

**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

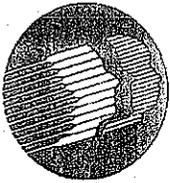
STATE SURVEY REPORT

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NAME OF FACILITY: Emeritus at White Chapel

DATE SURVEY COMPLETED: December 23, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p><b>3225.0</b></p> <p><b>3225.8.0</b></p> <p><b>3225.8.1</b></p> <p><b>3225.8.1.4</b></p>	<p>An unannounced annual and complaint survey was conducted at this facility beginning December 15, 2011 and ending December 23, 2011.</p> <p>The facility census on the entrance day of the survey was 111 residents. The survey sample was composed of 11 residents. The survey process included observations, interviews and review of resident clinical records, facility documents and facility policies and procedures.</p> <p><b>Assisted Living Regulations</b></p> <p><b>Medication Management</b></p> <p><b>An assisted living facility shall establish and adhere to written policies and procedures which shall address:</b></p> <p><b>Administration of medication, self-administration of medication, assistance with self-medication of administration, and medication management by an adult family member/support person.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on observation of the administration of medications conducted on 12/22/2011 it was determined that the facility failed to ensure that oral medications were prepared without being touched by hand prior to administration to four residents (Resident #SS1, Resident #SS2, Resident #SS3 and Resident #SS5) out of 16 sampled. The facility also failed to ensure that documentation of oral medications occurred after and not before the administration of medications to two residents (Resident #SS2 and Resident</p>	<p>3225.8.0</p> <p>The licensed staff member has received training on proper medication administration and documentation of administration after the medication is administered.</p> <p>The nursing staff has received training on proper medication administration and documentation.</p> <p>The RN resident care director has conducted medication administration medication pass with staff.</p> <p>The Resident Care Director will conduct random monthly medication administration pass competency observations on the nursing staff.</p> <p>Completion date: <i>2/29/12</i></p> <p><i>see Med PASS OBSERVATION form (Attached) instituted</i></p>



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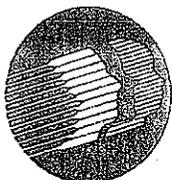
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	<p>#SS5) out of 16 sampled. Findings include:</p> <p>1. Observation of the administration of medication on 12/22/2011 revealed that E3 (assigned licensed staff member) released prescribed medications from blister packs into her bare hand then emptied the same medications into medication soufflé cups and administered medications to Resident # SS1.</p> <p>These findings were reviewed with E2 (DON/RN) on 12/22/2011.</p> <p>2. Observation of the administration of medications on 12/22/2011 revealed that E3 (assigned licensed staff member) released prescribed medications from blister packs into her bare hand then emptied the same medications into medication soufflé cups and administered medications to Resident #SS2. Next E3 (assigned licensed staff member) initialed the administration of oral medications on the medication administration record (MAR) dated December 2011 prior to the actual administration of medications to Resident #SS2.</p> <p>These findings were reviewed with E2 (DON/RN) on 12/22/2011.</p> <p>3. Observation of the administration of medications on 12/22/2011 revealed that E3 (assigned licensed staff member) released prescribed medications from blister packs into her bare hand then emptied the same medications into medication soufflé cups and administered medications to Resident #SS3.</p> <p>These findings were reviewed with E2 (DON/RN) on 12/22/2011.</p>	



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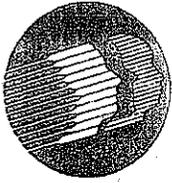
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3225.8.8	<p>4. Observation of the administration of medications on 12/22/2011 revealed that E3 (assigned licensed staff member) released prescribed medications from blister packs into her bare hand then emptied the same medications into medication soufflé cups and administered medications to Resident #SS5. Next E3 (assigned licensed staff member) initialed the administration of the prescribed oral medications on the medication administration record (MAR) dated December 2011 prior to the actual administration of medications to Resident #SS5.</p> <p>These findings were reviewed with E2 (DON/RN) on 12/22/2011.</p>	
3225.8.8	<p><b>Concurrently with all UAI-based assessments, the assisted living facility shall arrange for an on-site medication review by a registered nurse, for residents who need assistance with self-administration or staff administration of medication, to ensure that:</b></p>	<p>3225.8.8</p> <p>Physician was notified of the late finger stick and insulin administration errors.</p> <p>The RN Resident Care Director has provided staff trainings on providing medications at the prescribed times.</p>
3225.8.8.2	<p><b>Each resident receives the medications that have been specifically prescribed in the manner that has been ordered;</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on observations of medication administration, staff interviews and review of the clinical record it was determined that the facility failed to ensure that one resident (Resident #4) out of 16 sampled received medications specifically prescribed in the manner ordered by her physician. Findings include:</p>	<p>The RN resident care director has conducted medication administration medication pass with staff.</p> <p>The Resident Care Director will conduct random monthly medication administration pass competency observations on the nursing staff.</p> <p>Completion date: <i>2/29/12</i></p>



