



**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: Sunrise of Wilmington Assisted Living

DATE SURVEY COMPLETED: February 9, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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<p>3225.0</p> <p>3225.5.0</p> <p>3225.5.3</p>	<p>An unannounced annual and complaint survey was conducted at this facility beginning February 2, 2012 and ending February 09, 2012.</p> <p>The facility census on the entrance day of the survey was 78 residents. The survey sample was composed of 9 residents and included 7 selected residents and an additional subsample of 2 residents. The survey process included observations, interviews and review of resident clinical records, facility documents and facility policies and procedures.</p> <p>Assisted Living Regulations</p> <p>General Requirements</p> <p>The assisted living facility shall adopt internal written policies and procedures pursuant to these regulations. No policies shall be adopted by the assisted living facility which are in conflict with these regulations.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer 3225.13.1.</p> <p>Based on review of facility policies and procedures and staff interview it was determined that the facility failed to ensure that policies were developed pursuant to the Assisted Living Regulations. Findings include:</p> <p>Review of the facility policy and procedure manual revealed the absence of a policy or procedure pursuant to Section 3225.13, Service Agreements, of the Assisted Living Regulations. Instead the facility developed a policy entitled, "Individualized Service</p>	<p style="text-align: center;">Sunrise of Wilmington POC</p> <p><u>Regulation 3225.5.3 Assisted Living Regulations / Service Agreements</u></p> <ul style="list-style-type: none"> • What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Previously used Service Agreement will be re-implemented. This document has been attached for review and approval along with the POC. It will be completed no later than the day of admission. Effective date: 4-1-12. • How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Previously used Service Agreement will be re-implemented. It will include any new residents admitted to the community. Effective date: 4-1-12. • What measures will be put in place or what systemic changes will you make to ensure the deficient practice will not re-occur? Previously used Service Agreement will be re-implemented. Community will report newly signed service agreements on a monthly basis for reporting/compliance purposes. Effective date: 4-1-12.
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<p>3225.8.0</p> <p>3225.8.1</p> <p>3225.8.1.4</p>	<p>Plan In Automated Care System" that failed to include and to address all requirements pursuant to the section, 3225.13, Service Agreements, of the Assisted Living Regulations.</p> <p>Clinical record review also confirmed that the "Individualized Service Plan" developed for each referenced resident failed to address the inclusion of requirements, 3225.13.1, pursuant to, Service Agreements, 3225.13 of the Assisted Living Regulations.</p> <p>These findings were reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>Medication Management</p> <p>An assisted living facility shall establish and adhere to written policies and procedures which shall address:</p> <p>Administration of medication, self-administration of medication, assistance with self-medication of administration, and medication management by an adult family member/support person.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on observation of assistance with the self administration of medication conducted on 2/8/2012 it was determined that the facility failed to ensure two residents (Resident #SS1 and Resident #SS2) out of nine sampled were assisted with the self-administration of medications in accordance with facility policy and procedure. Findings include:</p>	<ul style="list-style-type: none"> • How the corrective action will be monitored to ensure the deficient practice will not re-occur? What Q.A. program will be put in place? Previously used Service Agreement will be re-implemented. Community will report newly signed service agreements on a monthly basis for QA purposes. Appropriate Departmental Coordinators will submit information to the Health Care Coordinator (HCC) who will monitor for compliance purposes. Effective date: 5-1-12. <p><u>Regulation 3225.8.1.4 Medication Management</u></p> <ul style="list-style-type: none"> • What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Medication Care Manager has been re-educated as to compliance with the 30 minute administration rule. Medication times in impacted area have been reviewed to confirm realistic time to administer based on current orders. Effective date: 4-1-12. • How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Medication times in impacted area have been reviewed as to the practical administration of all medications within the 30 minute before/after window for compliance. Effective date: 4-1-12.



