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

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: AL- Brookdale Hockessin **DATE SURVEY COMPLETED: November 16, 2020**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE-TION DATE
	An unannounced complaint survey was conducted at this facility beginning on November 10, 2020 and ending on November 16, 2020. The facility census on the first day of the survey was 44. The survey sample included three (3) residents. The survey process included observations, interviews, review of residents' clinical records, review of other facility documentation as indicated, and review of the State Agency's Investigative Section's records. **Abbreviations used in this state report are as follows:** ED - Executive Director; DDOCS – District Director of Clinical Services; DOM – Director of Maintenance; HWD – Health and Wellness Director; LPN - Licensed Practical Nurse; OA – Outside Agency; POA – Power of Attorney; RN – Registered Nurse; RN CM – RN Case Manager; Delirium - Serious disturbance in mental abilities that results in confused thinking and reduced awareness of surrounding; Dementia - a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning; Subarachnoid hemorrhage – a bleeding in the space between the brain and the tissue covering the brain; UAI – Uniform Assessment Instrument - an assessment form used to collect information about the physical condition, medical status and psychosocial needs of an applicant/resident in order to determine eligibility for an assisted living facility.	The following is the Plan of Correction for Brookdale Hockessin regarding the Statement of Deficiencies dated November 16, 2020. 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 any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. This Plan of Correction is our credible allegation of compliance as of 1/20/2021	
3225.0	**Regulations for Assisted Living Facilities**		
11.0	**Resident Assessment**		

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11.4	**The resident assessment shall be completed in conjunction with the resident.** **This requirement was not met as evidenced by:** Based on record review, it was determined that for three (R1, R2 and R3) of three sampled residents reviewed, the facility failed to ensure that the UAI was conducted in conjunction with the resident or their designated power of attorney. Findings include: 1. Review of R2's clinical records revealed the following: 5/18/19- An annual UAI was completed by E3 (former HWD) and stated, "No changes, reviewed and discussed with resident." The UAI was not signed by the resident or her guardian. 2/26/2020- R2 was re-admitted from a SNF. The "Significant Change" UAI completed by E3 documented that the UAI was completed with the healthcare provider's information, but it was not signed by E3 or dated. Also, the document was not signed by R2 (HWD) or her guardian. 11/16/2020 9:40 AM – Findings were reviewed with E1 (ED) and E2 (HWD) via phone interview. 2. Review of R3's clinical records revealed the following: 1/24/2020 – The Annual UAI, completed by E3 (former HWD) documented that the UAI was completed with the healthcare provider and R3, however, there was lack of R3 or her guardian's signature and the date for this assessment.	3225.11.4 1.Resident R3 has been discharged, unable to correct the deficient practice. Resident R1 has been discharged, unable to correct the deficient practice. The UAI for Resident R2 will be updated, reviewed with the resident and POA, signed by the nurse and POA or resident as appropriate. 2. Clinical Specialist or designee will audit Resident files for UAI completeness. If needed, Resident UAI will be re-written by the Clinical Specialist or designee and reviewed with the resident and/or POA, and signed per state regulation and Brookdale policy or a statement of review will be added to the UAI. The Health and Wellness Director will be educated on completing the UAI per state regulation and Brookdale policy. Re-training will be done by the Clinical Specialist and/or designee. 3. The Health and Wellness Director or designee will audit 10% of resident files and new move-is monthly for UAI completeness per state regulation and Brookdale policy. If needed corrections will be made by the Health and Wellness Director or designee. 4. The audit report will be shared with the Executive Director for review and brought to the quality assurance meeting for review and corrective action if indicated.	January 20, 2021

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	There was lack of evidence that the facility completed the initial UAI in conjunction with R3 or her guardian. 11/16/202 9:40 AM - Findings were reviewed with E1 (ED) and E2 (HWD) via phone interview. 3. Review of R1's clinical records revealed the following: 6/25/2020 (Completed prior to 7/3/2020 admission) – The Initial UAI completed by E3 (former DON) documented that the UAI was completed with the healthcare provider's information. The UAI was signed by FM1 on 7/19/2020, approximately 16 days after R1's admission. There was lack of evidence that the facility completed the initial UAI in conjunction with R1's Power of Attorney (FM1). 11/10/2020 2:30 PM – An interview with E2 (HWD) confirmed that there was a lack of evidence that the initial UAI was completed with R1's Power of Attorney (FM1). Findings were reviewed during the Exit Conference on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).		
11.5	**The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** **This requirement was not met as evidenced by:**	3225.11.5	

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	Based on interview and record review, it was determined that for one (R2) out of three sampled residents reviewed, the facility failed to conduct an annual UAI. Findings include: Review of R2's clinical records revealed the following: 5/2020- There was lack of evidence that the facility conducted the annual UAI. The last annual UAI's were completed on 5/18/2018 and 5/18/2019, respectively. 11/16/2020 9:40 AM - Findings were reviewed with E1 (ED) and E2 (HWD) via phone interview. Findings were reviewed during the Exit Conference via telephone on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).	1.The UAI for Resident R2 will have an annual update completed by the Health and Wellness Director by 1/20/2021. 2. Clinical Specialist or designee will audit Resident files for UAI updates per state regulations at a minimum 30 days after admission, and when there is a change of resident condition. Resident UAI will be updated per state regulation. The Health and Wellness Director will be educated on completing the UAI per state regulation and Brookdale policy. Clinical Specialist or Designee will conduct the re-training. 3. The Health and Wellness Director or designee will audit 10% of resident files including new move-ins monthly for UAI updates per state regulation and Brookdale policy. . 4 The results of the UAI audit will be given to the Executive Director for review and brought to the quality assurance meeting for review and corrective action if indicated.	January 20, 2021
13.0 **13.1**	**Service Agreements** **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.** **This requirement was not met as evidenced by:** Based on record review it was determined that for two (R1 and R2) out of three sample residents, the facility failed to have the resident participate in the development of the	3225.13.1 1. Resident R1 has been discharged, unable to correct the deficient practice. The UAI for Resident R2 will be updated by the Health and	January 20, 2020

