ED and APA's RCA revealed the deficient practice was related to two factors involving: An inaccurate reporting timeframe of 8 hours written in the facility's PM46 procedures – "Administrative Reporting and Investigation Procedure For: PM46 (Abuse, Neglect, Mistreatment,

Provider's Signature

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Title ED (WHA

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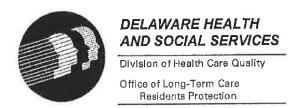
NAME OF FACILITY: Stockley Center ICF/ID

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Chata Again, subhasib, Aga gardhaffad. £		
	State Agency authority. As a result of lack of	Financial Exploitation, Medication Diver-	
	reporting, no investigation was conducted.	sion, and Significant Injury) and Injuries of	
	Findings were reviewed with E1 (Executive	Unknown Source"; And, A misunderstand-	
		ings by staff that they only needed to re-	
	Director), E2 (PA), and E4 (DRS) on 3/27/23	port allegations of PM46 reportable to	
	during the exit conference, beginning at 2:30 PM.	LTCRP/ DHCQ without informing admin-	
	2.30 PIVI.	istration caused the failure to report and	
		failure to timely report allegations.	
		C2. The Administrative Reporting and In-	
		vestigation Procedure For: PM46 (Abuse,	
		Neglect, Mistreatment, Financial Exploita-	
		tion, Medication Diversion, and Significant	
		Injury) and Injuries of Unknown Source policy was reviewed and revised on	
		3/28/2023, by the ED and APA to reflect	
		changes to the 2 (two) hour reporting re-	
		quirement.	
		C3. To immediately address the deficiency,	
		the APA and ED's updated PM46 Report-	
		ing Education Flyer was provided to staff	
		the DRS, DON, and ED to staff overseen by	
		these directors to educate staff on report-	
		ing requirements and signed vouchers	
		were obtained. In addition, the updated	
		Administrative Reporting and Investigation	
		Procedure For: PM46 (Abuse, Neglect,	
		Mistreatment, Financial Exploitation, Med-	
1		ication Diversion, and Significant (njury)	
		and Injuries of Unknown Source policy will	
		be sent by the DRS, DON, and ED to staff	
		overseen by these Directors to educate	
		staff, and signed vouchers by staff will be	
		obtained.	
		Attachment O: PM46 Reporting Flyer	
J	IIC .	A Second City of the politing Hyer	
		D1. For understanding of responsibilities	
		and requirements of PM46 reporting, un-	
		der the direction of the DRS and DON, the	
		DRS, DON, ADON, APA, RPA, SSA, QIDP,	
		TIII, ATII, ATS, RNE, and/or SE, the PM46	

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

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NAME OF FACILITY: Stockley Center ICF/ID

DATE SURVEY COMPLETED: March 27, 2023 STATEMENT OF DEFICIENCIES ADMINISTRATOR'S PLAN FOR COMPLETION **SECTION** SPECIFIC DEFICIENCIES **CORRECTION OF DEFICIENCIES** DATE reporting for 1 (one) month until consistency reaches 100% success. FINALLY For PM46 investigations and documentation compliance, under the direction of the ED, the APA and/or SCS will conduct PM46 file documentation reviews to assess that the PM46 reporting procedures were followed 1 (one) time quarterly thereafter for 100% success. 16 Del. Criminal background checks. 16 Del. Code, Ch. 11 Sub-Chapter IV §1141... 05/25/2023 (a) Purpose. — A1. The facility is unable to correct the The purpose of the criminal background past practice; however, to address the ci-Sub-Chapcheck and drug screening requirements of tation, the plan of action taken involved this section and § 1142 of this title is the the Executive Director (ED) contacting the protection of the safety and well-being of temporary staffing agency, Infojini, Inc., residents of long-term care facilities livia telephone on 3/28/2023 to inform the censed pursuant to this chapter. These secagency in details of the Delaware Backtions shall be construed broadly to accomground Check Center (BCC) credentialing plish this purpose. requirements to include sources generated by the BCC including the State and (b) Definitions. — Federal Criminal background Checks involving fingerprinting through the State (7) "SBI" means the State Bureau of Identi-Bureau of Investigation (SBI). fication. Attachment A: Email/Memo correspondence from the Executive Director (ED) to (c) An employer may not employ an appli-Infojini, Inc. regarding the Delaware Backcant for work in a facility before obtaining a ground Check Center (BCC) credentialing criminal history. The criminal history of any requirements. A2. The ED sent a follow-up email to the person not employed directly by the facility must be provided to the facility upon the agency, Infojini, Inc. on 3/28/2023 detailperson's commencement of work. ing the Delaware BCC credentialing requirements which involves fingerprinting (d) The requirements of subsection (c) of results from the SBI, as well as it being imthis section may be suspended for 60 days perative that the agency take immediate if the employer wishes to employ the applicorrective action. cant on a conditional basis. Attachment A: Email/Memo correspondence from the Executive Director (ED) to

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

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Director (ED) to all contract agencies that



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	7 FFF (Against CNA) the first day we ship.	have staff at Standard Country with a	
	7. E55 (Agency CNA) – the first day working at the facility was 10/10/22.	have staff at Stockley Center summarizing	
	at the facility was 10/10/22.	the Background Check Center (BCC) requirements.	
	8. E56 (Agency CNA) – the first day working	B3. The scope of credentialling for all staff-	
	at the facility was 10/10/22.	ing at Stockley Center was investigated by	
		the ED. First, the ED contacted the Dela-	
	3/27/23 2:30 PM - Findings were reviewed	ware Division of Human Services (DHR) via	
	with E1, E2 (PA), E29 (ADON), and E4 (DRS)	telephone on 3/28/2023, regarding the	
	during the Exit Conference.	State Merit Employees. The ED was in-	
		formed by DHR that all Stockley Center	
		Merit and Seasonal Casual employees are	
		vetted through the BCC to include finger-	
		printing results from the SBI. Second, to	
		assess all temporary agency staffs' BCC	
		credentialing documentation files, a sec-	
		ond sweep audit of Temporary Agency	
		Staff personnel files was completed on	
		3/31/2023, by the ED, Administrative Spe-	
		cialist III and Administrative Specialist II.	
		These files were moved to a central loca-	
		tion in the Executive Director's (ED) office	
		by the Administrative Specialist III and Ad-	
		ministrative Specialist II.	
		Attachment E: Memo stating a sweep of	
		Temporary Agency Staff personnel files	
		were audited.	
		B5. A memo to contracting temporary	
		staffing agencies was written by the ED re-	
		garding the requirements of fingerprinting	
		results from the SBI through of the BCC,	
		and then memo was approved by DDDS	
		Leadership on 4/17/2023. The ED emailed	
		this memo to each contracting temporary	
		staffing agency working with Stockley Cen-	
i		ter on 4/18/2023.	
		Attachment F: Memo to contracting tem-	
		porary agencies was developed by the Ex-	
		ecutive Director (ED) and approved by	
		DDDS Leadership and emailed to each	
	1	contracting temporary agency.	

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		C1. The ED's RCA revealed the deficient	
1		practice only involved temporary staffing	
		agency staff. It is noted that copies of	
		Criminal Background Checks were part of	
		the personnel file; however, these data	
		points were not vetted through the BCC.	
		The issue was the facility's new practice of	
		hiring temporary staffing agencies did not	
		include the specific BCC requirements as	
		part of the credentialing and hiring pro-	
		cesses for temporary staffing. The facility's	
		assumption of the agencies obtaining this	
		information automatically through the	
		BCC lead to the deficient practice.	
		C2. The ED and APA reviewed and will re-	
		vise The Pre-Employment Screening Ad-	
		ministrative Policy to reflect temporary	
		agency staffing hiring with BCC credential-	
i i		ing requirements and start date must be	
		after credentialing documentation is ob-	
		tained which includes Criminal Back-	
		ground Check Fingerprinting results from	
		the SBI vetted through the BCC.	
		C3. The Temporary Agency Staffing Hiring	
		Checklist was revised on 4/3/2023 by the	
		APA to reflect the credentialing require-	
1		ment of the BCC and copies of necessary	
		documentation, and a Temporary Agency	
		Staffing Hiring Approval form was created	
I		on 4/10/2023 by the ED and APA to reflect	
_		the credentialing requirement of the BCC	
		and copies of necessary documentation.	
		Attachment G: Temporary Agency Staffing	
		Hiring Checklist	
		Attachment H: Temporary Agency Staffing	
		Hiring Approval form	
		C4. The updated Pre-Employment Screen-	
		ing Administrative Policy will be provided	
		to staff by the ED for review, and a signed	

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		voucher will be completed. The APA will	
		track the completion of the is policy re-	
		view.	
		C5. Existing Temporary Staff. Obtaining	
		required personnel documentation	
		through the BCC for existing temporary	
		staff is being obtained by the Administra-	
		tive Specialist III (ASIII) and the Human Re-	
	27	sources Technician/Administrative Special-	
		ist I (ASI) through email reminders and	
		phone calls, and tracking credentialing	
		documents until complete records are ob-	
		tained. Copies of all required credentialing	
		documentation will be filed by the ASIII or	
		ASI in the ED office in the temporary staff-	
		ing personnel files.	
		C6. Future Temporary Staff. Prior to hiring	
		temporary agency staffing, the ED or de-	
		signee in absence of the ED is required to	
		review and sign the Temporary Agency	
		Staffing Hiring Approval form as well as re-	
		viewing associated credentialing BCC doc-	
1		umentation to ensure a complete record.	
		Copies of all required credentialing docu-	
		mentation will be filed in the temporary	
		staffing personnel files in the ED office by	
		the ASIII or ASI. The Temporary Agency	
1		Staff start date will be determined by re-	
		ceipt of all required documentation and	
		the signed Temporary Agency Staffing Hir-	
		ing Approval form.	
		Attachment G: Temporary Agency Staffing	
		Hiring Checklist	
		Attachment H: Temporary Agency Staffing	
		Hiring Approval form	
		D1. Existing Temporary Staff. The ASI and/	
		or the ASIII will email or phone contact re-	
1		minders with the current temporary staff-	

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

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	contact with patients at no cost and	influenza vaccination consent/declination	
	contingent upon availability of the vaccine.	forms were completed through the	
		direction of the DON.	
	(b) The facility shall keep on record a signed	Attachment Q: E5 E40, E41, E47, E48, E50,	
	statement from each employee stating that	E52, E53, E54, and E55 influenza	
	the employee has been offered vaccination	vaccination consent/declination forms.	
	against influenza and has either accepted		
	or declined such vaccination.	B. Analysis of the deficient practice and	
		review of records by the DON and ADON	
	This requirement was not met as evidenced	revealed that all staff have the potential to	
	by:	be negatively affected; therefore, a sweep	
		of all staff files for influenza vaccination	
	Based on record review and interview, it	consent/declination was reviewed to	
	was determined that for 10 (E5, E40, E41,	ensure complete records were obtained by	
	E47, E48, E50, E52, E53, E54 and E55) out of	the Assistant Director of Nursing (ADON)	
	19 sampled employees, the facility failed to	on 3/28/2023.	
	ensure that employees were offered	Attachment P: Memo stating a sweep of all	
	influenza vaccination and/or has accepted	staff for influenza vaccination	
	or declined such vaccination. Findings	consent/declination was reviewed	
	include:	consent/decimation was reviewed	
	meidae.	C1. The DON and ADON's BCA variated the	
	2/24/22 The feetite - detect the Common	C1. The DON and ADON's RCA revealed the	
	3/21/23 – The facility advised the Surveyor	deficient practice was an oversight by	
	that the following 10 employees declined	nursing because of the COVID	
	the influenza vaccination during the annual	requirements and restrictions. In so much	
	influenza vaccination period beginning no	as, the required use of facial masks despite	
	later than 10/1/22 through 3/1/2023:	influenza vaccination status as the	
		requirements for employees not	
	1. E52 (Activity Therapist I)	vaccinated for influenza is wearing a mask	
		during the height of the flu season.	
	2. E40 (Cook)	Subsequently, a key factor of tracking	
		influenza vaccination status and education	
	3. E41 (Agency CNA)	is to ensure non influenza vaccinated staff	
		wear masks, but since everyone was	
	4.E47 (Agency CNA)	wearing masks, the oversight occurred.	
		C2. The Temporary Agency Staffing Hiring	
	5. E48 (Agency CNA)	Checklist was revised by the APA was	
	or a to tribution of trip	completed on 4/3/2023 to reflect the	
	6. E53 (Agency RN)	requirement of obtaining influenza	
	O. LOS (ABERCY NIV)	vaccination/declination.	
		vaccination/decimation.	

