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

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STATE SURVEY REPORT

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe **DATE SURVEY COMPLETED:** 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility from September 12, 2011 through September 16, 2011. The facility census on the first day of the survey was one hundred and five (105). The survey sample was composed of sixteen (16) residents which included eleven (11) active and five (5) closed record reviews. Two sub-sampled residents were included for observations.	
3225	**Assisted Living Facilities**	
3225.5.5	**The assisted living facility shall develop and adhere to policies and procedures to prevent residents with diagnosed memory impairment from wandering away from safe areas. However, residents may be permitted to wander safely within the perimeter of a secured unit.** **This requirement is not met as evidenced by:** Based on record review and interview it was determined that although the facility had a policy for elopement prevention, recognition and management the contents of the policy were not reflective of the current system. The policy addressed a personal monitoring system that the facility did not have in place. Findings include: Review of the facility's policy titled "Elopement: Prevention, Recognition and Management" effective 9/2002 and last updated 11/2009 included the use of a personal monitoring system as an approach for residents at risk of elopement.	**3225.5.5** Unable to correct what has already occurred. A revised elopement policy was implemented in September 2011. (Attachment A) All nurses and all other staff will be inserviced on the revised policy. 12/1/11 Any elopements will be thoroughly investigated by the ED/designee. Identified issues will be corrected immediately to prevent further elopement events. Findings will be reported to quarterly QI committee. Ongoing

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An interview on 9/16/11 with the DON confirmed that the facility does not have a personal monitoring system in place. The facility instead keeps all doors except the front entrance locked and/or alarmed at all times. The DON stated that the front door is monitored by staff during the day and locked in the evening. This practice was not included in the policy. Observations on 9/15 and 9/16/11 revealed that staff was not always in view of the front door during the day allowing for a potential elopement.	
3225.8.0	**Medication Management**	
3225.8.3.5	**All expired or discontinued medication, including those of deceased residents, shall be disposed of according to the assisted living facility's medication policies and procedures.** **This requirement is not met as evidenced by:** Based on record review, review of facility policy and interview it was determined that the facility failed to dispose of Lorazepam (controlled class IV medication) for one (R12) out of 16 sampled residents according to the facility's policy and procedure. Findings include: The facility's policy and procedure for Controlled Substances Inventory and Tracking stated I. Purpose-to assure that controlled drugs (schedule II-V) will be properly…destroyed … c. Disposal of Controlled substances 2. A resident's controlled drugs should be destroyed with	**3225.8.3.5** Unable to correct, as medications have already been disposed of. All residents who receive narcotic medication are at risk for their medications being disposed of incorrectly. Licensed nursing staff have been re-inserviced on the correct way to dispose of narcotics. 9/26/11 and 11/10/11 Licensed nursing staff will bring narcotic count sheet to DON after disposing of any discontinued medications for her review. DON will stamp and initial her review.

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe

DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	two licensed nurses…document the destruction on the individual prescription's declining inventory record and have two nurses sign verifying the destruction. R12 had a physician order dated 1/14/11 for Lorazepam 2mg./ml concentrate take 0.5 ml (mg) by mouth or under the tongue every 6 hours as needed for anxiety or agitation. Review of the controlled medication utilization record for R12 dated 1/15/11 revealed that Lorazepam 27.5 ml was signed off as being destroyed by E3 (LPN). There were no other signatures on this document indicating that another licensed person witnessed the destruction of the medication. Review of the information and controlled medication record with E2 (DON) on 9/16/11 at 9:25 AM confirmed that it was the facility's policy to have two nurses sign and witness the destruction of controlled medications.	
3225.8.8.2	**Each resident receives the medications that have been specifically prescribed in the manner that has been ordered;** **This requirement is not met as evidenced by:** Based on record review and staff interviews it was determined that for two (R6 and R4) out of 16 sampled residents, the facility failed to ensure that the residents were administered their	

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

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	medications as prescribed. Findings include: 1. R6 had a physician's order dated 1/26/11 for cyanocobalamin (indicated for treatment of vitamin B_{12} deficiencies) 1000 mcg. (microgram) intramuscular injection every month. Review of the February and March 2011 Medication Administration Record (MAR) revealed that the facility's staff administered the injections on 2/4/11 and 3/4/11. Record review revealed laboratory result dated 2/14/11 of vitamin B-12 of 1024 (normal of 211-946 pg/mL). Review of the May 2011 physician's order sheet (POS) documented that there was a change in frequency of this injection from monthly to every other month, however, there was no date of this new order. Review of the monthly MAR for April through July 2011 documented that the frequency remained unchanged and there was no evidence that R6 received this injection. An interview with E3 (Licensed Practical Nurse) on 9/15/11 at 10 AM revealed that she documented the change on the above May 2011 POS, however, failed to document the date of the new order and failed to communicate this change to the pharmacy. Repeat laboratory test dated 8/10/11 noted result of 821 (normal range 200-950) for the Vitamin B12 level. Interview with R6 on 9/15/11 at approximately 9 AM revealed that the nurses administered the above injection on a monthly basis. An interview with E2 on 9/15/11 at approximately 10 AM revealed that the facility failed to ensure that the	**3225.8.8.2** #1-R6 Unable to correct as the event has already occurred. All residents have the potential for a medication not to be given as prescribed. All licensed nurses will be re-inserviced on how to take and transcribe a physicians order. 12/15/11 The Wellness Director or designee will conduct weekly random chart audits of 10 residents to ensure that any new orders have been properly transcribed onto their MAR. 12/1/11 Wellness Director will report findings to QI committee for 2 consecutive quarters. 1/1/12

