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

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

STATE SURVEY REPORT

NAME OF FACILITY: Stockley Center ICF/ID

DATE: SURVEY COMPLETED: October 4, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from October 1, 2024 through October 4, 2024. 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 thirty-eight (38). The survey sample totaled nine (9) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.1	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** Cross Refer to the CMS 2567-L survey completed October 4, 2024: W154 and W249.		
16 Del. Code, Ch.11 Sub-Chapter III	**Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents .** **§1131 Definitions.** **(12) "Neglect" means the failure to provide goods and services necessary to avoid**	**3201** **16 Del. Code,** **Ch.11 Sub-Chapter III** 1. (E8): A. The Temporary Certified Nursing Assistant (E8) failed to follow the Facility's protocol on 5/30/2023 on group assignments and the Facility's policy on incontinence	12/3/2024

Provider's Signature [signature] Ed.D. Title Executive Director/NHA Date 11/12/2024
DHCQ Provided a Corrected Survey 11/12/2024

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	physical harm, mental anguish, or mental illness. Neglect includes all of the following: **a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for thirteen (C1, C2, C7, C8, C10, C11, C12, C13, C14, C15, C16, C17 and C18) out of eighteen clients reviewed for resident rights, the facility failed to ensure that the clients were free from neglect when care and services were not provided for approximately two or more hours. Findings include: Review of facility documentation and other facility records revealed the following: 1. 5/29/23 – A facility assignment sheet documented that E8 (Agency CNA) was assigned to group 1 clients which included: C1, C7, C8, C10, C11, C12 and C13. 5/30/24 9:35 AM – A facility incident report documented that E8 did not complete incontinence care rounds every two hours for all the assigned clients from 5/29/23 to 5/30/23 on the 10:00 PM to 6:00 AM shift. 5/30/23 – A nursing progress note for C1, C7, C8, C10, C11, C12 and C13 documented body checks were completed with no skin breakdown noted. 10/1/24 1:38 PM – A review of facility documentation documented that the guidelines for this unit for the 10:00 PM to 6:00	care to ensure that care and treatment was provided to the residents every two hours. E8 falsified documentation stating that all the required rounds of care were completed; however, the camera evidence shows that they did not complete all the required rounds of care and spent an extended amount time in the break room. The results of E8's actions caused temporary skin issues for the residents. E8, Temporary Certified Nursing Assistant was terminated from Stockley Center as a result. B. All residents have the potential to be affected negatively by the deficient practice; all corrective actions set forth were applied to all residents of the facility. A sweep of documents during the investigation revealed that E8 and E9 assigned residents were only impacted. C. The Facility trained and/or counseled staff in PM46 investigations thereafter, as well as began monitoring of staff upon their retraining and return to resident care. In addition, the Facility initiated directives, reminders, and educational material to staff as it applies: I. All Direct Care staff were required to review the Residential Services Direct Care Assignments In-Service. (completed on 6/28/2023 & 7/26/2023) Attachment I: Residential Services Direct Care Assignments In-Service II. All Direct Care staff were required to review the Incontinent Care policy. (completed on 6/28/2023 & 7/26/2023)	