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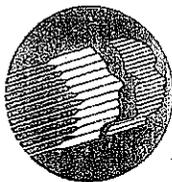
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	<p>1. Observations of medication administration conducted on 12/22/2011 revealed that E3 (assigned licensed staff member) performed a "finger stick" on Resident #SS4 then administered 6 units of the prescribed medication, "Novolog Flexpen 100/ml Unit", after obtaining a reading of 245 at approximately 9:38 AM. When questioned by this surveyor E3 (assigned licensed staff member) confirmed that Resident #SS4 had consumed her breakfast prior to the administration of the above referenced medication. Review of the medication administration record (MAR) dated December 2011 revealed a transcribed order was included that read "Finger stick three times daily before meals" with scheduled hours of administration at 7:30 AM, 11:30 AM and (4:30 PM) of the medication, "Novolog Flexpen 100/Unit", on a sliding scale basis to address blood sugar readings ranging from "below 70" to "above 400".</p> <p>Review of the "Physician's Order" form dated December 2011 confirmed Resident #SS4 was prescribed orders for "Finger stick three times daily before meals..." and "Novolog Flexpen 100/ml Unit" to be "used as directed on a sliding scale". These findings were reviewed with E1 (facility administrator) and E2 (RN/DON) on 12/23/2011.</p> <p>2. Observations of medication administration conducted on 12/22/2011 also revealed that E3 (assigned licensed staff member) administered the prescribed medication "Lantus Solostar Pen 100 Unit/ml Insulin Pen 30 (units)" to Resident #SS4 at approximately 9:38 AM, 2 hours later than the scheduled hour of</p>	



