

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145928		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2009	
NAME OF PROVIDER OR SUPPLIER GOLDEN MOMENTS SENIOR CARE CTR				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650			
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F 456	Continued From page 63			F 456			
F 465	the nurses station panel when activated.			F 465			
SS=B	483.70(h) OTHER ENVIRONMENTAL CONDITIONS						11/14/09
	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.						
	This REQUIREMENT is not met as evidenced by: Based on observations the facility failed to maintain the Soiled Utility Room, and the Medication Room in a clean and clutter free condition.						
	Findings include:						
	1. On 10/13/09 at 12:21pm, the Soiled Utility Room across from the front nurses station had a dirty, littered floor. The hopper was splattered with feces as was the wall behind the hopper. There was 7 containers of used sharps on the counter top in this room.						
	2. On 10/13/09 at 12:30pm, the nurses medication room at the front of the building was dirty with the floor littered with paper and other debris. The refrigerator had dried splatters on the inside door and the freezer section had a large coating of ice build up. The counter tops were also cluttered and soiled. There was no splash guard on one wall and the floor tile was in ill repair.						
F9999	FINAL OBSERVATIONS			F9999			
	LICENSURE VIOLATIONS						

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F9999	<p>Continued From page 64</p> <p>300.610a) 300.1210a) 300.1210b)6) 300.2040b) 300.2040e) 300.2040g) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</p> <p>b) All the information contained in the policies shall be available to the public, staff, residents and for review by Department personnel.</p> <p>c) These written policies shall include, at a minimum the following provisions: 2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray).</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p>	F9999					

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F9999	<p>Continued From page 65</p> <p>a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include at a minimum the following procedures:</p> <p>b)6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>. Section 300.2040 Diet Orders</p> <p>. b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered.</p> <p>e) A therapeutic diet means a diet ordered by the physician as part of a treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food in a form that the resident is able to eat (e.g., mechanically altered diet).</p> <p>g) The kinds and variations of prescribed therapeutic diets shall be available in the kitchen.</p>			F9999			

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F9999	<p>Continued From page 66</p> <p>If separate menus are not planned for each specific diet, diet information for each specific type, in a form easily understood by staff, shall be available in a convenient location in the kitchen.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility neglected to follow their Policy and Procedures for RESIDENTS REQUIRING PARTIAL ASSISTANCE (with feeding). They neglected to follow their diet Policy and Procedure for MECHANICAL SOFT diets. The facility neglected to follow their menu as written and neglected to follow the recipe for ground ham. The facility failed to have a Policy and Procedure for assisting resident who eat too fast and are at risk for choking, and failed to supervise 3 (R1, R9, R13) of 3 sampled residents during meals, who were identified as being at risk for choking due to eating too fast and food stuffing. These failures resulted in R13, who was identified as being on a Mechanical Soft diet and at risk for choking due to eating too fast and food stuffing, dying with the cause of death being asphyxiation due to food bolus in the wind pipe.</p> <p>Findings include:</p> <p>1. R13's Physician Order Sheet, POS, of October 2009, shows R13 had a diagnosis of Mental Retardation and Tardive Dyskinesia. R13</p>			F9999			

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F9999	<p>Continued From page 67</p> <p>had an order for a Mechanical Soft diet with 8 ounces of whole milk four times a day and use large bowls at meals.</p> <p>Speech Therapy Swallowing Evaluation of 5-9-08 states reason for referral is choking at meals. Evaluation shows R13 was edentulous and had an enlarged tongue. Bolus formation was somewhat, "sloppy" and is high risk for choking. Speech Therapy Discharge Note of 5-23-08 states, R13 should remain on a Mechanical Soft Diet and Skilled Speech Therapy was being discontinued secondary to progress plateaued/optimal. Note states R13 will need verbal/tactile cue to encourage safety guidelines and will attempt oral motor exercises: chin tuck, small sips/bites, alternate liquids and solids. Recommend: Supervision at meals, verbal cues as needed to encourage safety guidelines. Continue to serve one bowl at a time.</p> <p>R13's Minimum Data Set, MDS, of 7-31-09 reflects R13 requires set up and supervision at meals. R13 has a swallowing problem.</p> <p>R13's Nutritional Status RAP, Resident Assessment Protocol of 5-11-09 identifies a chewing and swallowing problem. The RAP states R13 requires supervision and cues while feeding self as he will eat too fast or drink too fast. Feeds self in supervised dining room for supervision. Diet served as ordered and intake monitored. Activities of Daily Living RAP of 5-1-09 states R13 feeds self with cues to slow down as he will eat rapidly.</p> <p>R13's Care Plan of 5-20-09 states R13 eats and drinks fast. Tries to eat from others tray or even off the floor or from trash cans. He has drank</p>			F9999			