Provider's Signature [signature] Ed.D. Title Executive Director Date 11/12/2024

NAME OF FACILITY: Stockley Center ICF/ID **DATE:** SURVEY COMPLETED: October 4, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	AM shift, CNA's were to provide toileting or incontinence care from 10:00 PM to 12:00 AM, 12:00 AM to 2:00 AM, 2:00 AM to 4:00 AM and 4:00 AM to 6:00 AM. 10/1/24 2:27 PM - An interview with E2 (DDD) confirmed that E8 missed two out of four incontinence care rounds during their 10:00 PM to 6:00 AM shift. E2 stated that the facility surveillance footage confirmed that on 5/29/23 from 10:06 PM to 11:54 PM, E8 did not provide any incontinence care rounds. In addition, from 1:47 AM to 3:51 AM, E8 was in the breakroom and did not provide any incontinence care rounds. The aforementioned note revealed that the toileting and incontinence care rounds from 10:00 PM to 12:00 AM and 2:00 AM to 4:00 AM were not completed. 10/2/24 9:37AM - An interview with E1 (NHA) and E2 confirmed E8 was terminated. 2. 5/29/23 – A facility assignment sheet documented that E9 (Agency CNA) was assigned to group 3 clients which included: C2, C14, C15, C16, C17 and C18. 5/30/24 9:35 AM – A facility incident report documented that E9 did not complete incontinence care rounds every two hours for all the assigned clients from 5/29/23 to 5/30/23 on the 10:00 PM to 6:00 AM shift. 5/30/23 – A nursing progress notes for C2, C14, C15, C16, C17 and C18 documented body checks were completed with no skin breakdown noted. 10/1/24 1:38 PM – A review of facility documentation documented that the guidelines for this unit for the 10:00 PM to 6:00	Attachment J: Incontinent Care policy. III. A memo was issued to all Direct Care staff reminding them of the protocol to complete initials rounds of assigned residents at the beginning of the shift. (completed on 4/22/2024) Attachment K: Memo to complete initial rounds at beginning of shift. IV. A memo to Facility Charge & Active Treatment Facilitators are required to check with each staff every two hours to ensure they completed and documented the incontinent care checks for each resident they were assigned for all direct care shifts that the Facility Charge or Active Treatment Supervisors shift covers. The Facility Charge and Active Treatment Supervisors will document in detail such checks on the Facility Charge Shift Monitoring Report or Active Treatment Supervisors Shift Monitoring Report. (completed on 4/22/2024) Attachment L: Memo to Facility Charge & Active Treatment Facilitators regarding required checks V. A memo to the direct care staff notifying them that effect immediately the protocol for documenting on the urinary and bowel elimination records will require the time incontinent care was provided and documented in after every incontinent care round, as	

Provider's Signature Kai-Ming Jonathan Ed.D. Title Executive Director/CEO Date 11/12/2024

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	AM shift, CNA's were to provide toileting or incontinence care from 10:00 PM to 12:00 AM, 12:00 AM to 2:00 AM, 2:00 AM to 4:00 AM and 4:00 AM to 6:00 AM. 10/1/24 2:27 PM - An interview with E2 (DDD) confirmed that E9 missed two out of four incontinence care rounds during their 10:00 PM to 6:00 AM shift. E2 stated that the facility surveillance footage confirmed that on 5/29/23 from 10:16 PM to 11:54 PM, E9 did not provide any incontinence care rounds. In addition, from 2:04 AM to 3:51 AM, E9 was in the breakroom and did not provide any incontinence care rounds. The aforementioned note revealed that the toileting and incontinence care rounds from 10 PM to 12 AM and 2 AM to 4 AM were not completed. 10/2/24 9:37AM - An interview with E1 (NHA) and E2 confirmed E9 resigned, however, the facility would have terminated them if it they had not resigned. 10/4/24 12:30 PM - Findings were reviewed with E1, E2, and E3 (DON) during the exit conference.	well as, continuous documentation of incontinent care for every resident they are assigned for every shift. (completed on 4/22/2024) Attachment M: Memo that all Urinary/Bowel Elimination Records will require a time and continuous documentation. VI. The following educational flyers were created and disseminated to staff for review and attestation as continuous education to mitigate issues. Attachment Q: Caring, Supporting, and Serving in Focus-Plan of Care (Introduction) (completed on 6/25/2024) Attachment R: Caring, Supporting, and Serving in Focus-GENTLE Perineal Care (completed 8/9/2024) D1. The facility will disseminate educational materials and reminders of the critical needs of resident regarding hygiene care and following assignments and grouping for residents for 100% compliance. I. The Assignments and Groupings form was modified to include the group the staff are assigned and the initials of the residents in the assigned group and an email sent to all Facility Charges and Active Treatment Supervisors on the protocol of the new form. (completed on 10/18/2024) Attachment N: Assignments/Groupings	