Provider's Signature 4

7. E5 (Program Administrator)

Title ED/NHK

Data 9/17/23



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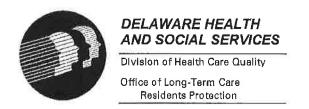
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		A STATE OF THE STA	
		Attachment G: Temporary Agency Staffing	
	8. E54 (Agency CNA)	Hiring Checklist	
	2 572 (4 2011)	C3. A Temporary Agency Staffing Hiring	
	9. E50 (Agency CNA)	Approval forms was created on 4/10/2023	
		by the ED and APA to reflect the	
	10. E55 (Agency CNA)	requirement of maintaining influenza	
		vaccination/declination records.	
	Review of the facility's vaccination records		
	documented the following employees	Attachment H: Temporary Agency Staffing	
		Hiring Approval form	
	, , , , , , , , , , , , , , , , , , ,	C4. The Administrative policy Influenza	
	lacked evidence of when the employee was	Vaccination was revised by the DON on	
	offered the influenza vaccination and	3/30/2023 to reflect facility practices and	
	declined.	the requirements of	
	Findings were reviewed with E1, E2 (PA),	vaccination/declination. The updated	
	E29 (ADON) and E4 (DRS) during the exit	administrative policy Influenza Vaccination	
	conference.	will be sent to staff by the ED, DRS, and	
		DON for staff education to the staff	
	ĺ	overseen by these directors. A signed	
		voucher will be obtained by staff.	
		Attachment R: Administrative policy	
		Influenza Vaccination updated.	
		D. Beginning October 1, 2023, staff	
		influenza consent/declination forms will be	
		maintained in Health Services and will be	
		monitored by the Director of Nursing	
		(DON) and the Assistant Director of Nursing	
		(ADON) monthly until May 1, 2024, until	
		consistency reaches 100% success. In	
		·	
		addition, flu stats are reported to the State by the DON and/or the ADON as required	
		l •	
		which will continue until consistency	
46 0.1.6		reaches 100% success.	05/25/2023
16 Del. C.	Blooming Chaffings	16 Dol C 11 81163	03/23/2023
11 §1162	Nursing Staffing:	16 Del. C. 11 §1162	
Nursing	I-) From manifestal banks for the second	A. The facility is unable to correct the past	
staffing:	(a) Every residential health facility must at	practice; however, the DRS promptly took	
	all times provide a staffing level adequate	action to address the deficiency by fixing	
	to meet the care needs of each resident,		

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	including those residents who have special	the visual display of staff names and titles	
	needs due to dementia or a medical	of RNs and RN Supervisors.	
	condition, illness or injury. Every residential	Attachment S: Email to the Resource	
	health facility shall post, for each shift, the	Management staff instructing them of	
	names and titles of the nursing services	proper protocol on the electronic bulletin	
	direct caregivers assigned to each floor,	boards/display boards.	
	unit or wing and the nursing supervisor on	,,	
	duty. This information shall be	B1. An analysis and interviews with	
	conspicuously displayed in common areas	resource management staff by the DRS	
	of the facility, in no fewer number than the	regarding present and past practices of	
	number of nursing stations. Every	displaying staff names and titles on the	
	residential health facility employee shall	electronic display boards revealed that all	
	wear a nametag prominently displaying his	staff have the potential to be affected	
	or her full name and title. Personnel hired	negatively by the deficient practice.	
	through temporary agencies shall be	B2. The DRS on 3/24/2023 instructed and	
	required to wear photo identification	emailed the Resource Management Unit	
	listing their names and titles.	staff (SSA and Operation Support Specialist	
		[OSS]) of the necessary requirements of	
	This requirement was not met as evidenced	proper protocol regarding the electronic	
	by:	bulletin boards/display boards showing the	
	'	Floor Nurse, Nursing Supervisor, Facility	
	Based on observation and interview, it was	Charge, and Certified Nursing Assistants	
	determined that for all shifts, the facility	staff scheduled for shifts that must be	
	failed to post the names and titles of the	posted daily each shift.	
	nursing services direct caregivers assigned	Attachment S: Email to the Resource	
	to each unit including the Supervisor on	Management staff instructing them of	
	duty. Findings include:	proper protocol on the electronic bulletin	
	,	boards/display boards.	
	3/21/23 10:05 AM through 3/24/23	201.00, 0.00.00	
	Observations of the electronic bulletin	C1. The DON, DRS, and APA's RCA revealed	
	boards on the Chandler and McCabe units	the deficient practice was a result of two	
	failed to display the names and titles of the	factors involving: New Resource	
	Nurses and Supervisor assigned for day and	Management staff (SSA and OSS) not fully	
	evening shifts.	executing their new responsibilities in the	
	T	area of display board requirements; And,	
	3/23/23 10:40 AM – During an interview,	lack of detailed information in the	
	E23 (RN) confirmed the daily staffing was	Administrative policy – Identification	
	not posted.	Badges/ Passes.	
-		C2. Since the DRS addressed the current	
		COL THE COLOR OF T	

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END Title ED INHA

SSA and OSS staff on the requirements for

___ Date 5/17/23



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

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

Provider's Signature Auffl Julia 20 NHA Date 5/17/23

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

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

PRINTED: 04/13/2023 FORM APPROVED

E 000 Initial Comments An unannounced Annual and Complaint Survey was conducted at this facility from March 20, 2023 through March 27, 2023. The facility census was 40 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness Survey was also conducted by The Division of Health Care Quality, Office of Long Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, Emergency Preparedness deficiencies were citad. E 037 EP Training Program CFR(s): 483.475(d)(1) \$403.748(d)(1), \$416.54(d)(1), \$418.113(d)(1), \$441.194(d)(1), \$460.84(d)(1), \$485.15(d)(1), \$485.68(d)(1), \$485.68(d)(1), \$485.42(d)(1), \$485.625(d)(1), \$485.68(d)(1), \$485.62(d)(1), \$485.62(d)(1	STATEMENT AND PLAN	T OF DEFICIENCIES OF CORRECTION	I IDENTIFICATION NUMBER		PLE CONSTRUCTION G	(X3) DATE	0938-039 SURVEY PLETED
STOCKLEY CENTER SUMMARY STATEMENT OF DESICIENCIES (RACH DESICIENCY MASS TRE PRECEDED BY PILL PRETENT REGULATORY OR LSC IDENTIFYING INFORMATION) FREGULATORY OR LSC IDENTIFYING INFORMATION FREGULATORY APPROPRIATE FROM INFORMATION APPROPRIATE FROM INFORMATIO			08G001	B. WING			
PRÉFIX TAG RESOLATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments An unannounced Annual and Complaint Survey was conducted at this facility from March 20, 2023 through March 27, 2023. The facility census was 40 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness Survey was also conducted by The Division of Health Care Quality, Office of Long Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, Emergency Preparedness deficiencies were cited. E 037 EP Training Program CFR(s): 483.475(d)(1), \$418.113(d)(1), \$443.134(d)(1), \$468.642(d)(1), \$484.1134(d)(1), \$486.542(d)(1), \$485.625(d)(1), \$485.625(d)(1), \$485.625(d)(1), \$485.727(d)(1), \$485.625(d)(1), \$485.625(d)(1), \$485.625(d)(1), \$485.727(d)(1), \$485.625(d)(1), \$485.625(d)(1), \$485.625(d)(1), \$485.727(d)(1), \$485.625(d)(1), \$485.625(d)(1), \$485.625(d)(1), \$485.727(d)(1), \$485.625(d)(1), \$485.	1				26361 PATRIOTS WAY	03/2	27/2023
An unannounced Annual and Complaint Survey was conducted at this facility from March 20, 2023 through March 27, 2023. The facility census was 40 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness Survey was also conducted by The Division of Health Care Quality, Office of Long Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, Emergency Preparedness deficiencies were citad. E 037 EP Training Program CFR(s): 483.475(d)(1), §448.113(d)(1), §441.134(d)(1), §446.084(d)(1), §448.13(d)(1), §448.13(d)(1), §448.13(d)(1), §448.13(d)(1), §448.13(d)(1), §448.13(d)(1), §448.13(d)(1), §485.22(d)(1), §485.22(PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	DBE	COMPLETION
staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years, educational materials of in part the topics of Emergency Preparedness and Fire Safety among other required topics. The ED discussed and directed the SE that the SE	E 037	An unannounced A was conducted at the 2023 through March was 40 on the first of the In accordance with Emergency Prepared conducted by The DOffice of Long Term this facility during the observations, interviewer Emergency Prepared cited. EP Training Program CFR(s): 483.475(d)(1), §443.475(d)(1), §483.73(d)(1), §483.9485.727(d)(1), §483.9485.727(d)(1), §483.9491.12(d)(1). *[For RNCHIs at §40.483.475(d)(1), §483.73(d)(1), §	nls facility from March 20, n 27, 2023. The facility census day of the survey. 42 CFR 483.73, an edness Survey was also division of Health Care Quality, and Care Residents Protection at element same time period. Based on lews, and document review, edness deficiencies were march 11. 6.54(d)(1), §418.113(d)(1), 0.84(d)(1), §482.15(d)(1), 4.75(d)(1), §485.625(d)(1), 5.542(d)(1), §486.360(d)(1), 5.542(d)(1), §486.360(d)(1), 6.542(d)(1), 6.542(d)		A. The facility is unable to correct the paperactice; however, to address the citatic plan of action taken involved the Directed Habilitative Services/Staff Educator (SE Nurse Educator (RNE) providing training Emergency Preparedness to E41 on 3/22/2023 and E40 on 4/11/2023. Attachment T: Emergency Preparedness training record for E40 and E41 B1. The Executive Director (ED) complet training timeliness analysis of staff Emergency Preparedness training. The structure of orientation scheduled timing conjunction with new hires was determinate the potential to negatively affect all by the deficient practice which could impall residents. B2. The ED directed the SE to develop a	ast on, the or of i) or g in as seted a	05/25/23
		staff, individuals prov arrangement, and vo expected roles. (ii) Provide emergend least every 2 years,	viding services under slunteers, consistent with their cy preparedness training at		educational materials of in part the topic Emergency Preparedness and Fire Safe among other required topics. The ED	s of ety	

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.

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

PRINTED: 04/13/2023 FORM APPROVED OMB NO. 0938-0391

STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						1	5
		08G001	B. WING		TREET ADDRESS SITE AND CORE	03/	27/2023
	NAME OF PROVIDER OR SUPPLIER STOCKLEY CENTER			26	TREET ADDRESS, CITY, STATE, ZIP CODE 6361 PATRIOTS WAY EORGETOWN, DE 19947		4
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IU PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X6) COMPLETION DATE
E 037	(iii) Maintain docum preparedness traini (iv) Demonstrate st procedures. (v) If the emergency procedures are sign must conduct traini procedures. *[For Hospices at § hospice must do all (i) Initial training in a policies and procedures expected roles. (ii) Demonstrate state procedures. (iii) Provide emerge least every 2 years. (iv) Periodically review emergency prepare employees (includir special emphasis procedures necess others. (v) Maintain docum preparedness traini (vi) If the emergency preparedness traini (vi) If the emergency procedures are sign must conduct traini procedures. *[For PRTFs at §44 program. The PRTF (i) Initial training in expolicies and procedures an	nentation of all emergency ng. aff knowledge of emergency or preparedness policies and nificantly updated, the [facility] ng on the updated policies and 418.113(d):] (1) Training. The lof the following: emergency preparedness lures to all new and existing and individuals providing ingement, consistent with their laff knowledge of emergency ency preparedness training at liew and rehearse its edness plan with hospice and nonemployee staff), with laced on carrying out the ary to protect patients and entation of all emergency	E	037	and/or the RNE to institute onboarding education packets for all new hires to be completed on the staff start date. Attachment U: Onboarding packets C1. The Director of Nursing (DON), Director of Residential Services (DRS), and Administration Program Administrator's (APA) Root Cause Analysis (RCA) reverse the deficient practice of staff start date working in the facility occurring prior to Emergency Preparedness training date a result of two factors involving; A false assumption that new staff orientation education which involves Emergency Preparedness can be deferred until rescheduled orientation courses are scheduled orientation resident of the completed; And, start dates of newly histaff do not always correspond with Orientation Training scheduled dates. C2. The Administration Policy - Emplo Education and Training Policy will be updated by the APA to include the onboarding requirements and specific which include Emergency Preparedne Fire Safety. The SE and/or APA will up the Orientation Training Checklists to it the onboarding education of newly hire staff. C3. Since Staff Orientation Training is scheduled 1 (one) time a month and s dates of new staff may not correspond orientation training classes, Onboardin Packets will be provided by the SE or or DRS or DRS designee to newly hire for educating the staff on various topic including include Emergency Prepared and Fire Safety. Staff Onboarding will scheduled to occur the first day of	rector sealed sof the sewas sealed was sealed sof the sewas sealed start with sealed	