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F9999	<p>Continued From page 68</p> <p>beverages that were too hot. He has no teeth. Care Plan approach includes, in part; Diet as ordered. Monitor intake. Serve meal in large bowls. Encourage to slow down when eating too fast. Allow intervals between fluids. Record review of Nutritional Risk Assessment of 5-22-09 shows chewing or swallowing problems, need of supervision during meals, R13 eating too fast and having behavior of food stuffing was not identified or assessed.</p> <p>Nurses Note of 10-3-09 at 12:21PM states R13 in feeding dining room observed by 2 CNA's Certified Nurse Aides, to not appear to be breathing. R13 assessed and apneic with cyanosis and unresponsive without pulse. R13 placed on floor - oral visual check done - nothing noted in mouth or throat. Abdominal thrusts performed with no results. 911 called CPR, Cardio Pulmonary Resuscitation, continued until EMS, Emergency Medical Services, arrival. R13 pronounced dead at 12:40 PM per EMS in attendance. Coroner called.</p> <p>On 10-9-09, E1, Administrator, stated R13 had behavior of stuffing food and would eat too fast. E1 stated R1 and R9 also have behavior of eating too fast.</p> <p>On 10-9-09, E6, Certified Nurse Aide (CNA), stated she got R13 out of bed before lunch on 10-3-09. E6 stated E5, Licensed Practical Nurse (LPN), pushed R13 in his wheelchair down to the assistance dining room while E6 went to 300 Hall to assist another resident. E5 gave R13 his bowl of ham. He already had the bowl of ham before she got down to the dining room. E7, CNA, gave R13 a bowl of mashed potatoes about 10 minutes after his ham. About 1 minute after R13</p>			F9999			

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F9999	<p>Continued From page 69</p> <p>had his mashed potatoes, she noted R13 slumped over in his wheelchair. E6 confirmed R13 had a behavior of eating too fast. E6 stated he was on a mechanical soft diet because he ate too fast and tried to swallow food whole. R13 did not take time to chew food. E6 stated the residents on Mechanical Soft Diets got ham that day for lunch. The ham was torn into pieces, not ground. E6 stated it depends on who's working in the kitchen. Sometimes the meat is ground and sometimes cut or torn into pieces. E6 stated she has seen R13 have things in his mouth that he should not have like Mardi gra beads. E6 stated on 10-3-09, R13 was not making any noises during the meal. No coughing. E6 stated she had seen him cough/choke before from eating too fast and too much food at a time. E6 stated she had not seen that on the day he died. On 10-13-09, E6 stated she was sitting at another table feeding a resident and E7 was also at the same table feeding a resident. E6 confirmed the table where R13 was sitting was across the room from the table where E6 and E7 were sitting. E6 confirmed E7's back was to R13 when she was feeding the other resident.</p> <p>E7 stated on 10-9-09, R13 was eating ham. E7 stated she did not give R13 his ham. E7 confirmed she gave R13 his mashed potatoes. There was no gravy on the mashed potatoes. E7 stated she was feeding a resident at another table and she turned around and noticed R13 was blue, slumped over with tongue hanging out. His lips and hands were blue. E7 stated R13 was on a mechanical soft diet because he had an eating disorder. He ate too fast and put too much food in his mouth at a time. Because of this he was served his food in bowls and given one bowl at a time. E7 stated residents on mechanical soft</p>			F9999			