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	<p>1. Observation of assistance with the self-administration of medications on the morning of 02/3/2011 revealed that Resident #SS1 received a medication, Levothyroxine 100 mcg 0.1mg tablet, 1 tablet by mouth daily, later than the scheduled time of 7:00 AM. Review of the MAR (medication administration record) dated February 2012 revealed that the prescribed medication, Levothyroxine 100mcg, 0.1mg tablet, was scheduled for administration at 7:00 AM every morning.</p> <p>However observation revealed that E3 (AWSAM staff member) prepared the above referenced medication and proceeded to assist Resident #SS1 with self administration of the medication at approximately 7:51 AM. According to the section "Guidelines for AWSAM" of the "Trainer's Manual: Assistance With Self Administration of Medication II" the "Facility must ensure that medications given by the DCPs (designated care providers) are within ½ hour before or ½ hour after time documented on MAR".</p> <p>The facility failed to ensure that Resident #SS1 was assisted with self administration of a medication at 7:00 AM as scheduled and in accordance with the MAR dated February 2012.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>2. Observation of assistance with self administration of medication on 2/8/2012 revealed that Resident #SS2 received a prescribed medication approximately one and one-half hour later than the scheduled hour of 7:00 AM as indicated by the MAR dated February 2012. Although review of</p>	<ul style="list-style-type: none"> • What measures will be put in place or what systemic changes will you make to ensure the deficient practice will not re-occur? Medication times in impacted area have been reviewed as to the practical administration of all medications within the 30 minute before/after window for compliance. Adjustments will be made as necessary. Effective date: 4-1-12. • How the corrective action will be monitored to ensure the deficient practice will not re-occur? What Q.A. program will be put in place? Medication care managers have been instructed to report any occurrences of not being able to administer medications within compliance window. Administration time adjustments will be made when and if necessary. Department Coordinator will monitor and report back at monthly QA. Effective date: 5-1-12.
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<p>3225.11.0</p> <p>3225.11.4</p>	<p>the above referenced MAR revealed the medication, Levothroxine 100mcg 0.1mg tablet, was scheduled for administration at 7:00 AM, E5 (AWSAM staff member) proceeded to pour the medication and to assist Resident #SS2 with self administration of the above referenced medication between 8:25 AM and 8:30 AM.</p> <p>According to the section "Guidelines for AWSAM" of the "Trainer's Manual: Assistance With Self Administration of Medication II" the "Facility must ensure that medications given by the DCPs (designated care providers) are within ½ hour before or ½ hour after time documented on MAR". The facility failed to ensure that Resident #SS2 was assisted with self administration of a medication at 7:00 AM as scheduled and in accordance with the MAR dated February 2012.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>Resident Assessment</p> <p>The resident assessment shall be completed in conjunction with the resident.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on clinical record review it was determined that the facility failed to complete UAI assessments with dates and signatures in conjunction with three residents (Resident #3, #4 and #5) out of 9 sampled. Findings include:</p>	<p>Regulation 3225.11.4 Resident Assessment/UAI</p> <ul style="list-style-type: none"> • What corrective action will be accomplished for those residents found to have been affected by the deficient practice? <p>Effective immediately, all initial UAI's will be completed manually with signatures/dates collected at the time the assessment takes place. UAI data will be then entered</p>



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3225.11.3	<p>1. Review of the initial UAI dated 9/13/2011 revealed the absence of the date and signature of Resident #3 or his representative.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>2. Review of the initial UAI dated 12/29/2011 revealed the absence of the date and signature of Resident #4 or her representative.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>3. Review of the UAI completed 1/9/2012 for a significant change revealed the absence of the date and signature of Resident #5 or his representative This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>Within 30 days prior to admission, a prospective resident shall have a medical evaluation completed by a physician.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on review of the clinical record and staff interview it was determined that the facility failed to ensure that two residents (Residents #2 and Resident #3) out of nine sampled had a medical evaluation completed by a physician within 30 days of admission. Findings include:</p> <p>1. Review of the clinical record revealed the absence of a medical evaluation</p>	<p>electronically into the medical record. Effective date: 4-1-12.</p> <ul style="list-style-type: none"> • How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents have the potential to be negatively affected. Effective immediately, HCC will re-educate RN's that all initial UAI's must be completed manually and must include signatures & dates at the time of admission. Any UAI's not properly completed will result in a potential delay in admission. Effective date: 4-1-12. • What measures will be put in place or what systemic changes will you make to ensure the deficient practice will not re-occur? Community will collectively report newly signed & dated UAI's on a monthly basis for reporting/compliance purposes. Effective date: 4-1-12. • How the corrective action will be monitored to ensure the deficient practice will not re-occur? What Q.A. program will be put in place? Community will collectively report properly completed UAI's on a monthly basis for QA purposes. Nurses will submit information to Health Care Coordinator (HCC) who will monitor and report for compliance purposes. Effective date: 5-1-12. <p>Regulation 3225.11.3 Medical Evaluations</p> <ul style="list-style-type: none"> • What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Physician will complete the History & Physical as required by regulation. H & P will be evaluated for completeness. The community will seek assistance from the family when the physician has not completed this task in a timely manner that may delay the admission of the resident. Effective date: 4-1-12.