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Event ID: F14T11

Facility ID: 08G001

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		08G001	B. WING	B. WING			0
NAME OF	PROVIDER OR SUPPLIER	The second secon			TREET ADDRESS, CITY, STATE, ZIP CODE	037	27/2023
\$46.0					6351 PATRIOTS WAY		
STOCKL	EY CENTER	Name of the state			GEORGETOWN, DE 19947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	arrangement, and vexpected roles. (ii) After Initial training preparedness training (iii) Demonstrate staprocedures. (iv) Maintain docume preparedness training (v) If the emergency procedures are signing must conduct training procedures. *[For PACE at §460 organization must divide and procedures. *[For PACE at §460 organization must divide and procedures and procedures and procedures and procedures are signing procedures, consisted (ii) Provide emergency least every 2 years. (iii) Demonstrate staprocedures, including what to do, where to case of an emergency procedures are signing must conduct training procedures. *[For LTC Facilities at Program. The LTC facilities at Program. The LTC facilities and procedures	olunteers, consistent with their ng, provide emergency ng every 2 years. aff knowledge of emergency entation of all emergency ng. preparedness policies and ifficantly updated, the PRTF ng on the updated policies and all of the following: mergency preparedness ures to all new and existing viding on-site services under notors, participants, and nt with their expected roles. The properties of go, and whom to contact in	EC	037	employment for all newly hired staff. So vouchers will be obtained from staff at the onboarding. After each onboarding orientation, the SE and/or RNE will instand obtained from each staff signed voice for the training education for 100% compliance. D. The APA and/or Standards Control Specialist (SCS) will complete a rando sampling of 5 (five) staff orientation/onboarding training records for 1 (one) month until consistency reaches 100% success (Emergency Preparedness trawas completed on the staff's start date 3 (three) consecutive evaluations. THE The APA and/or SCS will complete a resampling of 5 (five) staff orientation/onboarding training records for 1 (one) quarter until consistency reaches 100% success (Emergency Preparedness trawas completed on the staff's start date 3 (three) consecutive evaluations. FIN/The APA and/or SCS will complete a resampling of 5 (five) staff orientation/onboarding training records for 1 (one) biannually until consistency reaches 10 success (Emergency Preparedness trawas completed on the staff's start date 2 (two) consecutive evaluations.	tending and truct buchers m time a sining over N andom time a 6 ining over ALLY andom time book ining one of the book ining of the book ining one of the book ining of the book in the bo	



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

PRINTED: 04/13/2023 FORM APPROVED OMB NO. 0938-0391

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	PROVIDER OR SUPPLIER	Marian (1990)		STREET ADDRESS, CITY, STATE, ZIP CODE 26351 PATRIOTS WAY GEORGETOWN, DE 18947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	ETION
E 037	arrangement, and vexpected role. (ii) Provide emerger least annually. (iii) Maintain docum preparedness traini (iv) Demonstrate straini (iv) Demonstrate straini (iv) Demonstrate straini (iv) Demonstrate straini (iv) Provide initial training and existing staff, in under arrangement with their expected (ii) Provide emerger least every 2 years. (iii) Maintain docum (iv) Demonstrate straining training and exting and	entation of all emergency ng. aff knowledge of emergency in emergency of the following: ining in emergency ining in emergency les and procedures to all new individuals providing services, and volunteers, consistent roles. Incy preparedness training at entation of the training. In emergency of personnel must be oriented fic responsibilities regarding ency plan within 2 weeks of the training program must in the location and use of signals and firefighting the content of the updated, the CORFing on the updated policies and inficantly updated, the CORFing on the updated program.	E 03			

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Event ID: F14T11

Facility ID: 08G001

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CONTRACTOR OF THE PROPERTY OF		& MEDICAID SERVICES		-		MR NO	0938-0391
STATEMENT AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	E SURVEY IPLETED
		08G001	B. WING			1	C 27/2023
NAME OF	PRÓVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
STOCK	EV CENTER			20	351 PATRIOTS WAY		
STOCKL	EY CENTER			GE	ORGETOWN, DE 19947		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				-	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	personnel, and gue- cooperation with fire authorities, to all nei Individuals providing and volunteers, con roles. (ii) Provide emerger least every 2 years. (iii) Maintain docum- (iv) Demonstrate sta procedures. (v) If the emergency procedures are sign must conduct training procedures. *[For CMHCs at §48 CMHC must provide preparedness policies and existing staff, in under arrangement, with their expected r documentation of the demonstrate staff kr procedures. Therea emergency prepared years. This STANDARD is Based on review of determined that for t (10) sampled staff mensure that new staff Emergency Prepared Findings include: 1. The first day in the and as of the exit dat	sts, fire prevention, and efighting and disaster w and existing staff, a services under arrangement, sistent with their expected and preparedness training at entation of the training. Set knowledge of emergency by preparedness policies and ificantly updated, the CAH and on the updated policies and ificantly updated policies and ificantly updated policies and and on the updated policies and ificantly updated policies and volunteers, consistent oles, and maintain if the complete the comp	E	137			
	has failed to provide Preparedness trainin	the initial Emergency					

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Event ID: F14T11

Facility ID: 08G001

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE	SURVEY
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			A. BUILDING			;
		08G001	B, WING		03/2	7/2023
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 6351 PATRIOTS WAY		
STOCKL	EY CENTER			EORGETOWN, DE 19947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION	ID PREFIX TAG	PKOVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	Continued From pa	ge 5	E 037			
W 000	12/13/22, and as of the facility has failed Emergency Prepare		W 000		The state of the s	
100	Emergency Prepare at this facility from § 27, 2023. The defic report were based of review of clients' re- facility documentation	nnual, Complaint and edness Survey was conducted March 20, 2023 through March ciencies contained In this on observation, interview, cords and review of other on as indicated. The facility day of the survey was 40. The ed 14 residents.				
	as follows: ADON - Assistant D CNA - Certified Nur	sing Assistant; Health Care Quality;				
	DRS - Director of R ED - Executive Director of R IPP - Individual Property of NHA - Nursing Home PA - Program Admirector QIDP - Qualified Interprofessional; RN - Registered Nursel Professional	esidential Services; actor; gram Plan; ne Administrator; nistrator; ellectual Disability rse.	M. 440	A. The facility is upplied to correct the and	ant.	05/05/05
W 149	CFR(s): 483.420(d) The facility must de policies and proced	(1) velop and implement written	W 149	A. The facility is unable to correct the pa practice for C4,C5,C6,C7,C8,C12,C15; however, when the facility was made aw the neglectful practices by staff in a time matter, the facility took immediate action secure the residents' safety, provide neg	vare of ely i to	05/25/23

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Event ID: F14T11

Facility ID: 08G001

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	THE POINT WILDIONINE	a MEDICAID SERVICES			<u>U</u>	IVID NO.	. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		21,2020
					6351 PATRIOTS WAY		
STOCKL	EY CENTER						
		NATIONAL PROPERTY AND ADDRESS OF THE PARTY O			SEORGETOWN, DE 19947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
1	This STANDARD is Based on record redetermined that for C12 and C15) out of abuse/neglect reviet that C12 and C15 we care and services with the C12 and C15 we care and services with the control of a co	s not met as evidenced by: eview and interview, it was seven (C4, C5, C6, C7, C8, of seven clients sampled for w, the facility failed to ensure evere free from neglect when evere not provided for an entire to update staffing 4, C5, C6, C7 and C8, the evere free from end services were not end services were not end services were not end to the facility in 1973 with evere facility in 1973 with	W		residents' care, and assess the reside physical condition as well as staff iden as being involved were removed from direct resident care when internal investigations were conducted. Attachment L: Email/Memo from the Executive Director to the Management and Facility Charge Staff regarding PM Reporting and Daily Documentation and Expectations of Staff. B1. To immediately address the specific deficiency with management, the ED conducted an analysis of staff assignmy protocols regarding staff changes due outs and breaktimes with the DRS, AP Residential Program Administrator (RF Qualified Intellectual Disabilities Profes (QIDP) during a staff meeting on 3/29/to ensure staff are providing the requir resident care under various staff expectations. The conclusion of the an revealed that failing to provide resident leading to the deficient practices could the potential to negatively affect all resident of Staff responsibilities to residents, Staff Assignments with Residents and Management must be Checking and Correcting as necessary all staff assign on all three shifts, at the beginning of somition of the same to DRS, DON, APA, RPA, Social Services Administrator (SSA), QIDP, Active Treathers	tified the Staff 146 and ic	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
		08G001	B. WING _	and the second s	C 03/27/2023	3
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	W-1	
				26351 PATRIOTS WAY		10
STOCKL	EY CENTER			GEORGETOWN, DE 19947		
17.47.15	STIMMADY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5))
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		D BE COMPLE	
W 149	E33 stated this was E34 (Shift Building (Program Administration around 3:30 - 4:00 confirmed a previous investigator that whe tracker, there were was not assigned to 3/21/23 12:24 PM - (Program Administration and the shift was noted of information and to (DHCQ) nothing further shift on 6/22/condition C12 was see the client before resident up. She could be soaking wet with that shift, but E34 condition to Administration, they that shift, but E34 reveal (communication) but assigned to a call out and they are they	charge), as well as E35 rator). C12 received a full bath PM. E12 (Agency CNA) us statement to a DHCQ en she looked at the urinary no (staff) initials and the client or anyone in the staffing book. An Interview with E2 rator) revealed that she was dent until a DHCQ investigator une 2022). E2 stated that she recific details, but confirmed records to the DHCQ is documentation of care on E2 added that due to the lack the investigation by the State ther was done by the facility. An interview with E34 refirmed that E33 (CNA), early 22 made her aware of the found in. E34 did not actually e the CNA cleaned the onfirmed her statement to the that E33 reported C12's pad with urine and dripping onto the at a message was left for may have called back later rould not specifically remember ation. E34 also stated that E4 intial Services/DRS) came to beking at the staffing books for		Specialist (ATS), Therapist III (TIII), Active and Se. Attachment L: Email/Memo from the E: Director to the Management Staff and Charge Staff regarding PM46 Reportin Daily Documentation and Expectations B2. The APA revised the Documentation and respectations B2. The APA revised the Documentation and respectations B2. The APA revised the Documentation of daily documentation and not falsifyir documentation on 3/29/2023, for orien and reeducation conducted by the SE RNE. Attachment M: Documentation training PowerPoint B3. To immediately address the currer an educational flyer will be developed SE and/or RNE on Daily Documentation SE and Residential Team — DRS, RPA QIDP, and/or ATS, and a signed vouch be completed. B4. Until the facility PM46 procedures updated, the ED directed the APA (PM Coordinator), DRS, and DON regarding external entities will be reported and investigated by Stockley Center PM46 investigations are conducted. The ED up with a memo dated 3/23/2023. Attachment BB: Memo from Executive (ED) regarding addition of outside conto the PM46 Policy and Procedures B5. The APA and ED updated the PM Reporting Education Flyer on 3/29/202 include the requirement that staff mem can anonymously report PM46 to Long Care and Resident Protection/ Division Health Care Quality (LTCRP/DHCQ); the staff are obligated to report to Administration any suspected allegatic abuse, neglect, etc. immediately while	recutive Facility g and of Staff on rement g tation and It staff, by the n, The n by the n, SSA, ner will are 46 g all by followed Director uplaints 46 33 to bers g Term n of nowever, on of	

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Event ID:F14T11

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		08G001	B. WING	MANUTE PROPERTY OF THE PARTY OF	1	C 27/2023
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		-
STOCKL	EY CENTER			26351 PATRIOTS WAY		
				GEORGETOWN, DE 19947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	account for C12. 3/23/23 (around 1:0 (retired Program Addid not see C12 und E33 (CNA) found the start of the shift on 6 feces. E35 stated the it to the facility Chart that she did not repart Administration and Communication Book 3/23/23 1:14 PM - Arevealed there had lightly with staffing assignments assignments new command the facility Charassignments. No space assignments. No space revealed. 3/24/2023 12:02 PM interview with E1 (Note Aide originally as that included C12. It unknown if the Aide 6/22/22 was intervied document care for the reporting or investigation of neglect 2. Review of C15's crecords revealed the 7/1/22 - The communication of the communication in the communication of the c	0 PM) - An interview with E35 ministrator) revealed that she cared for, but was aware that e resident uncared for at the 3/22/22, laying in urine and lat E33 should have reported age or a Nurse. E35 confirmed fort the incident to anyone in heard it was an issue with the lock and staff assignment. In interview with E4 (DRS) been a problem in the past ments (when staff call out and led to be redistributed). E4 unication book was set up ge must sign off on ecific details of this incident. I - 1:12 PM - An (email) HA) identified E36 (CNA) as saigned to the resident group further revealed that it was originally assigned to R12 on wed about the fallure to me entire shift. There was no lation by the facility about this elinical record and other exploration book (a tool used to ints) did not include C15 for	W 14	maintaining their reporting anonymity flyer was sent by the DRS, DON, and staff overseen by these Directors to e staff and signed education vouchers obtained. Attachment O: PM46 Reporting Flyer B6. The Residential SSA is assigned and update all staff Assignments and groupings and Pick-up Lists. C1. The ED, DRS, DON, and APA's I revealed the deficient practice was re several factors which includes: Lack adequate staff documentation of resid hygiene care, lack of follow up by the lifts/transfers; Schedule changes effer assignments and these changes not accurately monitored my management of staff reviewing assignment change conjunction with lack of management monitoring; Administration's assumption past practices to not interfere with complaint investigations conducted the DHCQ/outside entities by conducting simultaneous internal investigations; I guidance in the facility's PM46 process conducting simultaneous investigation assumptions they had the right to anonymously report allegations of about the administration. Despite this realso have the obligation to report such to the administration while keeping the anonymity of direct reporting to LTCR DHCQ. C2. The ED updated the Performance and Measures for the positions of RPQIDP, ATS, Certified Nursing Assistan Active Treatment Facilitator (ATF), an Temporary Agency CNA. These perforplans and measures were reviewed b RPA, SSA, QIDP with all the staff design and the	ED to ducate vere to review to replace on based outside rough to reack ures for see, Resident uch ght staff to cases bir Plans A, SSA, at (CNA), dermance of DRS,	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPLETED
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		08G001	B. WING	The state of the s	03/27/2023
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
STOCKI	EY CENTER		1	6351 PATRIOTS WAY	
STOCKE	LI CLIVILIN		G	GEORGETOWN, DE 19947	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
W 149	7/1/22 - Review of turinary elimination is lacked documentation during the 2:00 PM 3/23/23 2:00 PM - Description of the 2:00 PM - D	he record including bowel and records and progress notes ion of care being provided to 10:00 PM shift. During an interview, E7 (CNA) med that the assignment for de C15. Furthermore, E7 IA) would not have known that to their group. During an interview, E37 cocess was to read the ok for assignment of clients, hat C15 was in E37's sted that no care was delivered. During an interview with E11 d that on 7/1/22 C15 was along 10:00 PM shift soiled, dressed in the same clothes further revealed that an completed and a Nurse was vas notified and did a skin Charge was unsure of how to During an interview, E10 (RN) I all the details of R15's abered that it happened. report an allegation of neglect assigned to a CNA and went	W 149	by titles detailing designated staffs' dutilexpectations of their job. Staff signature obtained designating their acknowledge and agreement. Attachment N: Performance Plan Databer C3. The SE and/or RNE will provide education on the updated Documentation and reeducat Attachment M: Documentation and reeducat Attachment M: Documentation training PowerPoint C4. The APA will update the Active Tre Supervisor's Shift Monitoring Report to the review of staffs' documentation of his care functions (Bowel and Urinary Elim Records). The APA will also update this to include the review of staff assignmer groupings of residents. When on duty the completes this monitoring report across shifts. C5. The APA will update the Facility Cheshift Monitoring Report to reflect the restaffs' documentation of hygiene care functions (Bowel and Urinary Elimination Records). The APA will also update this to include the review of staff assignmer groupings of residents. When on duty a designated as Facility Charge, this mor report is completed by Facility Charges who consist of APA, RPA, SSA, QIDP, ATII, and/or SE across all shifts. C6. The Administrative Reporting and Investigation Procedure For: PM46 (Ab Neglect, Mistreatment, Financial Exploid Medication Diversion, and Significant In and Injuries of Unknown Source policy reviewed and revised on 3/28/2023, by and APA to reflect facility protocol chart that include the same LTCRP/DHCQ reand simultaneous internal investigation be completed for outside complaints be investigated by external entities. The Air Application of the procedure for outside complaints be investigated by external entities.	es were ement consider the consideration that consider the consideration that consideration the consideration

