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

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

NAME OF FACILITY: Cadbury at Lewes Assisted Living **DATE SURVEY COMPLETED:** 5/21/12

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced complaint survey was conducted at this facility from May 16, 2012 through May 21, 2011. The facility census on the first day of the survey was thirty-five (35). The survey sample was composed of three (3) sampled residents which included two (2) active residents and (1) closed record review.	
3225	**Assisted Living Facilities**	
3225.5.0	**General Requirements**	
3225.5.12	**An assisted living facility that provides direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. The mandatory training must include:** **-communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons. This paragraph shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.** **This requirement is not met as evidenced by:** Based on interview and review of educational programs provided for the facility's staff revealed the facility failed to	1. In retrospect, as of May 21, 2012, Dementia Training was not provided; unable to retroactively do a plan of correction. — 5/21/12 2. All residents are at risk from staff that require Dementia Training. — 5/30/12 - On January 1, 2012, Alzheimer's Dementia training added to Annual Mandatory Updates (Attachment A) - On May 22, 2012, and May 30, 2012, Dementia Training was provided to staff (Attachment B) 3. Staff meeting was held on June 7, 2012 and June 8, 2012 to review requirement for Dementia Training (Attachment C). Mandatory Dementia Training for all Assisted Living CNA's to be completed by July 13, 2012 (Attachment D). — 7/13/12 4. An audit will be completed monthly to verify all new staff have completed new hire Dementia Training and reviewed at Quarterly QI (Attachment E). — 8/1/12

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	provide dementia specific training over the past year for all of the healthcare providers that participate in continuing education programs. Findings include: On 5/21/12 at 10:30 AM a review of the CNAs/healthcare providers training records revealed that the CNAs/healthcare providers did not have dementia specific training. An interview with E3 (staff educator) confirmed the facility did not provide dementia specific training for any of the healthcare providers in the facility. Review of the CNAs/healthcare providers records failed to have documentation indicating any of the CNAs/healthcare providers received dementia specific training from any other source. On 5/21/12 at 10:45 AM E1 (Assistant Administrator) was notified of this finding. On 5/21/12 at 3:00 PM this finding was also reviewed with E2 (DON) and E3.		
3225.8.0	**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 clinical record review and interview it was determined that the facility failed to ensure that one (R2) out of 3	1. In retrospect, R2 received medication without a physician's order, unable to retroactively do a plan of correction.	5/17/12

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	sampled residents only received medications that were ordered by the physician. Findings include: Review of R2's nurses notes revealed on 5/7/11 at 1:00 PM R2 complained of right hip pain. The nurse administered 2 Tylenol 325 mg by mouth at 8:30 AM. R2's daughter was called and she made an appointment for R2 to see an orthopedic physician. When R2's daughter came in to visit R2 on 5/7/11 she gave R2 Aleve for her pain as R2 stated she only had moderate relief from the Tylenol Review of R2's physician orders revealed R2 did not have an order for the Aleve. There was no evidence the nurse notified the physician that R2's daughter administered Aleve to R2. Review of this incident with E2 (DON) on 5/17/12 at 2:10 PM confirmed the nurse should have contacted the physician concerning R2's unrelieved pain to obtain an order for additional pain medication and the administration of Aleve by R2's daughter.	2. All residents are at risk of potentially not having orders for medications. A resident room audit will be done to verify there are no medications stored without MD notification, verification, and an MD order as appropriate (Attachment F). 3. On June 7, 2012 and June 8, 2012 a staff meeting was held for all Assisted Living staff to re-educate that medications should only be administered if the resident has an order for that medication (Attachment C). 4. Monthly audit on nurses notes will be done to verify any new medications noted with a physician's order. Monthly audits reported to Quarterly QI (Attachment F).	7/20/12 7/13/12 8/1/12
3225.11.0	**Resident Assessment**		
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.**	1. R1's UAI significant change was completed 5/17/12 (Attachment H).	5/24/12