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	Personalized Service Plan/ Service Agreement. Findings include: 1. Review of R2's clinical records revealed the following: 2/26/2020- The Significant Change UAI was completed by E3 (former HWD). 2/27/2020- The Personalized Service Plan was completed by E3 (former HWD) who signed and dated the document, however, the document was not signed or dated by R2 or her guardian. 8/26/2020- The Personalized Service Plan was not signed by staff or R2 or her guardian. 11/16/2020 9:40 AM - Findings were reviewed with E2 (HWD) and E1 (ED) via phone interview. 2. Review of R1's clinical records revealed the following: 7/3/2020 – R1 was admitted to the facility. 7/3/2020 – The admission Personal Service Plan (PSP), dated 7/3/2020, was signed by E3 (Former DON) on 7/13/2020 and R1's Power of Attorney (FM1) signed and dated the PSP on 7/17/2020, 4 days later. There was lack of evidence that a PSP was completed at the time of admission in conjunction with R1 and FM1. 11/10/2020 2:30 PM – An interview with E2 (HWD) confirmed the above findings. Findings were reviewed during the Exit Conference on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM). **The service agreement shall be reviewed when the needs of the resident have**	Wellness Director and reviewed with the resident and POA, signed by the nurse and POA or resident as appropriate. 2. Clinical Specialist or designee will audit Resident files for UAI completeness. Resident UAI will be re-written and reviewed with the resident and/or POA, and signed per state regulation and Brookdale policy or a statement of review will be added to the UAI. The Health and Wellness Director will be educated on completing the UAI per state regulation and Brookdale policy. Re-education will be done by the Clinical Specialist or designee. 3. The Health and Wellness Director or designee will audit 10% of resident files including new move-ins monthly for UAI completeness per state regulation and Brookdale policy. 4. The UAI audit report will be given to the Executive Director for review and brought to the quality assurance meeting for review and corrective action if indicated.	
13.6			

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	changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated. **This requirement was not met as evidenced by:** Based on interview and record review, it was determined that for two (R1 and R3) of three sampled residents, the facility failed to revise the service agreement when the needs of the resident's change. Findings include: 1. Review of R1's clinical records, the Division's Investigative Section's records, and hospital records revealed the following: 7/3/2020 – R1 was admitted to the facility with diagnoses including dementia. 7/13/2020 12:46 AM – A Nursing Progress Note stated, "This nurse arrived at 1125 pm 911 just had left and escorted resident back into the building. Resident assessed for injuries. Noted resident with abrasions to left knee and large bruise to the left forearm. ED [E1] arrived shortly after me [E3]. This nurse investigated resident room and noted resident window up, screen on the outside on the ground. resident stated he climbed out of the window. He was looking to 'life (sic) my life' and get a ride to Europe. Called resident son, daughter and daughter in law. Son [FM1] made aware and will (sic) he [FM1] came in to provide 1:1 overnight. Resident is in bed at this time and appears comfortable. Regional team made aware of the incident." 7/13/2020 – The Significant Change UAI Assessment stated that R1 eloped from the facility and the UAI and PSP were revised with interventions that were put into place.	3225.13.6 1 Resident R1 has been discharged, unable to correct the deficient practice. Resident R3 has been discharged, unable to correct the deficient practice. 2 Executive Director or designee will audit 10% of resident service agreements for need to revise due to resident changes in condition. Service agreements that require changes will be discussed with resident, family, and /or POA per state regulation and Brookdale policy. 3. Executive Director or designee will review 10% of resident service agreements	January 20, 2021

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	7/13/2020 – The Personal Service Plan (PSP) was revised and included the following: The section Cognitive/Psychological revealed that R1 needed help to participate in community activities because of memory loss as R1 was not always oriented to place and time. This change in orientation may impact R1's decision making. A section for Behavior Management was added to the PSP which stated that R1 attempts to exit the building without needed supervision. The interventions included, but were not limited to 1) Redirect R1 away from exit using a gentle voice and other preferred activities 2) Direct to an appropriate wandering place 3) See Cognitive/Psychological Section related to wandering 4) Be alert to resident's pattern and reason for exit attempts (e.g. change of shift, end of a party as families leave) and involve in meaningful activity prior to these points in time. The document included E3's (Former HWD's) signature and was dated 7/16/2020. There was lack of evidence that when the PSP dated 7/13/2020 was reviewed and revised that, the facility incorporated the intervention of 1:1 supervision to be provided 24 hours a day by an outside agency. 7/13/2020 – R1's Care Profile indicated that R1 had behavior in which R1 attempts to exit the building without needed supervision. Again, this document failed to include that R1 was to be on 1:1 supervision. 10/9/2020 – A Nurse Progress Note documented, "At 00:05 (12:05) AM the Nurse [E4/LPN] was notified by the 1-on-1 (1:1) aide that the resident was in a state of distress. He (R1) had mentioned that he wanted to leave the building. The resident was very com-	monthly and execute a revised service agreement if indicated. 4 This report will be reviewed at the quality assurance meeting for review and corrective action if indicated.	

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	bative with the nursing staff. He was punching and kicking and scratching. The aide informed me that he was attempting to access the 2nd floor 400 hall balcony to 'leave the building'. The resident was able to be redirected on multiple occasions to ensure his safety. The resident was repeatedly kicking, scratching, and he had pushed the staff. He was trying to gain access outside from the upper floor 400 hall balcony. The resident's family POA [Power of Attorney], the building Executive Director [E1], and DR [R1's Attending Physician] were contacted. His son was able to verbally convince him to listen to the staff and his 1-on-1 aide in regard to 'calming down' and trying to get some rest. Resident was in his room until the following morning at the change of shift. His 1 on 1 aide had left at 6:30 [AM] in the morning. A nurse proceeded to sit with him until the change of shift at 7:00 AM. During the shift report the resident was seen going back to his room after getting a cup of coffee. After giving my part of the report I proceeded to go check on the resident in his room. That was when I saw that he wasn't in his room. So I went running down the hall to the balcony and found the resident standing facing me on the outside of the railing. I tried to reach out and make a grab for him, but he jumped. He landed on the sidewalk below 0705 (7:05 AM)." 11/10/2020 2:30 PM – An interview with E2 (HWD) confirmed that the 7/13/2020 Personal Service Plan completed by E3 (former HWD) failed to include the 1:1 supervision as a follow-up to R1's elopement on 7/13/2020. Findings were reviewed during the Exit Conference via telephone on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).		