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<p>3225.13.0</p> <p>3225.13.1</p>	<p>performed and completed by the physician for Resident #2 within 30 days of admission to the assisted living facility on 10/4/2011.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>2. Review of the clinical record revealed the absence of a medical evaluation performed and completed by the physician for Resident #3 within 30 days of admission to the assisted living facility on 9/21/2011.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>Service Agreements</p> <p>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.</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 complete service agreements for four residents (Resident #2, #3, #4 and #7) out of 9 sampled prior to or no later than the day of admission.</p>	<ul style="list-style-type: none"> • How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other new residents have the potential to be negatively affected. The HCC has educated marketing/sales that no H&P in hand prior to admission will result in no admission. Again, the community will seek assistance from the family when an admission is in jeopardy due to an incomplete H & P. Effective date: 4-1-12. • What measures will be put in place or what systemic changes will you make to ensure the deficient practice will not re-occur? Community will properly completed & timely submissions of history & physicals on a monthly basis prior to admission. HCC will monitor for compliance. Effective date: 4-1-12. • How the corrective action will be monitored to ensure the deficient practice will not re-occur? What Q.A. program will be put in place? Community will collectively report properly completed H&P's on a monthly basis for QA purposes. Director of Community Relations (DCR) will submit required information to Health Care Coordinator (HCC) will monitor and report for compliance purposes. Effective date: 5-1-12. <p><u>Regulation 3225.13.1 Service Agreements</u></p> <ul style="list-style-type: none"> • What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Previously used Service Agreement will be re-implemented. It will be completed no later than the day of admission. Effective date: 4-1-12. • How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents have the potential to be affected. Previously used Service Agreement will be re-implemented. It will include any new residents admitted to the



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	<p>Findings include:</p> <p>1. Review of Resident #2's clinical record revealed the absence of an initial service agreement completed prior to or no later than 10/4/2011, the day of his admission to the assisted living facility.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>2. Review of the clinical record revealed that the initial service agreement dated 9/21/2011 was incomplete without the signature of Resident #3 prior to and after the day of his admission to the assisted living facility on 9/21/2011.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>3. Review of the clinical record revealed a service plan that was incomplete without a date, the signature and date of Resident #4 and the signature and date of facility staff prior to and after admission of the resident to the assisted living facility on 1/9/2012.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>4. Review of the clinical record revealed that the initial service agreement dated 2/25/2011 was incomplete without the signature and date of Resident #7 prior to and upon the day of his admission to the assisted living facility on 2/24 /2011.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care</p>	<p>community. Effective date: 4-1-12.</p> <ul style="list-style-type: none"> • What measures will be put in place or what systemic changes will you make to ensure the deficient practice will not re-occur? Previously used Service Agreement will be re-implemented. Community will report newly signed & approved service agreements on a monthly basis for reporting/compliance purposes. Effective date: 4-1-12. • How the corrective action will be monitored to ensure the deficient practice will not re-occur? What Q.A. program will be put in place? Previously used Service Agreement will be re-implemented. Community will report newly signed & approved service agreements on a monthly basis for QA purposes. Appropriate Departmental Coordinators will submit information to the Health Care Coordinator (HCC) who will monitor for compliance purposes. Effective date: 5-1-12.
