



**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

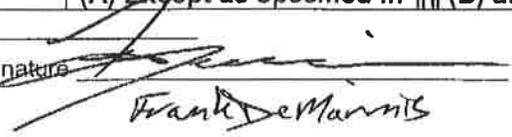
STATE SURVEY REPORT

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NAME OF FACILITY: Emeritus at White Chapel

DATE SURVEY COMPLETED: April 1, 2013

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3225</p> <p>3225.12.0</p> <p>3225.12.1</p> <p>3225.12.1.3</p>	<p>An unannounced annual and complaint survey was conducted at this facility beginning March 20, 2013 and ending April 1, 2013. The facility census on the entrance day of the survey was 108. The survey sample was composed of 11 residents. The survey process included observations, interviews, review of resident clinical records, facility documents and facility policies and procedures.</p> <p>Regulations for Assisted Living Facilities</p> <p>Services</p> <p>The assisted living facility shall ensure that:</p> <p>Food service complies with the Delaware Food Code</p> <p>This requirement is not met as evidenced by:</p> <p>Based on observations and interviews during the tour of the kitchen on 4/1/2013, it was determined that the facility failed to comply with sections: 3-305.11 (A) (2), and 6-501.11 of the State of Delaware Food Code.</p> <p>3-3 Protection from Contamination After Receiving</p> <p>3-305 Preventing Contamination from the Premises</p> <p>3-305.11 Food Storage</p> <p>(A) Except as specified in ¶¶ (B) and</p>	<p>This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors.</p>

Provider's Signature 

Title Executive Director

Date 5/27/13



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3225.13.0	<p>(C) of this section, food shall be protected from contamination by storing the food:</p> <p>(2) Where it is not exposed to splash, dust, or other contamination.</p> <p>This requirement is not met as evidenced by:</p> <p>1. Observations at 8:36AM on 4/1/13 of ten pies in 9 and 1/2 inch diameter tins stored next to the hand washing sink were uncovered. At 8:39AM an interview with the Food Service Director confirmed the finding.</p> <p>6-5 Maintenance and Operation</p> <p>6-501 Premises, Structures, Attachments, and Fixtures - Methods</p> <p>6-501.11 Repairing</p> <p>The physical facilities shall be maintained in good repair.</p> <p>This requirement is not met as evidenced by:</p> <p>1. Observations at 8:42AM on 4/1/13 of the chemical storage room revealed that the new floor was in disrepair. This finding was confirmed by the Maintenance Director.</p>	<p>I. Corrective Action</p> <p>Facility staff was in-serviced to the current regulations and expectation regarding safe food storage and handling. Food was removed from service and disposed of. There was no direct resident impact.</p> <p>II. How to Identify Other Residents</p> <p>A sanitation audit was completed for non-compliance with food handling and storage standards and practices.</p> <p>III. Systemic Changes</p> <p>The facility will educate staff upon hire, annually, and as needed regarding proper cooling and food handling techniques and standards. An additional space was cleared and consolidated to create an appropriate space for cooling and maintaining food handling standards. ED, DSD or their designees will complete random sanitation checks monthly.</p> <p>IV. Monitoring/QA</p> <p>Basic food storage and potential food contamination monitoring will be made through the continued use of the sanitation checklist (Addendum 1) and will be included in Quality Assurance Committee to ensure no hazardous trends are noted.</p>
3225.13.5	<p>Service Agreements</p> <p>The service agreement shall be developed and followed for each resident consistent with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.</p>	<p>V. Completion Date</p> <p>June 15th, 2013</p>