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	2. Review of R3's clinical records revealed the following: 1/24/2020 – The Annual UAI was completed by E3 (former HWD). 3/16/2020 – The Personalized Service Plan was completed approximately two months after the annual UAI was completed on 1/24/2020. The Personalized Service Plan was signed by E3 (former HWD) on 3/16/2020 and by the resident's POA on 3/20/2020. 11/16/2020 9:40 AM - Findings were reviewed with E2 (HWD) and E1 (ED) via phone interview. Findings were reviewed during the Exit Conference via telephone on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM). **Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients** **(11) "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.** **This requirement was not met as evidenced by:** Based on record review, staff interviews and review of other documentation as indicated it was determined that for one (R1) out of three (3) residents reviewed, the facility failed to ensure attention to the safety needs of R1. On 7/13/2020, R1 eloped from the facility and was found walking on the highway.		
16 Del. Code Chapter 11, Subchapter III, § 1131			

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	On 10/9/2020, R1 was left unsupervised and was found behind a 2nd floor balcony rail before falling from the balcony onto the cement sidewalk. Findings include: Review of R1's clinical records, the Division's Investigative Section's records, and the hospital records revealed the following: 7/3/2020 – R1 was admitted to the facility with diagnoses including dementia. 7/12/2020 11:39 PM – A Nurses Progress Note documented that around 10:00 PM, R1 was displaying aggressive behaviors toward the nurse who was explaining to R1 that it was not safe to leave the building as R1 was trying to follow one of the staff members who was going outside of the building. R1 became combative and pushed the nurse, held onto the door and broke his wristwatch on the door. R1 sustained a bruise on his left arm. R1 was reassured by the nurse and returned back to his room. There was lack of evidence that the facility assessed R1's risk of elopement after R1 attempted to leave the building at approximately 10:00 PM on 7/12/2020 and they failed to develop an individualized plan to lower R1's risk for elopement. 7/13/2020 12:46 AM – A Nursing Progress Note stated, "This nurse arrived at 1125 pm 911 just had left and escorted resident back into the building. Resident assessed for injuries. Noted resident with abrasions to left knee and large bruise to the left forearm. ED [E1] arrived shortly after me [E3]. This nurse investigated resident room and noted resident window up, screen on the outside on the ground. resident stated he climbed out of the window. He was looking to 'life (sic) my life' and get a ride to Europe. Called resident	16.11.III,1131 1. Resident R1 has been discharged, unable to correct the deficient practice. Door alarms were placed on balcony doors on 10/22/2020. 2. Health and Wellness Director will assess residents for elopement risk and need for alternative placement. Resident individualized service plans will be audited and updated if indicated. The Health and Wellness Director will re-educated on Resident Neglect, elopement precautions, working with residents who have dementia, residents who have behaviors, and working with aggressive residents. Associates will re-trained on developing and updating the Individualized Service Plan for residents when indicated. Associates will be re-educated on appropriate admissions to assisted living per state regulations and Brookdale policy.	

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	son, daughter and daughter in law. Son [FM1] made aware and will (sic) he come in to provide 1:1 overnight. Resident is in bed at this time and appears comfortable. Regional team made aware of the incident." 7/13/2020 – The facility reported to the State Agency that the facility received a call at approximately 11:10 PM that there was a man walking on the highway and staff went outside and found R1 approximately 200 feet away from the community. R1 was resistive to return to the facility and 911 was called and R1 was escorted back to the facility. Upon investigation, R1 knocked the screen out of his window, climbed out of the window and sustained an abrasion to the left knee. The 5 day follow-up by the facility documented that a care plan meeting was held with R1, FM1, E1 (ED) and E3 (former HWD), 1:1 supervision was put into place indefinitely and R1's room was changed to upstairs (2nd floor) along with a 1:1 companion. All facility windows were inspected and will have stops in place that only allow the windows to be raised a certain amount of inches (without assistance) for safety. Due to the facility's failure to assess R1's risk of elopement after the previous day's attempt to leave the facility on 7/12/2020 at approximately 10:00 PM and failure to develop a plan to reduce R1's risk for elopement, R1 eloped from the facility and was observed walking on the highway by a passerby who was driving on the highway. After this incident, a decision was made to relocate R1 to the 2nd floor. There was lack of evidence that the facility identified that the 2nd floor balcony doors were a potential safety hazard for R1 who was exit seeking. The balcony doors were not set up to alarm when opened.	3. The Health and Wellness Director or designee will audit 10% of resident individualized service plans monthly to maintain and verify resident assessments are documented per state regulation and Brookdale policy. 4. This audit report will be reviewed by the ED and brought to the quality assurance meeting for review and corrective action if indicated. Completion date: January 20, 2021	

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	7/13/2020 – The Significant Change UAI Assessment stated that R1 eloped from the facility and the UAI and PSP were revised with interventions that were put into place. 7/13/2020 – The Personal Service Plan was revised and included the following: The Cognitive/Psychological section revealed that R1 needed help to participate in community activities because of memory loss as R1 was not always oriented to place and time This change in orientation may impact R1's decision making. A section for Behavior Management was added to the PSP which stated that R1 attempts to exit the building without needed supervision. Interventions included, but were not limited to 1) Redirect R1 away from exit using a gentle voice and other preferred activities 2) Direct to an appropriate wandering place 3) See Cognitive/Psychological Section related to wandering 4) Be alert to resident's pattern and reason for exit attempts (e.g. change of shift, end of a party as families leave) and involve in meaningful activity prior to these points in time. The document included E3's (Former HWD) signature and was dated 7/16/2020, however, there was no signature by R1's POA, FM1. 7/13/2020 – R1's Care Profile indicated that R1 had behaviors in which R1 attempts to exit the building without needed supervision. 9/24/2020 through 10/1/2020 – Review of the following Nurses Progress Notes documented that R1 was not provided 1:1 supervision for safety. - 9/24/2020 8:38 PM – "Resident was noted walking on the hallway by himself no private aide was on duty on this shift...". - 9/26/2020 9:19 PM – "Resident continues on monitoring for exit seeking. One to One aid unavailable this shift (3-11) ...(Name of		