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	new order was implemented to ensure that R6 received the injections every other month as ordered and specifically prescribed by the physician. Subsequent to this interview, the surveyor was provided a "consultation form" dated 3/14/11 which documented the above change to every other month. 2. R4 had a physician's order for a finger stick blood sugar (FSBS) twice a day at 7:30 AM and 4:30 PM with sliding scale insulin coverage with Novolog (insulin). Review of the August 2011 medication administration record (MAR) noted that for August 2011 the 4:30 PM FSBS was documented as "ate" 12 out of 31 opportunities and blank for 9 out of 31 opportunities. Review of the September 2011 MAR noted that "ate" was documented 4 out of 13 opportunities and was blank 4 out of 13 opportunities. An interview on 9/14/11 with nurse E4 revealed that the resident must have eaten dinner before the nurse could get to her. An interview with the DON E2 on 9/16/11 confirmed there were missing FSBS readings for R4 that may have resulted in the resident missing insulin coverage for elevated blood sugars and consequently the facility failed to specifically follow the prescribed orders of the physician.	#2 R4- Unable to correct as event has already occurred. All diabetic residents have the potential to be affected by not having their FSBS checked as ordered. A list will be developed to identify all diabetics who require blood sugar monitoring prior to meals. This will be posted in CNA office as well as nurses station. 12/1/11 All nursing staff to include CNA's, and dining services staff members, will be re-inserviced on the importance of ensuring that residents get their blood sugars checked and receive medication as prescribed. 12/1/11 Wellness Director or designee will audit resident MAR weekly to check that FSBS are being done prior to resident meals. If during the review it is noted that any particular resident is consistently missing their FSBS it will be investigated to see if this is due to resident non-compliance or nursing error. If it is due to resident refusal then an appointment will be set up between the resident and Registered Dietitian for nutrition counseling. If due to nursing error then staff will receive one on one counseling and progressive disciplinary action. 12/1/11
3225.9.0 3225.9.8	**Infection Control** **The assisted living facility shall have policies and procedures for infection control as it pertains to staff, residents, and visitors.**	

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	This requirement is not met as evidenced by: Based on observation and interview it was determined that the facility failed to have a policy and procedure for dressing changes that would include infection control techniques. The facility failed to follow standard procedures for infection control techniques to prevent contamination of the wounds while performing dressing changes for one (R10) out of 16 sampled residents. Findings include: On 8/11/11 R10 was identified as having pressure ulcers to her right and left heel and was sent to the wound center. Review of the wound center discharge instructions dated 9/7/11 revealed an order for topical treatments for R10's stage III pressure ulcers to her right and left heels. The topical treatment for Wound #1 right heel and Wound #2 left heel was to apply a thin film of enzymatic agent (Santyl Collagenase) to wound bed only, then cover with clean dressing: once daily to both heels ulcers. Wound must be covered by a dressing at all times. Use gauze wrap around the foot and heel to hold in place. On 9/13/11 at 12:40 PM E3 (LPN) was observed performing a dressing change to R10's heels. E3 had her dressing change equipment sitting on top of the nurse's desk. E3 sat in a chair while R10 sat in a wheelchair at the nurse's desk. E3 lifted R10's left leg and placed it on E3's leg without a barrier. E3 wore gloves to remove R10's slipper and cut the old dressing off her left heel. E3 then lifted R10's left leg and placed R10's foot in the	**3225.9.8** Unable to correct as event has already occurred. Any residents who have wounds have the potential to be exposed to infection due to poor wound care techniques. A new wound care policy was implemented in September 2011 and licensed staff was re-inserviced on 9/26/11 and 11/10/11. (Attachment B) Wellness Director or designee will observe two wound changes weekly to ensure policy is being followed correctly. Staff who are not following policy will receive one on one counseling and progressive disciplinary action. 12/1/11 Wellness Director will report findings at QI committee for 2 consecutive quarters. 1/1/12

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	slipper without the wound being covered and put her foot back on the floor. E3 removed her gloves washed her hands and proceeded to remove the old dressing from R10's right heel using the same technique she used to remove the old dressing from R10's left foot. After removing all the old dressings from R10's heels, E3 washed her hands and donned gloves. Then E3 lifted up R10's left leg put it over her leg, using her gloved hands she removed the slipper by holding the bottom of the slipper from E3's right foot, therefore contaminating her glove. Using the same gloves E3 cleansed the left heel wound using normal saline and a 4x4-gauze pad with R10's leg still on E3's leg. The 4x4 used to clean the wound was placed on the nurse's desk. Skin prep was applied around the wound. Santyl was applied to the wound bed. Alleyne Gentle dressing was put over the wound then E3 used gauze to wrap around the dressing and taped the end of the gauze in place. Then E3 put R10's right foot back in the slipper and placed R10's foot on the floor. The entire wound care that included cleansing of the wound and applying the new dressing was done using E3's leg to support R10's leg and foot. After removing her gloves and washing her hands, E3 was observed using the same technique of cleansing R10's right heel wound and applying a new dressing. E3 cleaned the top of the nurse's desk with a chloride wipe then used the same wipe instead of a clean one to clean her scissors that she placed in her pocket.	