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F9999	<p>Continued From page 70</p> <p>diets were given small chopped up pieces of ham that day. E7 stated R13 had in the past tried to take other residents food. E7 stated she did not think he took other residents food on 10-3-09 because the other residents, R1 and R21, who were sitting with R13 at the time, would have thrown a fit if he took their food.</p> <p>E4, Licensed Practical Nurse, LPN, stated on 10-9-09, she was working on 10-3-09. She was in room 105 when E6, CNA, came running saying R13 was not responsive or breathing. E4 went to the dining room. E4 states R4 was leaning forward and edges of his face and his hands were already blue. E7 helped put R12 onto the floor. E4 looked into R13's mouth and saw nothing so she did abdominal thrusts and nothing came up. CPR was started. E4 stated she thought R13 had a heart attack. 911 was called and CPR continued and food started to come out. Abdominal thrusts were done and E5 did finger sweep and got food out of R13's mouth. First she got mashed potatoes and then ham out of R13's mouth. EMS arrived and R13 was pronounced dead.</p> <p>On 10-9-09, E5, LPN, stated she was working on 10-3-09 and that R13 was her resident. E5 stated R13 was on a mechanical soft diet. Up until that day she did not know why he was on a mechanical soft diet. She now knows it was because he would eat fast. E5 stated she did not remember if she gave him the ham. She did take him to the dining room but did not stay. E5 confirmed she did a finger sweep after food started to come out of his mouth. E5 stated she first got out mashed potatoes and small flat pieces of ham. E5 confirmed the ham was not ground.</p>			F9999			

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F9999	<p>Continued From page 71</p> <p>On 10-9-09, E9, Dietary Manager, provided the menu for the noon meal on 10-3-09. The menu showed residents on Mechanical Soft Diets should have received Ground Swedish Meatballs, Parslied Noodles, Seasoned Green Peas, Chilled Peaches, Bread and Margarine. According to the above interviews, the residents on a Mechanical Soft Diet got cut up/torn ham and mashed potatoes with no gravy. E9 stated that ham and mashed potatoes with gravy, a vegetable and mixed fruit was the alternate. E9 stated they have a machine that grinds meat. He stated there was no recipe, they just add the meat and grind. E9 later provided a recipe for mechanical soft baked ham that showed the ham is to be ground with cream gravy. E9 confirmed the ham should have been ground with gravy.</p> <p>E8, the cook, stated he was the cook on 10-3-09. He stated he had baked a whole ham that he had cut into slices. He confirmed he did not grind the ham according to the recipe. He said the ham was tender so he just tore it up into pieces. E8 confirmed there was a meat grinder in the kitchen, but he did not think the ham needed to be ground. E8 confirmed he does not always grind the meat. If the meat is hard he would grind it. If it is soft meat he would mush it or tear it.</p> <p>Facility Incident Investigation Report of 10-6-09 states on 10-3-09 at 12:21PM, R13 was in the dining room and given a bowl of mechanical soft ham to begin his meal. Two CNA's, E6 and E7 were in the dining room during the entire meal service, supervising. About ten minutes following the first bowl of food being delivered to R12, E7 gave R13 his second bowl of food which was</p>			F9999			

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F9999	<p>Continued From page 72</p> <p>mashed potatoes. At that time there was nothing alarming about his condition. E7 then went to another table to assist a resident with eating. Within ten seconds, the CNA's turned back towards R13 and noted that he wasn't breathing, head was slumped, and a dusky color was noted. Only half of mashed potatoes were consumed....While performing chest compressions, food was noted to be regurgitating into mouth, and particles were manually removed. EMS arrived after 12:26PM and took over CPR. Downtime not established by EMS from Nurses. EMS unable to suction resident due to thick consistency of particles in oral cavity. Asystole was noted on cardiac monitor. R13 was pronounced dead at 12:40PM...Preliminary autopsy report states that R13 died of asphyxia secondary to choking, and death was ruled accidental. "R13 has no diagnosis, of "eating disorder", but does have behaviors of eating too fast at times. Care plan states "encourage me to slow down when eating too fast"..."Spoke with Z1, R13's Physician, at 1:05pm on 10/5/09, and described to him the scenario of events on 10/3/09. Dr. stated that R13 "could have had a fatal arrhythmia or massive MI (Myocardial Infarction) that caused him to aspirate on the mashed potatoes." There is nothing in the report about R13 getting the wrong consistency of meat.</p> <p>On 10-9-09, Z1 stated he was unaware R13 got pieces of ham and not ground. Z1 stated it is a concern if R13 did not get ground meat as called for on the Mechanical soft diet. Z1 stated it was a possibility that R13 could have had a heart attack or arrhythmia which caused his death. The autopsy would tell. Z1 stated check with the Pathologist and get his opinion. Z1 stated the Pathologist would know from his autopsy.</p>			F9999			