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	outside agency) called @ 2108 (9:08 PM) to notify staff that an overnight aide would not be coming in tonight...". - 9/27/2020 9:16 PM – "Resident continues on monitoring for exit seeking. Resident currently does not have...1:1 aid this shift or for overnight. Noted resident has increased agitation and wandering this shift r/t (related to) change in routine...". - 10/1/2020 10:59 PM – "Aide (Staff from the outside agency) reports that there will not be an aide for overnight and 11-7 (11:00 PM – 7:00 AM). (Name of outside agency) will not be here to do 1:1 on 10/3/2020 and 10/4/2020. Safety maintained.". It was unclear what the facility's system was to ensure 1:1 supervision for R1's safety during the documented periods of no 1:1 supervision by the outside agency staff. There was lack of evidence of reassessment of R1's risk for elopement and no revision to the plan to reduce R1's elopement risk. 10/9/2020 12:05 AM – A Nurse Progress Note documented "At 00:05 (12:05) AM the Nurse [E4/LPN] was notified by the 1-on-1 aide that the resident was in a state of distress. He had mentioned that he wanted to leave the building. The resident was very combative with the nursing staff. He was punching and kicking and scratching. The aide informed me that he was attempting to access the 2nd floor 400 hall balcony to 'leave the building'. The resident was able to be redirected on multiple occasions to ensure his safety. The resident was repeatedly kicking, scratching, and he had pushed the staff. He was trying to gain access outside from the upper floor 400 hall balcony. The resident's family POA [Power of Attorney], the building Executive Director [E1], and DR [R1's Attending Physician] were contacted. His son was able to verbally convince him to listen to the staff and		

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	his 1-on-1 aide in regard to 'calming down' and trying to get some rest. Resident was in his room until the following morning at the change of shift. His 1 on 1 aide had left at 6:30 [AM] in the morning. A nurse proceeded to sit with him until the change of shift at 7:00 AM. During the shift report the resident was seen going back to his room after getting a cup of coffee. After giving my part of the report I proceeded to go check on the resident in his room. That was when I saw that he wasn't in his room. So I went running down the hall to the balcony and found the resident standing facing me on the outside of the railing. I tried to reach out and make a grab for him, but he jumped. He landed on the sidewalk below 0705 (7:05 AM)." Despite that R1's POA (FM1) did not want to have R1 sent to the hospital when R1 was distressed, combative and attempted to jump over the balcony rails, the facility failed to identify and eliminate a significant hazard of R1 accessing the 2nd floor balcony after the incident at approximately 12:05 AM. In addition, the facility failed to notify E3 (former HWD) and failed to reassess the current interventions to ensure safety for R1. Due to these failures, R1 was left unsupervised until R1 was observed behind the 2nd floor balcony railing and subsequently fell onto the cement sidewalk. 10/9/2020 – Review of the facility's incident report to the State Agency and the Division's Investigative Section records stated that R1 displayed distressed behavior at the beginning of the night shift beginning at 11:00 on 10/8/2020 and around midnight, E4 (LPN) was called by E5 (LPN) due to R1's combative behavior. When E4 arrived on the 2nd floor, E4 observed E5 and OA1 (Outside Agency) staff attempting to stop R1 from climbing over the balcony railing in an attempt to		

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	"leave this place." After this incident, the OA1 staff provided 1:1 supervision until 6:30 AM on 10/9/2020 and before OA1 left R1, OA1 reported to E5 (LPN) and at that time E5 provided 1:1 supervision. A written statement by E5 stated that she provided 1:1 supervision until 7:00 AM. A written statement by E4 stated that he observed R1 ambulating alone at 6:45 AM. After E4 completed the shift change report, E4 proceeded to check on R1. E4 observed that R1 was not in his room and immediately, E4 proceeded to the 2nd floor balcony where R1 was observed holding onto the outside of the balcony rail before falling onto the cement sidewalk. 10/9/2020 7:10 AM – Review of the Fire Company and the State Police dispatch record revealed that the call was received at 7:10 AM. 10/9/2020 – Review of the hospital's emergency room records revealed that R1 sustained multiple rib fractures, a cervical (neck bone) fracture, subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain) and non-operative management was recommended as R1 was showing tremendous signs of delirium (serious disturbance in mental abilities that results in confused thinking and reduced awareness of surroundings) and agitation. 10/9/2020 – Review of the hospital's consultation note for the cervical fracture stated that R1's past medical history included previous suicidal ideations, as well as an admission to a hospital after R1 was found to have abdominal and chest stab wounds after expressing his intent to commit suicide. 10/14/2020 – Review of the hospital's Discharge Summary documented a discharge diagnosis of subarachnoid hemorrhage and R1		

Provider's Signature _____ Title ED Date 12/22/2020

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	was placed on comfort care and expired on 10/14/2020. 11/10/2020 2:00 PM – An interview with E6 (DOM) revealed that on 10/9/2020, E6 arrived at the facility at 6:30 AM and was informed by a nurse that R1 was exit seeking over the course of the night shift. E6 verbalized he did not recall which nurse reported this information to him. Approximately 5 minutes after the conversation with the nurse, E6 saw R1 on the ground and E6 stated it was already day shift when this took place. 11/10/2020 2:30 PM – An interview with E2 (HWD) was conducted and revealed that E2 became the Interim DON on 10/6/2020. E2 verbalized that she was not notified when R1 attempted to jump from the 2nd floor balcony the first time on 10/9/2020 at approximately 12:05 AM. In addition, E2 was not notified when R1 jumped from the 2nd floor balcony on 10/9/2020 at approximately 7:05 AM, but she assisted in obtaining written statements from the two LPNs who worked the night shift for the facility's incident investigation. E2 stated that the facility does not have a risk assessment for elopement of a new resident, however, in her experience as a HWD in another facility, when an elopement occurs, the residents are typically placed in a facility with a secured unit. E2 stated that for a new prospective resident, the nurse conducting the review would follow the "Admission/Move-In Review Criteria." 11/16/2020 8:10 AM – A subsequent interview with E6 (Director of Maintenance) revealed that the facility installed an alarm on the 2nd floor balcony doors after R1 fell from the balcony on 10/9/2020. 11/16/2020 8:33 AM – An interview with E10 (DDOCS) revealed that E10 was made aware		