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe

DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	On 9/13/11 at 2:35 PM review of the dressing change with E3 confirmed that she failed to use proper infection control techniques while performing R10's dressing changes. On 9/13/11 at 2:45 PM E2 (DON) was asked if the facility had a policy and procedure for dressing changes that included proper infection control techniques. E2 stated that the facility did not have one but they would develop one. On 9/14/11, E2 provided a policy and procedure for Wound Care-Infection control.	
3225.11.0	**Resident Assessment**	
3225.11.3	**Within 30 days prior to admission, a prospective resident shall have a medical evaluation completed by a physician,** **This requirement is not met as evidenced by:** Based on record review and staff interviews it was determined that for one (R6) out of 16 sampled residents, the facility failed to ensure that the medical evaluation was conducted within 30 days prior to admission. In addition, the documentation of the medical evaluation failed to be complete. Findings include: R6 was originally admitted to the facility on 1/8/11. Review of R6's two page "Physician's History and Physical" documented that R6 was examined by a physician on 11/16/10 (greater than 30 days prior to admission) and in addition, this documentation included the signature	**3225.11.3** Resident R6 had new H&P completed on 11/22/11. All residents admitted to the facility have the potential to be affected by the deficient practice. Wellness Director will insure that all new residents have the H&P fully completed and dated 30 days or less prior to date of admission. 11/1/11 Wellness Director or designee will complete a monthly audit of all new admissions to ensure that the H&P has been completed per State regulations. Results will be reported to QI committee for 2 consecutive quarters. 1/1/12

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	of the physician and date of 12/5/10 (greater than 30 days from date of admission) indicating that there was no change from the initial examination conducted on 11/16/10. An interview with E2 (Director of Nursing) on 9/15/11 at 9 AM revealed that the pre-printed "Physician's History and Physical" forms are three pages, thus, the one page was missing from the record. Additionally, the medical evaluation was not conducted within 30 days prior to admission.	
3225.11.5	**The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** **This requirement is not met as evidenced by:** Based on record review and interview it was determined that for three (R10, R2 and R11) out of 16 sampled residents the facility failed to reassess the residents using the UAI tool when a significant change in condition occurred. Findings include: 1. Review of R10's most recent UAI identified, as an annual dated 9/14/10 documented she did not have any skin care services that included special mattress, pressure relief device or positioning device. It also documented that R10 did not have skin ulcers and she required normal skin care, including diabetic skin assessment.	

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe

DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Review of R10's nurses notes revealed on 8/11/11 R10 was observed with blisters to both of her heels. R10 was sent to the wound clinic where discharge instructions were given that included wound care cleansing and treatments to be done daily along with other off loading procedures. Review of R10's UAI with E2 (DON) on 9/13/11 at 2:40 PM confirmed the facility failed to develop a significant change UAI documenting the care and service required for R10's stage III pressure ulcers to her heels. 2. R2's annual UAI dated 3/4/11 indicated the resident needed supervision for mobility, transfers self, and used no mobility devices (i.e. cane, walker, wheelchair). The UAI did not include any safety problems or hospice services. On 7/9/11 the resident record documented a fall that required hospital treatment. The resident returned from the hospital on hospice services. Nurses' notes after the readmission included; 7/13/11 She is on no meds at this time. 7/14/11 Resident out of bed to wheelchair 7/15/11 Resident ambulated with care managers assist. The facility failed to conduct a new assessment to reflect the changes in mobility, resident safety and the use of hospice services. This was confirmed by interview with the	**3225.11.5** For resident R10 an Annual/Significant Change UAI was completed on 9/14/11. For resident R2 a Significant change was completed on 11/17/11. Resident R11 was discharged to a higher level of care prior to Significant change being completed, therefore unable to correct. All residents have the potential to be missed for a significant change UAI. Ongoing, the Wellness Director or designee will read the Nursing and CNA 24 hour report on a daily basis, to check for any documented changes in care or needs. 11/1/11 Once it has been established that a residents' care needs have changed, then a Significant Change UAI and new service agreement will be completed and all staff will be made aware of changes. Immediate and ongoing Wellness Director or designee will complete monthly chart audits (10 residents) to ensure that all UAI's are reviewed and signed within 10 days of completion. This will be reported back to QI committee for 2 consecutive quarters. 1/1/12

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe **DATE SURVEY COMPLETED:** 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	DON, E2 on 9/16/11. 3. R11's initial UAI dated 4/9/11 and 30 day UAI dated 5/11/11 documented short term memory loss but no wandering behaviors. R11 developed exit seeking behaviors on 7/29/11 resulting in an elopement from the facility to a local business approximately a quarter mile down a two lane residential road connecting the facility to the shopping center. Following this incident the resident was moved to the secured dementia unit. The nurse documented on the initial service agreement dated 4/11/11 that on 7/30/11 the resident was moved to the secured unit related to elopement risk. The facility failed to reassess R11 for the newly developed behaviors requiring the move to a secured unit in the building. This was confirmed by interview with the DON, E2 on 9/16/11.	
3225.12.0	**Services**	
3225.12.1.2	**Meals and snacks are varied, palatable, and of sufficient quality and quantity to meet the daily nutritional needs of each resident with specific attention given to the special dietary needs of each resident;** **This requirement is not met as evidenced by:** Based on observation, record review and interview it was determined that the facility failed to ensure one (R5) out of 16 sampled	