ovider's Signature [signature] Title Asst. Executive Director Date 7/3/12

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	This requirement is not met as evidenced by: Based on clinical record review and interview it was determined that the facility failed to develop a UAI for one (R1) out of 3 sampled residents who had a decline in cognition and required moving from the assisted living apartment to Safe Harbor (Memory Enhancement/Support Unit) for the residents safety. Findings include: Review of R1's UAI assessment form dated 7/26/11 documented R1 required assistance with toileting and could toilet herself at night, independent with mobility, she required set up with water and supplies for bathing. The UAI also stated she had vascular dementia with confusion. It also documented she could understand others. R1 was living in an apartment alone in the assisted living facility. Review of R1's nurses notes revealed documentation that on 6/4/11 R1 was in the hall chewing on something and the staff found R1 had "2 buttons in her mouth". The nurse tried to explain to her but R1 "could not understand" that she needed to remove the buttons from her mouth. On 9/10/11 at 2 pm documentation revealed R1 had 2 plus edema on bilateral legs. R1 was encouraged to elevate her legs, however, "resident will not comply due to not understanding". On 10/3/11 the nurses notes documented that R1 redressed herself with several layers of inappropriate clothing. Then nurses notes continued to state that R1 had "very poor short term memory".	2. All residents are potentially at risk of not having a significant change UAI completed. The Unit Manager will review the twenty-four hour report sheet to assess residents with significant changes. A log will be completed when a significant change is noted, and deemed as a major deterioration or improvement in a resident's health status or ability to perform activities of daily living. A major alteration in behavior or mood resulting in ongoing problematic behavior or the elimination of behavior on a sustained basis. 7/20/12 3. The Assisted Living nurses educated on June 7, 2012 and June 8, 2012 UAI regulation to complete with any significant change of status. The Assisted Living Manager educated the Assisted Living Nurses on documenting all residents change(s) in status on the twenty-four hour report and alert charting. 7/13/12 4. Log will be audited monthly to verify significant change UAIs complete. Report Quarterly QI (Attachment I). 8/1/12

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	Review of R1's UAI and cognition status with E2 (DON) on 5/17/12 at 11:15 AM confirmed R1 has had a decline in cognition that included the need to be toileted by staff and could not remember how to provide care for herself. E2 confirmed that R1 needed a new UAI completed. On 5/21/12 at 11:00 AM E2 (DON) stated a UAI assessment and mini mental were completed on R1. R1 was moved to Safe Harbor after the assessments were completed.		
3225.13.0	**Service Agreements**		
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.**	1. R1's service agreement updated 4/18/12; 5/17/12 (Attachment J) and R2's service agreement updated 6/11/12 (Attachment K).	6/11/12
3225.13.2	**The service agreement or contract shall address the physical, medical, and psychosocial services that the resident requires as follows:**	2. All residents are potentially at risk of not having service agreements updated. The Unit Manager will review the twenty-four hour report to assess residents with significant changes. A log will be completed when a significant change is noted and deemed as a major deterioration or improvement in a resident's health status or ability to perform activities of daily living, a major alteration in behavior or mood resulting in ongoing problematic behavior, or elimination of behavior on a sustained basis. The log will include that a service agreement was updated based on needs identified in the UAI (Attachment H).	7/20/12
3225.13.2.10	**Assistive technology and durable medical equipment** **This requirement is not met as evidenced by:**		

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	Based on record review, interview and observation it was determined that the facility failed to revise the Service Agreements for two (R1 and R2) out of 3 sampled residents due to their change of status and moving to Safe Harbor. Findings include: 1. Review of R1's Service Agreement revealed it was last updated 7/26/11 and did not address changes in her needs for care that included the use of a wander guard. 2. Review of R2's record revealed several elopement attempts that resulted in a need for a wander guard to be placed on R2. R2 was moved to Safe Harbor on 3/22/12. Review of R2's service agreement revealed it was not updated to include the wander guard. The physician ordered R2 to wear this device on 3/16/12. Review of R1 and R2's Service Agreement with E2 (DON) confirmed on 5/17/12 at 11:15 AM the above findings.	3. The Assisted Living nurses educated on June 7, 2012 and June 8, 2012 on the service agreements and these agreements should be current for case provided (Attachment C). 7/13/12 4. Log will be audited monthly to verify service agreements updated/completed based on resident needs. Report to quarterly QI (Attachment H) 8/1/12
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**	1. In retrospect, the (3) employees out of compliance for the required 12 hours per year are unable to be retroactively corrected. 5/21/12