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<p>3225.13.2</p>	<p>coordinator) on 2/9/2012.</p> <p>The service agreement or contract shall address the physical, medical, and psychosocial services that the resident requires as follows:</p> <p>Based on clinical record review and staff interview it was determined that the facility developed service agreements that failed to describe all the services to be provided and failed to identify the providers of the unidentified services and to determine when and how these services would be provided for six residents (Residents #1, #3, #4, #5, #6 and #7) out of nine sampled. Findings include:</p> <p>1. Review of Resident #1's clinical record revealed that the annual service agreement dated May 31, 2011 failed to include and to address all services described in 13.2.4 (housekeeping and trash removal); 13.2.6 (banking, record keeping, and personal spending services); 13.2.7 (transportation services); 13.2.8 (individual living unit furnishings); 13.2.9 (notification procedures when an incident occurs or there is a change in the health status of the resident); 13.2.10 (assistive technology and durable medical equipment); 13.2.11 (rehabilitation services); 13.2.12 (qualified interpreters for people who have a hearing impairment or who do not speak English); and 13.2.13 (reasonable accommodations for persons with disabilities as defined by applicable state and federal law), as required in this section of the regulations.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p>	<p>Regulation 3225.13.2 Service Agreements (Physical, Medical, Psychosocial Services)</p> <ul style="list-style-type: none"> • What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Previously used Service Agreement will be re-implemented. It will be completed no later than the day of admission and more clearly identifies the physical, medical, and psychosocial services available to the resident. Effective date: 4-1-12. • How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents have the potential to be affected. Previously used Service Agreement will be re-implemented. It will include any and all new residents admitted to the community. Effective date: 4-1-12. • What measures will be put in place or what systemic changes will you make to ensure the deficient practice will not re-occur? Previously used Service Agreement will be re-implemented. Community will report newly signed & approved service agreements on a monthly basis for reporting/compliance purposes. Effective date: 4-1-12. • How the corrective action will be monitored to ensure the deficient practice will not re-occur? What Q.A. program will be put in place? Previously used Service Agreement will be re-implemented. Community will report newly signed & approved service agreements on a monthly basis for QA purposes. Appropriate Departmental Coordinators will submit information to Health Care Coordinator (HCC) who will monitor and reports for compliance purposes. Effective date: 5-1-12.
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	<p>2. Review of Resident #3's closed clinical record revealed that the service agreement dated 9/21/2011 failed to include and to address all services described in 13.2.4 (housekeeping and trash removal); 13.2.6 (banking, record keeping, and personal finances); 13.2.7 (transportation services); 13.2.8 (individual living unit furnishings); 13.2.9 (notification procedures when an incident occurs or there is a change in the health status of the resident); 13.2.10 (assistive technology and durable medical equipment); 13.2.11 (rehabilitation services); 13.2.12 (qualified interpreters for people who have a hearing impairment or who do not speak English); and 13.2.13 (reasonable accommodations for persons with disabilities as defined by applicable state and federal law), as required in this section of the regulations.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>3. Review of Resident #4's clinical record revealed the current service agreement that was developed without a date also failed to include and to address all services described in 13.2.4 (housekeeping and trash removal); 13.2.6 (banking, record keeping, and personal finances); 13.2.7 (transportation services); 13.2.8 (individual living unit furnishings); 13.2.9 (notification procedures when an incident occurs or there is a change in the health status of the resident); 13.2.10 (assistive technology and durable medical equipment); 13.2.11 (rehabilitation services); 13.2.12 (qualified interpreters for people who have a hearing impairment or who do not speak English); and 13.2.13 (reasonable accommodations for persons with disabilities as defined by applicable</p>	
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	<p>state and federal law), as required in this section of the regulations.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>4. Review of Resident #5's closed clinical record revealed that the service agreement dated 1/9/2012 failed to include and to address all services described in 13.2.4 (housekeeping and trash removal); 13.2.6 (banking, record keeping, and personal finances); 13.2.7 (transportation services); 13.2.8 (individual living unit furnishings); 13.2.9 (notification procedures when an incident occurs or there is a change in the health status of the resident); 13.2.10 (assistive technology and durable medical equipment); 13.2.11 (rehabilitation services); 13.2.12 (qualified interpreters for people who have a hearing impairment or who do not speak English); and 13.2.13 (reasonable accommodations for persons with disabilities as defined by applicable state and federal law), as required in this section of the regulations.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>5. Review of Resident #6's clinical record revealed that the service agreement dated 6/17/2011 failed to include and to address services described in 13.2.7 (transportation services); 13.2.8 (individual living unit furnishings); and 13.2.13 (reasonable accommodations for persons with disabilities as defined by applicable state and federal law), as required in this section of the regulations.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care</p>	