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	residents received the appropriate diet. R5 was ordered a pureed diet but was observed to be eating a mechanical soft diet. Findings include: R5 was admitted to the facility with diagnoses that included ALS (Amyotrophic Lateral Sclerosis- The disorder causes muscle weakness and muscle shrinking (atrophy) throughout the body. In ALS, both the upper motor neurons and the lower motor neurons die, causing them to stop sending messages to the muscles. Unable to function, the muscles gradually weaken and waste away (atrophy). http://simple.wikipedia.org/wiki/ALS) and cataracts. Review of R5's record revealed she had a diet notification form completed dated 10/13/10 indicting R5 was to receive a mechanical soft with pureed meats, honey thickened liquids diet. Review of R5's nurses notes dated 6/29/11 documented R5 choked on her breakfast and an abdominal thrust was performed with positive effects. On 8/5/11 a diet notification was completed stating that R5 was to receive a purred diet with honey thickened liquids. On 9/13/11 at 12:10 PM E6 (Care Manager) was observed giving R5 her plate that consisted of a mechanical soft diet of stuffed shells. R5 was observed eating four bites from her plate before E5 (Care Manager) noticed R5's food consistency and immediately removed R5's plate from her. E5 explained the diet	**3225.12.2** Unable to correct as event has already occurred. All residents on a modified diet have the potential to be affected. E6 was counseled immediately on which resident was to receive the proper diet. The Dining Services Director in conjunction with the Registered Dietician have developed a list of all residents on a physician ordered modified diet. All dietary wait staff and CNAs serving meals in Reflections will be inserviced on the Physician Ordered Modified Diet lists by 12/1/11. DSD will observe 2 meals weekly in Reflections and 3 meals in the AL dining room giving special attention to those residents on a modified diet. Any identified dietary errors will be corrected immediately. The staff member will be counseled and given progressive disciplinary action as needed. 12/1/11

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	consistency error to E6 and ordered a purred diet for R5. Review of the incident with E2 (DON) on 9/14/11 at 2:05 PM confirmed R5 should not have received a mechanical soft diet but should have received a puréed diet instead.	
3225.12.1.3	**Food service complies with the Delaware Food Code** **Delaware Food Code 2011** **Chapter 3 Food** **3-5 LIMITATION OF GROWTH OF ORGANISMS OF PUBLIC HEALTH CONCERN** **3-501 Temperature and Time Control** **3-501.16 Potentially Hazardous Food (Time/Temperature Control for Safety Food), Hot and Cold Holding.** **(A)** ***Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19,*** **and except as specified under ¶ (B) and in ¶ (C) of this section, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be maintained:. (1) At 57oC (135oF) or above,** ***except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above;*** **P or (2) At 5°C (41°F) or less. P**	

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	This regulation is not met as evidenced by: Based on temperature readings taken in the True-brand refrigerator in the kitchen on 09/15/11, it was determined that the facility failed to maintain potentially hazardous foods at 41°F or less. Findings include: 1. The surveyor's minimum recording thermometer reached a temperature of 51.8 °F after 15 minutes inside the refrigerator. This unit was not recovering cold holding temperature properly.	**3225.12.1.3** All food items in the True Brand refrigerator were immediately discarded and the unit taken out of use. A new refrigeration unit was purchased and installed on 10/15/11. All dietary staff will be re-inserviced on proper time/temperature control for food safety by 12/1/11. DSD will complete Weekly Sanitation audit, which includes insuring refrigerator temperatures are taken, and report results to quarterly QI committee. (Attachment C) 1/1/12 and ongoing
3225.13.0	**Service Agreement**	
3225.13.1	**A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement.**	
3225.13.2	**The service agreement or contract shall address the physical, medical, and psychosocial services that the resident requires as follows:**	
3225.13.2.9	**Notification procedures when an incident occurs or there is a change in the health status of the resident;** **This requirement is not met as evidenced by:**	

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe

DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Based on record review and staff interviews it was determined that for 16 (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, and R16) out of 16 sampled residents, the facility failed to ensure that the notification procedure was in the service agreement (SA). Findings include: Review of the "Resident General Service Plan" for all 16 residents revealed that the facility failed to include the notification procedure. An interview with E2 (Director of Nursing) on 9/15/11 at 9 AM revealed that the current SA utilized for all residents does not have a section for the notification procedure and that the organization will be revising the SA to incorporate this information. The following Service Plans were missing the necessary notification information; 1. R1 10/19/10 2. R2 3/4/11 3. R3 7/28/11 4. R4 4/5/11 5. R5 3/10/11 6. R6 1/8/11 7. R7 7/12/11 8. R8 7/22/11 9. R9 10/5/10 10. R10 9/14/10 11. R11 5/11/11 12. R12 3/7/10 13. R13 6/8/11 14. R14 3/17/11 15. R15 8/1/10 16. R16 8/17/11	
3225.13.3	**The resident's personal attending**	

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe

DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	physician(s) shall be identified in the service agreement by name, address, and telephone number. **This requirement is not met as evidenced by:** Based on record review and staff interviews it was determined that for 16 (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, and R16) out of 16 sampled residents, the facility failed to ensure that the resident's personal attending physician's information was in the service agreement (SA). Findings include: Review of R6's "Resident General Service Plan" (Service Agreement/SA) for all 16 residents revealed the facility failed to include the residents' personal attending physician's name, address, and telephone number. An interview with E2 (Director of Nursing) on 9/15/11 at 9 AM confirmed that the facility failed to include this information on the SA. The following service plans were missing the physician's information; 1. R1 10/19/10 2. R2 3/4/11 3. R3 7/28/11 4. R4 4/5/11 5. R5 3/10/11 6. R6 1/8/11 7. R7 7/12/11 8. R8 7/22/11 9. R9 10/5/10 10. R10 9/14/10 11. R11 5/11/11 12. R12 3/7/10	**3225.13.2.9** **3225.13.3** All residents who were in the sample have had their emergency notification and physician information added to their service agreements. 10/1/11 All residents have the potential for their physician and emergency notification information to be omitted from the service agreement. All new admissions will have the emergency notification and physician information placed on their service agreement. A revised service agreement has been implemented that includes room for physician and emergency notification to meet State standards. (Attachment D) 10/1/11 All residents will be updated to the revised service agreement. 1/1/12 Wellness Director or designee will complete monthly audits of 10 charts to ensure the residents' pertinent information is included. This will be reported back to QI committee for 2 consecutive quarters. 1/1/12