Provider's Signature [signature] Title Executive Director/NHA Date 11/12/2024

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		II. The Facility Charge Shift Monitoring Report was modified to include the requirement of verbal verification of each staff's assignment and the residents in that assignment at the beginning and middle of the shift. (completed 10/16/2024) Attachment O: Facility Charge Shift Monitoring Report III. The Active Treatment Shift Monitoring Report was modified to include the requirement of verbal verification of each staff's assignment and the residents in that assignment at the beginning and end of the shift. (completed 10/16/2024) Attachment P: Active Treatment Supervisors Shift Monitoring Report IV. The following educational flyers were created and disseminated to staff for review and attestation as continuous education to mitigate issues. Attachment S: Caring, Supporting, and Serving in Focus-See Something Say Something (completed 10/13/2024) Attachment T: Caring, Supporting, and Serving in Focus-Quick Tips (completed 10/16/2024) D2. The Active Treatment Supervisors will review the Urinary and Bowel Elimination Records for all residents to ensure continuous documentation with noted times daily for one month for 100% compliance.	

Provider's Signature [signature] Ed.D Title Executive Director/CEO Date 11/12/2024

NAME OF FACILITY: Stockley Center ICF/ID

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		Documenting on the Active Treatment Supervisors Shift Monitoring Report. THEN The Active Treatment Supervisors will review the Urinary and Bowel Elimination Records for all residents to ensure continuous documentation with noted times weekly for one month for 100% compliance. Documenting on the Active Treatment Supervisors Shift Monitoring Report. THEN The Active Treatment Supervisors will review the Urinary and Bowel Elimination Records for all residents to ensure continuous documentation with noted times twice a month for 100% compliance. Documenting on the Active Treatment Supervisors Shift Monitoring Report. 2. (E9): The Temporary Certified Nursing Assistant (E9) failed to follow the Facility's protocol on 5/30/2023 on group assignments and the Facility's policy on incontinence care to ensure that care and treatment was provided to the residents every two hours. E9 falsified documentation stating that all the required rounds of care were completed; however, the camera evidence shows that they did not complete all the required rounds of care and spent an extended amount time in the break room. The results of E9's actions caused temporary skin issues for the residents. E9, Temporary Certified Nursing Assistant resigned during the investigation. However, the actions of E9 would have led to termination from Stockley Center if E9 had not resigned.	

Provider's Signature Kate Markham, Ed.D Title Executive Director NHA Date 11/12/2024

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		B. All residents have the potential to be affected negatively by the deficient practice; all corrective actions set forth were applied to all residents of the facility. A sweep of documents during the investigation revealed that E8 and E9 assigned residents were only impacted. C. The Facility trained and/or counseled staff in PM46 investigations thereafter, as well as began monitoring of staff upon their retraining and return to resident care. In addition, the Facility initiated directives, reminders, and educational material to staff as it applies: I. All Direct Care staff were required to review the Residential Services Direct Care Assignments In-Service. (completed on 6/28/2023 & 7/26/2023) Attachment I: Residential Services Direct Care Assignments In-Service II. All Direct Care staff were required to review the Incontinent Care policy. (completed on 6/28/2023 & 7/26/2023) Attachment J: Incontinent Care policy. III. A memo was issued to all Direct Care staff reminding them of the protocol to complete initials rounds of assigned residents at the beginning of the shift. (completed on 4/22/2024) Attachment K: Memo to complete initial rounds at beginning of shift. IV. A memo to Facility Charge & Active Treatment Facilitators are required to check with	

Provider's Signature Kathleen Jenkins, Ed.D Title Executive Director (Interim) Date 11/12/2024

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		each staff every two hours to ensure they completed and documented the incontinent care checks for each resident they were assigned for all direct care shifts that the Facility Charge or Active Treatment Supervisors shift covers. The Facility Charge and Active Treatment Supervisors will document in detail such checks on the Facility Charge Shift Monitoring Report or Active Treatment Supervisors Shift Monitoring Report. (completed on 4/22/2024) Attachment L: Memo to Facility Charge & Active Treatment Facilitators regarding required checks V. A memo to the direct care staff notifying them that effect immediately the protocol for documenting on the urinary and bowel elimination records will require the time incontinent care was provided and documented in after every incontinent care round, as well as, continuous documentation of incontinent care for every resident they are assigned for every shift. (completed on 4/22/2024) Attachment M: Memo that all Urinary/Bowel Elimination Records will require a time and continuous documentation. VI. The following educational flyers were created and disseminated to staff for review and attestation as continuous education to mitigate issues.	