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	<p>This requirement is not met as evidenced by:</p> <p>Based on clinical record review and staff interview it was determined that the facility developed a service agreement that failed to address behaviors of resistance to care with time frames and specific interventions for one resident (Resident #5) out of eleven sampled. The facility also developed service agreements that failed to address fall risk and falls with time frames for goals and specific interventions as exhibited by two residents (Resident #5 and Resident #8) out of eleven sampled. Findings include:</p> <p>Cross refer 3225.13.5, example 1b. 1a. Review of the annual service agreement dated 9/19/2011 and annual service agreement dated 9/27/2012 revealed that Resident #5 exhibited behaviors resistant to care that included ADLs (Activities of Daily Living), the acceptance of medications and prescribed treatments, specifically physical therapy. Further review of the annual service agreements dated 9/19/2011 and 9/27/2012 revealed that the facility failed to develop time frames for goals and specific interventions to address Resident #5's resistance to care.</p> <p>Additionally the facility failed to reevaluate, develop and implement specific interventions that addressed Resident #5's continuing behaviors of resistance to care. These findings were reviewed with E1 (executive director) and E2 (RN/DON) on 4/1/2013.</p> <p>1b. Review of the clinical record revealed that Resident #5 was admitted to the long</p>	<p>6-5 Maintenance and Operation 6-501 Premises, Structures, Attachments, and Fixtures - Methods 6-501.11 Repairing The physical facilities shall be maintained in good repair.</p> <p>I. Corrective Action</p> <p>The floor was replaced with a tile floor, to bring into compliance and repair.</p> <p>II. How to Identify Other Residents</p> <p>Physical plant survey was completed to audit for areas where compliance with repair or physical plant standards are not met. There was no resident impact.</p> <p>III. Systemic Changes</p> <p>The Maintenance Director and Executive Director will be responsible for monthly physical plant walkthrough and document in Safety Committee Monthly.</p> <p>IV. Monitoring/QA</p> <p>The management team/MOD will on their daily rounds note physical plant issues and log in the maintenance directors log. Maintenance log is reviewed at standup for compliance with completion. Monthly safety /physical plant surveys will be reviewed during the QA/QI meetings.</p> <p>V. Completion Date</p> <p>June 15th, 2013</p>