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	of the 7/13/2020 elopement, but was given the "impression that the resident stepped outside" by F3 (former HWD) and until E10 reviewed the Nurse Progress Note today, she was not aware of what actually occurred. E10 stated that if she was provided accurate information, she would have considered other living arrangements to meet the resident's needs. E10 verbalized that she relied on what she was told by E3 and it was not her practice to review documentation of the incident, such as the Nurse Progress Notes. E10 stated that she became aware of the 10/9/2020 incident after R1 fell from the balcony. 11/16/2020 10:14 AM – An interview with E1 (ED) revealed that after R1 eloped from the facility on 7/13/2020, a meeting was held with FM1, E3 (former HWD) and E1. During the meeting, it was decided that R1 required 1:1 supervision for safety to remain in the facility. After this meeting, E1 was approached by FM1 about potentially reducing some of the 1:1 supervision provided by the outside agency and E1 and FM1 agreed to eliminate the 7:00 AM to 3:00 PM coverage because there was usually enough day shift staff at the facility to provide coverage without 1:1 supervision by the outside agency staff. E1 confirmed after the first attempt to jump from the 2nd floor balcony on 10/9/2020 at approximately 12:05 AM, that no new interventions were implemented. E1 confirmed that the balcony door did not have an alarm and that the alarm was implemented after R1 fell from the balcony on the morning of 10/9/2020. Findings were reviewed during the Exit Conference via telephone on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).		

Provider's Signature _____ Title ED Date 12/22/2020

Jones, Tomeka N (DHSS)

From: Jones, Tomeka N (DHSS)
Sent: Thursday, December 10, 2020 9:48 AM
To: 'ghenry1@brookdale.com'
Cc: OHagan, Nancy (DHSS); Reed, Kim (DHSS); Smith, Robert (DHSS); Edwards, Melanie (DHSS)
Subject: Brookdale - Complaint survey ending on 11/16/20
Attachments: Plan of Correction Instructions 2013.docx; AL - Brookdale Hockessin_CV_11-16-2020 _PrvdrLtr_Def.docx; AL - Brookdale Hockessin_CV_11-16-2020.docx

Categories: Egress Switch: Unprotected
Tracking:

Recipient	Delivery	Read
'ghenry1@brookdale.com'		
OHagan, Nancy (DHSS)	Delivered: 12/10/2020 9:51 AM	Read: 12/10/2020 9:51 AM
Reed, Kim (DHSS)	Delivered: 12/10/2020 9:51 AM	Read: 12/10/2020 9:59 AM
Smith, Robert (DHSS)	Delivered: 12/10/2020 9:51 AM	
Edwards, Melanie (DHSS)	Delivered: 12/10/2020 9:51 AM	

Switch-MessageId: c115647283cf48dbbfe1d40c20e70e77

Dear Mr. Henry,

Attached please find the POC directions, provider letter and state report for the Complaint survey ending on November 16, 2020.

Please sign, complete and/or cross-reference, and date the State Report; **returning to DHSS_DHCQ_POC@delaware.gov electronic mailbox.**

Regards,

Tomeka

Tomeka Jones
Administrative Specialist I

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality - Long Term Care Residents Protection
3 Mill Road
Suite 308
Wilmington, DE
Mainline: (302) 421-7410
Office: (302)-421-7438
Fax: (302) 421-7401
Tomeka.Jones@delaware.gov

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

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: AL- Brookdale Hockessin **DATE SURVEY COMPLETED: November 16, 2020**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE-TION DATE
	An unannounced complaint survey was conducted at this facility beginning on November 10, 2020 and ending on November 16, 2020. The facility census on the first day of the survey was 44. The survey sample included three (3) residents. The survey process included observations, interviews, review of residents' clinical records, review of other facility documentation as indicated, and review of the State Agency's Investigative Section's records. **Abbreviations used in this state report are as follows:** ED - Executive Director; DDOCS – District Director of Clinical Services; DOM – Director of Maintenance; HWD – Health and Wellness Director; LPN - Licensed Practical Nurse; OA – Outside Agency; POA – Power of Attorney; RN – Registered Nurse; RN CM – RN Case Manager; Delirium - Serious disturbance in mental abilities that results in confused thinking and reduced awareness of surrounding; Dementia - a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning; Subarachnoid hemorrhage – a bleeding in the space between the brain and the tissue covering the brain; UAI – Uniform Assessment Instrument - an assessment form used to collect information about the physical condition, medical status and psychosocial needs of an applicant/resident in order to determine eligibility for an assisted living facility.		
3225.0 **11.0**	**Regulations for Assisted Living Facilities** **Resident Assessment**		

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: AL- Brookdale Hockessin **DATE SURVEY COMPLETED: November 16, 2020**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE-TION DATE
11.4	**The resident assessment shall be completed in conjunction with the resident.** **This requirement was not met as evidenced by:** Based on record review, it was determined that for three (R1, R2 and R3) of three sampled residents reviewed, the facility failed to ensure that the UAI was conducted in conjunction with the resident or their designated power of attorney. Findings include: 1. Review of R2's clinical records revealed the following: 5/18/19- An annual UAI was completed by E3 (former HWD) and stated, "No changes, reviewed and discussed with resident." The UAI was not signed by the resident or her guardian. 2/26/2020- R2 was re-admitted from a SNF. The "Significant Change" UAI completed by E3 documented that the UAI was completed with the healthcare provider's information, but it was not signed by E3 or dated. Also, the document was not signed by R2 (HWD) or her guardian. 11/16/2020 9:40 AM – Findings were reviewed with E1 (ED) and E2 (HWD) via phone interview. 2. Review of R3's clinical records revealed the following: 1/24/2020 – The Annual UAI, completed by E3 (former HWD) documented that the UAI was completed with the healthcare provider and R3, however, there was lack of R3 or her guardian's signature and the date for this assessment.		