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	evidenced by: Based on interview and review of the facility's resident assistants and CNAs education documentation it was determined that the facility failed to ensure the resident assistants/CNAs received a minimum of 12 hours of regular in-service education. Findings include: On 5/21/12 and a confirmation on 5/25/12 at 2:25 PM from E3 (staff educator) revealed that 3 of the 13 resident assistances/CNAs did not have the required 12-hours of regular in-service education.	2. All CNA's are at potential risk for not having required inservice hours (12 hours/year) for resident care. The inservice log will be reviewed monthly by the staff educator and a copy given to the CNA (also monthly) for review. Education will be implemented by staff educator to maintain compliance.	7/13/12
		3. All CNA's will be educated on requirement of 12 hours of education per year and resources available for required education. The 12 hours per year is required for all CNA's and will be reviewed at the employee's evaluation for compliance (Attachment C).	7/13/12
3225.19.0	**Records and Reports**	4. Review CNA inservice log monthly by staff educator to ensure 12 hours/year and report to Quarterly QI (Attachment E).	8/1/12
3225.19.5	**Incident reports, with adequate documentation, shall be completed for each incident. Records of incident reports hall be retained in facility files for the following:**		
3225.19.5.2	**Falls without injury and falls with injuries that do not require transfer to an acute care facility or do not require reassessment of the resident.** **This requirement is not met as evidenced by:** Based on record review, review of the facility's policy and procedure and interview it was determined that the facility failed to complete an incident report for one (R2) out of 3 sampled residents that fell out of bed. Findings include: The facility's policy and procedure for	1. R2's Fall Incident Report from 10/22/11 was completed (Attachment L). R2's Fall Risk Assessment updated on 6/28/12 (Attachment M).	6/28/12
		2. The Unit Manager/LPN will complete all Fall Risk Assessments after each fall and quarterly (Attachment N).	5/5/12
		3. A Fall Packet with nurse education was done on 3/1/12 and 3/2/12. The Fall Packet includes a checklist inclusive of Fall Risk Assessment (Attachment O). The Unit Manager will complete an Assisted Living tracker for Quarterly Assessment(s) inclusive of fall risk assessment (Attachment P).	6/21/12

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	"Fall Prevention" stated "To institute individualized practices so as to minimize resident's risk of falling and to maximize resident safety from falls; to assess each resident of their fall risk on admission, after each fall, quarterly, and with each significant change in condition." R2 had diagnoses that included memory impairment, Alzheimers disease, and osteopenia. R2's nurses notes dated 10/22/11 documented that at approximately 4:40 PM R2's daughter reported to the nurse that R2 fell getting out of bed this morning. R2's daughter stated she felt that it was a result of R2's bed being too high R2 did not report the fall to any of the daytime nurses. However, at 4:30 PM R2 complained of back pain documented as a 7/10 (on a 0-10 pain scale) Tramadol was given. The nurse notes continued to document that R2's daughter lowered R2's bed by placing the box spring on the floor. An interview with E4 (ADON) on 5/17/12 at 2:18 PM revealed the facility failed to complete an incident report of R2's fall and failed to complete a fall risk assessment for R2 after her fall.	4. Monthly audit of fall log to verify fall risk assessments were completed after each fall monthly and report to Quarterly QI (Attachment Q).	8/1/12
3225.19.7 3225.19.7.5 3225.19.7.5.2	**Reportable incidents include:** **Resident elopement** **Any circumstance in which a cognitively impaired resident, whose whereabouts are unknown to staff, exits the facility.**	1. R1 had no incident report for wandering/elopement on 3/8/11 and R2 had no incident report for wandering/elopement on 6/10/11; the reporting state agency was not notified of elopement for R1 or R2. The facility is unable to retroactively do a plan of correction.	5/21/12

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	This requirement is not met as evidenced by: Based on record review, review of the facility's policy and procedures, and interview it was determined that the facility failed to complete an incident report and failed to notify the state agency for two (R1 and R2) out of 3 sampled residents who eloped from the facility. Findings include: The facility's policy and procedure for "Elopement" stated "4. When a resident has been found: ... Complete an Incident Report and make the proper notations in the resident's Medical record; Report the incident to the State Authorities" 1. R1 was admitted to the facility with diagnoses that included transient ischemic attacks, vascular dementia, and carotid stenosis. Review of R1's nurses notes documented on 3/8/11 that R1 was found by the security guard wandering outside by the cottages. R1 was brought back to Safe Harbor. There was no evidence that an incident report was completed for this elopement or notification of the state agency. 2. R2 had diagnoses that included memory impairment and Alzheimers disease. R2's nurses notes documented on 6/7/11 that R2 had increased confusion after dinner. She did not recognize her room and was very difficult to reorient and redirect. On 6/10/11 R2's nurses notes	2. The facility has an Elopement Binder that indicates all residents at risk for elopement. The elopement at risk binder is located at the facility's main entrance, Assisted Living Nurses Station and Skilled Unit. Prevention of wandering for memory impaired residents in Assisted Living policy was updated 7/6/12 (Attachment R). 7/13/12 3. Staff were educated on June 7, 2012 and June 8, 2012 on Elopement Binder and Wandering Policy (Attachment C). On March 1, 2012 and March 2, 2012 staff nurses were inserviced on Incident Reports of elopement which must be completed and reported to the State Agency (Attachment O). 7/13/12 4. Monthly audit of nurses notes to verify an incident report was completed for all elopements and reported to the State Agency. Report to QI quarterly (Attachment U). 8/1/12