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	<p>term care facility with diagnoses that included dementia, Parkinson's disease, status post colon resection with colostomy, hypertension, and congestive heart failure. According to the annual UAI dated 9/19/2011 Resident #5 was alert and oriented to time, place and person and exhibited no short-term and long-term memory problems. Review of the above referenced UAI also revealed that Resident #5 was assessed at risk for falling due to "dizziness/vertigo". Review of the current annual UAI dated 9/27/2012 revealed that Resident #5 was oriented to person only and exhibited short-term memory problems. Additionally the UAI dated 9/27/2012 revealed that Resident #5 was at risk for falls due to the conditions of Parkinson's disease, dizziness/vertigo and falls sustained within the last 31 to 180 days.</p> <p>Further review of the clinical record revealed that Resident #5 sustained approximately nine falls between 3/18/2012 and 8/19/2012. Review of the annual service agreement dated 9/19/2011, however, revealed the facility failed to address fall risk and actual falls sustained by Resident #5, between 3/18/2012 and 8/19/2012, with time frames for goals and specific interventions. Additionally review of the service agreement dated 9/27/2012 revealed that while it addressed falls, the facility failed to review and to revise the service agreement and to develop goals with time frames and specific interventions that addressed fall risk and/or actual falls sustained by Resident #5.</p> <p>These findings were reviewed with E1 (executive director) and E2 (RN/DON) on</p>	<p>3225.13.5 Service Agreements</p> <p>I. Corrective Action</p> <p>Both Resident #5 and #8 have both moved out of facility</p> <p>Due to placement of residents and discharged status correction of care plans and future service agreements is not possible</p> <p>II. How to Identify Other Residents</p> <p>Other residents identified with fall activity have been reviewed to ensure specific service agreements inclusive of goals and interventions outlined are in place.</p> <p>Other residents identified with behaviors interfering with care have also been reviewed to ensure service agreements inclusive of goals and interventions outlined.</p>
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	<p>4/1/2013.</p> <p>2. Clinical record review revealed Resident #8 was admitted to the assisted living facility on 6/18/2012 with diagnosis that included dementia, hypertension, osteoarthritis, atrial fibrillation, and asthma, carcinoma of the lung, peripheral vascular disease and gait dysfunction. According to the initial UAI dated 6/14/2012 and the UAI completed for a significant change and dated 8/17/2012 Resident #8 was alert and oriented to person and place and experienced short-term memory problems. Additionally the above referenced UAI assessment dated 6/14/2012 also revealed that Resident #8 was at risk for falls due to inability to transition from a seated to standing position and balance problems when standing. Further review of the initial UAI dated 6/14/2012 and the UAI completed for a significant change and dated 8/17/2012 revealed that Resident #8 required supervision, cueing and coaching for mobility and one person physical assistance for toileting and transfers.</p> <p>Review of the clinical record also revealed that Resident #8 sustained approximately six falls between June 18, 2012 and August 8, 2012. However the initial service agreement dated 6/14/2012 revealed absence of the development of time frames for goals and specific interventions to address the risk for falls or actual falls sustained by Resident #8. Additionally the facility failed to review and revise the service agreement completed for a significant change and dated 8/17/2012 with time frames for goals and specific interventions after Resident #8 sustained another six falls</p>	<p>III. Systemic Changes</p> <p>Falls are tracked and trended for root cause analyses and resident specific factors assessed. Basic interventions have been added to daily assignment board for review. Falls will be referred for screening by physical therapy available at the center to assess appropriateness for PT/OT interventions as needed.</p> <p>When appropriate for behaviors, the facility will initiate a managed/negotiated risk agreement as part of service agreement. Ombudsman as well as State involvement will be elicited to enhance the facility's resources in this area. Residents at risk including their specific interventions were addressed and updated.</p> <p>Staff have also been in-service on documentation expectations of these focus residents to better determine effectiveness. All residents will continue to be offered additional resources available to them which may include medication, therapeutic support, etc as uniquely identified for each resident.</p> <p>IV. Monitoring/QA</p> <p>To ensure continued monitoring of occurrence and specific resident interventions, Director of Nursing will review and present falls analysis at quality assurance meetings.</p> <p>Random audit of 10% fall occurrences, UAI and service plan for consistency in fall interventions will also be done at QA meeting.</p> <p>The Director of Nursing and/or designee will continue to monitor effectiveness of interventions through resident report and daily observations. Random audit of 10% behavioral occurrences for UAI and service plan for consistency in behavioral interventions will also</p>

V. Completion Date

June 15, 2013



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<p>3225.19.0</p> <p>3225.19.5</p> <p>3225.19.5.1</p>	<p>between 8/21/2012 and 2/5/2013. From the fall sustained on 2/5/2013 Resident #8 sustained an injury that required hospitalization for surgery</p> <p>These findings were reviewed with E1 (executive director) and E2 (RN/DON) on 4/1/2013.</p> <p>Records and Reports</p> <p>Incident reports, with adequate documentation, shall be completed for each incident. Records of incident reports shall be retained in facility files for the following:</p> <p>All reportable incidents.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on clinical record review and staff interviews it was determined that the facility failed to ensure that an incident of alleged abuse was completed with adequate documentation for one resident (Resident #2) out of eleven sampled. Findings include:</p> <p>Review of Resident #2's clinical record revealed diagnoses that included hypertension, diabetes mellitus, degenerative joint disease and depression. According to the annual UAI dated 9/5/2012 Resident #2 was alert and oriented to person, place and time but experienced short-term memory problems. Additionally Resident #4 was independent for eating, toileting, mobility, transferring, grooming, dressing and bathing.</p> <p>Clinical record review revealed a nurse's</p>	<p>3225.19.0 Records and Reports</p> <p>I. Corrective Action</p> <p>Alternate room arrangements were offered and documented on two such occasions as refused. Upon the daughter of resident #5 using foul language toward resident #2 the ombudsman was consulted and assisted the Executive Director in investigation. The Office of the Ombudsman was supportive of visitation restraint of the party unless the other resident was not in the room. Documentation to this affect was sent to the responsible party. Subsequently the resident was discharged to another facility with higher level of care.</p> <p>II. How to Identify Other Residents</p> <p>A review of the current residents was conducted and there are no current situations requiring <u>incident reporting.</u></p> <p>III. Systemic Changes</p> <p>The Executive Director will be responsible for maintaining incident reports which include logging and filing by month for review at appropriate committee which may include root cause and assessment at safety and risk committee monthly meeting(s)</p>