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F9999	<p>Continued From page 73</p> <p>The County Coroner DEATH INVESTIGATION REPORT for R13 states R13 was "found unresponsive-eating- mouth full- some food extracted by staff - much debris seen in ottopharynx (Ham)?...Cause of death-asphyxiation due to food bolus." On 10-13-09 at 11:40AM, Z5, Corner, stated when he got to the facility there were ham pieces and mashed potatoes that staff had retrieved from R13's mouth,.lying on the floor next to R13's body. Staff told Z5 that R13 was on a mechanical soft diet and had behavior of eating too fast.</p> <p>On 10-13-09, Z3, Pathologist, stated he did the autopsy on R13. Z3 stated the autopsy showed R13's death was due to choking. There was nothing to suggest a heart attack or Thrombosis. Z3 stated he removed a substantial amount of ham from R13's wind pipe. The ham was not ground and not chewed. Z3 stated the ham pieces were at least 2 inches long and 1/2 inch wide. Z3 stated he removed a wad of ham the size of a tangerine. Z3 stated there was a bit of mashed potatoes in the stomach and he remove a piece of pineapple from R13's mouth. Z3 stated the cause of death was from choking and absolutely not coronary.</p> <p>2. On 10-9-09, E1, Administrator, identified R1 as being a resident who is at choking risk due to eating too fast. Record review of R1's POS of October 2009, shows an order for a Mechanical soft diet to be served in bowls. R1's MDS of 9-4-09 shows R1 requires set up help only and supervision at meals. R1 is on a Mechanical Soft diet and is identified as having a chewing problem. R1's NURSING ASSESSMENT</p>			F9999			

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F9999	<p>Continued From page 74</p> <p>SUMMARY of May 2009 states R1 is on a Mechanical Soft diet and chews rapidly and is served food in separate large bowls at intervals related rapid eating. The Facility ALL RESIDENTS PROBLEMS/GOALS assessment of 5-27-09 states a problem of mechanical soft diet, chewing difficulty, poor condition of teeth, history of eating rapidly requiring cues to slow down... with goal that R1 will tolerate mechanical soft diet without signs/symptoms of choking or aspiration and maintain adequate nutrition. R1's Care Plan of 6-25-2009 identifies a problem of R1 eating too fast. Need cues to slow down. R1 has some difficulty with chewing due to poor condition of teeth. Care Plan approaches include, in part: Observe for and report any difficulty chewing/swallowing; Large bowls at meals. Give food at intervals to deter rapid eating; Diet as ordered. Monitor intake.</p> <p>On 10-9-09, during noon meal, R1 was observed to get baked fish in a bowl. There were large chunks of fish the size of a silver dollar or larger. Observation showed all residents on Mechanical Soft diets had large pieces of baked fish sent out on their trays.</p> <p>Record review of the menu for the noon meal on 10-9-09, called for flaked lemon pepper fish. E9, Dietary Manager, stated the kitchen did not need to alter the fish as the menu called for flaked fish. E9 stated he did not have a menu or guidelines for the flaked fish.</p> <p>Z2, Registered Dietitian/Menu Specialist, who wrote the menus, stated on 10-9-09 that their should be a recipe for the flaked fish. Z2 stated staff should take a fork and flake the fish into small pieces. Z2 stated she would recommend</p>			F9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145928		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2009	
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F9999	<p>Continued From page 75</p> <p>this be done in the kitchen. Z2 stated, "Absolutely not correct that the fish would be sent out of the kitchen in large pieces."</p> <p>E8, the cook, stated on 10-13-09 that E9 had told him the fish for the mechanical soft diets could be whole because the menu said flaky.</p> <p>R1 was observed on 10-13-09 from 11:30AM to 12:35PM, during noon meal, to be sitting in a geriatric recliner in the assisted dining room. R1 was sitting at a round table and facing the wall. E24, CNA, asked R1 what she wanted first, her chicken, potatoes or broccoli. R1 stated she would take her broccoli first. E24 gave R1 a bowl of broccoli. R1 was observed to feed herself the broccoli very quickly, cough while eating and lick the bowl. R1 was not within vision of the two CNA's in the dining room feeding other residents. R1 was facing the wall and E24 had her back to R1. E23, CNA, was at a table sitting with E24 and facing R1 but could not see R1 as R1's back of chair was blocking her vision. At 12:45PM, E23 and E24 were asked if they could see R1 eat while in the dining room and both stated, "No." E24 stated R1 gets her food in bowls 1 at a time due to eating very fast.</p> <p>3. R9's Minimum Data Set (MDS), dated 8-14-09, documented that R9's diagnosis was, in part, Cerebral Palsy and that she required supervision with eating. R9's Care Plan, dated 3-12-09, documented that R9 ate rapidly, could finish her meal within meals and that she needed clues to slow down.</p> <p>During the noon meal, on 10-13-09 at 11:10a.m., R9 was served at least one glass of water, a plate containing ground chicken, broccoli, plain</p>			F9999			