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	documented R2 was found on the loading dock with increased confusion. There was lack of evidence that the incident was reported to the state agency. On 5/17/12 at 2:10 PM review of R1 and R2's elopements outside the facility with E2 (DON) and E4 (ADON) confirmed the facility failed to complete incident reports for R1 and R2's elopement and they did not notify the state agency. **16 Del. C. Chap. 11 § 1131 Definition** **(9) 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, observation and interview it was determined that the facility neglected 2 (R1 and R2) out of 3 sampled residents. Both R1 and R2 demonstrated long and short term memory problems, inability to understand others, had behaviors that included wandering and elopement. The facility failed to assess R1 and R2 in order to provide these residents with the proper interventions to ensure their safety. The facility also failed to ensure R1's complaints of pain were addressed. Findings include: 1. R1 was admitted to the facility with	1. In retrospect, the facility is unable to retroactively do a plan of correction on the following: • Previous assessments of R1 and R2 safety interventions. • R2's pain monitoring and MD notification for unrelieved pain. • R1's status changes, elopement risk assessment and reassessment for elopement. R1's mini mental state exam, UAI, service agreement due to previous status changes. • R2's status changes not previously assessed for increased confusion, wandering and elopement. • R2's status changes did not previously reflect a UAI, service agreement, elopement assessment or mini mental state exam. • R2 did not reflect previous supervision for behaviors of elopement and wandering.	6/30/12

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	diagnoses that included transient ischemic attacks, vascular dementia, hypertension, kidney disease, congestive heart failure, and carotid stenosis. The facility's policy and procedure for Elopement stated: Procedures 2. On admission and whenever there is a change in a resident's cognitive or ambulatory ability, a nurse will complete an assessment addressing potential elopement risk. Review of R1's nurses notes revealed the following: On 3/8/11 R1 was found outside by the security guard wandering by the cottages. R1 was brought back to Safe Harbor (Secured unit). Review of R1's medical record revealed there was no evidence that an elopement risk assessment or a mini mental assessment was completed for R1. There was no evidence that an incident report was completed for this elopement. On 3/9/11 A wanderguard was put in place. R1 was placed in Safe Harbor until PM Care (approximately 8 pm) when she was returned to her apartment with hourly checks. On 3/16/11 the every hour checks were discontinued per the E5 (Assisted Living Manager/DON). Review of R1's chart failed to have evidence that R1 was assessed for elopement risk prior to E4 (Prior AL Manager/ DON) discontinuing the checks. On 3/22/11 at 4:15 AM R1 was found	• R1's UAI completed 5/17/12; mini mental state exam completed 5/17/12; elopement risk assessment completed 5/18/12 and service agreement completed 5/17/12. All assessments updated to reflect current status of residents physical and safety needs. • R2's UAI completed 3/26/12; mini mental state exam completed 6/28/12; elopement risk assessment completed 6/28/12 and service agreement completed 6/11/12. All assessments were updated to reflect current status of residents physical and safety needs. • R1 was relocated to Safe Harbor 6/26/12. • R2 was relocated to Safe Harbor 3/22/12. • R2's pain medication was changed due to ineffectiveness of Tylenol; R2's Vicodin PRN was ordered by MD. (Attachment T: (1) Nurses notes with move dates to Safe Harbor for R1 and R2; (2) Verification of R1's and R2's UAI, MMSE, elopement risk assessments and service agreements; (3) R2's pain medication change copy MD order). 2. All residents are at potential risk of significant changes with safety interventions, behaviors, elopement, wandering and pain. All residents are at potential risk of developing pain that is unrelieved and requiring MD notification. All residents are at potential risk of requiring a significant change UAI, MMSE, Elopement Assessment and a Service Agreement. All residents are at potential risk of elopement that requires a facility completed incident report.	7/13/12