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe

DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	13. R13 6/8/11 14. R14 3/17/11 15. R15 8/1/10 16. R16 8/17/11	
3225.13.6	**The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated.** **This requirement is not met as evidenced by:** Based on record review and staff interviews it was determined that for 6 (R6, R16, R4, R11, R2, and R10) out of 16 sampled residents, the facility failed to review the service agreement when a change in resident needs was identified. Findings include: 1. R6 had a physician's order dated 1/26/11 for cyanocobalamin (indicated for treatment of vitamin B_{12} deficiencies) 1000 mcg. (microgram) intramuscular injection every month dated 1/26/11. Review of R6's "Resident General Service Plan" (Service Agreement/SA) dated 1/8/11 documented that R6 self administered his medication. An interview with E2 (Director of Nursing) on 9/16/11 at 9 AM confirmed that the facility failed to revise the above service plan to document that the facility's staff administered the injection. 2. R16 had a service agreement dated 6/12/11 that documented under safety that the resident was an occasional wander risk related to confusion. On 7/13/11 staff	**3225.13.6** Resident R6 had service agreement updated (11/15/11) to reflect that nursing staff were giving him his B12 injections. Resident R16 had Significant Change UAI and Service Agreement updated on 10/14/11. Resident R4 had significant Change UAI and Service Agreement updated on 11/17/11 to reflect daytime arrangements and elopement risk. Resident R11 was discharged to a higher level of care before service agreement could be updated. Resident R2 had Significant Change UAI and service agreement updated on 11/17/11 to reflect hospice care and fall risk.

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	added that R16 was not allowed to sit outside or on porch or by lobby door related to elopement risk. No specific approaches to the service agreement were identified to prevent elopement prior to 7/13/11. Nurses' notes documented; 6/19/11 Resident trying to leave building 7/17/11 Resident found walking down driveway 7/17/11 Resident walking down driveway again 7/18/11 Resident wandering outside building 7/19/11 Resident tried to walk out front door 7/20/11 Numerous attempts to leave the building 7/22/11 Resident walked out front door 7/25/11 Exited building via emergency door 9/4/11 Resident found in parking lot sitting in her wheelchair A new service agreement was initiated on 8/17/11. There were no approaches related to wandering and elopement. This was confirmed by interview with E2, DON on 9/16/11. 3. R4 had a Service Agreement dated 4/5/11 that documented under the area of safety that the resident was a wander risk related to confusion and must have staff or family when outside of building. On 5/8/11 R4 eloped from the facility and was found walking down Route 1, a multiple lane highway. The resident made	Resident R10 had Annual/Significant Change UAI and service agreement completed on 9/14/11 to reflect changes in skin integrity and wound care. All residents admitted to the facility have the potential to be affected by the deficient practice. Ongoing, the Wellness Director will ensure that a new service agreement is initiated every time a UAI is completed and that it is reviewed and signed by responsible party within 10 days of completion. 10/1/11 Wellness Director or designee will complete monthly chart audits (10 residents) to ensure that all Service agreements are reviewed and signed within 10 days of completion. This will be reported back to QI committee for 2 consecutive quarters. 1/1/12

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	four more elopement attempts between 5/11 and 8/3/11. After 8/3/11 the facility started having R4 spend her day including all meals on the secured unit and would return her to her own room to sleep at night. The facility failed to initiate a new service agreement with the resident's responsible party when R4's needs changed. This was confirmed by interview with the DON, E2 on 9/16/11. 4. R11 developed exit seeking behaviors on 7/29/11 resulting in an elopement from the facility to a local business down a residential road. The resident was moved to the secured dementia unit. The nurse documented on the initial service agreement dated 4/11/11 that on 7/30/11 the resident was moved to the secured unit related to elopement risk. The facility failed to implement a new service agreement between the facility and the resident's responsible party when the resident's care need's significantly changed. This was confirmed by interview with the DON, E2 on 9/16/11. 5. R2's annual UAI and service agreement dated 3/4/11 did not include any safety problems or hospice services. On 7/9/11 the resident record documented a fall that required hospital treatment. The resident returned from the hospital on hospice services.	