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W 149 Continued From page 10 made for how assignments were made. CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Create a corresponding checklist for internal investigations regarding outside complaints being investigated by external entities. C7. The updated Administrative Reporting and Investigation Procedure For: PM46	CENTER	ERS FUR MEDICARE	& MEDICAID SERVICES			O	MB NO.	. 0938-0391
NAME OF PROVIDER OR SUPPLIER STOCKLEY CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 26351 PATRIOTS WAY GEORGETOWN, DE 19947 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 149 Continued From page 10 made for how assignments were made. 2 Province a corresponding checklist for internal investigations regarding outside complaints being investigation Procedure For: PM46			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 26351 PATRIOTS WAY GEORGETOWN, DE 19947 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 149 Continued From page 10 made for how assignments were made. 2 Parism of CAL OF CALOR OF A CALOR OF CORRECTION W 149 STREET ADDRESS, CITY, STATE, ZIP CODE 26351 PATRIOTS WAY GEORGETOWN, DE 19947 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Create a corresponding checklist for internal investigations regarding outside complaints being investigated by external entities. C7. The updated Administrative Reporting and Investigation Procedure For: PM46			08G001	B. WING			1	
STOCKLEY CENTER 26351 PATRIOTS WAY GEORGETOWN, DE 19947 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 149 Continued From page 10 made for how assignments were made. 26351 PATRIOTS WAY GEORGETOWN, DE 19947 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETIC DATE OCTOSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Create a corresponding checklist for internal investigations regarding outside complaints being investigated by external entities. C7. The updated Administrative Reporting and Investigation Procedure For: PM46	NAME OF F	PROVIDER OR SUPPLIER	k	L			03/	2112023
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PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 149 Continued From page 10 made for how assignments were made. 2 Design and Investigation Procedure For: PM46	STOCKL	LEY CENTER						
W 149 Continued From page 10 W 149 investigations regarding outside complaints being investigated by external entities. C7. The updated Administrative Reporting and Investigation Procedure For: PM46	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE RIATE	(X5) COMPLETION DATE
other records revealed the following: 11/4/22 10:00 to 6:00 - E9 (Agency CNA) was assigned to C4, C5, C6, C7 and C8. 11/4/22 to 11/5/22 The facility investigation reported that E9 left the facility at 1:24 AM and returned to the facility at 1:24 AM and returned to the facility at 3:04 AM. 3:17 AM to 3:37 AM - E9 completed rounds on C6 and C7 documented that both received incontinence care. According to the record, C6 was a two person for bed mobility, however, E9 provided care to C6 without a second person. 3:37 AM to 3:37 AM - E9 entered C8's room and documented that C8 voided. C8 was a two person for bed mobility, however, E9 provided care to C8 without a second person. 11/5/22 5:08 AM to 5:08 AM - E9 entered C6's room completed rounds and documented timat co change a totally dependent client requiring two persons for bed mobility. E9 falsified C6's documentation on the urinary elimination record and changed C6 without a second person. 5:23 AM to 5:28 AM - E9 entered C8's room, completed rounds and documented that C8 voided. C8 without a second person. 5:23 AM to 5:28 AM - E9 entered C8's room, completed rounds and documented that C8 voided. C8 without a second person for bed mobility. E9 falsified C6's documentation on the urinary elimination record and changed C6 without a second person. 5:23 AM to 5:28 AM - E9 entered C8's room, completed rounds and documented that C8 voided. E9 provided incontinence care alone to C8 who required two persons for bed mobility. According to a timeline provided by the facility for the night of 11/5/22 from 10:00 PM to 6:00 AM.		made for how assigned to C4, C8 other records reveal 11/4/22 10:00 to 6:00 assigned to C4, C5 11/4/22 to 11/5/22 Treported that E9 left returned to the facil 3:17 AM to 3:37 AM C6 and C7 docume incontinence care. A was a two person for provided care to C6 3:37 AM to 3:37 AM documented that C person for bed mob care to C8 without a 11/5/22 5:08 AM to 11/	griments were made. 5, C6, C7 and C8's clinical and aled the following: 00 - E9 (Agency CNA) was, C6, C7 and C8. The facility investigation the facility at 1:24 AM and ity at 3:04 AM. 1 - E9 completed rounds on inted that both received According to the record, C6 or bed mobility, however, E9 without a second person. 1 - E9 entered C8's room and 88 voided. C8 was a two ellity, however, E9 provided a second person. 5:08 AM - E9 entered C6's ands and documented that C6 two person for bed mobility ute would not be adequate ally dependent client requiring mobility. E9 falsified C6's are urinary elimination record hout a second person. - E9 entered C8's room, and documented that C8 incontinence care alone to be persons for bed mobility.	W	149	investigations regarding outside completed being investigated by external entities. C7. The updated Administrative Report and Investigation Procedure For: PM46 (Abuse, Neglect, Mistreatment, Financia Exploitation, Medication Diversion, and Significant Injury) and Injuries of Unkno Source policy will be sent by the DRS, I and ED to staff overseen by these Direct to educate staff and signed vouchers by will be obtained. D1. For hygiene care documentation at management monitoring (bowel and unielimination records), under the direction DRS, the RPAs (2) will each complete reviews of a random sampling of 5 (five residents' hygiene care documentation total between the two RPA) across all residential units and across three shifts (five) days a week for 1 (one) month uniconsistency reaches 100% success. THEN A random sampling of 5 (five) residents' hygiene care documentation (10 total between the two RPA) across all reside units and across three shifts for 5 (five) every two weeks for 1 (one) month until consistency reaches 100% success. FINALLY A random sampling of 5 (five) residents' hygiene care documentation (10 total between the two RPA) across all reside units and across three shifts for 1 (one) a month thereafter for 100% success. D2. For Assignments/ Grouping/ Pick-u Lists. Assignments/Groupings and management monitoring, under the direction of the DRS, the RPA and/or Facility Chapper (DRS, APA, RPA, SSA, QIDP, Till, ATII).	aints ing al wn DON, ctors y staff nd nary of the) (10 for 5 fil ntial days	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		08G001	B. WING			03/2	; !7/2023
NAME OF E	PROVIDER OR SUPPLIER	Lives or contain a contain contains that the second contains to	T	S	TREET ADDRESS, CITY, STATE, ZIP CODE	Nucrei -	
	EY CENTER			_	6351 PATRIOTS WAY SEORGETOWN, DE 19947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149	E9 spent one hour ato five clients (C4, C3 spent 19 minutes had to C1. 3/22/23 10:10 PM revealed that by the (CNA) was gone, E Also, E43 provided were not reassigned E9's absence. 3/22/23 10:10 PM - (RN Supervisor), E4 Nurse (E46, RN) refor and could not fir to look for E9 and were returned. E44 building and check parking lot, but E9 was supposed to never returned. E44 building and check parking lot, but E9 what around 3:00 AM It was further revea communication with this was neglect or forwarded to E4 (Di DRS). 3/23/23 1:14 PM - E was unable to recal Review of the facilit that neglect was un C8 were checked or concerns. The facilit the above residents falsifled documenta	and 23 minutes providing care C5, C6, C7 and C8). E9 and elping E43 (CNA) provide care During an interview with E43 time it was realized that E9 9 returned a little bit later. confirmation that residents d to another CNA for care in During an interview with E44 44 revealed that the Charge ported that they were looking and E9. E44 sent a staff person was unable to locate E9. It was a CNA from another unit that to go to pick up food, but E9 4 sent staff to look outside the E9's car which was in the was not found. E44 revealed M E9 returned into the facility.	W 1	49	groupings each Day (daily) for all reside across all residential units and across the shifts for 1 (one) month until consistence reaches 100% success. THEN 2 (two) times a week for all residents as all residential units and across three shifts for 1 (one) month until consistency reaches success. THEN 1 (one) time every 2 (two) weeks for all residents across all residential units and across three shifts for 1 (one) month unconsistency reaches 100% success. FINALLY At least 1 (one) time a month for all residents across all residential units and across all residential units and across all residential units and across the shifts thereafter for 100% success. D3. For understanding of responsibiliting requirements of PM46 reporting, under direction of the DRS and DON, the DRS and DON, the DRS and/or SE the PM46 Reporting Education of the DRS and DON, the DRS and/or SE the PM46 Reporting Education of the ED, the APA Reporting Education of the ED, the APA and/or SCS will consuccess. Staff will sign an education vor FINALLY 1 (one) time a quarter thereafter for 100 success. Staff will sign an education vor FINALLY 1 (one) time a quarter thereafter for 100 success. Staff will sign an education vor FINALLY 1 (one) time a quarter thereafter for 100 success. Staff will sign an education vor FINALLY 1 (one) time a quarter thereafter for 100 success. Staff will sign an education vor FINALLY 1 (one) time a quarter thereafter for 100 success. Staff will sign an education vor FINALLY 1 (one) time a quarter thereafter for 100 success. Staff will sign an education vor FINALLY 1 (one) time a quarter thereafter for 100 success. Staff will sign an education vor FINALLY 1 (one) time a quarter thereafter for 100 success. Staff will sign an education vor FINALLY 1 (one) time a quarter thereafter for 100 success. Staff will sign an education vor FINALLY 1 (one) time a quarter thereafter for 100 success. Staff will sign an education vor FINALLY 1 (one) time a quarter thereafter for 100 success. The PM46 reporting for 1 (o	cross ifts for s 100% d titl idents hree es and the S, OON), RNE, on nursing, or 3 % ucher. direction iduct sess ine o) month is.	