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	wandering in her room (apartment) and hourly checks were initiated. At 12:30 PM R1 was found in the Bistro lunch area by activity staff members. R1 had coffee with the staff and then was escorted back to the unit. R1's wander guard was working properly there were no witnesses of R1 leaving the Tides Unit (Assisted Living apartment area). On 3/23/11 R1 was put in Safe Harbor during the day until it was time for PM care then she was taken back to her apartment and put on hourly checks. On 4/17/11 at 2:30 PM an alarm went off. R1 was noted in the hallway by the exit door near room 128. The nurse noted the exit door opened. On 4/27/11 the security guard responded to the wanderguard alarm in the hallway near the dining room. R1 was found near the soda machine. R1 tried to leave again and she was taken to Safe Harbor for safety precautions. On 5/21/11 R1 continued to wander setting off alarms, mostly by the wellness center. R1 was put in Safe Harbor for safety precautions. On 5/26/11 R1 was restless after dinner. R1 wandered in the hallway setting alarms off 3 times. The facility's policy and procedure stated "Prevention of Wandering for Memory Impaired Residents in Assisted Living. To prevent residents with memory	The unit manager for Assisted Living will review the 24-hour report to assess residents with significant changes. A log will be completed when a significant change is noted; "significant change" is deemed as a major deterioration or improvement in a resident's health status or ability to perform activities of daily living, a major alteration in behavior or mood resulting in ongoing problematic behavior or elimination of behavior on a sustained basis. The log will include that a Service Agreement was updated based on needs identified in the UAI (Attachment I). The facility has an Elopement Binder that indicates all residents for elopement risk. The Elopement Risk Binder is located at the facility's main entrance, Assisted Living Nurses Station, and Skilled Unit. The Prevention of Wandering for Memory Impaired Residents in Assisted Living Policy was updated 7/6/12 (Attachment R) The facility will follow PRN Medication Administration Record, documenting effectiveness. MD will be notified if pain is unrelieved X 3 days (Attachment S).

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	impairment from wandering away from safe areas. Procedures: Resident with memory impairment is identified using the UAI assessment and Mini-Mental Exam. These assessments are completed prior to admission and reviewed 30 days after admission and revised, if necessary. The assessments are updated annually or when a significant change in the resident's condition occurs. ... 3. When a resident is assessed to be at risk for wandering, the family and physician are notified and arrangements are made for transfer to the Assisted Living memory Enhancement/Support Unit. This is a secure unit. 4. If a room on the Memory Enhancement/Support Unit is not currently available, a transfer to the Health Center may occur. The resident would remain there until a room became available on the Memory Enhancement/Support Unit (Safe Harbor). A wanderguard bracelet would be initiated so that the Resident would be safe from wandering to an unsafe area. 5. If a room is not currently available in the Health Center, a private duty aide may be required to maintain resident's safety until a bed becomes available in the Memory Enhancement/Support Unit. The private duty aide would be the resident's expense." Review of R1's UAI assessment dated 7/26/11 documented R1 was oriented to person only with short and long term	3. The Assisted Living nurses were educated on June 7, 2012 and June 8, 2012 on the following: 1) The UAI and regulation to complete with any significant change in status 2) Assisted Living Manager educated the Assisted Living nurses on documenting all resident change(s) in status on the 24-hour report and alert charting. 3) Service Agreement(s) reflecting of "current" care provided per the significant change UAI. 4) Elopement Binder and Wandering Policy. 5) Pain Medication PRN documentation and MD notification if ineffective X 3 days (Attachment C). Staff were educated on March 1, 2012 and March 2, 2012 on Incident Report requirements for elopement (Attachment O). 4. Assisted Living Manager will audit UAI/Service Agreement Log (Significant Change) monthly to verify the UAI/Service Agreement was updated and completed. Report to quarterly QI (Attachment I). Monthly audit of nurses notes to verify an incident report was completed for all elopements and reported to the State Agency. This will be reported in quarterly QI (Attachment U). Monthly audit will be done of all resident(s) on PRN pain medications, evaluate effectiveness and if unrelieved X 3 days was MD notified completed and alternative treatment plan obtained. Report to quarterly QI (Attachment S).	7/13/12 8/1/12