Provider's Signature [signature], EdD Title Executive Director, NHA Date 11/12/2024

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		Attachment Q: Caring, Supporting, and Serving in Focus-Plan of Care (Introduction) (completed on 6/25/2024) Attachment R: Caring, Supporting, and Serving in Focus-GENTLE Perineal Care (completed 8/9/2024) D1. The facility will disseminate educational materials and reminders of the critical needs of resident regarding hygiene care and following assignments and grouping for residents for 100% compliance. I. The Assignments and Groupings form was modified to include the group the staff are assigned and the initials of the residents in the assigned group and an email sent to all Facility Charges and Active Treatment Supervisors on the protocol of the new form. (completed on 10/18/2024) Attachment N: Assignments/Groupings II. The Facility Charge Shift Monitoring Report was modified to include the requirement of verbal verification of each staff's assignment and the residents in that assignment at the beginning and middle of the shift. (completed 10/16/2024) Attachment O: Facility Charge Shift Monitoring Report III. The Active Treatment Shift Monitoring Report was modified to include the requirement of verbal verification of	

Provider's Signature Kevin M. Jenkins, Ed.D Title Executive Director/DHSS Date 11/12/2024

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		each staff's assignment and the residents in that assignment at the beginning and end of the shift. (completed 10/16/2024) Attachment P: Active Treatment Supervisors Shift Monitoring Report IV. The following educational flyers were created and disseminated to staff for review and attestation as continuous education to mitigate issues. Attachment S: Caring, Supporting, and Serving in Focus-See Something Say Something (completed 10/13/2024) Attachment T: Caring, Supporting, and Serving in Focus-Quick Tips (completed 10/16/2024) D2. The Active Treatment Supervisors will review the Urinary and Bowel Elimination Records for all residents to ensure continuous documentation with noted times daily for one month for 100% compliance. Documenting on the Active Treatment Supervisors Shift Monitoring Report. THEN The Active Treatment Supervisors will review the Urinary and Bowel Elimination Records for all residents to ensure continuous documentation with noted times weekly for one month for 100% compliance. Documenting on the Active Treatment Supervisors Shift Monitoring Report. THEN The Active Treatment Supervisors will review the Urinary and Bowel Elimination Records for all	

Provider's Signature [signature], C.O.D. Title Executive Director/NHA Date 11/12/2024

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		residents to ensure continuous documentation with noted times twice a month for 100% compliance. Documenting on the Active Treatment Supervisors Shift Monitoring Report.	

Provider's Signature [signature] Title Executive Director Date 11/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 10/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments	E 000		

An unannounced Annual and Complaint survey was conducted at this facility from October 1, 2024 through October 4, 2024. The facility census was 38 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, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.

W 000 INITIAL COMMENTS W 000

An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from October 1, 2024 through October 4, 2024. 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 thirty-eight (38). The survey sample totaled nine (9) residents.

Abbreviations/definitions used in this report are as follows:

ADON - Assistant Director of Nursing;
CNA - Certified Nursing Assistant;
DDD - Developmental Disabilities Director;
DHCQ - Division of Health Care Quality;
DON - Director of Nursing;
DRS - Director of Residential Services;
ED - Executive Director;
IPP - Individual Program Plan;