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3225.13.4	<p>coordinator) on 2/9/2012.</p> <p>6. Review of Resident #7's closed clinical record revealed that the service agreement dated 2/25/2011 failed to include and to address all services described in 13.2.4 (housekeeping and trash removal); 13.2.6 (banking, record keeping, and personal finances); 13.2.7 (transportation services); 13.2.8 (individual living unit furnishings); 13.2.9 (notification procedures when an incident occurs or there is a change in the health status of the resident); 13.2.10 (assistive technology and durable medical equipment); 13.2.11 (rehabilitation services); 13.2.12 (qualified interpreters for people who have a hearing impairment or who do not speak English); and 13.2.13 (reasonable accommodations for persons with disabilities as defined by applicable state and federal law), as required in this section of the regulations.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>The facility shall be responsible for appropriate documentation in the service agreement for services provided or arranged by the facility.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on clinical record review it was determined that the facility failed to complete service agreements with dates and signatures in conjunction with two residents (Resident #5 and Resident #7) out of 9 sampled. Findings include:</p> <p>1. Review of the service agreement dated 1/9/2012 revealed the absence of</p>	<p><u>Regulation 3225.13.4 Service Agreements (Signatures & Dates)</u></p> <ul style="list-style-type: none"> • What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Previously used Service Agreement will be re-implemented. It will be completed no later than the day of admission and more clearly identifies the physical, medical, and psychosocial services available to the resident. Effective date: 4-1-12. • How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents have the potential to be affected. Previously used



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<p>3225.13.5</p>	<p>Resident #5's signature and the date signed.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>2. Review of the service agreement dated 2/25/2011 revealed the absence of Resident #7's signature and the date signed.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</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>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 develop and to implement service agreements with goals and interventions that addressed elopement risk and actual elopements exhibited by two residents (Resident #2 and Resident #3) out of nine sampled. Findings include:</p> <p>Cross refer 3225.19.7, 3225.19.7.2 Neglect as defined in 16 Del.C 1131.</p> <p>1. Review of the clinical record and staff interview conducted on 2/9/2012 revealed that the facility failed to develop a service agreement with goals and interventions that addressed the assessed risk of elopement and actual elopements exhibited by Resident #2.</p>	<p>Service Agreement will be re-implemented. It will include any and all new residents admitted to the community. Effective date: 4-1-12.</p> <ul style="list-style-type: none"> • What measures will be put in place or what systemic changes will you make to ensure the deficient practice will not re-occur? Previously used Service Agreement will be re-implemented. Community will report newly signed & approved service agreements on a monthly basis for reporting/compliance purposes. Effective date: 4-1-12. • How the corrective action will be monitored to ensure the deficient practice will not re-occur? What Q.A. program will be put in place? Previously used Service Agreement will be re-implemented. Community will report newly signed & approved service agreements on a monthly basis for QA purposes. Appropriate Departmental Coordinators will be responsible for seeing that service agreements are properly signed and dated and submit those results monthly for QA/compliance purposes. Effective date: 5-1-12. <p>Regulation 3225.13.5 Service Agreements (Unique Physical & Psychosocial Needs)</p> <ul style="list-style-type: none"> • What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #2 and #3 no longer reside at the community. Previously used Service Agreement will be re-implemented. This document has been attached for review and approval along with the POC. It will be completed no later than the day of admission and more clearly identifies that person's unique physical and psychosocial needs while recognizing their individual capabilities and preferences. Effective date: 4-1-12. • How will you identify other residents having the potential to be affected by the same



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<p>3225.17.0</p> <p>3225.17.2</p> <p>3225.17.2.2</p> <p>3225.18.0</p> <p>3225.18.4.</p> <p>3225.18.4.5</p>	<p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>2. Review of the service agreement dated 9/21/2011 revealed that the facility failed to include goals with time frames and specific interventions to address identified elopement risk and the actual elopement exhibited by Resident #3.</p> <p>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 elopement risk and/or actual elopement committed by Resident #3.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>Environment and Physical Plant</p> <p>Assisted living facilities shall:</p> <p>Be clean.</p> <p>1. Observations on 2/9/2012 at 8:50 AM revealed that the dining room chairs had a thick layer of dust. Dining room staff confirmed the finding.</p> <p>Fire Safety and Other Emergency Plans</p> <p>The assisted living facility shall promote staff knowledge of fire and other emergency safety by:</p> <p>Maintaining records for two years of facility fire and other emergency drills/training sessions.</p>	<p>deficient practice and what corrective action will be taken? No other residents have the potential to be affected. Previously used Service Agreement will be re-implemented. It will be updated to reflect any such changes in physical & psychosocial needs. Effective date: 4-1-12.</p> <ul style="list-style-type: none"> • What measures will be put in place or what systemic changes will you make to ensure the deficient practice will not re-occur? Previously used Service Agreement will be re-implemented. Community will report approved/updated service agreements on a monthly basis specifically identifying and residents who may be at risk for potential elopement and have other related needs. Effective date: 4-1-12. • How the corrective action will be monitored to ensure the deficient practice will not re-occur? What Q.A. program will be put in place? Previously used Service Agreement will be re-implemented. Community will report newly signed & approved/updated service agreements on a monthly basis for QA purposes. Appropriate Departmental Coordinators will be responsible to see that service agreements address any physical/psychosocial needs of their respective resident population. That information will be submitted monthly for QA/compliance purposes. Effective date: 5-1-12. <p>Regulation 3225.17.0 Environment & Physical Plant / Dining Room Chairs</p> <ul style="list-style-type: none"> • What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Chairs were cleaned once identified prior to the survey team exiting the community. Effective date: 4-1-12. • How will you identify other residents having the potential to be affected by the same