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE-TION DATE
	There was lack of evidence that the facility completed the initial UAI in conjunction with R3 or her guardian. 11/16/202 9:40 AM - Findings were reviewed with E1 (ED) and E2 (HWD) via phone interview. 3. Review of R1's clinical records revealed the following: 6/25/2020 (Completed prior to 7/3/2020 admission) – The Initial UAI completed by E3 (former DON) documented that the UAI was completed with the healthcare provider's information. The UAI was signed by FM1 on 7/19/2020, approximately 16 days after R1's admission. There was lack of evidence that the facility completed the initial UAI in conjunction with R1's Power of Attorney (FM1). 11/10/2020 2:30 PM – An interview with E2 (HWD) confirmed that there was a lack of evidence that the initial UAI was completed with R1's Power of Attorney (FM1). Findings were reviewed during the Exit Conference on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).		
11.5	**The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** **This requirement was not met as evidenced by:**		

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	Based on interview and record review, it was determined that for one (R2) out of three sampled residents reviewed, the facility failed to conduct an annual UAI. Findings include: Review of R2's clinical records revealed the following: 5/2020- There was lack of evidence that the facility conducted the annual UAI. The last annual UAI's were completed on 5/18/2018 and 5/18/2019, respectively. 11/16/2020 9:40 AM - Findings were reviewed with E1 (ED) and E2 (HWD) via phone interview. Findings were reviewed during the Exit Conference via telephone on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).		
13.0	**Service Agreements**		
13.1	**A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement.** **This requirement was not met as evidenced by:** Based on record review it was determined that for two (R1 and R2) out of three sample residents, the facility failed to have the resident participate in the development of the		

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE-TION DATE
	Personalized Service Plan/ Service Agreement. Findings include: 1. Review of R2's clinical records revealed the following: 2/26/2020- The Significant Change UAI was completed by E3 (former HWD). 2/27/2020- The Personalized Service Plan was completed by E3 (former HWD) who signed and dated the document, however, the document was not signed or dated by R2 or her guardian. 8/26/2020- The Personalized Service Plan was not signed by staff or R2 or her guardian. 11/16/2020 9:40 AM - Findings were reviewed with E2 (HWD) and E1 (ED) via phone interview. 2. Review of R1's clinical records revealed the following: 7/3/2020 – R1 was admitted to the facility. 7/3/2020 – The admission Personal Service Plan (PSP), dated 7/3/2020, was signed by E3 (Former DON) on 7/13/2020 and R1's Power of Attorney (FM1) signed and dated the PSP on 7/17/2020, 4 days later. There was lack of evidence that a PSP was completed at the time of admission in conjunction with R1 and FM1. 11/10/2020 2:30 PM – An interview with E2 (HWD) confirmed the above findings. Findings were reviewed during the Exit Conference on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).		
13.6	**The service agreement shall be reviewed when the needs of the resident have**		

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	changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated. **This requirement was not met as evidenced by:** Based on interview and record review, it was determined that for two (R1 and R3) of three sampled residents, the facility failed to revise the service agreement when the needs of the resident's change. Findings include: 1. Review of R1's clinical records, the Division's Investigative Section's records, and hospital records revealed the following: 7/3/2020 – R1 was admitted to the facility with diagnoses including dementia. 7/13/2020 12:46 AM – A Nursing Progress Note stated, "This nurse arrived at 1125 pm 911 just had left and escorted resident back into the building. Resident assessed for injuries. Noted resident with abrasions to left knee and large bruise to the left forearm. ED [E1] arrived shortly after me [E3]. This nurse investigated resident room and noted resident window up, screen on the outside on the ground. resident stated he climbed out of the window. He was looking to 'life (sic) my life' and get a ride to Europe. Called resident son, daughter and daughter in law. Son [FM1] made aware and will (sic) he [FM1] came in to provide 1:1 overnight. Resident is in bed at this time and appears comfortable. Regional team made aware of the incident." 7/13/2020 – The Significant Change UAI Assessment stated that R1 eloped from the facility and the UAI and PSP were revised with interventions that were put into place.		

NAME OF FACILITY: AL- Brookdale Hockessin **DATE SURVEY COMPLETED: November 16, 2020**

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	7/13/2020 – The Personal Service Plan (PSP) was revised and included the following: The section Cognitive/Psychological revealed that R1 needed help to participate in community activities because of memory loss as R1 was not always oriented to place and time. This change in orientation may impact R1's decision making. A section for Behavior Management was added to the PSP which stated that R1 attempts to exit the building without needed supervision. The interventions included, but were not limited to 1) Redirect R1 away from exit using a gentle voice and other preferred activities 2) Direct to an appropriate wandering place 3) See Cognitive/Psychological Section related to wandering 4) Be alert to resident's pattern and reason for exit attempts (e.g. change of shift, end of a party as families leave) and involve in meaningful activity prior to these points in time. The document included E3's (Former HWD's) signature and was dated 7/16/2020. There was lack of evidence that when the PSP dated 7/13/2020 was reviewed and revised that, the facility incorporated the intervention of 1:1 supervision to be provided 24 hours a day by an outside agency. 7/13/2020 – R1's Care Profile indicated that R1 had behavior in which R1 attempts to exit the building without needed supervision. Again, this document failed to include that R1 was to be on 1:1 supervision. 10/9/2020 – A Nurse Progress Note documented, "At 00:05 (12:05) AM the Nurse [E4/LPN] was notified by the 1-on-1 (1:1) aide that the resident was in a state of distress. He (R1) had mentioned that he wanted to leave the building. The resident was very com-		

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	bative with the nursing staff. He was punching and kicking and scratching. The aide informed me that he was attempting to access the 2nd floor 400 hall balcony to 'leave the building'. The resident was able to be redirected on multiple occasions to ensure his safety. The resident was repeatedly kicking, scratching, and he had pushed the staff. He was trying to gain access outside from the upper floor 400 hall balcony. The resident's family POA [Power of Attorney], the building Executive Director [E1], and DR [R1's Attending Physician] were contacted. His son was able to verbally convince him to listen to the staff and his 1-on-1 aide in regard to 'calming down' and trying to get some rest. Resident was in his room until the following morning at the change of shift. His 1 on 1 aide had left at 6:30 [AM] in the morning. A nurse proceeded to sit with him until the change of shift at 7:00 AM. During the shift report the resident was seen going back to his room after getting a cup of coffee. After giving my part of the report I proceeded to go check on the resident in his room. That was when I saw that he wasn't in his room. So I went running down the hall to the balcony and found the resident standing facing me on the outside of the railing. I tried to reach out and make a grab for him, but he jumped. He landed on the sidewalk below 0705 (7:05 AM)." 11/10/2020 2:30 PM – An interview with E2 (HWD) confirmed that the 7/13/2020 Personal Service Plan completed by E3 (former HWD) failed to include the 1:1 supervision as a follow-up to R1's elopement on 7/13/2020. Findings were reviewed during the Exit Conference via telephone on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).		