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kai-Stefan Fountain, Ed.D.	Kai-Stefan Fountain, Ed.D, ExeDir/NHA	10/30/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 10/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	Continued From page 1 NHA - Nursing Home Administrator; PA - Program Administrator; QIDP - Qualified Intellectual Disability Professional; RN - Registered Nurse; ADLs - activities of daily living; Neglect - the failure of a caregiver to meet a dependent person's basic physical and emotional needs, including the need for shelter, food, clothing, medical care, and emotional support; Profound intellectual disability - condition where individuals are completely dependent on others for all ADLs and to maintain their physical health and safety.	W 000		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview, record review and a review of other facility documentation as indicated, it was determined for one (C5) out of nine investigative sampled clients, the facility failed to thoroughly investigate allegations of neglect. Findings include: 1/30/68 - C5 was admitted to the facility with diagnoses including, but not limited to, profound intellectual disability. 11/28/23 - A facility incident report documented that E5 (Agency LPN) reported that C5 was found laying in urine and feces during the 6:00 AM to 2:00 PM shift. E5 indicated that urine could be smelled at the doorway prior to entering C5's room. E5 reported the incident to the charge	W 154	W154 A. The facility is unable to correct the past deficient practice regarding the staff (E6) not following the Facility's protocol plan for incontinence care resulting in a missed incontinence care check but no injury to C5; however, the facility took action to ensure that all residents were not effected through the incident being reported to State Officials for the proper reporting and investigation procedure, the staff (E6) was removed from client care and the schedule pending the investigation and was retrained. The Facility is unable to correct the past deficient practice to ensure that a thorough investigation with evidence was completed. The Facility's future practices changed to ensure that previous relevant shift employee(s) will be interviewed for investigations. B. All Residents have the potential to be affected negatively by the deficient practice; all corrective actions set forth are applied to all residents of the facility. B1. The Developmental Disabilities Director of Habilitation Services/ PM 46 Coordinator (DHS) sent an email on 10/18/2024 to all trained investigators directing them that moving forward, it will be a requirement that investigations must include interview(s) with relevant previous shift	12/3/2024

Kai-Stefan Jamison, Ed.D.
eSIGN 855157

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 10/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 2 nurse on duty, vital signs were obtained, and a skin check was completed per documentation. The facility incident report documented that video surveillance was reviewed and determined that assigned caregiver [E7] on 11/28/23 for C5 entered the room at 5:08 AM and exited at 5:14 AM. The incident report also included a copy of the CNA flow sheet indicating that C5 had voided and was signed off that care was completed. The aforementioned note indicated that E7 entered room, provided care to C5 and exited the room in six minutes. 11/28/23 11:48 AM - An incident report was submitted to the state agency reporting that E6 (Agency CNA) did not complete morning incontinence care on C5 and an investigation was initiated. 11/28/23 11:58 AM - An electronic communication documented that E2 (DDD) initiated an internal investigation and determined by a review of surveillance cameras and facility documentation that the assigned staff on 11/27/23, 10:00 PM to 6:00 AM shift, completed proper protocol of incontinence care on C5. 10/1/24 2:27 PM - An interview with E2 (DDD) revealed that an investigation was completed and determined that C5 did not receive morning care on 11/28/23 from E6. E2 stated that surveillance footage, CNA flow sheets, and incontinence logs were reviewed to determine when care was provided. E2 stated that no adverse effects were noted to C5 and that was confirmed by a skin check completed by nursing staff. 10/2/24 9:37 AM - An interview with E1 (NHA)	W 154	W154(cont). employee(s) assigned o the resident(s), and any additional employee(s) deemed necessary during the investigation despite any confession and/or video and documentation evidence. Attachment A: Email and memo Regarding PM 46 Investigation process. B2. The DHS updated the PM46 Checklist on 10/18/2024 to include steps to include (a) the interviewing relevant previous shift employee(s), (b) sending an email to the contracted agency stating the temp agency staff are under investigation, (c) returning with training and monitoring, and/or dismissal from services notice. Attachment B: PM46 Monitoring Checklist. B3. The Executive Director created an educational flyer on 10/21/2024 on the review and expectations of PM46 Investigations. Attachment C: Education Quick Review and Expectations in Focus-PM46 Investigations educational flyer C1. The Memo to all trained investigators was sent to all Investigators to review in an email and in Relias (training system) for staff to attest and understand the requirements set forth in the document. Attachment A: Email and Memo regarding PM46 Investigations C2. The PM46 Checklist to include steps to include the interviewing previous shift, sending an email to the contracted agency stating the temp staff are under investigation, returning with training/monitoring, and/or a termination notice was sent to all Investigators to review in an email and in Relias (training system) for staff to attest and understand the requirements set forth in the document. Attachment B: PM46 Monitoring Checklist C3. The Education Quick Review and Expectations In Focus-PM46 Investigations educational flyer was assigned to all	