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		& MEDICAID SERVICES				0.938-039
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		08G001	B. WNG		Caraci-000	C 27/2023
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STOCKL	EY CENTER	×		26351 PATRIOTS WAY		
				GEORGETOWN, DE 19947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X9) COMPLETION DATE
				(one) time a week upon reporting for (one) month until consistency reaches success. FINALLY (one) time quarterly thereafter for 10 success. D5. The Therapy Department (PT) and the content of	100%	
				Residential Management Team – each and QIDP will complete a random sand of 5 (five) residents each (5 residents per reviewer) on each residential unit various shifts and with various staff, unthe Lift, Gait Belt, and Transfer Competencies tool for 1 (one) time and for 2 (two) months until consistency real 100% success (correct application of transfer) over 3 (three) consecutive	h RPA npling each on tilizing veek aches	
				evaluations. THEN A random sampling of 5 (five) resident (5 residents each per reviewer) on each residential unit on various shifts and warious staff, utilizing the Lift, Gait Bell Transfer Competencies tool for 2 (two a month until consistency reaches 100 success (correct application of lift/transover 3 (three) consecutive evaluations FINALLY A random sampling of 5 (five) resident	ch ith , and times % sfer)	
	*			(5 residents each per reviewer) on ear residential unit on various shifts and w various staff, utilizing the Lift, Gait Belt Transfer Competencies tool for 1 (one month until consistency reaches 100% success (correct application of lift/transover 3 (three) consecutive evaluations	h ith , and i time a sfer)	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
,			A. BUILU	ING_	· · · · · · · · · · · · · · · · · · ·	c	;
		08G001	B. WING		- um	03/2	7/2023
NAME OF F	ROVIDER OR SUPPLIER		ieee earn com		FREET ADDRESS, CITY, STATE, ZIP CODE		
STOCKL	EY CENTER		- 1		351 PATRIOTS WAY		
OTOGICE	ET OLITICA			G	EORGETOWN, DE 19947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149	requiring 24-hour careful requiring 24-hour care Director), E2 (PA), and the exit configures of the facility must endit reached a conficial sin accordance stablished proceduring the facility documentation of the facility documentation of the facility documentation of the facility failed to were reported immediately to the seven clients samp the facility failed to were reported immediately. Findings in The facility failed to were reported immediation Diversion Injuries of Unknown 2019, stated that the person, "Reports in delay, to the nurse charge/Facility Chacontinued to state, reports the incident Quality (Division of Protection)".	www with E1 (Executive and E4 (DRS) on 3/27/23 erence, beginning at 2:30 PM. IT OF CLIENTS (2) Issure that all allegations of ect or abuse, as well as source, are reported administrator or to other nee with State law through ures. Is not met as evidenced by: (I, record review and review of on, it was determined that for on, it was determined that for on, it was determined that for election abuse/neglect review, ensure allegations of neglect ediately to State officials nelude: Ittled, "Reporting and dure For: PM46 (Abuse, ent, Financial Exploitation, on, and Significant Injury) and in Source", last revised July are eye witness/reporting icident immediately, without and the supervisor in irge." The facility policy "Immediately (within 8 hours) in to the Division of Health Care Long Term Care Residents	W		A1. The facility is unable to correct the padeficient practice for C4,C5,C6,C7,C8,C12,C15; nevertheless, the ED identifie error in timely reporting distinctions for allegations of abuse, neglect, etc. under PM46 as defined as immediately reportist to administration, and within 2 hour reporting to LTCRP/DHCQ. Subsequen ED and APA acted by updating the PM4 procedures as well as providing staff education using an updated PM46 Repeducation Flyer under the direction of the carried out by the DRS, DON, APA, RP staff. Attachment L: Email/Memo from the Ex Director to the Management Staff and PC harge Staff regarding PM46 Reporting Daily Documentation and Expectations B1. A review conducted by the ED and the past year (12 months) of PM 46 investigations and outside complaints rethat the timely reporting of allegations of abuse, neglect, etc. (PM 46 reportables deficient practice of the reporting requir of within 2 hours of the allegation. Subsequently, the ED and APA concludal residents have the potential to be neaffected by the deficient practice. B2. To initially addresses the specific deficiency with Management and Facilit Charge Staff regarding timely reporting allegations of abuse, neglect, etc. under PM46, on 3/29/2023, the ED conducted meeting with the DRS, APA, RPA, QID	s the the ing by resulty, the 46 orting he ED A to ecutive facility and of Staff APA of evealed if evealed if evealed if evealed if even the ement ded that gatively of er a staff	05/25/23
	1. According to a re	eport to the State Agency on					

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CENTE	KS FUR WIEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A BUILD		LE CONSTRUCTION	COM	E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
STOCKL	EY CENTER			ı	6351 PATRIOTS WAY GEORGETOWN, DF 19847		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	7/1/22, C15 was for feces. Also, C15 hat that morning. This wo completed a skin of that it was reported 2. According to a fac C4, C5, C6, C7 and (Agency CNA) left the returned at 3:07 AM coverage and E9 did that she was leaving aware until 11/8/22, not reported to the Signature of Sig	und saturated in urine and d the same clothes on from vas reported to a Nurse that neck. There was no evidence	W	The second secon	During meeting, the ED discussed and expressed expectations of managemen for management to convey the requirem staff expectations regarding PM46 Reports ED followed up with an email and nonveying the same to DRS, DON, APASSA, QIDP, ATS, TIII, ATII, and SE. B3. The APA and ED updated the PM46 Reporting Education Flyer on 3/29/2023 include the requirement that staff membanonymously report PM46 to Long Termand Resident Protection/ Division of Hecare Quality (LTCRP/DHCQ); however, staff are required to immediately report Administration any suspected allegation abuse, neglect, etc. (PM 46 reportables flyer was sent by the DRS, DON, and Elstaff overseen by these Directors to edustaff, and signed vouchers were obtained. C1 The ED and APA's RCA revealed the deficient practice was related to two fact involving: An inaccurate reporting timefres hours written in the facility's PM46 procedures — "Administrative Reporting Investigation Procedure For: PM46 (Abun Neglect, Mistreatment, Financial Exploited Medication Diversion, and Significant Injund Injuries of Unknown Source"; And, Amisunderstandings by staff that they only needed to report allegations of PM46 reportable to LTCRP/ DHCQ without information and Injuries of Unknown Source policy were administration caused the failure to reportable to timely report allegations. C2. The Administrative Reporting and Investigation Procedure For: PM46 (Abun Neglect, Mistreatment, Financial Exploite Medication Diversion, and Significant Injund Injuries of Unknown Source policy were viewed and revised on 3/28/2023, by than APA to reflect changes to the 2 (two reporting requirement.	nents to prting, nemo of RPA, S to ers can n Care alth the o of the cate d. This D to cate d. This D t	

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CENTERS FO	OR MEDICARE	& MEDICAID SERVICES		0	MB NO 0.938-0391
STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		08G001	B. W <u>NG</u>		C 03/27/2023
NAME OF PROVID	DER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
STOCKLEY C	ENTER			26351 PATRIOTS WAY	
				GEORGETOWN, DE 19947	No.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFI TAG		BE COMPLETION
				C3. To immediately address the deficie APA and ED's updated PM46 Reporting Education Flyer was provided to staff th DON, and ED to staff overseen by thes directors to educate staff on reporting requirements and signed vouchers were obtained. In addition, the updated Administrative Reporting and Investigat Procedure For: PM46 (Abuse, Neglect, Mistreatment, Financial Exploitation, Medication Diversion, and Significant Ir and Injuries of Unknown Source policy sent by the DRS, DON, and ED to staff overseen by these Directors to educate and signed vouchers by staff will be ob Attachment O: PM46 Reporting Flyer D1. For understanding of responsibilities requirements of PM46 reporting, under direction of the DRS and DON, the DR ADON, APA, RPA, SSA, QIDP, TIII, ATRNE, and/or SE, the PM46 Reporting Education Flyer will be reviewed with a (one) time a month for 3 (months) until consistency reaches 100% success. Sign an education voucher. FINALLY For understanding of responsibilities as requirements of PM46 reporting, under direction of the DRS and DON, the DR ADON, APA, RPA, SSA, QIDP, TIII, ATRNE, and/or SE, the PM46 Reporting Education Flyer will be reviewed with a (one) time a quarter thereafter for 100f success. Staff will sign an education vold to the ED, the APA and/or SCS will cold pM46 file documentation reviews to as that the PM46 reporting procedures we followed daily upon reporting for 1 (one until consistency reaches 100% success.)	de DRS, ee sion sion siury) will be staff tained. ss and the S, DON, TII, ATS, II staff 1 taff will the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1 double the S, DON, TII, ATS, II staff 1

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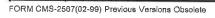
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION A. BUILDING	CON	TE SURVEY MPLETED C
E TORES	0.2	C
08G001 B. WNG		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	103	/27/2023
STOCKLEY CENTER 26351 PATRIOTS WAY GEORGETOWN, DE 19947		
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THEN For PM46 investigations and docum compliance, under the direction of the APA and or SCS will conduct PM46 documentation reviews to assess the PM46 reporting procedures were fol biweekly (twice a week) upon report (one) month until consistency reach success. THEN For PM46 investigations and docum compliance, under the direction of the APA and or SCS will conduct PM46 reporting procedures were fol (one) time a week upon reporting for month until consistency reaches 100 success. FINALLY For PM46 investigations and docum compliance, under the direction of the APA and/or SCS will conduct PM46 documentation reviews to assess the PM46 reporting procedures were fol (one) time a week upon reporting for month until consistency reaches 100 success. FINALLY For PM46 investigations and docum compliance, under the direction of the APA and/or SCS will conduct PM46 reporting procedures were foll (one) time quarterly thereafter for 10 success.	e ED, the file to the cover of	



Event ID: F14T11

Facility ID: 08G001

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PRINTED: 04/13/2023 FORM APPROVED OMB NO. 0938-0391

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100	LE CONSTRUCTION	(X3) DATE COME	PLETED
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		08G001	B. WING		1	7/2023
NAME OF	PROVIDER OR SUPPLIER	Lange Super-land Assembly		STREET ADDRESS, CITY, STATE, ZIP CODE		
CTOCK	EY CENTER			26351 PATRIOTS WAY		Ì
STOCKL	ET CENTER	0.0000000000000000000000000000000000000		GEORGETOWN, DE 19947		
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W 189	initial and continuin employee to perfore efficiently, and com This STANDARD in Based on record redetermined that for members, the facilitistaff received timely during their oriental include: Review of the facilitine following: 1) E40's (Cook) first 1/17/23. There was was provided news Training, E40 was 4/10/23. 2) E41's (Agency Cwas 12/13/22. The E41 was provided in Training, E41 was 4/10/23. 3) E48's (Agency Cwas 7/26/22 and E4 Abuse Prohibition The E61's (Program Afacility was 12/5/22 staff Abuse Prohibition The E61's (Agency Cwas 12/5/22 staff Abu	ovide each employee with g training that enables the m his or her duties effectively,	W 189	A. The facility is unable to correct the practice E5, E40, E41, E48, and E50; however, to address the citation, the paction taken involved the SE or RNE providing training in Abuse Prohibition on 12/12/2022, E40 on 4/11/2023, E43/22/2023, E48 on 8/11/2022, and E51/9/2023. Attachment V: Abuse Prohibition train records for E5, E40, E41, E48, and EB1. A sweep was conducted by SE of Abuse Prohibition training records - 1 staff received the Abuse Prohibition to orientation, and the ED completed an of the timing of staff Abuse Prohibition training. The structure of orientation scheduled timing in conjunction with hires was determined to have the pot negatively affect all staff by the deficit practice which could impact all reside B2. The ED directed the SE to develor implement onboarding packets consist educational materials of in part the to Abuse Prohibition – Abuse/Neglect and directed the SE that the and/or the RNE to institute onboardin education packets for all new hires to completed on the staff start date. Attail U: Onboarding packet C1. The DON, DRS, and APA's RCA revealed the deficient practice of staff dates of working in the facility occurrity to the Abuse Prohibition training date result of two factors involving; A false assumption that new staff orientation education which involves education in Prohibition — Abuse/Neglect and Clie can be deferred until regularly schediorientation courses are scheduled and orientation courses are scheduled and	olan of n to E5 1 on 0 on ing 50 f the 00% of raining in analysis n new cential to ent onts. op and sting of pics of nd Client The ED ne SE g be achment f start ng prior was a n Abuse nt Rights uled	05/25/23

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Facility ID: 08G001

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PRINTED: 04/13/2023 FORM APPROVED 0MB NO 0.938-0391

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	ES	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER;	(X2) MULTI A. BUILDI	PLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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		08G001	B. W <u>NG</u>		03/2	27/2023
NAME OF PROVIDER OR S	UPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STOCKLEY CENTER				26351 PATRIOTS WAY		
				GEORGETOWN, DE 19947		
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Facility ID: 08G001

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
A TENT			A, BUILDI	NG	c	
		08G001	B. WING	Hamber College College Hamber College College	03/27/2023	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
STOCKL	EY CENTER			26351 PATRIOTS WAY GEORGETOWN, DE 19947		
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W 191	Abuse Prohibition T 3/27/23 9:35 AM - A revealed that new e staff was four days the new employees Prohibition Training 3/27/23 2:30 PM - F E1 (ED), E2 (PA), E Exit Conference. STAFF TRAINING CFR(s): 483.430(e) For employees who must focus on skills toward clients' beha This STANDARD is Based on record re determined that for out five CNA's, the for guidelines on be for nine clients (C5, C22 and C23). Find A training review vo 4/29/22 for the follo C18, C19, C20, C22 included: Target Sy Behaviors; How to p Behaviors; and Res Behaviors. CNAS E47, E48, E48 with the facility and training.	raining on 2/13/23. An interview with E29 (ADON) employee orientation for all in length and during this time, were provided Abuse. Findings were reviewed with E29 and E4 (DRS) during the PROGRAM (2) Work with clients, training and competencies directed evioral needs. In not met as evidenced by: Eview and interview, it was four (E47, E48, E49 and E50) facility failed to ensure training chavior plans were completed C7, C9, C17, C18, C19, C20,	W 1	and Client Rights training was complete the staff's start date) over 3 (three) consecutive evaluations. FINALLY The APA and/or SCS will complete a ral sampling of 5 (five) staff orientation/ onboarding training records for 1 (one) biannually until consistency reaches 10 success (Abuse Prohibition – Abuse/Ne and Client Rights training was complete the staff's start date) over 2 (two) conseevaluations.	glect d on ndom time 0% glect d on glect d on cutive t 7, E48, ns for nowever, rent f to be adion, ng alysis of menting residents ad by the flyer rent froral f to be ation to rr Analyst nt ng:	