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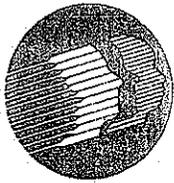
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<p>3225.13.0</p> <p>3225.13.5</p>	<p>administration at 7:30 AM. Review of the MAR dated December 2011 revealed the transcribed order of the above referenced medication was scheduled for administration twice daily at 7:30 AM and (8:00 PM). Also included in the "Physician's Order" form dated December 2011 was the prescribed medication order that stated "Lantus Solostar Pen 100Unit/ml Insulin Pen 30 subcutaneously twice daily". However Resident #SS4 failed to receive the morning dosage of "Lantus Solostar Pen 100Unit/ml Insulin Pen 30 (units)" subcutaneously at the scheduled hour of administration, 7:30 AM, on 12/22/2011 and instead received it at 9:38 AM.</p> <p>This finding was reviewed with E1 (facility administrator) and E2 (RN/DON) on 12/23/2011</p> <p><b>Service Agreements</b></p> <p><b>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.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Cross refer 3225.19.7, 3225.19.7.2 Neglect as defined in 16 Del.C 1131.</p> <p>Based on clinical record review and staff interviews it was determined that the facility developed service agreements that failed to include interventions specific to the risk of elopement and actual elopements exhibited by three residents (Resident #1, Resident #2 and</p>	<p>3225.13.0</p> <p>Residents 1,2, and 4 now reside in a secure memory care neighborhood with service agreements to prevent elopement.</p> <p>Each resident will be evaluated on move in and at least every six months using the unsupervised absence evaluation.</p> <p>The community has a wander guard system which will be applied on residents at risk to elope. The community also has a secure memory care neighborhood for residents with high risk to elope and or wandering behaviors. At risk residents will either have a wonder guard or placement in the memory care neighborhood.</p> <p>The resident Care director will update the resident's service agreements after significant events and changes in status.</p> <p><i>2/29/12</i></p>
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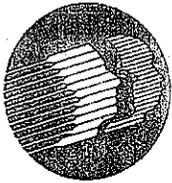
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	<p>Resident#4) out of 16 sampled. Findings include:</p> <p>1. Review of the service agreement dated 3/1/2011 revealed that it was absent the risk for elopement and actual elopements exhibited by Resident #1. Additionally the facility failed to review and revise the service agreement and to develop, implement and monitor the effectiveness of goals and interventions that addressed the risk of elopement and/or to address actual elopements committed by Resident #1.</p> <p>These findings were reviewed with E1 (facility administrator) and E2 (RN/DON) on 12/23/2011.</p> <p>2. Review of the service agreement dated 4/25/2011 revealed that while it addressed "risk for wandering" it was absent the development of time frames for goals and specific interventions to address an actual elopement exhibited by Resident #2. Additionally the facility failed to review and revise the service agreement and to develop, implement and monitor the effectiveness of goals and interventions that addressed the risk of elopement and/or to address actual elopements committed by Resident #2.</p> <p>These findings were reviewed with E1 (facility administrator) and E2 (RN/DON) on 12/23/2011.</p> <p>3. Review of the service agreement dated 10/4/2011 revealed that it was absent the risk for elopements and an actual elopement exhibited by Resident #4. Additionally the facility failed to review and revise the service agreement and to develop, implement and monitor the</p>	
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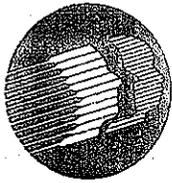
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<p>3225.19.7</p> <p>3225.19.7.2</p>	<p>effectiveness of goals and interventions that addressed the risk of elopement and/or to address actual elopements committed by Resident #4.</p> <p>These findings were reviewed with E1 (facility administrator) and E2 (RN/DON) on 12/23/2011.</p> <p><b>Reportable incidents include:</b></p> <p><b>Neglect as defined in 16 Del.C 1131.</b></p> <p><b>16 Del., C., Chapter 11, Subchapter III</b></p> <p><b>Subchapter III. Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients</b></p> <p><b>Section 1131. Definitions.</b></p> <p><b>When used in this subchapter the following words shall have the meaning herein defined. To the extent the terms are not defined herein, the words are to have their commonly-accepted meaning.</b></p> <p><b>(9) "Neglect" shall mean:</b></p> <p><b>a. Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals and safety.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on clinical record review and staff interviews it was determined that the facility failed to provide a safe environment for three residents (Resident #1, Resident #2 and Resident #4) out of 16 sampled who eloped from the facility without the</p>	<p>3225.19.7</p> <p>Residents 1,2, and 4 now reside in a secure memory care neighborhood with service agreements to prevent elopement</p> <p>Each resident will be evaluated on move in and at least every six months using the unsupervised absence evaluation.</p> <p>The community has a wander guard system which will be applied on residents at risk to elope. The community also has a secure memory care neighborhood for residents with high risk to elope and or wandering behaviors. At risk residents will either have a wonder guard or placement in the memory care neighborhood.</p> <p>The resident Care director will update the resident's service agreements after significant events and changes in status.</p> <p><i>2/29/12</i></p>