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3225.19.6	<p>note dated 6/24/2012 and timed (5:00 PM) that stated "... (Resident #2 down) to (nurses') station in tears...states roommate (Resident #5's relative) was "cursing" at her and "calling her names" last evening...". Another nurse's note labeled late entry, dated 6/24/2012 and timed (12:00 AM) stated "... (Resident #5's relative) yelled at (Resident #2) to turn the radio down. Calling (Resident #2) stupid, thief and ugly (and) said to (Resident #2) she is going to call the police on her...".</p> <p>Upon this surveyor's two requests for the written report of the above referenced incident of alleged abuse the facility failed to provide a documented report. Additionally the facility was unable to provide a completed investigation of the incident of abuse alleged by Resident #2 that occurred on 6/24/2012.</p> <p>These findings were reviewed with E1 (executive director) and E2 (RN/DON) on 4/1/2013.</p> <p>Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on clinical record review, review of facility documents and staff interview it was determined that the facility failed to immediately report an incident of abuse alleged by Resident #2. Findings include:</p> <p>Review of the clinical record revealed that</p>	<p>IV. Monitoring/QA</p> <p>To ensure continued monitoring, incident reports will be reviewed for completeness with appropriate investigation form(s) utilized and retained. The Executive Director or designee will be responsible for review of all incident reports monthly prior to logging and/or file retention.</p> <p>V. Completion Date</p> <p>June 15, 2013</p> <p>3225.19.6 Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.</p> <p>I. Corrective Action</p> <p>Alternate room arrangements were offered and documented on two such occasions as refused. Upon the daughter of resident #5 using foul language toward resident #2 the ombudsman was consulted and assisted the Executive Director in investigation. The Office of the Ombudsman was supportive of visitation restraint of the party unless the other resident was not in the room. Documentation to this affect was sent to the responsible party. Subsequently the resident was discharged to another facility with higher level of care.</p> <p>Incident was not reported within the 8 hour timeframe. As the resident is discharged and due to timeline there is no corrections which can be made to this deficient practice.</p>



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<p>16 Del., C., Chapter 11, Subchapter II, § 1121</p>	<p>the allegation of abuse reported by Resident #2 was directed toward her by a relative of her roommate (Resident #5) on 6/24/2012. However this surveyor was unable to obtain the facility report of this incident of alleged abuse upon two requests of the facility and following review of facility documents.</p> <p>Additionally a review conducted of documents submitted by the facility to the Division on 4/11/2013 revealed the absence of a report of the above referenced incident. The facility failed to immediately report an incident of alleged abuse within 8 hours of its occurrence to the Division.</p> <p>This finding was reviewed with E1 (executive director) and E2 (RN/DON) on 4/1/2013.</p> <p>Rights of Patients</p> <p>Patient's Rights.</p> <p>It is the intent of the General Assembly, and the purpose of this section, to promote the interests and well-being of the patients and residents in sanatoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this state that the interests of the patient shall be protected by a declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with such rights, which shall include but not be limited to the following:</p> <p>(24) Every patient and resident shall be free from verbal, physical or mental</p>	<p>II. How to Identify Other Residents</p> <p>Reportable incidents within the last 12 months were reviewed and appear to have been submitted timely. <u>No other issues were identified.</u></p> <p>III. Systemic Changes</p> <p>Director of Nursing and Executive Director will review 24 hour report daily and determine if any occurrence meets reportable criteria. Staff (specifically nurses responsible for reporting) will be re-inserviced on what reportable events criteria include and if in doubt to notify DON or ED accordingly off shift</p> <p>IV. Monitoring/QA</p> <p>Incident reports will be reviewed for completeness with appropriate investigation form(s) utilized and retained.</p> <p>The Executive Director or designee will be responsible for review of all incident reports monthly prior to logging and/or file retention. Any incident report meeting reportable criteria will be followed up on within 5 days.</p> <p>V. Completion Date</p> <p>June 15, 2013</p> <p>16 Del., C., Chapter 11, Subchapter II, § 1121</p> <p>Rights of Patients Patient's Rights.</p>