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Event ID: F14T11

Facility ID: 08G001

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PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) areas of Behavior Supports/Plans; and, lack of tracking of behavior supports/plans training of staff. C2. The APA will update the Behavior Services and Supports training will be added to the staff orientation. The Behavior Services and Supports training will be added to the staff orientation training schedule by the SE and/or RNE. The BA, APA, and/or the SE or RNE will provide the training during orientation allowed by the SE and/or RNE. The BA, APA, and/or BAPA and/or BAPA to and/or Behavior Supports/Plans. The staff will be developed by the APA and/or BAPA and/or BAPA BAPA,					GEORGETOWN, DE 19947		
of tracking of behavior supports/plans fraining of staff. C2. The APA will update the Behavior Services training PowerPoint for orientation. The Behavior Services and Supports training will be added to the staff orientation training schedule by the SE and/or RNE. The BA, APA, and/or the SE or RNE will provide the training during orientation classes as scheduled. Attachment W: Behavioral Services training PowerPoint C3. To immediately address the deficiency with current staff an educational flyer will be developed by APA and/or BA on Behavior Supports/Plans, The staff will be educated on the information by the APA, BA, SE, DRS, RPA, and/or CIDP, and a signed voucher will be completed. C4. The Administration Policy - Employee Education and Training Policy will be updated by the APA to include orientation training in Behavior Supports/Plans. D. The APA and/or SCS will complete a random sampling of 5 (five) staff orientation/ onboarding training records for 1 (one) time a month until consistency reaches 100% success (Behavior Supports/Plans training was completed during orientation) over 3 (three) consecutive evaluations. THEN The APA and/or SCS will complete a random sampling of 5 (five) staff orientation/ onboarding training records for 1 (one) time a	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI.	X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP	DBE	
quarter until consistency reaches 100% success (Behavior Supports/Plans training was completed during orientation) over 3 (three) consecutive evaluations. FINALLY The APA and/or SCS will complete a random sampling of 5 (five) staff orientation/ onboarding training records for 1 (one) time					areas of Behavior Supports/Plans; and of tracking of behavior supports/plans of staff. C2. The APA will update the Behavior Services training PowerPoint for orien. The Behavior Services and Supports the will be added to the staff orientation the schedule by the SE and/or RNE. The IAPA, and/or the SE or RNE will provid training during orientation classes as scheduled. Attachment W: Behavioral Services the PowerPoint C3. To immediately address the defict with current staff an educational flyer of developed by the APA and/or BA on B Supports/Plans. The staff will be educated information by the APA, BA, SE, D RPA, and/or QIDP, and a signed vouce be completed. C4. The Administration Policy - Employed Education and Training Policy will be up the APA to include orientation training Behavior Supports/Plans. D. The APA and/or SCS will complete random sampling of 5 (five) staff orient onboarding training records for 1 (one) month until consistency reaches 100% success (Behavior Supports/Plans train was completed during orientation) over (three) consecutive evaluations. THEN The APA and/or SCS will complete a random sampling of 5 (five) staff orientation/onboarding training records for 1 (one) quarter until consistency reaches 100% success (Behavior Supports/Plans train was completed during orientation) over (three) consecutive evaluations. FINAL APA and/or SCS will complete a rando sampling of 5 (five) staff orientation).	training tra	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILU	ING			
		08G001	B. WING			27/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 26351 PATRIOTS WAY GEORGETOWN, DE 19947	ODE		
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W 191	CNA's should have	ge 16 irmed that the aforementioned signed off on the training for 9, C17, C18, C19, C20, C22	W 1	biannually until consistency re success (Behavior Supports/P was completed during orientat (two) consecutive evaluations.	lans training ion) over 2	Ť.;	
W 249	Director), E2 (PA) a during the exit conf PROGRAM IMPLE CFR(s): 483.440(d) As soon as the interproduction formulated a client's each client must restreatment program interventions and so and frequency to su		W 2	A. The facility is unable to corre deficient practice regarding the application for C6 and missed repositioning time for C8. DON se to apply the splint on the 03/24/missed reliner time positioning the corrected at the time of the sinformation was presented on the survey exit interview; however, immediate need of C8 the DRS recliner location to ensure the C the proper location(s) needed to program plan 03/27/2023.	missed splint ecliner ant COTA to C6 2023. The for C8 could not survey as this ne day of the to address the checked the C8 recliner is in a implement the	05/25/23	
	Based on observatinterview, it was defected to consistently implement and C8) out of 10 s failed to implement specified in the indifacility failed to provise pecified in the indinclude: 1. Review of C6's c	is not met as evidenced by: ion, record review, and termined that the facility failed ement interventions identified ogram plan (IPP) for two (C6 ampled clients. The facility an arm splint to C6 as vidual program plan. The vide a recliner for C8 as vidual program plan. Findings linical records revealed; admitted to the facility.		Attachment X: Email from the Coccupational Therapist Assistal regarding a sweep of splint com B1. The ED held a staff meeting as well as sent a follow up ema DRS, DON, APA, RPA, SSA, Q ATII, and SE regarding expecta (Positioning and implementatio Plans which contain splint appli resident recliner positioning use this staff meeting with the DRS, QIDP, the ED completed an acc of splint use and recliner positio staff following program plans (If securing needed equipment. The stage of the securing needed equipment.	nt (COTA) apliance. g on 3/29/2023, il and memo to IDP, ATS, TIII, tions of staff n of Program cations and e time). During APA, RPA, ademic analysis aning related to PPs), and		

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STATEMENT OF DEFICIENCIES NAME OF PROVIDER OR SUPPLIER STOCKLEY CENTER SUMMARY STATEMENT OF DEFICIENCIES (ACA) DEFICIENCY MUST BE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION) W 249 Continued From page 17 3/28/07 - C6's IPP stated that the restorative splint plan was to be implemented by Activities staff and direct care staff (CMA) per the plan's wearing schedule 9:00 AM to 1:00 PM, four hours per day. 3/20/23 10:55 AM - C6 was observed out of bed in his wheelchalr with no left arm splint. 3/21/23 11:55 AM - C6 was observed without a left arm splint in place per the IPP, Additionally, E26 stated that the QIDP (Qualified Intellectual Disabilities Professional) was responsible to ensure placement of the splint. 3/22/23 1:16 PM - An interview with E26 con 3/21/23 from 3 poly the splint to C6 on 3/21/23 from 3 poly the splint to C6 on from place per staff and to ensure that C6 has his splints in place per the IPP. 3/22/23 1:33 PM - C6 was observed in bed without an arm splint. 3/22/23 1:16 PM - An interview with E26 confirmed that the CNA or Activities staff were responsible for applying the splint to C6 on 3/21/23 from 3 poly the splint to C6 on 3/21/23 from 3 place per staff and to ensure that C6 has his splints in place per the IPP. 3/22/23 1:33 PM - An interview with E26 (CIDP), confirmed that he was responsible to ensure that C6 has his splints in place per staff and to ensure that C6 has his splints in place per staff and to ensure that C6 has his splints in place per staff and to ensure that C6 has his splints in place per staff and to ensure that IPP is being followed. E28 stated that the was unaware that C6 did not have he see nordected during rounds if they were completed. 2. Review of C6's clinical records revealed: 2. Review of C6's clinical records revealed: 2. Review of C6's clinical records revealed: 3. The D6N indred the therapy Department of National Provided Confusion of National Provided Confusion of National Provided Confusion of National Provided Confusion of Na	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
AWAGE OF PROVIDER OR SUPPLIER STOCKLEY CENTER SITREET ADDRESS, CITY, STATE, 2IP CODE 2831 PATRIOTS WAY GEORGETOWN, DE 19947 GEACH DEPOISENCY MUST BE PRECEDED BY PULL RESULATION OR LSC IDENTIFYING INFORMATION) W 249 Continued From page 17 3728/07 - C6's IPP stated that the restorative spirit plan was to be implemented by Activities staff and direct care staff (CNA) per the plan's wearing schedule 9:00 AM to 1:00 PM; four hours per day. 3721/23 11:55 AM - C6 was observed out of bed in his wheelchair with no left arm splint. 3721/23 11:55 AM - C6 was observed without a left arm splint in place. An interview with E26 (RN), confirmed that C6 did not have an arm splint in place per the IPP. Additionally, E26 stated that the CIDP (Qualified Intellectual Disabilities Professional) was responsible to ensure placement of the splint. 3/21/23 1:53 PM - C8 was observed in bed without an arm splint. 3/21/23 1:59 PM - C8 was observed in bed without an arm splint. 3/21/23 1:59 PM - An interview with E27 (CNA) confirmed that she forgol to apply the splint to C6 on 3/21/23 from 500 AM to 1:00 PM. CNA (C8) confirmed that the CNA or Activities staff were responsible for applying the splint to C6 on 3/21/23 in the place by staff and to ensure the IPP is being followed, E28 stated that he was unaware that C6 did not have his splint applied on 3/21/23 and it would have been corrected during rounds if they were completed. 2. Review of C6's clinical records revealed: 3/24/60 - C8 was admitted to the facility.			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			COM	PLETED
STOCKLEY CENTER 2835 PATRIOTS WAY GEORGETOWN, DE 19847 GEORGETOWN, DE 19848 GEORGETOWN, DE 19848 GEORGETOWN, DE 19848 GEORGETOWN, DE 19848 GEORGETOWN, DE 19849 GEORGETOWN, DE 19840 GEORGETO			08 G001	B. WING		The state of the second		
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PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W 249 Continued From page 17 3/28/07 - C6's IPP stated that the restorative splint plan was to be implemented by Activities staff and direct care staff (CNA) per the plan's wearing schedule 9:00 AM to 1:00 PM, four hours per day. W 249 3/20/23 10:55 AM - C6 was observed out of bed in his wheelchair with no left arm splint. 3/21/23 11:55 AM - C6 was observed without a left arm splint in place per the IPP. Additionally, E26 stated that the GIDP (Qualified Intellectual Disabilities Professional) was responsible to ensure placement of the splint. 3/21/23 1:16 PM - An interview with E27 (CNA) confirmed that the CNA or Activities staff were responsible for applying the splint to C6 on 3/21/23 from 9:00 AM to 1:00 PM. CNA (C6) confirmed that the CNA or Activities staff were responsible for applying the splint to C6 on 3/21/23 1:33 PM - An interview with E28 (QIDP), confirmed that the CNA or Activities staff were responsible for applying the splint per the IPP. 3/22/23 1:33 PM - An interview with E28 (QIDP), confirmed the twas responsible to ensure that C6 has his splints pilote to ensure that C6 did not have his splint applied on 3/21/23 and it would have been corrected during rounds if they were completed. 2. Review of C8's clinical records revealed; 3/24/60 - C8 was admitted to the facility.	STOCKL	EY CENTER						
W 249 Continued From page 17 3/28/07 - C6's IPP stated that the restorative splint plan was to be implemented by Activities staff and direct care staff (CNA) per the plan's wearing schedule 9:00 AM to 1:00 PM; four hours per day. 3/20/23 10:55 AM - C6 was observed out of bed in his wheelchalr with no left arm splint. 3/21/23 11:55 AM - C6 was observed without a left arm splint in place. An interview with E26 (RN), confirmed that C6 did not have an arm splint in place per the IPP. Additionally, E26 stated that the QIDP (Qualified Intellectual Disabilities Professional) was responsible to ensure placement of the splint. 3/21/23 1:53 PM - C6 was observed in bed without an arm splint. 3/21/23 1:53 PM - An interview with E27 (CNA) confirmed that she forgot to apply the splint to C6 on 3/21/23 from 9:00 AM to 1:00 PM. CNA (C6) confirmed that the CNA or Activities staff were responsible to ensure that C6 has his splints in place by staff and to ensure the IPP is being followed. E28 stated that he was unaware that C6 did not have has splint applied on 3/21/23 and it would have been corrected during rounds if they were completed. 2. Review of C6's clinical records revealed: 3/24/60 - C8 was admitted to the facility.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE RIATE	(X5) COMPLETION DATE
2/29/22 - C8's individual program plan (IPP)		3/28/07 - C6's IPP s splint plan was to be staff and direct care wearing schedule 9: per day. 3/20/23 10:55 AM - in his wheelchalr with a splint in place per the stated that the QIDP Disabilities Profession ensure placement of a splint in place per the stated that the QIDP Disabilities Profession ensure placement of a splint in place per the stated that the QIDP Disabilities Profession ensure placement of a splint in place per the stated that the QIDP Disabilities Profession ensure placement of a splint in place per the stated that the QIDP Disabilities Profession ensure placement of a splint in the splint in that the Cresponsible for apply a splint in the IPP is being following that C6 did a splints in the IPP is being following if they were considered that C6 did a splints in the IPP is being following if they were considered that C6 did a splints in the IPP is being following if they were considered that C6 did a splints in the IPP is being following if they were considered that C6 did a splints in the IPP is being following if they were considered that C6 did a splints in the IPP is being following if they were considered that C6 did a splints in the IPP is being following if they were considered that C6 did a splints in the IPP is being following in the IPP is being fol	stated that the restorative implemented by Activities staff (CNA) per the plan's 100 AM to 1:00 PM; four hours 100 AM to 1:00 PM. CNA (C6) NA or Activities staff were 100 AM to 1:00 PM. CNA (C6) NA or Activities to 1:00 AM to 1:00 PM. CNA (C6) NA or Activities to 1:00 AM to 1:00 PM. CNA (C6) NA or Activities to 1:00 AM to 1:00 PM. CNA (C6) NA or Activities to 1:00 AM to 1:00 PM. CNA (C6) NA or Activities to 1:00 AM to 1:00 PM. CNA (C6) NA or Activities to 1:00 AM to 1:00 PM. CNA (C6) NA or Activities to 1:00 AM to 1:00 P	W2		through the use of and following prograplans has the potential to negatively at residents who use splints, and recliner positioning time. Under the direction of checking of all splints was conducted to COTA regarding splints locations and use for all residents, on 03/24/2023, and DON informed the therapy department responsibilities regarding splint applications of splints were in locations for application and use. The DRS checked facility's/ residents' recliners, 100% of recliners were in locations for residents for positioning 03/27/2023. Attachment L: Email/Memo from the Executive Director to the Management and Facility Charge Staff regarding PN Reporting and Daily Documentation and Expectations of Staff B2. The DON directed the Certified Occupational Therapist Assistant (COTA complete a sweep of splint compliance was completed on 3/24/2023. Attachment Email from the Certified Occupational Therapist Assistant (COTA) regarding as sweep of splint compliance B3. The DON informed the therapy department staff of their responsibilities ensure that all splints are being applied per guidelines and monitored by the Therap Department-Occupational Therapists (CAttachment Y: Email from the Director of Nursing (DON) to the Therapy Departmenting them that they are to ensure all splints are being applied per guideline and monitored by the Therapy Departmenting them that they are to ensure all splints are being applied per guideline and monitored by the Therapy Departmenting them that they are to ensure all splints are being applied per guideline and monitored by the Therapy Departmenting them that they are to ensure all splints are being applied per guideline and monitored by the Therapy Departmenting them that they are to ensure all splints are being applied per guideline and monitored by the Therapy Departmenting them that they are to ensure all splints are being applied per guideline and monitored by the Therapy Departmenting them that the deficient practice was	am fect all s for DON, by the splint d the of their tions, l on the s' use Staff 46 d A) to per by DT), of ent that hes ent cA	