NAME OF FACILITY: **Brandywine Assisted Living Seaside Pointe** DATE SURVEY COMPLETED: **9/16/11**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The facility failed to initiate a new service agreement with the resident's responsible party to reflect R2's changes and the corresponding needs made for resident safety and the use of hospice services. This was confirmed by interview with the DON, E2 on 9/16/11. 6. Review of R10's service agreement revealed the most recent service agreement/Resident General Service Plan was completed on 9/14/10. This service agreement documented that R10 did not have pressure ulcers or skin problems. Review of R10's record revealed she developed blisters on both of her heels that were observed on 8/11/11. R10 was sent to the wound clinic on 8/11/11. The wound clinic sent discharge instructions to the facility for care of R10's pressure ulcers and preventative measures to prevent further break down and to enhance healing of the pressure ulcers. The instructions entailed off-loading techniques that included keeping weight off wound/affected area/limb at all times.- no pressure to heel wounds, must be off loaded at all times. Turn every 2 hours. Avoid position directing pressure to wound site. Limit side lying to 30 degree tilt. Limit Head of Bed elevation to 30 degrees in bed. Float heels on pillows when in bed to keep pressure off the heels at all times. Wear when in bed: Mutlipodus/Waffle/ or foam boot ordered for both her heels (2 boots) to keep the pressure off her wounds. This is critical to keep pressure off the heels!!. Keep the wounds covered at all times.	

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The facility failed to develop a new Service Agreement after R10 developed changes in skin and pressure ulcer status. Review of the Service Agreement with E2 (DON) on 9/13/11 at 2:40 PM E2 confirmed the facility failed to develop a new Service Agreement for significant change when R10 developed stage III pressure ulcers.	
3225.16.0	**Staffing**	
3225.16.14	**Assisted living facility resident assistants shall, at a minimum:**	
3225.16.14.3	**Receive, at a minimum, 12 hours of regular in-service education annually which may include but not be limited to the topics listed in 16.14.2.** **This requirement is not met as evidenced by:** Based on review of Resident Aide (Care Manager) in-service records on 09/15/11, it was determined that the facility failed to ensure a minimum of 12 hours of regular in-service annually for Care Managers. Findings include: 1. Twelve (12) (E 9, E10, E11, E12, E13, E14, E15, E16, E17, E18, E19, & E20) out of twenty- two (22) Care Manager records reviewed, revealed less than 12 hours of in-service had been completed for the prior year.	**3225.16.14.3** No residents were affected by the deficient practice. The identified 12 CNAs not meeting the CEU requirement will be required to attend a mandatory 6 hour training. This training shall consist of infection control, MSDS, fire and life safety, Residents Rights, HIPPA, disaster plan, caring for residents with memory impairment, and reporting of abuse, neglect, and mistreatment. 1/30/12 CNA CEUs will be recorded on the inservice record by the BOM/designee and reviewed quarterly at QI. Any CNA found to not meet the CEU standards will be required to attend a mandatory 6 hour training with the topics as listed above.
3225.17.0	**Environment and Physical Plant**	
3225.17.6.1	**A clean and sanitary environment;** **This requirement is not met as**	

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	evidenced by: Based on observation and interview it was determined that the facility failed to ensure #SS2 had a scooter that was clean and free from food debri. Findings include: On 9/13/11 at 9:40 AM #SS2 was observed in his room sitting on his electric scooter. The bottom of the scooter where his feet rested was caked with food debri. The sides of the scooter had dried liquid spills. On 9/14/11 at 9:50 AM during the medication pass observation #SS2 was observed sitting on his scooter. The caked food debri and dried liquid spills were again observed. At 10:08 AM E2 (DON) was shown #SS2's scooter who stated she would call and have the scooter cleaned.	**3225.17.6.1** Resident #SS2 had his scooter cleaned by 9/15/11. Weekly cleaning of the scooter has been added to his service agreement. All residents who use a wheelchair have the potential to be affected by the deficient practice. Residents wheelchairs will be cleaned quarterly, or as needed. 11/21/11 Wheelchair cleaning will be assigned to the Environmental Services Department. The staff will be inserviced on proper wheelchair cleaning. 1/1/12 Maintenance Director will perform a random monthly audit of 10 wheelchairs and ensure procedure is being followed, to be reported back to QI committee for 2 consecutive quarters. 1/1/12
16 Del.C., Chapter 11, Subchapter II, §1121 (1)	**Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.** **This requirement is not met as evidenced by:** Based on observation and interview it was determined the facility failed to provide dignity for two (R5 and #SS1) out of 18 sampled residents who were observed being fed by staff while the staff stood beside them. Findings include:	

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
16 Del.C Chapter 11, Subchapter III, §1113 (9) (a)	On 9/13/11 at 12:05 PM through 12:35 PM lunch observations were made in the Reflections Unit. During the lunch observation, E5 (Care manager) and E6 (Care Manager) were observed standing beside R5 and #SS1 feeding them instead of sitting in a chair beside them. An interview with E5 revealed the staff fed R5 and #SS1 in order to get them to eat. On 9/14/11 at 12:45 PM R5 and #SS1 were observed in the dining room for lunch. E7 (Care Manger) was observed standing and feeding the residents their lunch. The observation was reviewed with E1 (Administrator) and E2 (DON) on 9/15/11 at 1:15 PM. **Neglect:** **(a) Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals, and safety.** **This requirement is not met as evidenced by:** Based on record review and interview it was determined that for four (R14, R10, R4 and R11) out of 16 sampled residents the facility failed to address the physical health and safety needs of the residents. R14 was not supervised while bathing resulting in a fall with injury, R10 was not provided with physician ordered pressure relieving devices and R4 and R 11 were not properly supervised to prevent elopement from the facility. Findings include:	**16 Del C, Chapter 11, Subchapter II 1121 (1)** Care managers E5 and E6 were immediately counseled on the deficient practice. 9/15/11 Residents who are required to be fed by staff may be affected by the deficient practice. All CNAs will be inserviced on proper resident feeding techniques. 12/1/11 CNAs will be observed feeding twice a week by DSD and twice a week by Reflections Co-ordinator. Any improper resident feeding techniques will be corrected immediately. 12/1/11