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	memory problems. It also documented R1 did not have a problem understanding others and she had a history of wandering inside and outside the building and wore a wanderguard. Review of R1's nurse notes documented : On 9/10/11 revealed R1 presented this morning with plus 2 edema on bilateral legs. Encouraged R1 to elevate her legs; however R1 could not comply due to "not understanding". On 10/3/11 R1 sometimes redresses herself with several layers of inappropriate clothing. R1 has" very poor short term memory". On11/7/11 2 pm R1 will be eating her meals in Safe Harbor. On 5/17/12 at approximately 9:35 AM surveyor met R1 who was being escorted by a CNA from Safe Harbor to the Tides Unit. R1 could not tell the surveyor her name. R1 ambulated and sat down in a chair when the CNA touched her arm and verbally directed her. On 5/17/12 at 9:10 AM review of R1's wandering and cognition level with E2 (DON) confirmed R1 needed to have a UAI and a mini mental assessment. E2 continued to state that R1 was residing in an apartment on the Tides unit, not in Safe Harbor. E2 stated that R1 had a wanderguard on and everyone was aware of her wandering behavior. The facility had cameras on at all times and there was	

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	always someone at the desk. E2 stated R1 ate her meals in Safe Harbor, had a companion 3 hours a day in the afternoons and was taken back to her apartment for PM care and bed. E2 stated she was aware that R1 could no longer toilet herself. R1 had remained in her apartment instead of Safe Harbor or the medical center until a bed could be found for her in Safe Harbor. On 5/21/12 at approximately 9:10 AM E2 stated that R1 had a mini mental and UAI completed. E2 continued to state that R1's family was in agreement to place R1 in Safe Harbor for her safety. An interview was conducted with E2 and E4 (ADON/investigator) on 5/17/12 at 10:30AM. E4 confirmed the facility failed to perform a mini mental for R1, failed to perform Elopement risk assessments, UAI assessments and failed to update the service agreement. 2a. R2 was admitted to the facility with diagnoses that included hypertension, congestive heart failure, mild depression, memory impairment and osteopenia. Review of R2's nurses notes revealed: On 3/12/11 R2 was found wandering in halls on the independent living unit by another resident. A wanderguard was placed on R2's left ankle. On 3/12/11 an elopement risk assessment was completed and documented that based on the assessment R2 was an elopement risk. A wander bracelet was being implemented for safety measures.	

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	Review of R2's nurses notes documented : On 3/14/11 1:30 PM R2 had confusion today and filled sink in kitchen with water and had sink locked so it over flowed. R2 continued to have increased confusion and she was not sure how to get back to her room. Hourly checks were initiated. On 3/21/11 10:00 AM an incident report was completed and sent to state agency regarding R2 being found sleeping in another residents bed R2's nurses notes documented the following: On 3/22/11 it was documented that R2's daughter did not want R2 to wear a wanderguard on. On 3/25, 3/28 and 5/11/11 R2's nurses notes documented R2's confusion was increasing. R2 was asking to go home and the staff had to remind her that she lived in an apartment in the Tides unit. On 6/7/11 R2 was noted with increased confusion after dinner. R2 did not recognize her room and very difficult to reorient and redirect. On 6/10/11 R2 was found on the loading dock with increased confusion The nurses notes documented from 7/21/-7/2711 R2 was started on Aricept, Valaporic acid, and Depakote. On 7/28/11 3-11 R2 was very agitated confused and yelling at staff regarding	

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	another resident. On 8/1/11 R2 was very confused and wanted to "hop a bus and go to her home". On 8/12/11 R2 had been confused. Both daughters were visiting with R2 also noticed her elevated confusion. Review of R2's record failed to have evidence that a mini mental, another elopement assessment or a UAI assessment was completed. R2's nurse's notes dated 8/28/11 documented R2 showed signs of increased confusion early this morning R2 stated a little girl slept in her room and R2 was looking for her. R2 then said she was going home. R2 did not remember living in the facility and had increased confusion. Daughter agreed to have wander guard placed on R2. R2 was put on every hours checks to ensure her safety. On 8/29/11 R2 went out a door at 4 PM the alarm sounded and R2 was brought back in immediately. At 7:00 PM R2 became confused and could not find her room. On 8/30/11 at 11:00 AM R2's wander guard was removed by E5 (Past DON) as R2 did not show signs of increased confusion today. There was no evidence a mini mental was completed, a UAI assessment was completed or a new elopement risk assessment was completed prior to E5 (Past DON) removing R2's wanderguard used for R2's safety. On 8/30/11 at 9:35 PM the nurses notes document that R2 continued to show some	