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F9999	<p>Continued From page 76</p> <p>mashed potatoes and cornbread and a separate bowl of fruit. R9's cornbread was not cut into small pieces.</p> <p>R9 was observed dragging her spoon across her plate, into the bowl of fruit and scooping up large portions of food and large pieces of cornbread. R9 rapidly ate her food, did not drink between mouthfuls and did not completely swallow each mouthful of food. Staff did not intervene R9's rapid eating and clue R9 to slow down her food consumption nor clue her to drink water between quick spoonfuls of food.</p> <p>(A)</p> <p>300.1210a)</p> <p>Section 300.2010 Director of Food Services</p> <p>a) A full-time person, qualified by training and experience, shall be responsible for the total food and nutrition services of the facility. This person shall be on duty a minimum of 40 hours each week.</p> <p>1) This person shall be either a dietitian or a dietetic service supervisor.</p> <p>2) The person responsible for the food service may assume some cooking duties but only if these duties do not interfere with the responsibilities of management and supervision</p> <p>This Regulation was not met as evidenced by:</p>			F9999			

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F9999	<p>Continued From page 77</p> <p>Based on record review the Director of Food Services has not completed the class to become a supervisor.</p> <p>Findings include:</p> <p>E9 was hired as the Director of Food Services on 8/22/08. He enrolled in the 90 hour managers class to become qualified on 3/17/09. At the time of the survey he had not completed the classes to become a dietetic service supervisor.</p> <p style="text-align: center;">(B)</p> <p>300.7040d)</p> <p>Section 300.7040 Activities</p> <p>d) Activity programming shall be planned and provided throughout the day and evening, at least 7 days a week for an average of 8 hours per day.</p> <p>This Regulation was not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to plan, implement, and evaluate the provision of individualized activities to meet the needs, abilities and preferences for five of thirteen residents on the Alzheimer Unit with dementia and behaviors (R2, R8, R10, R16 and R15).</p> <p>Findings include:</p> <p>1. R2's Care Plan, dated 1-19-09, documented, in part, that R2's past interests were dancing, playing cards, walking, music, church, flowers and reading and that she enjoyed watching TV in</p>			F9999			

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F9999	<p>Continued From page 78 her room.</p> <p>On 10-13-09 and 10-14-09, R2 was observed laying in bed without any activities provided.</p> <p>2. R10's Care Plan, dated 1-13-09, documented that staff were to take R10 to current activities and assist him to participate. R10's Profile and Activities Program Information sheet, dated 1-07, documented that R10 enjoyed music, movies, busy box and building blocks.</p> <p>On 10-13-9 and 10-14-09, R10 was observed laying in bed without any activities provided, sitting in a reclining chair asleep; being provided incontinent care by staff; or being fed by staff at meals.</p> <p>3. R8's Care Plan, dated 3-6-09, documented that she was to be encouraged and assisted with activity participation.</p> <p>On 10-13-09, R8 was not engaged and/or encouraged to participate in activities. R8 was observed in bed asleep and/or assisted with her noon meal.</p> <p>4. Interview of E14, Alzheimer's Unit Activity Director, on 10-15-09, and she stated that she was not aware of any updated evaluations and/or assessments for R2, R8 and R10. E14 stated that R10 had a history of decline; however, she was not aware of an updated assessment and/or evaluation to meet his activities needs with his history of decline.</p> <p>5. On 10-13-09 and 10-14-09, R15 and R16 were seen wandering the Alzheimer Unit either unengaged in activities and/or picking at the walls</p>			F9999			