



**Resident:** Margaret D.  
**State:** West Virginia  
**Type of Facility:** Assisted Living  
**Residency:** 8/24/98 – 9/30/99

## THE BEFORE PICTURE

### An introduction to Margaret D.

- Age: 78
- Life's occupation: Homemaker
- 2 children
- Enjoyed sewing

### Facility assessment of Margaret D. upon admission:

- Alzheimer's Disease
- Had had a stroke

## A PROFILE IN NEGLECT

### How Margaret D. was neglected:

- Because of her Alzheimer's Disease and increased wandering away from home, Mrs. D.'s family felt that they could no longer care for her safely at home and admitted her to the facility on August 24, 1998. Mrs. D.'s family discussed her wandering with facility staff, and they assured Mrs. D.'s family that they were equipped to care for her and keep her safe.
- Subsequent to her admission, Mrs. D.'s cognitive and physical abilities deteriorated. Mrs. D.'s wandering and elopement\* behaviors and frequent falls put her at high risk.
- From the time of her admission until the time of her death, Mrs. D. left the facility without notice by facility staff on 15 occasions. On one occasion, Mrs. D. was shocked by an electric fence while wandering from the facility.
- During her stay at the facility, Mrs. D. also experienced more than 22 falls. Several of the falls resulted in injury, including skin tears, bruises, scratches, and displacement of teeth.
- Despite these ongoing risks to her safety, the facility failed to effectively implement care and treatment plans to address Mrs. D.'s behaviors and conditions, such as bed or chair sensors, a Wanderguard bracelet, involvement in planned group activities, or relocation to a room where visual supervision was readily available.
- The facility also failed to determine that it could not effectively care for Mrs. D. and seek alternative placement to a facility with a contained living unit for residents for whom elopement is a risk.
- Unsupervised by staff, Mrs. D. wandered from the facility again on September 30, 1999. At 6:45 p.m., she was found outside of the facility on the roadway, unresponsive, and with head injuries. She died of her injuries a few hours later at the hospital.

**The human cost of neglect:**

- Multiple injuries from falls
- Death

**The financial cost of neglect:**

- Unknown

**ANY CONSEQUENCES TO THE FACILITY?**

- Did the survey agency fine the facility for this neglect?.....**No**
- What was the amount of fine actually paid?.....**\$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? .....**Not applicable**

- Did the survey agency place the facility on state monitoring status?.....**No**
- Was the facility’s license placed on probationary status or revoked for this neglect?.....**No**
- Was this neglect criminally prosecuted? .....**No**