DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: AL Arden Courts of Wilmington

DATE SURVEY COMPLETED: April 3, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	
	An unannounced Complaint Survey was conducted at this facility from April 2, 2024 through April 3, 2024. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was twenty-six (26). The survey sample totaled eight (8) residents. Abbreviations/definitions used in this state report are as follows: ED - Executive Director; EMR – Electronic Medical Record; LPN – Licensed Practical Nurse; RC – Resident Caregiver; RSD – Resident Services Director; SA (Service Agreement) - allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living provides. These include: lodging, board, housekeeping, personal care, and supervision services; UAI (Uniform Assessment Instrument) - a document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical, and psychosocial needs and status. The assisted living facility shall be required to use the UAI to evaluate each resident on both an initial and ongoing basis in accordance with these regulations.		
3225.5.0	**General Requirements**		

Provider's Signature Stacy Bligman Title ED Date 5/15/24

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3225.5.5	**The assisted living facility shall develop and adhere to policies and procedures to prevent residents with diagnosed memory impairment from wandering away from safe areas. However, residents may be permitted to wander safely within the perimeter of a secured unit.** Based on interview and review of other facility documentation, it was determined that the facility's "Missing Residents" Policy there was no evidence of specific timeframes of a missing resident search. Findings include: 4/2/24 – During the survey, located in their Clinical Care Interdisciplinary/Nursing Policy and Procedure, there was an Elopement Policy that stated it is an official document of ProMedica Coldwater Regional Hospital with a date of 5/2022. On review, there was no evidence that the policy had anything do with the assisted living. 4/2/24 – Per facility documentation and interview with E1 (ED) at approximately 11:00 AM, E1 confirmed the last elopement drill with the staff was performed in August of 2023. There was no evidence of elopement drills with the staff since August 2023. 4/3/24 - Per interview with E1 and E2 (RSD) at approximately 2:00 PM, both confirmed there is not a separate assessment to identify resident wandering/elopement risk at admission. E2 stated the UAI assessment is utilized for this area. E2 confirmed they rely on family input of past behaviors and not all family members are forthcoming. E2 stated she has not specifically asked for any wandering/elopement episodes of the resident prior to assessment.	General Requirements A. All residents have the potential to be harmed by this practice. B. The correct policy has been Implemented and entered into the Emergency Response Manual, The RSC Manual and the Community Watch Profile Binder. (I also emailed a copy of the correct policy to licensing for review on 5/3/24). C. The Missing Resident policy does have a time line listed for notifying the police, family, physician, RDO and QA consultant. D. As part of the orientation process all new staff will be trained and given a copy of the Missing Resident policy along with the Missing Patient Actions Table. E. All current staff will be educated on the Missing Resident Policy and the Missing Patient Actions Table by the RSC/ED. This will be completed by May 31st, 2024. F. The last Missing Resident Drill was completed on 11/28/2023 as per the POC dated 12/20/23. (Copies of drills attached for review) G. As part of our UAI assessment we will implement a Behavioral Symptoms Assessment tool to be used to determine if a potential resident has a history or is currently exhibiting exit seeking behaviors or previous elopements. This practice will be ongoing.	

Provider's Signature *Stacy Wigman* Title *ED* Date *5/14/24*

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	4/3/24 - Findings were reviewed with E1 and E2 (RSD) at the exit conference beginning at approximately 2:10 PM. 4/4/24 – The facility provided a policy from their Emergency Response Manual "Assisted Living Missing Resident Search Plans" dated 1/2020. This policy lacked evidence of the timeframes for a search for a missing resident. The policy indicated "found in a reasonable amount of time" rather than specific timeframes to advance the search to the next step or a timeframe of calling for assistance from the police. 5/3/24 – E1 contacted that State Agency a month after the survey exit by email stating "... I did find the most current policy for a missing resident", with an attached policy dated 6/2021 that included the time frame of calling the police if a resident is not located in 20 to 30 minutes. This policy was not available to staff, administration, or the surveyor during the survey. This policy was not implemented at the time R1's elopement.	
16 Delaware Code, Chapter 11, Subchapter III	**Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents. (81 Del. Laws, c. 206, § 31; 83 Del. Laws, c. 22, § 1.)** **12) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following:** **a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** Based on interview, record review and review of other facility documentation, it was	**16 Delaware Code, Chapter 11, Subchapter III** A. All residents have the potential to be affected by this practice. B. All potential residents will have a UAI, a Behavioral Symptoms Assessment, a review of all clinical information and a meeting with POA to gain additional information on potential residents for existing exit seeking behavior and/or previous elopement. If it is found that potential resident has had an elopement from a previous setting or currently