Kai-Stefan Jamison, Ed.D. eSIGN 855157

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 10/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

W 154 Continued From page 3

and E2 confirmed that only the day shift staff was interviewed on 11/28/23. E2 stated that the investigation determined that the 10:00 PM to 6:00 AM shift completed their incontinence care based on reviewing surveillance cameras and a review of the facility documentation. E2 stated that during an interview, E6 admitted she did not complete the first morning round of incontinence care for C5. E2 stated that E6 was retrained for six months and remained on staff. E2 confirmed that no skin break down or redness occurred related to lack of incontinence care.

The facility investigation lacked evidence of interviewing all direct care staff that were involved in care with C5 between 11/27/23 and 11/28/23.

10/4/24 12:30 PM - Findings were reviewed with E1, E2, and E3 (DON) during the exit conference.

W 249 PROGRAM IMPLEMENTATION
CFR(s): 483.440(d)(1)

As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by:
Based on observation, record review, and interview, it was determined that the facility failed to consistently implement interventions identified on the individual program plan (IPP) for one (C4)

W 154 W154 cont). investigators to review in Relias (training system) for staff to attest and understand the requirements set forth in the document.
Attachment C: Education Quick Review and Expectations in Focus-PM46 Investigations educational flyer
D1. The DD DHS/PM46 Coordinator completed a sweep on 10/18/2024 of the last years' worth of PM46investigations to determine the extent of the deficient practice. A Memo of the sweep was sent to the Executive Director. Attachment D: Memo of PM46 Investigation sweep
D2. The DD DHS/PM46 Coordinator or designee will complete and review the PM46 Checklist prior to the completion of any PM46 Investigation to ensure the deficient practice is not repeated for each investigation. Attachment B: PM46 Monitoring Checklist.
D3. The Standards Control Specialist will review the PM46 Investigation Checklist quarterly to ensure accuracy of the investigation requirements for 100% compliance.

W 249 12/3/2024
W249
The facility is unable to correct the past deficient practice regarding the staff (E4) not following the program plan for C4 specific to 2-person assist resulting in the injury of C4; however, during the time of the injury, C4 received medical care at the facility as well as an x-ray, the incident was reported as a reportable incident of significant injury (PM46). The facility took action to ensure that all residents were not effected through the incident was reported to State Officials through the proper reporting and investigation procedure, the staff (E4) was removed from client care pending the investigation and was retrained. At the time of reported incident all staff were provided education material on transferring residents dos and don'ts. Attachment E: Transferring Residents Basics
B. All residents have the potential to be affected negatively by the deficient practice; all corrective actions set forth are applied to all residents of the facility.