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	<p>abuse, cruel and unusual punishment, involuntary seclusion, withholding of monetary allowance, withholding of food and deprivation of sleep.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer 3225.19.6.</p> <p>Based on review of the clinical record, review of facility documents and staff interview it was determined that the facility failed to ensure that one resident (Resident #2) was free from one incident of alleged abuse and another incident of substantiated abuse. Findings include:</p> <p>1. Clinical record review revealed a nurse's note dated 6/24/2012 and timed (5:00 PM) that stated "... (Resident #2 down) to (nurses') station in tears... states roommate's (Resident #5 relative) was "cursing" at her and "calling her names" last evening...". Another nurse's note labeled late entry, dated 6/24/2012 and timed (12:00 AM) stated "... (Resident #5's relative) yelled at (Resident #2) to turn the radio down. Calling (Resident #2) stupid, thief and ugly (and) said to (Resident #2) she is going to call the police on her...".</p> <p>However further review of the clinical record and facility documents revealed the absence of a completed incident report and a thorough investigation of the incident of alleged abuse reported by Resident #2 on 6/24/3012. The facility policy "Abuse Prevention, Identification & Reporting" states "... Alleged Resident to Resident Abuse... Staff are encouraged to report signs or symptoms of resident aggressive behavior ... Immediately</p>	<p>I. Corrective Action</p> <p>Alternate room arrangements were offered and documented on two such occasions as refused. Upon the daughter of resident #5 using foul language toward resident #2 the ombudsman was consulted and assisted the Executive Director in investigation. The Office of the Ombudsman was supportive of visitation restraint of the party unless the other resident was not in the room. Documentation to this affect was sent to the responsible party. Subsequently the resident was discharged to another facility with higher level of care.</p> <p>II. How to Identify Other Residents</p> <p>The current resident census was reviewed. There are no current situations requiring intervention.</p> <p>III. Systemic Changes</p> <p>The Executive Director will be responsible for re-inservicing residents on resident rights at Resident Council and ongoing through admission and general orientation. Goals are to be proactive in early identification of resident rights issues. Posters for Ombudsman and Department of Long Term Care Residents Protection Abuse are posted and up to date. Care Plan meetings in the future will include discussion of cohabitation in semi-private residence to be proactive in identification of issues.</p>
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	<p>separate involved residents. Safeguard all involved residents...begin investigation process...".</p> <p>These findings were reviewed with E1 (executive director) and E2 (RN/DON) on 4/1/2013.</p> <p>2. Review of a facility incident report dated 7/2/2012 and timed 12:00 PM stated "(Resident #2) states her roommate's (Resident #5 relative) continues to harass and verbally abuse her, calling her a ("lying black ---") and threw her (Resident #2's) walker out of the room". Review of documented interviews and the observation of surveillance cameras conducted during the investigative process confirmed that Resident #2's walker was moved from its location outside the door of her room to placement against the wall of the corridor opposite her room's door by Resident #5's relative.</p> <p>As a result of the substantiation of the above referenced abuse the relative of Resident #2's roommate (R5) was restricted to visits with Resident #5 "in a common area (i.e. the living room or foyer to pick up for outside activities) ".</p> <p>These findings were reviewed with E1 (executive director) and E2 (RN/DON) on 4/1/2013.</p>	<p>IV. Monitoring / QA To ensure continued monitoring, incident reports will be reviewed for completeness with appropriate investigation form(s) utilized and retained. The Executive Director or designee will be responsible for review of all incident reports monthly prior to logging and/or file retention.</p> <p>V. Completion Date June 15th, 2013</p>