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	determined that for one (R1) out of eight sampled residents, the facility failed to provide safety measures to a resident to prevent elopement. Findings include: 12/20/23 - R1 was admitted to the facility. The initial UAI completed by E2 (RSD) on 12/19/23 indicated that R1 had no fall risk, had short term memory problem, was anxious, had no history of wandering and a positive history of disruptive or assaultive behavior. 12/22/23 – Per EMR entry at 3:53 AM by E5 (LPN), E5 noted that during the night, R1 continued to seek an exit and was very agitated but able to be redirected. There was no indication that this information of exit seeking was relayed to the supervisor or physician. 12/26/23 – Per EMR entry at 1:01 AM by E6 (LPN), E6 observed R1 to be exit seeking, R1 stating he was "going to Milford Police Station", had snacks packed in his bag and was moving from house to house. E6 indicated redirection and cuing of R1 was not successful and that R1 then sat in the hallway a long time. There was no indication that this information of exit seeking was relayed to the supervisor or physician. The H&P completed by P1 (Physician) on 12/27/23 indicated that R1 had been angry with aggression and a behavior disorder where he reportedly attacked staff members and a police officer at the rehab facility resulting in hospitalization. P1 also indicated during this exam documentation that R1 was screened for fall risk and the screening was positive. At the time of this admission, P1	is showing exit seeking behavior, we will require the POA to provide 1 on 1 companion until exit seeking behavior subsides and a Negotiated Risk will be completed with the POA to confirm everyone is on the same page. C. All current residents are having a chart review to be completed by 5/24/24 and a Behavioral Symptoms Assessment will be completed by the RSS or nurse designee in conjunction with a review of all UAI assessments. D. All current staff will be educated in notifying documenting exit seeking behaviors to the nursing supervisor and the on-coming shift. Staff will document in the communication book. This will be completed by 5/24/24 E. The RSS will use the 24-hour report to document any changes in which a resident is exit seeking and that the physician has been notified, staff has been notified and what safety measures were implemented, such as 15 or 30 minute checks, etc. F. If it is found a potential resident had a previous elopement, we will not admit that resident to our community without having the POA providing a one on one until it is deemed the resident is no longer an elopement risk. We will secure all benches in the gazebo and courtyard. This will be completed by 5/10/24.

Provider's Signature [signature] Title ED Date 5/15/24

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	stated R1 was thought to be hemodynamically stable and was discharged from the hospital to the nursing facility. E7 stated that R1 always packs his clothes but never brings them out of his room. E7 stated that R1 takes his clothes out of the closet and then his wife puts them back. E7 stated she had never witnessed R1 to be exit seeking prior to this incident. 3/28/24 - Per statement documentation, E1 (ED) noted at approximately 8:20-8:25 AM, a RC asked everyone for assist in looking for R1. A second search was done and when R1 was not located, E1 had staff searching outside of the grounds. E1 then noted that the phone rang, it was the police notifying them they had found R1 and would be returning him to the facility. The Surveyor could not confirm the timing of the search steps as none of the employee statements reviewed contained timeframes. Per the police report completed by P3 (Police Officer) dated 3/28/24 the incident occurred at 8:29 AM and was dispatched to him at 8:30 AM. A family located in a nearby development had called the police when an unknown person was knocking on their door and appeared confused and disoriented. P3 arrived at approximately 8:40 AM and notified EMS to have the resident evaluated. P3 completed an internet search of the surrounding area locating Arden Courts. P3 called the facility and was told that it was their resident, and they were conducting an active search. Per the report, P3 indicated the EMS was in contact with the Emergency Room and R1 was cleared to return to the facility. On return, P3 noted he turned over R1 to E1 who then stated to P3 that "R1 was agitated after waking up so his caretaker walked him		

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	around the back courtyard secured by a 6' foot fence. E1 advised that the caretaker then allowed R1 to be out in the courtyard and when no one was looking, R1 propped a chair, climbed and scaled over the fence and fled the facility". 4/2/24 - Per interview with E1 at approximately 10:00 AM, E1 stated R1 had no attempts to leave the facility prior to this incident. E1 stated that E7 notified her that R1 was missing at 8:10 AM and a search was in place. E1 stated she notified the facility Regional Director of Operations at 8:25 AM and informed him that R1 was missing and that a full search by the facility was in process, including three staff searching by car. E1 stated that on review, the camera facing the parking lot did capture R1 out of the building in the lot at 8:06 AM, however there was no camera in the courtyard where the resident used a chair against the fence and climbed over. E1 stated as she was calling the police at 9:01 AM, the police called her and notified E1 that R1 was located and would be returning to the facility. 4/2/24 - Per Interview with E2 (RSD) at approximately 10:00 AM, E2 stated she relies on the family to provide information of past behaviors including wandering/exit seeking and that families are not always forthcoming. E2 confirmed there is not a separate assessment for wandering/elopement risk. E2 stated she uses the UAI section to notate the risk and does not ask specifically of families of past behaviors of the resident. 4/2/24 – Per interview with E7 (RC) at approximately 1:00 PM, E7 stated when she arrived for her shift at 7:00 AM on 3/28/24, R1 was agitated and trying to get out. She opened the door and walked him around the		

Provider's Signature [signature] Title ED Date 5/16/24

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	courtyard to help settle R1's agitation and then returned into the building. At 7:45 AM, E7 stated she observed that R1 was pushing on the gate door and notified E3 (Building Coordinator). E7 stated E3 went out to the courtyard while R1 was there and deemed the courtyard gate was secure. E7 then stated R1 was "looking for the milkman". E3 and E7 returned to the building and E7 stated she went to set the tables in the dining area for breakfast. E7 stated she went to R1's room between 8:00 AM- 8:10 AM after setting the table and found the door locked. She stated R1 never locks his door. After knocking, she let herself in and R1 was not in his room. E7 stated she then asked housekeeping for assistance in locating R1. E7 stated the courtyard was checked in two areas. When not located, E7 stated she notified the whole facility via walkie-talkie to start a search. E7 stated there is usually a 15-minute timeframe for a full search to be initiated by the facility. Despite clinical documentation of R1 exit seeking behavior and packing of his belongings on numerous occasions, the facility failed to assess and develop a plan for resident safety. This failure put the resident in immediate jeopardy of their safety and well-being. 4/3/24 - Findings were reviewed with E1 and E2 at the exit conference beginning at approximately 2:10 PM.		

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