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	1. R14 was admitted to the facility on 3/25/10 with diagnoses that included Vertigo, Glaucoma of the right eye, blindness of the left eye, hypertension and asthma. Review of R14's 3/17/11 annual UAI revealed a fall risk assessment was completed indicating R14 had gait problems, confusion, and dizziness/vertigo and fell in the last 30 days. R14 was also assessed as being alert to person and place only. For bathing R14 was assessed as needing to be set up with water and supplies; and needing occasional assistance with her back, feet, and peri-care. For assistive devices she had a bath bench and grab bar/tub rail. R14 was also assessed as being visually impaired due to blindness of the left eye. Review of R14's Service Agreement dated 3/17/11 revealed R14 was to be supervised with her bath or shower with limited assist. On 6/17/11 at 7:00 AM R14's nurses notes documented that R14 fell in the bathroom shower and there were no witnesses to the fall. R14 was discovered sitting upright on the shower floor with her legs extend. Neuro checks were negative. No visible hematoma was noted in occipital region or nearby. R14 complained of pain to her right hand and her right hand had mild swelling and she was unable to grasp the writer's hands. Ice was applied to her right hand. R14 was assisted to a standing position and an aide proceeded to give her a shower. R14's vital signs were documented as BP 160/93 Pulse was 89	**16 Del.C Chapter 11** **Subchapter III, 1113 (9) (a)** #1-Unable to correct deficient practice as all events have occurred. Shower schedules will be reviewed and a revised schedule will be implemented. This revised schedule will indicate which residents cannot be left alone during their shower. Service Agreements will reflect the same and will be updated during annual or significant change. 12/1/11 Shower schedule will be updated to reflect changes and staff will be in-serviced on new shower schedule. 12/1/11 Ongoing the Wellness Director or designee will monitor and update shower schedule as residents have changes in their care needs.

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe

DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	with respirations of 18. At 10:50 AM R14's nurses notes documented R14 complained of right hip and ankle pain and her right wrist continued to be swollen. 911 was called and R14 was transported to the hospital. R14 was diagnosed with congestive heart failure, distal ulnar and radial fracture and pelvic fracture of the inferior and superior ramus on the right side. Review of the incident report completed by the facility revealed a staff member was in the hallway when she heard R14 fall. Review of the incident with E2 (DON) on 9/15/11 at 12:00 noon confirmed the facility neglected to provide supervision to R14 while she was taking a shower as indicated in R14's Service Agreement. E2 stated that R14 would not have started a shower without someone telling her to have a shower. The staff probably thought she was a set only instead of requiring supervision for the shower. 2. R10 was admitted to the facility in 8/2004 with diagnoses that included diabetes mellitus type II, osteoarthritis, congestive heart failure, atrial fibrillation with pacemaker and gastroespogeal reflux disease. In 2010 R10 began receiving Hospice Care. Review of R10's nurse notes documented on 8/11/11 that the hospice aide reported blisters to R10's heels and that the heels have blackened areas with the left heel having a small opened area. The nurse practioner was notified and the wound center was contacted.	#2-Resident R10 had boots obtained by 9/17/11. All residents admitted to the facility have the potential to be affected by the deficient practice. The Wellness Director or designee will read the Nursing 24 hour report on a daily basis, to check for any documented changes in care or needs. Nursing staff will also be re-inserviced on communicating to the Wellness Director any physician orders that may have a potential for delay in implementing them. Any delay for filling an order will be documented in the medical record with the reason for the delay and the anticipated fill date of the order. The Wellness Director or designee will conduct weekly random chart audits of 10 residents to ensure any new orders have been transcribed and followed through on as ordered on their MAR. Wellness Director will report findings to QI committee for 2 consecutive quarters. 1/1/12

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Review of the wound center discharge instructions details dated 8/29/11 revealed a note for off-loading while R10 was in bed she needed to wear a multipodius/waffle or foam boot to keep her heel off the bed-she needs a high density foam boot ordered for both her heels to keep the pressure off her wounds. The 9/7/11 discharge instructions from the wound care center for off-loading had the same instructions as 8/29/11 but also added an additional comment concerning off-loading. "This is critical to keep pressure off the heels!!" On 9/13/11 at 1:15 PM review of the wound center instructions with E3 (LPN) revealed R10 did not have boots. E3 continued to state that the facility failed to order boots for R10 to off-load her heels while she was in bed as instructed by the wound center. 3. R4 had an annual UAI dated 4/5/11 that included a diagnosis of dementia. The resident was assessed as having short term memory problems and no history of wandering. The Service Agreement dated 4/5/11 documented under the area of safety that the R4 was a wander risk related to confusion and must have staff or family when outside of building. On 5/8/11 at 5:30 PM R4 was discovered to be missing by the facility when she did not show up for dinner. The resident was later found walking up Route 1 highway adjacent to the facility by a passing	