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	2. Review of R3's clinical records revealed the following: 1/24/2020 – The Annual UAI was completed by E3 (former HWD). 3/16/2020 – The Personalized Service Plan was completed approximately two months after the annual UAI was completed on 1/24/2020. The Personalized Service Plan was signed by E3 (former HWD) on 3/16/2020 and by the resident's POA on 3/20/2020. 11/16/2020 9:40 AM - Findings were reviewed with E2 (HWD) and E1 (ED) via phone interview. Findings were reviewed during the Exit Conference via telephone on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM). **Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients** **(11) "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.** **This requirement was not met as evidenced by:** Based on record review, staff interviews and review of other documentation as indicated it was determined that for one (R1) out of three (3) residents reviewed, the facility failed to ensure attention to the safety needs of R1. On 7/13/2020, R1 eloped from the facility and was found walking on the highway.		
16 Del. Code Chapter 11, Subchapter III, § 1131			

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	On 10/9/2020, R1 was left unsupervised and was found behind a 2nd floor balcony rail before falling from the balcony onto the cement sidewalk. Findings include: Review of R1's clinical records, the Division's Investigative Section's records, and the hospital records revealed the following: 7/3/2020 – R1 was admitted to the facility with diagnoses including dementia. 7/12/2020 11:39 PM – A Nurses Progress Note documented that around 10:00 PM, R1 was displaying aggressive behaviors toward the nurse who was explaining to R1 that it was not safe to leave the building as R1 was trying to follow one of the staff members who was going outside of the building. R1 became combative and pushed the nurse, held onto the door and broke his wristwatch on the door. R1 sustained a bruise on his left arm. R1 was reassured by the nurse and returned back to his room. There was lack of evidence that the facility assessed R1's risk of elopement after R1 attempted to leave the building at approximately 10:00 PM on 7/12/2020 and they failed to develop an individualized plan to lower R1's risk for elopement. 7/13/2020 12:46 AM – A Nursing Progress Note stated, "This nurse arrived at 1125 pm 911 just had left and escorted resident back into the building. Resident assessed for injuries. Noted resident with abrasions to left knee and large bruise to the left forearm. ED [E1] arrived shortly after me [E3]. This nurse investigated resident room and noted resident window up, screen on the outside on the ground. resident stated he climbed out of the window. He was looking to 'life (sic) my life' and get a ride to Europe. Called resident		

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	son, daughter and daughter in law. Son [FM1] made aware and will (sic) he come in to provide 1:1 overnight. Resident is in bed at this time and appears comfortable. Regional team made aware of the incident." 7/13/2020 – The facility reported to the State Agency that the facility received a call at approximately 11:10 PM that there was a man walking on the highway and staff went outside and found R1 approximately 200 feet away from the community. R1 was resistive to return to the facility and 911 was called and R1 was escorted back to the facility. Upon investigation, R1 knocked the screen out of his window, climbed out of the window and sustained an abrasion to the left knee. The 5 day follow-up by the facility documented that a care plan meeting was held with R1, FM1, E1 (ED) and E3 (former HWD), 1:1 supervision was put into place indefinitely and R1's room was changed to upstairs (2nd floor) along with a 1:1 companion. All facility windows were inspected and will have stops in place that only allow the windows to be raised a certain amount of inches (without assistance) for safety. Due to the facility's failure to assess R1's risk of elopement after the previous day's attempt to leave the facility on 7/12/2020 at approximately 10:00 PM and failure to develop a plan to reduce R1's risk for elopement, R1 eloped from the facility and was observed walking on the highway by a passerby who was driving on the highway. After this incident, a decision was made to relocate R1 to the 2nd floor. There was lack of evidence that the facility identified that the 2nd floor balcony doors were a potential safety hazard for R1 who was exit seeking. The balcony doors were not set up to alarm when opened.		

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	7/13/2020 – The Significant Change UAI Assessment stated that R1 eloped from the facility and the UAI and PSP were revised with interventions that were put into place. 7/13/2020 – The Personal Service Plan was revised and included the following: The Cognitive/Psychological section revealed that R1 needed help to participate in community activities because of memory loss as R1 was not always oriented to place and time This change in orientation may impact R1's decision making. A section for Behavior Management was added to the PSP which stated that R1 attempts to exit the building without needed supervision. Interventions included, but were not limited to 1) Redirect R1 away from exit using a gentle voice and other preferred activities 2) Direct to an appropriate wandering place 3) See Cognitive/Psychological Section related to wandering 4) Be alert to resident's pattern and reason for exit attempts (e.g. change of shift, end of a party as families leave) and involve in meaningful activity prior to these points in time. The document included E3's (Former HWD) signature and was dated 7/16/2020, however, there was no signature by R1's POA, FM1. 7/13/2020 – R1's Care Profile indicated that R1 had behaviors in which R1 attempts to exit the building without needed supervision. 9/24/2020 through 10/1/2020 – Review of the following Nurses Progress Notes documented that R1 was not provided 1:1 supervision for safety. - 9/24/2020 8:38 PM – "Resident was noted walking on the hallway by himself no private aide was on duty on this shift...". - 9/26/2020 9:19 PM – "Resident continues on monitoring for exit seeking. One to One aid unavailable this shift (3-11) ...(Name of		

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	outside agency) called @ 2108 (9:08 PM) to notify staff that an overnight aide would not be coming in tonight...". - 9/27/2020 9:16 PM – "Resident continues on monitoring for exit seeking. Resident currently does not have...1:1 aid this shift or for overnight. Noted resident has increased agitation and wandering this shift r/t (related to) change in routine...". - 10/1/2020 10:59 PM – "Aide (Staff from the outside agency) reports that there will not be an aide for overnight and 11-7 (11:00 PM – 7:00 AM). (Name of outside agency) will not be here to do 1:1 on 10/3/2020 and 10/4/2020. Safety maintained.". It was unclear what the facility's system was to ensure 1:1 supervision for R1's safety during the documented periods of no 1:1 supervision by the outside agency staff. There was lack of evidence of reassessment of R1's risk for elopement and no revision to the plan to reduce R1's elopement risk. 10/9/2020 12:05 AM – A Nurse Progress Note documented "At 00:05 (12:05) AM the Nurse [E4/LPN] was notified by the 1-on-1 aide that the resident was in a state of distress. He had mentioned that he wanted to leave the building. The resident was very combative with the nursing staff. He was punching and kicking and scratching. The aide informed me that he was attempting to access the 2nd floor 400 hall balcony to 'leave the building'. The resident was able to be redirected on multiple occasions to ensure his safety. The resident was repeatedly kicking, scratching, and he had pushed the staff. He was trying to gain access outside from the upper floor 400 hall balcony. The resident's family POA [Power of Attorney], the building Executive Director [E1], and DR [R1's Attending Physician] were contacted. His son was able to verbally convince him to listen to the staff and		