Kai-Stephen Jamison, Ed.D.
eSIGN 855157

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 10/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 4 out of four sampled clients. The facility failed to provide a two person assist during toileting, which resulted in a fall without harm. Findings include: 8/25/83 - C4 was admitted to the facility with diagnoses including, but not limited to, profound intellectual disability. 12/22/22 - The instructional guidelines (IG) for the toilet back support with fastex seatbelt revealed that C4 required two staff during transfer and standing. One staff member is to assist with standing (using gait belt) and a second staff is to perform care. While C4 is seated on the toilet, one staff is required to provide constant supervision. 10/15/23 - A facility incident report revealed that C4 had a witnessed fall during the transfer to the toilet by one staff member. C4 was returned to bed using a hoyer lift and a skin assessment was completed by staff. No injuries were noted to C4's legs but "documented possible bruise to left outer ankle. Staff documented will continue to monitor for change in weight bearing status. The facility ordered an x-ray to rule out injury." E4 (CNA) was removed from providing care and reassigned to the kitchen pending an investigation. 10/16/23 - An x-ray report revealed that no fracture or dislocation of C4's bilateral hips, bilateral femurs, bilateral ankles, or bilateral tibias or fibulas. The report showed C4 sustained a twisted left knee. 10/3/24 11:30 AM - An interview with E4 (CNA) confirmed that C4 requires a two-person assist for transfer for toileting. E4 confirmed that on 10/15/23 she did not transfer C4 per the IG. E4	W 249	W249 (cont) B1. The Executive Director (ED) sent an email to all staff on 10/12/2024 with an educational flyer Caring, Supporting, and Serving in Focus-Lifts and Transfers. Attachment F: Email and Caring, Supporting, and Serving in Focus-Lifts and Transfers educational flyer. B2. The ED sent an email to all staff on 10/13/2024 with an educational flyer Caring, Supporting, and Serving in Focus-See Something; Say Something for Resident Safety. Attachment G: Email and Caring, Supporting, and Serving in Focus-See Something; Say Something educational flyer for Resident Safety. B3. The DHS sent an email on 10/16/2024 to the DD Program Administrators, Qualified Intellectual Disabilities Professionals, Active Treatment Supervisor, Physical Therapists, and Social Service Administrator instructing them to complete a sweep of all Residential Certified Nursing Assistants, Nursing Assistants, and Active Treatment Facilitators by completing a Gait Belt and Lift Transfer Compliance Survey. Attachment H: Email and Gait Belt and Lift Transfer Compliance Survey. C. The DHS and ED's root cause analysis revealed that the deficient practice was related to staff (E4) not following the program plan specific to 2-person assist resulting in the injury of C4, despite her training. C1. The Caring, Supporting, and Serving in Focus-Lifts and Transfers educational flyer was sent to staff to review in an email and in Relias (training system) for staff to attest and understand the requirements set forth in the document. Attachment F: Email and Caring, Supporting, and Serving in Focus-Lifts and Transfers educational flyer. C2. The Caring, Supporting, and Serving in Focus-See Something; Say Something educational flyer was sent to staff to review in an email and in Relias (training system) for staff to attest and understand the requirements set forth in the document. Attachment G: Email and Caring, Supporting, and Serving in Focus-See Something; Say Something educational flyer for Resident Safety. C3. The Facility will utilize the Gait Belt and Lift Transfer Compliance Survey for monitoring staff's knowledge of the	

Kai-Stefan Jantzen, Ed.D.
eSIGN 855157

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	28351 PATRIOTS WAY GEORGETOWN, DE 19947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 5 stated she completed several months of a retraining program and will not initiate care with C4 without having the second person assist ready before transferring. 10/3/24 1:30 PM - An interview with E2 (DDD) revealed that the facility would have expected E4 to have had the second person assist prior to attempting to transfer C4 and to not attempt to transfer alone. E2 stated the facility has a program book that outlines the guidelines for each resident's care and assessments related to disciplines, so she should have been familiar with the resident. E2 stated that E4 should have been familiar with this book and should have referenced it if there was a question as to how to care for any client at the facility. E2 also stated that all staff are trained to be a second support person, so anyone could have assisted with the transfer. 10/4/24 12:30 PM - Findings were reviewed with E1 (NHA), E2, and E3 (DON) during the exit conference.	W 249	W249 (cont) requirements for a 2-person assist. Attachment H: Email and Gait Belt and Lift Transfer Compliance Survey. D. The DD PAs and QIDPs will complete a Gait Belt and Lift Transfer Compliance Survey for 6 (six) residents a week for 7 (seven) weeks to cover every resident for 100% compliance. THEN, The DD PAs and QIDPs will complete a Gait Belt and Lift Transfer Compliance Survey for 16 (sixteen) residents at random every month for 3 (three) months for 100% compliance. THEN, Each Facility Charge and ATSs will complete a Gait Belt and Lift Transfer Compliance Survey for 2 (two) residents at random every quarter thereafter for a 100% compliance.	

Kai-Stefan Jantzen, Ed.D.
eSIGN 855157