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe

DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	motorist. No reassessments of the resident's mental status and wandering were found for this resident. Review of the facility's incident report and investigation failed to determine how the resident got out of the building. Nurses' notes documented attempts to leave the building on 5/11/11, 5/12/11, and on 8/3/11 twice. An interview with the DON, E2 on 9/15/11 about the security of the building for residents at risk of elopement revealed that all the exterior doors except the front entrance are alarmed. The front entrance is monitored by staff during the day and evening and locked at night. Observations on 9/15 and 9/16/11 revealed that the staff person assigned to monitor the front door was not always there. Despite these measures R4 still eloped from the facility. No changes were made to the resident's service plan. No changes were made to facility procedures. After four attempted elopements the facility moved R4 to the secured unit for the day and evening hours including all meals. R4 is brought back to her room at night to sleep. The resident's service plan was not updated to reflect these changes. This was confirmed by interview with the administrator, E1 and DON E2 on 9/16/11. 4. R11's initial RAI assessment dated 4/9/11 and 30 day assessment dated 5/11/11 documented a diagnosis of dementia, short term memory problems and no history of wandering. Nurses' notes on 7/24 and 7/26/11 documented that the resident was found	#3- Resident R4 has had a significant change UAI and service agreement updated on 11/17/11. #4- Resident R11 was discharged to a higher level of care prior to updating information. All new admissions will have elopement assessment completed. All other current residents will be assessed for elopement risk during an annual or significant change assessment. 1/1/11 Residents who are identified as being at risk will have interventions put in place on their service agreement under the elopement category. Ongoing Wellness Director will report all elopements to quarterly QI committee. Ongoing

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	wandering in other resident rooms. A nurse's note dated 7/29/11 documented the resident tried to leave the building four times between 11 AM and 4 PM and had been exit seeking all day. No new approaches were documented. A nurse's note dated 7/29/11 at 11 PM documented R11 was found at 8:10 PM in another resident room and was redirected back to her own room. The note further described that the resident was discovered missing at 9:50 PM. The facility initiated a search inside and outside the building. An employee from a store near the facility alerted the facility that the resident was there. Review of the nurse's note and the facility's investigation revealed that the resident opened a window in a stairwell, removed the screen and left the building. The facility failed to provide adequate supervision and safety measures to a resident who had been exhibiting exit seeking behaviors all day. The resident was moved to the secured dementia unit after this incident. The facility however failed to update the UAI and the service plan to reflect the wandering and exit seeking behaviors that had developed and what approaches the facility had initiated. This was confirmed by interview with the administrator, E1 and DON, E2 on 9/16/11.	

NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe

DATE SURVEY COMPLETED: 9/16/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
16 Del.C Chapter 11, Subchapter III, §1113 (9) (c)	**Neglect:** **c. Failure to carry out a prescribed treatment plan for a patient or resident.** **This requirement is not met as evidenced by:** Based on record review and interview it was determined that for two (R3 and R15) out of 16 sampled residents, the facility administered oxygen without a physician's order as part of the treatment plan. In addition, the facility failed to have a policy and procedure for oxygen administration and management. Findings include: 1. R3 was admitted to the facility on 7/30/10 with diagnoses including cerebral vascular accident, transient ischemic attack, hypothyroidism, diastolic dysfunction, hypertension, coronary artery disease, and hyperlipidemia. Review of the 30 day UAI assessment dated 9/1/10 and the "Resident General Service Plan" (Service Agreement/SA) dated 9/1/10 documented that the facility's staff would administer R3's medications. A nurse's note (N.N.) dated 5/21/11 timed 10 AM documented that R3 was wheezing and was complaining of shortness of breath. Vital signs were taken and pulse oxygen saturation on room air was 84%. Nurse applied oxygen at 4 liters and oxygen saturation was 98%. R3 was sent to the hospital for evaluation and returned on the same day at 5:15 PM with diagnosis of congestive heart failure. Subsequent N.N. dated 7/1/11 and timed 6:30 PM documented that R3 offered complaints of	**16 Del.C Chapter 11** **Subchapter III, 1113 (9) (c)** Unable to correct deficient practice as all events have occurred. Any resident admitted to the facility has a potential for requiring emergency oxygen administration therefore is at risk for the deficient practice. A revised Emergency Medical Care policy was initiated and all licensed staff were given in-service on 9/26/11 and 11/10/11. (Attachment B)E) Any issues noted during the quarter regarding inappropriate emergency oxygen use will be presented at quarterly QI committee, as well as correctional actions taken to ensure incident does not reoccur. 1/1/12

NAME OF FACILITY: **Brandywine Assisted Living Seaside Pointe** DATE SURVEY COMPLETED: **9/16/11**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	shortness of breath and was wheezing. R3 was noted to have oxygen saturation of 84%. Oxygen at 2 liters was administered via facemask and oxygen saturation increased to 96%. Reassessment two hours after noted oxygen saturation of 94%. Review of R3's monthly physician's orders for May 2011 and July 2011 lacked evidence of an order for oxygen administration. Interview with E2 (Director of Nursing) on 9/15/11 at approximately 8:45 AM confirmed that R3 did not have an order for the oxygen for the above two dates. In addition, E2 confirmed that the facility did not have a policy and procedure for oxygen administration. Follow-up interview with E2 on 9/16/11 at 9 AM revealed that a physician's order was obtained on 9/15/11 for oxygen at 2 liters per nasal cannula when the oxygen saturation was less than 90%. In addition, E2 related that the facility will be developing a policy for oxygen management. 2. R15's record contained a nurse's note that documented on 5/6/11 at 5 PM "upon entering room noticed resident starring blankly not verbally responsive. BP 110/65 pulse 92, O2 sat 83% on room air place on O2 at 6L via mask called MD Order received to send to ER via 911". The resident did not have a physician's order for the use of oxygen. The facility had no available policy for the use of oxygen on an ongoing or emergency basis.	Donna Wingar, ED 11/22/11