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<p>3225.19.7</p> <p>3225.19.7.2</p>	<p>This requirement is not met as evidenced by:</p> <p>1. Review of the fire drill records on agreement with goals and interventions that addressed the assessed risk of elopement and actual elopements exhibited by Resident #2.</p> <p>2. Review of the service agreement dated 9/21/2011 revealed that the facility failed to include goals with time frames and specific interventions to address identified elopement risk and the actual elopement exhibited by Resident #3.</p> <p>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 elopement risk and/or actual elopement committed by Resident #3.</p> <p>This finding was reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>Reportable incidents include:</p> <p>Neglect as defined in 16 Del.C 1131.</p> <p>16 Del. C., Chapter 11, Subchapter III</p> <p>Subchapter III. Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients</p> <p>Section 1131. Definitions.</p> <p>When used in this subchapter the following words shall have the meaning herein defined. To the extent the terms</p>	<p>deficient practice and what corrective action will be taken? There were no residents affected by this observation. Dining room chairs are cleaned on a regular basis as part of the duties of the Dining Room Care Manager and monitored by the Dining Services Coordinator. Effective date: 4-1-12.</p> <ul style="list-style-type: none"> • What measures will be put in place or what systemic changes will you make to ensure the deficient practice will not re-occur? Dining room chairs are cleaned on a regular basis as part of the duties of the Dining Room Care Manager and monitored by the Dining Services Coordinator. Effective date: 4-1-12. • How the corrective action will be monitored to ensure the deficient practice will not re-occur? What Q.A. program will be put in place? Dining room chairs are cleaned on a regular basis as part of the duties of the Dining Room Care Manager and monitored by the Dining Services Coordinator for compliance purposes. Effective date: 4-1-12. <p>Regulation 3225.18.0 Fire Safety and Other Emergency Plans / Service Agreements</p> <ul style="list-style-type: none"> • What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #2 and #3 no longer reside at the community. A service agreement has been drafted and modified to better meet the regulatory requirements pursuant to Section 3225.18.0, which includes goals and interventions that address the risk of elopement and/or actual elopement and emergency drills. These areas have been added to the service agreement and address team member assistance during facility, fire and other emergency drills. Effective date: 4-1-12. • How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents have



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	<p>are not defined herein, the words are to have their commonly-accepted meaning.</p> <p>(9) "Neglect" shall mean:</p> <p>a. Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals and safety.</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 one resident (Resident #1) out of 9 sampled was properly seated, secured and without incident during transportation from the facility to a scheduled dental visit. The facility also failed to provide a safe environment for two residents (Resident #2 and Resident #3) out of 9 sampled who eloped from the facility without the knowledge of staff. Findings include:</p> <p>1. Review of the clinical record revealed that Resident #1 had diagnoses that included hypothyroid, osteoarthritis, hypertension, asthma, glaucoma and macular degeneration. According to the annual UAI dated 5/30/2011 Resident #1 was alert and oriented to person, place and time. Resident #1 also had intact short- term memory and long- term memory. The above referenced UAI assessment also indicated that Resident #1 ambulated with the assistance of a walker and used a manual wheelchair for long distances.</p> <p>Further review of the clinical record revealed a nurse's note dated 5/12/2011</p>	<p>the potential to be affected. Effective immediately, a modified service agreement has been developed, reviewed internally and implemented and includes wandering/elopement and other emergency drills. Effective date: 4-1-12.</p> <ul style="list-style-type: none"> • What measures will be put in place or what systemic changes will you make to ensure the deficient practice will not re-occur? Community will collectively report approved/updated service agreements on a monthly basis specifically identifying goals and interventions that address the risk of elopement and/or actual elopement and level of assistance during community emergency drills. Effective date: 4-1-12. • How the corrective action will be monitored to ensure the deficient practice will not re-occur? What Q.A. program will be put in place? Community will report updated service agreements on a monthly basis for QA purposes. Appropriate Departmental Coordinators will be responsible to see that service agreements address specific interventions of their respective resident population with a focus on safety. That information will submitted monthly for QA/compliance purposes. Effective date: 5-1-12. <p>Regulation 3225.19.7 Reportable Incidents</p> <ul style="list-style-type: none"> • What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Team-member involved was counseled and re-educated on proper transportation procedures. Incident was properly reported by regulation and was reviewed by an investigator from LTCRP. Effective date: 6-1-11.