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	confusion. R2 asked to be escorted to her apartment because she didn't know where it was. On 11/5/11 at 2:00 PM the nurse's notes documented R2 slept with the resident in room 139. The resident in room 139 was nude and incontinent. R2 was redirected to her apartment to "get cleaned up and change into fresh clothes" On 1/1/12 R2 noted with usual confusion this shift. She kept insisting she had to go home but not here. On 1/11/12 R2 was very confused this shift redirected to room several times. R2 locked herself out of room several times without the keys and walking into other residents' rooms On 3/16/12 at 9:00 PM the nurse was alerted by security that resident was observed walking outside the facility along the east side of the property and R2 was assisted back to the facility. No injuries noted. At 1:10 PM the facility placed a wander guard on R2's right ankle. Review of R2's record revealed she was not wearing a wander guard that both the facility and daughter agreed R2 should wear for her safety. R2 was found by the security guard not by the nursing staff. The facility failed to provide supervision and interventions for R2 who was an elopement risk. The facility failed to complete a mini mental, UAI assessment or an elopement risk assessment even after R2 had eloped from the facility.	

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	On 3/21/12 when making rounds at 6:00 AM R2 was not in her bed. Her night gown was lying on her bed. The facility did a room to room search. R2 was found sleeping in bed with another resident. Resident was assisted back to her room. Resident was last seen between 2:30-3:00 AM wander guard in place. The facility failed to reassess R2 even though the nurse's notes documented her increased confusion, wandering, and elopement to ensure R2's safety. The facility held a meeting with the family on 3/26/12 where it was decided to move R2 to Safe Harbor. On 3/26/12 the facility updated R2's UAI to documenting R2 was alert to herself only, had a history of wandering in and out of the facility and required a wanderguard. On 5/17/12 review of R2's Service Agreement dated 2/22/12 was completed with E2 (DON) and E4 (ADON). R2's Service Agreement failed to have documentation that R2 should be wearing a wanderguard. On 3/16/12 a physician order was written for R2 to wear a wanderguard. Review of the April 2012 and May 2012 monthly physician orders revealed the order was not carried over for the staff to follow. On 5/17/12 at 2:28 PM E2 and E4 confirmed that R2 should have had a wanderguard on after it was agreed on with the family. E5 (Past DON) should not have removed the wanderguard. The Assisted living healthcare staff failed to	

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	supervise R2 who demonstrated behaviors of elopement and wandering. E2 and E4 continued to confirm that Service agreement needed to document the need for R2 to wear a wanderguard 2b. Review of R2's nurses notes dated 5/7/11 written at 1:00 PM revealed R2 had difficulty getting up out of bed and ambulating. R2 had difficulty with her walker. R2 was shaking from the pain of right hip area and leg. R2's pain level was documented as 9 out of 10. Two Tylenol 325 mg were given at approximately 8:30 AM by the nurse. There was no evidence that the nurse reassessed R2's pain. R2's daughter was called and she said she would make an appointment with an orthopedist for R2. Later in the day R2's daughter came in and gave R2 Aleve for her unrelieved pain as R2 had only moderate relief from the Tylenol. The nurse documented that R2's pain was 7 out of 10 prior to R2's daughter giving R2 the Aleve. On 5/8/11 at 5:00 AM R2 was offered Tylenol but refused as R2's daughter had just given her Aleve for the pain going down R2's right leg. At 10:00 AM R2 was taken to the hospital by daughter due to her severe right hip pain. R2 returned from the hospital at approximately noon with diagnoses of osteoarthritis of the right hip and sciatica. R2 had a new order for Vicodin for pain and prednisone. Review of R2's chart revealed the facility failed to reassess R2's pain after the Tylenol was administered at approximately 8:30 AM to ensure R2 had adequate pain relief. The facility failed to call the	

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	physician concerning R2's unrelieved pain on 5/7/11 that was 9 out of 10 then 7 out of 10 after receiving Tylenol that lead to R2's daughter administering Aleve to R2. On 5/17/12 at 2:10 PM meeting with E2 (DON) and E4 (ADON) confirmed the facility failed to monitor R2's pain and failed to notify the physician of R2's unrelieved pain.	