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Event ID: F14T11

Facility ID: 08G001

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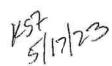
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
,,,,,			A. BUILL	ZING		С		
		08G001	B. WING			03/2	7/2023	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 6351 PATRIOTS WAY			
STOCKL	EY CENTER				EORGETOWN, DE 19947			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 249	stated that "C8 may tolerated as an alte wheelchair position edema (swelling of reclined, utilizing a in the front. On 6/14 (recliner) completed for use in Residenti Configure chair is a wheelchair position 3/20/23 11:16 AM sitting in wheelchair observed holding a television. 3/21/23 12:05 PM - wheelchair watchin was observed in his 3/22/23 9:58 AM - C wheelchair in his rorecliner observed. 3/24/23 11:16 AM - confirmed that C8 if the West Wing, She have a recliner in his 3/27/23 2:30 PM - F	representation of the positioned in a recliner as rective to out of bed or to assist with chronic foot feet). The chair should be push button seat belt fastened 1/22 Configure Chair IG d (was approved) for this client all and Activity areas. Ilso an alternate out of ing like recliner." - C8 was observed out of bed, in his room. C8 was rainstick and watching C8 was observed sitting in his g television and no recliner is room. C8 was observed sitting in his om watching television and no econfirmed that C8 does not is room on the McCabe unit. Findings were discussed with E29 (ADON) and E4 (DRS)	W:	249	and/or lack of understanding among the and responsibilities of the Residential Management Staff leading to the lack monitoring by management; And, this management monitoring led to staffs' approach at times with implementing plans for which splint application and time positioning protocols are detailed C2. Regarding expectations of roles aduties. The ED updated the Performa Plans and Measures for the positions SSA, QIDP, ATS, CNA, ATF, and Ter Agency CNA. These performance pla measures were reviewed by DRS, RFQIDP with all the staff designated by detailing designated staffs' duties and expectations of their job. Staff signature were obtained designating their acknowledgment and agreement. Attain Performance Plan Database C3. The facility will utilize an existing Competencies and Compliance tool for monitoring splint use by the Therapy Department (OT). C4. The APA, DON, and DRS will create the part of positioning) Checklist monitority be implemented by RPA and QIDP D1. For splint application, the Therap Department (OT) will complete a rand sampling of 5 (five) residents on each residential unit on various shifts and various staff, utilizing the Splint Competencies and Compliance tool for (one) time a week for 2 (two) months consistency reaches 100% success (application of splints) over 3 (three) consecutive evaluations. THEN For splint application, the Therapy Department (OT) will complete a rand sampling of 5 (five) residents on each residential unit on various shifts and various shifts and sealing of 5 (five) residents on each residential unit on various shifts and sampling of 5 (five) residents on each residential unit on various shifts and sampling of 5 (five) residents on each residential unit on various shifts and sampling of 5 (five) residents on each residential unit on various shifts and sampling of 5 (five) residents on each residential unit on various shifts and sampling of 5 (five) residents on each residential unit on various shifts and sampling of 5 (five) residents on each residential unit on vari	of lack of indolent program recliner it. and nce of RPA, mporary ns and PA, SSA, titles it. are achment or sate a me is ng tool of the with cor 1 until correct dom		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:			LE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		08G001	B, WING				C 27/2023
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 6351 PATRIOTS WAY DEORGETOWN, DE 19947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
					various staff utilizing the Splint Competer and Compliance tool for 2 (two) times an until consistency reaches 100% success (correct application of splints) over 3 (three consecutive evaluations. FINALLY For splint application, the Therapy Depart (OT) will complete a random sampling of (five) residents on each residential unit or various shifts and with various staff utilizin Splint Competencies and Compliance too (one) time a month until consistency react 100% success (correct application of splints) over 3(three consecutive evaluations. D2. For Rotational Positioning, each RPA QIDP will complete a random sampling of (five) residents on each residential unit on various shifts and with various staff utilizin Rotational Positioning Checklist Tool for 1 time weekly for 3 (three) months until consistency reaches 100% success (correposition according to the program plans) of (five) residents on each residential unit on various shifts and with various staff utilizin Rotational Positioning, each RPA and QIDP will complete a random sampling of (five) residents on each residential unit on various shifts and with various staff utilizin Rotational Positioning Checklist Tool for e 2 (two) weeks for 2 (two) months until consistency reaches 100% success (correposition according to the program plans) of (five) residents on each residential unit on various shifts and with various staff utilizing Rotational Positioning, each RPA and QIDP will complete a random sampling of (five) residents on each residential unit on various shifts and with various staff utilizing Rotational Positioning Checklist Tool for 1 time a month until consistency reaches 10 success (correct position according to the program plans) over 3 (three) consecutive evaluations.	month e) ment for g the of g the (one) g the very ct ver g the (one) g the (one)	

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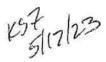
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		SURVEY PLETED
		08G001	B. W <u>NĢ</u>			C 27/2023
NAME OF	PROVIDER OR SUPPLIER	08001		STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/2	2112025
STOCKL	EY CENTER			26351 PATRIOTS WAY		
OTOGRE				GEORGETOWN, DE 19947	ON	(Ve)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC [DENTIFYING INFORMATION]	ID PREFI TAG		D BE	(X\$) COMPLETION DATE
W 331	services in accord		W 331	A . The facility is unable to correct the p deficient practice regarding the staff E3 following the program plan for C2 speci and transfers resulting in the injury of C however, during the time of the injury, C medical care at the facility as well as at hospital, the incident was reported as a incident of significant injury (PM46), and system was inspected for proper function which it was deemed to be properly fundincident was reported to State Officials proper reporting and investigation proces was removed from client care and from the building. E38 no longer works facility as well. B. At the time of the investigation E38 was removed from patient care pending the of the investigation. To address the issingled a staff meeting on 3/29/2023, as was a follow up email and memo to DRS, DRPA, SSA, QIDP, ATS, TIII, ATII, and regarding expectations of staff (following Plans which contain lift and transfer guild During this staff meeting with the DRS, QIDP, the ED completed an academic lifts and transfers related to staff following plans. The analysis concluded that failing provide required care through the use of following program plans has the potent negatively affect all residents. Attachm Email/Memo from the Executive	8 not ic to lifts 2: 2 received the reportable the lift on for ction. The through the adures, removed for the respective removed for the removed respective removed respective removed removed respective removed	

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O	MB NO.	0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		08G001	B. WING				G 67/0000
NAME OF	PROVIDER OR SUPPLIER	Annual Company of the Company	L	-	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	27/2023
					26361 PATRIOTS WAY		
STOCKL	EY CENTER				GEORGETOWN, DE 19947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Based on record redetermined that for residents reviewed to ensure adequate assistive devices. The person assistance of overhead lift. The lift resulted in bruising, eye and a fractured. Review of C2's clinical commented that E3 attempting to transfebed. E38 documents his sling under him, the lift and swung it too hard and it hit him 12/25/22 4:26 PM - from E39 (Adaptive documented that the was checked and it is sufficiently presents with right eye 1.5 cm (corepair method: tissued dressing." X-rays of fractures." C2 was directured to the facilital size and call the commented that the comment	eview and interview, it was one (C2) out of two sampled for accidents, the facility failed staff assistance and/or the facility failed to provide two during a transfer using the it hit R2 in the face which a laceration under the right nose. Findings include: The Incident Report 88 (Agency CNA) was er R2 from a wheelchair to his ed, "I was attempting to put got It under him. Then I took to get to resident, I swung it m on his right eye." An email correspondence Equipment Tech II) to overhead lift in R2's room was working correctly. Review of hospital ED ment) records documented, the swelling and bruising to the swelling and bruising to entimeter) laceration (cut) and each sive (liquid glue)no R2's nose showed "bone ischarged the same day and	W3	331	Director to the Management Staff and Fac Charge Staff regarding PM46 Reporting at Daily Documentation and Expectations of C1. The DRS, DON, APA, and ED's RCA revealed that the deficient practice was refactors involving unclear expectations and insufficiency understanding of roles and responsibilities of the Residential Manage Staff leading to the lack of monitoring by management; a lack of management more staffs' work can cause staff to become apin their approach to duties with implement program plans in which lifts and transfer guidelines are detailed; And, E38 who was trained in lifts and transfers both 1 person person, and trained in following Instruction guidelines in program plans took it upon Eself to conduct the lift transfer on her own the assistance of another staff person, what to C2 injury. C2. Regarding expectations of roles and the ED updated the Performance Plans and Measures for the positions of RPA, SSA, ATS, CNA, ATF, and Temporary Agency These performance plans and measures reviewed by DRS, RPA, SSA, QIDP with staff designated by titles detailing designates staffs' duties and expectations of their job signatures were obtained designating the acknowledgment and agreement. Attachr Performance Plan Database C3. The faciutilize an existing Lift, Gait Belt, and Trans Competencies tool for monitoring splint us the Therapy Department (PT) and the Re Management Team - RPA and QIDP. D1. The Therapy Department (PT) and Residential Management Team - each Ries and Residential Residenti	lated to Vor ment initoring pathetic ting is and 2 half is without hich led duties, and QIDP, CNA, were all the ted ir ment N: litty will offer se by sidential	

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			MB NO	0.938-0391
	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION DING	(X3) DATE	SURVEY
		08G001	B. W <u>NG</u>	TV	03/2	27/2023
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STOCK	EV CENTED			26351 PATRIOTS WAY		
STOCK	EY CENTER		·	GEORGETOWN, DE 19947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(XS) COMPLETION DATE
				QIDP will complete a random sampling (five) residents each (5 residents each reviewer) on each residential unit on vishifts and with various staff, utilizing the Gait Belt, and Transfer Competencies 1 (one) time a week for 2 (two) months consistency reaches 100% success (correct application of lift/transfer) over (three) consecutive evaluations. THEN The Therapy Department (PT) and Remanagement Team — each RPA and Complete a random sampling of 5 (five residents each (5 residents each per non each residential unit on various shift with various staff, utilizing the Lift, Gai and Transfer Competencies tool for 2 times a month until consistency reach success (correct application of lift/transfer (PT) and Remanagement Team — each RPA and Complete a random sampling of 5 (five residents each (5 residents each per non each residential unit on various shift with various staff, utilizing the Lift, Gai and Transfer Competencies tool for 1 time a month until consistency reaches uccess (correct application of lift/transfer Competencies tool for 1 time a month until consistency reaches uccess (correct application of lift/transfer Competencies tool for 1 time a month until consistency reaches uccess (correct application of lift/transfer Competencies tool for 1 time a month until consistency reaches uccess (correct application of lift/transfer Competencies tool for 1 time a month until consistency reaches uccess (correct application of lift/transfer Competencies tool for 1 time a month until consistency reaches uccess (correct application of lift/transfer Competencies tool for 1 time a month until consistency reaches uccess (correct application of lift/transfer Competencies tool for 1 time a month until consistency reaches uccess (correct application of lift/transfer Competencies tool for 1 time a month until consistency reaches until to the province of lift/transfer Competencies tool for 1 time a month until consistency reaches until the province of lift/transfer Competencies tool for 1 time a month until consistency reache	per arious in Lift, tool for suntil in 3 sidential QIDP will eviewer) fts and t Belt, (two) esidential QIDP will eviewer) fts and t Belt, (one) s 100% sfer)	