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	<p>and timed 1:00 PM that stated "(Resident #1) out to ... (dental appointment) with (facility caregiver). When getting off the bus (Resident #1) fell out her (wheelchair) onto the ground... Completed dental (appointment)... arrived back to (facility)...". However review of the facility incident report dated 5/12/2011 and timed (1:00 PM) stated "While being transferred from facility bus, (Resident #1's) walker leg bent and resident dropped to the floor...". Review of an attached statement to the above referenced incident report completed by E4 (assigned caregiver/van driver) on 5/12/2011 and timed 11:00 AM stated "Had (Resident #1) on walker (a rollator with wheels and seat), her walker wheels bent and she went on the floor... has a 14cm laceration (with) bleeding across (right) wrist...". During an interview conducted with E1 (executive director) and E5 (licensed staff member) on 2/9/2012 it was stated that upon arrival at her dentist's office E4 (assigned caregiver/van driver) prepared Resident #1 for dismount from the bus. Resident #1 was seated on her rollator and as E4 (assigned caregiver/van driver) wheeled her toward the van lift to lower the resident to the ground, the rollator did not transition from the floor of the van onto the lift. Instead the rollator with Resident #1 seated in it fell backwards.</p> <p>The facility failed to ensure that Resident #1 was provided a safe environment including adequate and secure seating and ambulatory assistance for long distances in accordance with her service agreement while transported to a dental appointment.</p> <p>2. Review of the clinical record revealed that Resident #2 was admitted to the</p>	<ul style="list-style-type: none"> • How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents have the potential to be affected. Proper transportation procedures are reviewed with all team-members on an annual basis. Actual drivers are instructed one on one. Effective date: 6-1-11. • What measures will be put in place or what systemic changes will you make to ensure the deficient practice will not re-occur? Proper transportation procedures are reviewed with all team-members on an annual basis. Actual drivers are instructed one on one. Effective date: 6-1-11. • How the corrective action will be monitored to ensure the deficient practice will not re-occur? What Q.A. program will be put in place? Proper transportation procedures are reviewed all team members on an annual basis. Actual drivers are instructed one on one. Effective date: 6-1-11
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	<p>assisted living facility on 10/4/2011 with diagnoses that included dementia and hypertension. Clinical record review also revealed that an initial UAI dated 9/27/2011 indicated Resident #2 was alert and oriented to person and place and experienced short-term memory loss. The same UAI also indicated Resident #2 had a history of wandering "outside".</p> <p>Further review of the clinical record revealed the documentation of an actual elopement on 10/5/2011. The clinical record also revealed that Resident #2 attempted elopement from the facility on the dates of 10/10/2011 and 10/11/2011. A nurse's note dated 10/5/11 and timed (1:00 PM) revealed "(Resident #2) eloped (from the) building (and was observed) walking down (2 lane street facing the facility) and returned to the facility then immediately fitted for a Wanderguard alarm.</p> <p>Another nurse's note dated 10/7/2011 and without a specific time referred to another elopement that was documented as having occurred during the second half of the 3-11 shift on 10/5/2011. According to this nurse's note dated 10/7/2011 "(Resident #2) eloped again...and was returned to the facility accompanied by state police...". On 10/10/2011 at (8:30 AM) another nurse's note stated (Resident #2) "was trying to run away and to cross (a 2 lane street facing facility)." A nurse's note dated 10/11/2011 and timed (9:00 AM) revealed Resident #2) was prevented from eloping through the front door of the facility by his private duty aide.</p> <p>According to a completed facility incident report dated 10/5/2011 and timed 11:15 PM Resident #2's absence was unknown</p>	<p><u>Regulation 3225.19.7 Reportable Incidents</u></p> <ul style="list-style-type: none"> • What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Incident regarding resident #2 was self reported as required by the community and followed-up by an investigator from LTCRP. Appropriate interventions were put in place after the resident eloped. Resident #2 was discharged due to behavioral/safety issues from the community when it became apparent that we could no longer meet his needs. Effective date: 4-1-12. • How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were affected. When it is determined that a resident has a history of wandering prior to admission to the community will either be automatically fitted with a wanderguard or admitted to our memory care unit, whichever better meets their safety needs. Effective date: 4-1-12. • What measures will be put in place or what systemic changes will you make to ensure the deficient practice will not re-occur? When it is determined that a resident has a history of wandering prior to admission to the community will either be automatically fitted with a wanderguard or admitted to our memory care unit, whichever better meets the safety needs of the resident. For current residents