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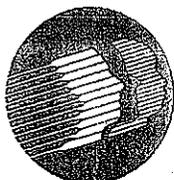
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	<p>knowledge of staff . Findings include:</p> <p>1. Review of the clinical record revealed that Resident #1 was admitted to the assisted living facility on 3/26/2011 with diagnoses that included dementia with psychotic features, ambulatory dysfunction, osteoarthritis and hyperlipidemia. According to the initial UAI dated 3/1/2011 Resident #1 was oriented to person only and experienced short-term and long-term memory loss. The above referenced UAI assessment also indicated that Resident #1 was absent a history of wandering.</p> <p>However further review of the clinical record revealed the documentation of two actual elopements that occurred on the day shift, 5/26/2011 and 5/28/2011. The clinical record also revealed that Resident #1 attempted elopement from the facility on the dates of 5/20/2011 and 5/27/2011. A nurse's note dated 5/20/2011 and timed 4:55 PM revealed "(Resident #1) attempting to leave facility...". Another nurse's note dated 5/26/2011 and timed (1:30 PM) stated "... (Resident #1) brought back to facility by (city) police at 1:00 PM...". On 5/27/2011 at (2:00 PM) another nurse's note stated (Resident #1) attempting to leave. Constant reorienting and redirection...". A nurse's note dated 5/28/2011 and timed (2:30 PM) revealed "(Resident #1) went around (a) corner from (the) facility to look for a home for (her) cat...". According to the completed facility incident report dated 5/26/2011 Resident #1's absence was unknown until she was returned to the facility by police approximately 15 minutes after her presence was last observed by facility staff. Review of the facility incident report of the elopement of Resident #1 from the</p>	



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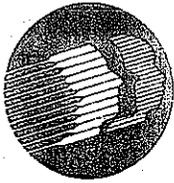
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	<p>facility on 5/28/2011 revealed that Resident #1 was "looking for a home for her cat when she wandered out of facility...". The facility failed to ensure that a safe environment was provided for Resident #1 who was absent a history of wandering but committed two actual elopements and two attempted elopements from the facility.</p> <p>These findings were reviewed with E1 (facility administrator) and E2 (RN/DON) on 12/23/2011.</p> <p>2. Clinical record review revealed that Resident #2 had diagnoses that included dementia with psychotic features, depression, hypertension and status post CVA (cardiovascular accident). According to the annual UAI dated 4/25/2011 Resident #2 was oriented to person and place only and experienced short-term memory loss. Additionally the above referenced UAI assessments indicated that Resident #2 was absent a "history of wandering".</p> <p>Further review of the clinical record revealed a nurse's note dated 1/15/2011 and timed (7:00 AM) that stated "(Resident #2) found outside in the front of the building at (4:30 AM). (Resident #2) was last seen 10 minutes prior in his room...stated he fell outside...had...hematoma to right side of face above eye...laceration next to eye...(and) abrasion to (right) hand...sent to (acute care facility)...". The clinical record also revealed documentation of three attempts of elopement committed by Resident #2 on 6/15/2011, 6/20/2011 and 6/28/2011. However another nurse's note documented on 7/14/2011 at (8:45 PM) revealed that Resident #2 "was found</p>	



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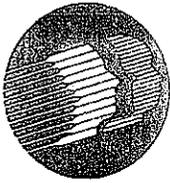
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	<p>walking away from the residence" and returned to the facility by staff.</p> <p>The facility failed to ensure that a safe environment was provided for Resident #2 who had a history of an actual elopement with injury and hospitalization and attempted elopements from the facility. These findings were reviewed with E1 (facility administrator) and E2 (RN/DON) on 12/23/2011.</p> <p>3. Clinical record review revealed that Resident #4 had diagnoses that included dementia, hypertension, depression and COPD (chronic obstructive pulmonary disease). According to the annual UAI dated 10/4/2011 Resident #4 was oriented to person only and experienced short-term memory and long-term memory loss. Additionally the above referenced UAI assessments indicated that Resident #4 was assessed "no" for a "history of wandering".</p> <p>However review of the clinical record revealed that a nurse's note dated 10/11/10 and timed 4:00 PM stated "... (Resident #4) walking down Marrows Road brought back by (driver)...". Additionally the nurse's note dated 8/19/2011 and timed 3:30 PM stated "(Resident #4) wandered outside facility ... Easily redirected back inside in a few minutes". Another nurse's note dated 8/22/2011 and timed 10:00 PM stated "... (Resident #4) outside of facility..."</p> <p>The facility failed to ensure that a safe environment was provided for Resident #4 who had a history of an actual elopement and attempted elopements from the facility. These findings were reviewed with E1 (facility administrator) and E2</p>	
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	(RN/DON) on 12/23/2011.	<p><i>Executive Director</i> 2/15/12</p> <p><i>NHA</i></p> <p><i>[Signature]</i></p> 
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