NAME OF FACILITY: AL- Brookdale Hockessin **DATE SURVEY COMPLETED: November 16, 2020**

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	his 1-on-1 aide in regard to 'calming down' and trying to get some rest. Resident was in his room until the following morning at the change of shift. His 1 on 1 aide had left at 6:30 [AM] in the morning. A nurse proceeded to sit with him until the change of shift at 7:00 AM. During the shift report the resident was seen going back to his room after getting a cup of coffee. After giving my part of the report I proceeded to go check on the resident in his room. That was when I saw that he wasn't in his room. So I went running down the hall to the balcony and found the resident standing facing me on the outside of the railing. I tried to reach out and make a grab for him, but he jumped. He landed on the sidewalk below 0705 (7:05 AM)." Despite that R1's POA (FM1) did not want to have R1 sent to the hospital when R1 was distressed, combative and attempted to jump over the balcony rails, the facility failed to identify and eliminate a significant hazard of R1 accessing the 2nd floor balcony after the incident at approximately 12:05 AM. In addition, the facility failed to notify E3 (former HWD) and failed to reassess the current interventions to ensure safety for R1. Due to these failures, R1 was left unsupervised until R1 was observed behind the 2nd floor balcony railing and subsequently fell onto the cement sidewalk. 10/9/2020 – Review of the facility's incident report to the State Agency and the Division's Investigative Section records stated that R1 displayed distressed behavior at the beginning of the night shift beginning at 11:00 on 10/8/2020 and around midnight, E4 (LPN) was called by E5 (LPN) due to R1's combative behavior. When E4 arrived on the 2nd floor, E4 observed E5 and OA1 (Outside Agency) staff attempting to stop R1 from climbing over the balcony railing in an attempt to		

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	"leave this place." After this incident, the OA1 staff provided 1:1 supervision until 6:30 AM on 10/9/2020 and before OA1 left R1, OA1 reported to E5 (LPN) and at that time E5 provided 1:1 supervision. A written statement by E5 stated that she provided 1:1 supervision until 7:00 AM. A written statement by E4 stated that he observed R1 ambulating alone at 6:45 AM. After E4 completed the shift change report, E4 proceeded to check on R1. E4 observed that R1 was not in his room and immediately, E4 proceeded to the 2nd floor balcony where R1 was observed holding onto the outside of the balcony rail before falling onto the cement sidewalk. 10/9/2020 7:10 AM – Review of the Fire Company and the State Police dispatch record revealed that the call was received at 7:10 AM. 10/9/2020 – Review of the hospital's emergency room records revealed that R1 sustained multiple rib fractures, a cervical (neck bone) fracture, subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain) and non-operative management was recommended as R1 was showing tremendous signs of delirium (serious disturbance in mental abilities that results in confused thinking and reduced awareness of surroundings) and agitation. 10/9/2020 – Review of the hospital's consultation note for the cervical fracture stated that R1's past medical history included previous suicidal ideations, as well as an admission to a hospital after R1 was found to have abdominal and chest stab wounds after expressing his intent to commit suicide. 10/14/2020 – Review of the hospital's Discharge Summary documented a discharge diagnosis of subarachnoid hemorrhage and R1		

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	was placed on comfort care and expired on 10/14/2020. 11/10/2020 2:00 PM – An interview with E6 (DOM) revealed that on 10/9/2020, E6 arrived at the facility at 6:30 AM and was informed by a nurse that R1 was exit seeking over the course of the night shift. E6 verbalized he did not recall which nurse reported this information to him. Approximately 5 minutes after the conversation with the nurse, E6 saw R1 on the ground and E6 stated it was already day shift when this took place. 11/10/2020 2:30 PM – An interview with E2 (HWD) was conducted and revealed that E2 became the Interim DON on 10/6/2020. E2 verbalized that she was not notified when R1 attempted to jump from the 2nd floor balcony the first time on 10/9/2020 at approximately 12:05 AM. In addition, E2 was not notified when R1 jumped from the 2nd floor balcony on 10/9/2020 at approximately 7:05 AM, but she assisted in obtaining written statements from the two LPNs who worked the night shift for the facility's incident investigation. E2 stated that the facility does not have a risk assessment for elopement of a new resident, however, in her experience as a HWD in another facility, when an elopement occurs, the residents are typically placed in a facility with a secured unit. E2 stated that for a new prospective resident, the nurse conducting the review would follow the "Admission/Move-In Review Criteria." 11/16/2020 8:10 AM – A subsequent interview with E6 (Director of Maintenance) revealed that the facility installed an alarm on the 2nd floor balcony doors after R1 fell from the balcony on 10/9/2020. 11/16/2020 8:33 AM – An interview with E10 (DDOCS) revealed that E10 was made aware		

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	of the 7/13/2020 elopement, but was given the "impression that the resident stepped outside" by F3 (former HWD) and until E10 reviewed the Nurse Progress Note today, she was not aware of what actually occurred. E10 stated that if she was provided accurate information, she would have considered other living arrangements to meet the resident's needs. E10 verbalized that she relied on what she was told by E3 and it was not her practice to review documentation of the incident, such as the Nurse Progress Notes. E10 stated that she became aware of the 10/9/2020 incident after R1 fell from the balcony. 11/16/2020 10:14 AM – An interview with E1 (ED) revealed that after R1 eloped from the facility on 7/13/2020, a meeting was held with FM1, E3 (former HWD) and E1. During the meeting, it was decided that R1 required 1:1 supervision for safety to remain in the facility. After this meeting, E1 was approached by FM1 about potentially reducing some of the 1:1 supervision provided by the outside agency and E1 and FM1 agreed to eliminate the 7:00 AM to 3:00 PM coverage because there was usually enough day shift staff at the facility to provide coverage without 1:1 supervision by the outside agency staff. E1 confirmed after the first attempt to jump from the 2nd floor balcony on 10/9/2020 at approximately 12:05 AM, that no new interventions were implemented. E1 confirmed that the balcony door did not have an alarm and that the alarm was implemented after R1 fell from the balcony on the morning of 10/9/2020. Findings were reviewed during the Exit Conference via telephone on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).		