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	<p>until he was returned to the facility by state police approximately 45 minutes after his presence was last observed at 9:45 PM by facility staff on 10/5/2011. The facility failed to ensure that a safe environment was provided for Resident #1 who had a history of wandering but committed two actual elopements and two attempted elopements from the facility.</p> <p>These findings were reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p> <p>3. Clinical record review revealed that Resident #3 was admitted for respite care to the assisted living facility on 9/21/2011 with diagnoses that included Alzheimer's disease, dementia, hypertension, pacemaker, and congestive heart failure. According to the initial UAI dated 9/13/2011 Resident #3 was alert and oriented to person, place and time. The same UAI also revealed that Resident #3 experienced short-term memory and long-term memory loss. Additionally the above referenced UAI assessment indicated that Resident #3 had a "history of wandering" outside.</p> <p>According to the completed facility incident report dated 11/18/2011 Resident #3 eloped through the front door of the facility between 3:00 PM and 4:00 PM and returned to his home, approximately 5 minutes away, by car on 11/18/2011. The facility was unaware of the elopement until notified by Resident #3's roommate. Resident #3 was returned to the facility by a family member at approximately 5:30 PM. Further review of the facility incident report of the elopement from the facility on 11/18/2011 revealed that Resident #3 was "homesick".</p>	<p>whose safety needs change over time, they will be reviewed in a similar fashion. Service agreements will reflect any potential history of wandering / elopement risk. Any resident who actually elopes from the building will either be admitted to memory care or a private duty aide put in place until such a unit becomes available. Activities Department is in the process of forming a "walking club" which will allow residents (including those at-risk) the freedom to enjoy the outdoors in a supervised and safe manner. Effective date: 4-1-12.</p> <ul style="list-style-type: none"> • How the corrective action will be monitored to ensure the deficient practice will not re-occur? What Q.A. program will be put in place? Residents who are at-risk for safety will be identified and reviewed on a regular basis with interventions implemented as necessary. Service plans will be adjusted accordingly. This information will be reviewed at least monthly on our "Clinical Call" and monthly QA. Effective date: 5-1-12. <p>Regulation 3225.19.7 Reportable Incidents</p> <ul style="list-style-type: none"> • What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Incident regarding resident #3 was self reported as required by the community and followed-up by a representative of LTCRP. Resident #3 was on a respite stay when he eloped from the community and was discharged home as planned shortly after. Effective date: 4-1-12. • How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were affected. When it is determined that a resident has a history of wandering prior to admission to the community will either be automatically fitted with a wanderguard or admitted to our memory care unit, whichever better meets their safety needs. Effective date: 4-1-12.
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	<p>The facility failed to ensure that a safe environment was provided for Resident #3 who was assessed as having a history of wandering "outside". These findings were reviewed with E1 (executive director) and E2 (health care coordinator) on 2/9/2012.</p>	<ul style="list-style-type: none"> • What measures will be put in place or what systemic changes will you make to ensure the deficient practice will not re-occur? When it is determined that a resident has a history of wandering prior to admission to the community will either be automatically fitted with a wanderguard or admitted to our memory care unit, whichever better meets the safety needs of the resident. For current residents whose safety needs change over time, they will be reviewed in a similar fashion. Service agreements will reflect any potential history of wandering / elopement risk. Any resident who actually elopes from the building will either be admitted to memory care or a private duty aide put in place until such a unit becomes available. Activities Department is in the process of forming a "walking club" which will allow residents (including those at-risk) the freedom to enjoy the outdoors in a supervised and safe manner. Effective date: 4-1-12. Walking Club: 6-1-12. • How the corrective action will be monitored to ensure the deficient practice will not re-occur? What Q.A. program will be put in place? Residents who are at-risk for safety will be identified and reviewed on a regular basis with interventions implemented as necessary. Service plans will be adjusted accordingly. This information will be reviewed at least monthly on our "Clinical Call" and monthly QA. Effective date: 4-1-12.



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Joseph F. Kauczka

Provider's Signature: *Joseph F. Kauczka, NHA* Title: Executive Director Date: April 5, 2012