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PRINTED: 04/13/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B, WING		C		
NAME OF PROVIDER OR SUPPLIER			·	STREET ADDRESS, CITY, STATE, ZIP CODE	03/27/2023	
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)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
W 331	the McCabe unit. E phone call from E42 C2 was "hit in the fa C2's room E17 imm and a laceration jus applied pressure to confirmed she was herself, despite kno was two person ass Findings were revier Director), E2 (PA) a during the exit confe NURSING SERVIC	king the day of the incident on 17 stated she received a 2 (RN) asking for her help as ace with the lift." Upon entering rediately saw C2 had swelling it under the right eye. E17 the area. E38 (agency CNA) attempting to transfer C2 by wing that C2's transfer status sist at all times. wed with E1 (Executive and E4 (DRS) on 3/27/23 prence, beginning at 2:30 PM.	W 33	A. The facility is unable to correct the particle resulting in the deficiency regar	ast rding 05/25/23	
	as prescribed by the client needs. This STANDARD is Based on observation interview, it was determined five clients reviewed treatments, the facility CNAs were providing signing off their treatment binder on units. Findings included the control of	ast Include other nursing care physician or as identified by not met as evidenced by: on, record review and ermined that for five out of for non-medication by failed to ensure that the grare and consistently ements in the designated the Chandler and McCabe de: Review of the treatment included the following		the application of treatments not being documented in the Treatment Administr Records (TAR) for C2,C3,C4,C6,C7. A of treatment products was conducted by DON and ADON on 3/27/23, 100% of the the counter treatment products were avisor use for C2,C3,C4,C6,C7. B1. To immediately address the specific deficiency with management, the ED conducted an analysis with the DRS, AFRPA, QIDP during a staff meeting on 3/29/2023, regarding the lack of staff documentation of application of resident treatments and documentation in the TA ensure staff are providing the required in care. The conclusion of the analysis revithat other residents! TARs did not have initials indicating application of treatment which leads to failing to document applied treatments in the TAR does not confirm the treatments were in fact applied, which essential in providing resident care. The of not documenting the application of treatments application of treatments.	sweep / the le over allable PA, RS to esident ealed staff ts ed that ch is failure	

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Event ID: F14T11

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NAME OF PROVIDER OR SUPPLIER STOCKLEY CENTER STOCKLEY CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE) O8G001 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 26351 PATRIOTS WAY GEORGETOWN, DE 19947 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DATE) DATE DATE	STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STOCKLEY CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 26351 PATRIOTS WAY GEORGETOWN, DE 19947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED DATE DATE DATE						
STOCKLEY CENTER 26351 PATRIOTS WAY GEORGETOWN, DE 19947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED ACTION			08GD01	B. WING		03/27/2023
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC					26351 PATRIOTS WAY	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX				X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION DPRIATE DATE
W 339 Continued From page 21 - Acne face wash to back twice a day; - Hibiciens liquid 4%, bath weekly on Saturday 2:00 PM -10:00 PM shift; - Apply Abreva cram to lips five times a day or until healed; - Coal tar shampoo three times a week on Monday, Wednesday, Friday, 2:00 PM -10:00 PM shift. None of the abovementioned treatments were signed off as being done by the CNAs. 3/22/23 11:30 AM - During an interview, E13 (CNA) confirmed that the binder located at the nurses' station is where the CNAs check their assignments. In addition, the treatment record addresses the treatments that are to be done for each resident and are signed off when completed. 3/23/23 10:05 AM - During an interview, E20 (CNA) confirmed that if a residents gets bathed, uses any special shampoo or cream it is documented in the treatment record is where the CNAs sign off their treatments and tasks. 3/23/23 11:04 AM - During an interview, E21 (CNA) confirmed that the treatment record is where the CNAs sign off their treatments and tasks. 3/23/23 11:04 AM - During an interview, E21 (CNA) confirmed there were multiple blank and incomplete documents in the binder. E22 stated that Administrative staff are supposed to be doing audits to ensure they are being done. 3/22/23 10:05 AM - Review of the treatment 3/22/23 10:05 AM - Review of the treatment	W 339	- Acne face wash to - Hibiclens liquid 49 2:00 PM -10:00 PM - Apply Abreva creatuntil healed; - Coal tar shampoo Monday, Wednesds shift. None of the abover signed off as being 3/22/23 11:30 AM - (CNA) confirmed the nurses' station is weassignments. In adaddresses the treat each resident and acompleted. 3/23/23 10:05 AM - (CNA) confirmed the uses any special shadocumented in the 3/23/23 10:12 AM - (CNA) confirmed the where the CNAs signasks. 3/23/23 11:04 AM - confirmed there we incomplete documented and the where the CNAs signasks.	b back twice a day; 6, bath weekly on Saturday i shift; am to lips five times a day or three times a week on ay, Friday, 2:00 PM -10:00 PM mentioned treatments were done by the CNAs. During an interview, E13 that the binder located at the here the CNAs check their dition, the treatment record timents that are to be done for are signed off when During an interview, E20 that if a residents gets bathed, hampoo or cream it is treatment record. During an interview, E11 that the treatment record is gn off their treatments and During an interview, E22 (RN) tre multiple blank and ents in the binder. E22 stated staff are supposed to be doing treatment record revealed: Teatment record revealed:	W 3	potential to negatively affect all residaddition, the DON and ADON condus weep of all residents Over the Cour Treatment products and found that 1 the products were available for use firesidents. Attachment L: Email/Memo from the Executive Director to the Manageme and Facility Charge Staff regarding F Reporting and Daily Documentation Expectations of Staff B2. During the 3/29/2023, staff meet analysis, the ED discussed and exprexpectations of management and for management to convey the requirem staff expectations regarding Complet Documentation of various needs and treatments and Management must be Checking and Correcting TARs acrosshifts. The ED followed up with an ememo conveying the same to DRS, APA, RPA, SSA, QIDP, ATS, TIII, ASE. Attachment L: Email/Memo from the Executive Director to the Manageme and Facility Charge Staff regarding F Reporting and Daily Documentation Expectations of Staff B3. A sweep conducted by the APA the need for documentation training staff; therefore, the APA revised the Documentation training PowerPoint the requirement of daily documentation training PowerPoint 1/29/2023, for orientation and reeduconducted by the SE and RNE. Attam: Documentation training PowerPo B4. To immediately address the curran educational flyer will be developed SE and/or RNE on Daily Documentation.	ents. In cted a ster 00% of or all ent Staff end essed ents to ction and less all mail and DON, FII, and ent Staff end end ent staff end end ent staff end end ent staff end end ent staff end ent staff, d by the ction. The

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
08G001		B. WING			C 03/27/2023		
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	031	2112023
					6351 PATRIOTS WAY		
STOCKL	EY CENTER				GEORGETOWN, DE 19947		and the books are seen
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	record dated 3/8/23 non-medication treat and swelling in the I remove at bedtime; - Coal tar shampoo Monday, Wednesday shift; - Apply Selsun blue on Sunday, Tuesday - Elevate both legs in during the day and on the Aboversigned off as being a 3/23/23 10:45 AM - confirmed the treatment of the CNAs. 3/24/23 10:00 AM - Supervisor) confirmed the treatment of the aboversigned incomplete document of the Aboversigned off as being a 3/23/23 10:45 AM - confirmed the treatment of the CNAs. 3/24/23 10:00 AM - Supervisor) confirmed and incomplete document of the attestic several times. 3. Review of C6's treatment of C6's treat	included the following atments: s (help prevent blood clots egs) apply in the morning and three times a week on my, Friday, 2:00 PM -10:00 PM (shampoo) four times a week y, Thursday, Saturday; in recliner chair one hour one hour in the evening. The mentioned treatments were done by the CNAs. During an interview, E23 (RN) ments were not signed off by the composition of the multiple blank timents. E24 stated that she intion of Administration the poo on Monday, ment during hygiene care; in bathing.	W3	339	Agency CNAs) will be educated on documentation training by the SE and Residential Team — DRS, RPA, SSA, Cand/or ATS, and a signed voucher will completed. C1. The ED, DRS, DON, and APA's Refevealed the deficient practice was related four factors which includes: lack of adestaff documentation of resident treatmenter the TAR; confusion and/or lack of understanding among the roles and responsibilities of the residential manastaff leading to the lack of monitoring be management; some ambiguities writter TAR policy, The staffs' lackadaisical apto the important of documentation desponsibilities and revised by the DON on 4/14/2023, Attachment Z: Medication Administration Record (TAR), and Orientation/In-service was reviewed and revised by the DON on 4/14/2023, Attachment Z: Medication Administration Record (TAR) In-service update C3. Regarding expectations of roles and duties. The ED updated the Performant Plans and Measures for the positions of SSA, QIDP, ATS, Certified Nursing Ass (CNA), Active Treatment Facilitator (AT and Temporary Agency CNA. These performance plans and measures were reviewed by DRS, RPA, SSA, QIDP with the staff designated by titles detailing designated staffs' duties and expectation designating their acknowledgement and agreement. Attachment N: Performance Plan Datast Attachment N: Performance Plan Datast	be CA ated to quate ents on gement y in the poroach off and ce f RPA, sistant F), th all ons of d	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
					С		
		08G001	B. WING			03/	27/2023
NAME OF PROVIDER OR SUPPLIER STOCKLEY CENTER				2	TREET ADDRESS, CITY, STATE, ZIP CODE 6351 PATRIOTS WAY GEORGETOWN, DE 19947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 339	5. Review of C4's tr 3/15/23, revealed: - Botene for oral hyg- - Ammonium lactate daily; - Vitamin E oil to lips - Use of insert in brie 3/23/23 approximate interview, E8 (CNA) treatments are comexpected to record if 3/23/23 around 12:0 E28 (QIDP) confirm and incomplete docadoes not monitor the completion. 3/23/23 around 12:0 E5 (PA) confirmed the documents was not (DRS) provided the 3/23/23 1:14 PM - A revealed that the Q's monitoring the CNA'	ene care until resolved, eatment record, dated giene twice daily; lotion to dry skin areas twice twice daily; ef with incontinent care. ely 11:30 AM - During an revealed that when pleted on clients the CNA is in the treatment book. DO PM - During an interview, ed there were multiple blank uments. E28 stated that he ese documents for DO PM - During an interview, hat monitoring these part of his responsibilities, E4 oversight. In interview with E4 (DRS) is (QIDP) were responsible for	W	339	C4. The SE and/or RNE will provide education on the revised Documentation training during orientation and reeducat C5. The APA will update the Active Treatment Supervisor's Shift Monitorin Report to include the review of staffs' documentation on TARs. When on dut ATS completes this monitoring report all shifts. C6. The APA will update the Facility Cl Shift Monitoring Report to reflect the reof staffs' documentation on TARs. Whe duty and designated as Facility Charge monitoring report is completed by Facil Charge staff who consist of APA, RPA, SSA, QIDP, TIII, ATII, and/or SE acrosshifts. D. The ATS will review TARs on each sacross residential units for each reside times a week for 1 (one) month until consistency reaches 100% success (all TARs are documented) over three (three consecutive evaluations. The ATS will document on the Active Treatment Supervisor's Report. THEN The ATS will review TARs on each shifts randomly selected residents on each residential unit every 2 (two) weeks for (one) month until consistency reaches success (all TARs are documented) over three (three) consecutive evaluations. ATS will document on the Active Treatment Supervisor's Report. THEN The ATS will review TARs on each shifts randomly selected residents on each residential unit once a month for 2 (two months until consistency reaches 100% success (all TARs are documented) over three (three) consecutive evaluations.	tion. g y the across harge view en on e, this sity s all shift for 1 100% er The er The ment it for	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED STATEMENT OF CORRECTION COMPLETED AND PLAN OF CORRECTION COMPLETED COM	/EY
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	23
STOCKLEY CENTER 26351 PATRIOTS WAY GEORGETOWN, DE 19947	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPILED TO THE APPROPRIATE DEFICIENCY)	(X8) PLETION PATE
ATS will document on the Active Treatment Supervisor's Report. FINALLY The ATS will continue to review TAR documentation for each scheduled shift across residential units, and document on the Active Treatment Supervisor's Report. The APA or SCS will review the Active Treatment Supervisor's Report compliance with the monitoring. A monthly report of the findings will be completed and reported to the Residential Management Team (DRS, RPA, SSA, QIDP, and ATS).	

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