

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

PRINTED: 12/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505489	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/21/2012
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NAME OF PROVIDER OR SUPPLIER SEA MAR COMMUNITY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 SOUTH HENDERSON STREET SEATTLE, WA 98108
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated with Partial Extended Survey conducted at Sea Mar Community Care Center on 12/05/12, 12/07/12, 12/18/12 and 12/21/12. A sample of 7 residents was selected from a census of 97. The sample included 6 current residents and 1 discharged resident.</p> <p>On 12/18/2012 an immediate jeopardy was identified related to F-323 Accidents. The facility abated the jeopardy on 12/21/12.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2720070</p> <p>The survey was conducted by:</p> <p>Liza Masher RN, BSN Susan Abrisz, MSW</p> <p>The survey team is from:</p> <p>The Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, Region 4, Unit D 20425 72nd Avenue South, Suite 400 Kent WA, 98032-2388</p> <p>Telephone: (253) 234-6004 Fax: (253) 395-5070</p> <p><i>Mike Annette</i> 12-28-12 Residential Care Services Date</p>	F 000	<p>RECEIVED</p> <p>JAN 07 2013</p> <p>DSHS/ADSA/RCS Region 4</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Coocena Trivedi</i> Administrator	TITLE	(X6) DATE 1/4/2013
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Received Time Jan. 4. 2013 11:33AM No. 5670

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F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide safe and secured environment, and ensure adequate monitoring and supervision of 1 of 4 sampled residents (#1) who was cognitively impaired with known elopement risks. These failures resulted in the Resident #1's avoidable accident that caused his death when he was hit and killed while walking on a highway after eloping from the facility. This placed all other cognitively impaired residents with eloping and exit seeking behaviors residing at the facility's "secured" ALC (Alzheimer's Living Center) unit at risk. The facility's failure to ensure that their patio area was secured for exit seeking residents and failure to adequately supervise exit seeking residents was identified as immediate jeopardy. A safety plan was obtained 12/18/12. The facility was notified on 12/18/12 that these failed practices were found to be immediate jeopardy. The facility abated the jeopardy on 12/21/12. Findings include:	F 323 F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION /DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The facility initiated safety steps immediately and has continued to make changes to ensure that facility residents are safe including: On 12/4/2012 Facility began process for the installation of a security keypad on the door from the ALC unit to the ALC garden/patio; assigned additional staff on the unit. Additionally, the Resident Care Manager has increased her time in the ALC in order to more closely monitor the unit operations and to provide additional support/guidance and training to staff as needed related to resident engagement and safety. Facility identified the need for a more robust process for elopement risk assessment and care planning; policies and procedures, assessment tools, etc. developed. This has been completed and is being implemented. On 12/5/2012 tree branches in the ALC patio/garden were again trimmed back and some trees close to the fence were pulled up; unit programming was reviewed and restructured to include supervised time in the ALC patio/garden area and an early evening activity for residents. Calendar was developed and ALC staff were oriented on the activities listed for the rest of the month of December. Staff were informed of the programming changes – including the resident/group outdoor time/activities and the need for resident monitoring/supervision at all times while they are in the patio/garden area.	1/9/2013	

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F 323	<p>Continued From page 2</p> <p>According to the MDS (Minimum Data Set) dated 11/20/12, Resident #1 was admitted to the facility on [REDACTED] with diagnoses that included [REDACTED]. The MDS indicated that Resident #1 was cognitively impaired and exhibited wandering behaviors and disorganized thinking. The MDS indicated that Resident #1 was independent with ambulation.</p> <p>Upon admission, the admitting nurse identified the resident as being high risk for wandering and/or elopement due to his history of successful elopement from the prior facility.</p> <p>According to the 12/4/12 Facility's Incident Report Statement "... (name of the resident) had been transferred to ... (facility) from another Skilled Nursing Facility after he succeeded in eloping ..."</p> <p>UNSAFE ENVIRONMENT:</p> <p>According to the facility's Incident Report Statement dated December 4, 2012, the resident eloped on December 3, 2012 through Alzheimer's Unit Walking Garden possibly by climbing or slipping under the wooden fence there. On the evening of 12/04/12 the administrator was informed by the police the resident was involved in an accident while walking on 509 highway and was deceased.</p> <p>Observation on 12/5/12 at 12:23 p.m. of the Alzheimer's Unit Walking Garden revealed a tree with lower branches next to South fence was present and could be used by a resident to steady self and climb the fence. In the South East corner of the fence was a clay pot for plants approximately 18-24 inches tall reducing the</p>	F 323	<p>On 12/5-7/2012 ALC staff were retrained on the existing policy for managing ALC residents at increased risk for elopement.</p> <p>On 12/6/2012 – Initial safety plan was faxed to Susan Abrisz, DSHS outlining work that had been completed and would be completed by that day.</p> <p>On 12/7/2012 – Audible door alarm was installed on the ALC unit door leading to the patio/garden area secondary to delay in getting approval for keypad from DOH.</p> <p>On 12/18/2012 – New facility policies and procedures, assessment tools and processes developed relative to elopement, alert charting and ALC programming were faxed to Susan Abrisz.</p> <p>12/18/2012 – Effective at 4:45 PM the safety monitoring/process for the ALC was changed to have a 24/7 dedicated person assigned to monitor the ALC unit door leading to the ALC patio/garden and to ensure that no resident went into the patio/garden unsupervised. Specific instructions were prepared in English and in Spanish for the assigned person and the floor nurse. This measure will be in effect until the completion of the new fence and installation of the door keypads in the ALC unit. Plan and instructions were faxed to Liza Masher, DSHS on 12/18/2012. On this day, work was also started on new, sturdier fence. 27 inches was added to the fence height. New fence was completed on January 3, 2013. This is in compliance with the Directed Plan of Correction.</p> <p>On 12/19/2012 facility staff were in-serviced on new policies and procedures, assessment tools, care plans, etc. relative to resident elopement. Elopement risk assessments for ALC residents and for other residents in the facility identified to be at risk for elopement were started. These resident elopement assessments will be completed by 1/9/2013.</p>	

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F 323	<p>Continued From page 3</p> <p>height needing to be scaled to approximately four feet. A bench was also observed next to the North side of the fence that could provide approximately 18 inches step up to help climb through the fence. Additionally, a gap of 8-9 inches between the ground and the lower edge of the fence was also observed which could potentially be used for an exit or could entrapped a cognitively impaired resident.</p> <p>The DNS reported that she notified the AIT (Administrator In Trainee) about the tree and the gap by the fence on November 2012 but observation on 12/5/12 at 12:23 revealed no changes.</p> <p>Review of the facility's work order dated 6/4/12 staff wrote "Patio fence ... ALC unit patio ... The wooden post on fence ... is very wobbly (wobbly) since resident climbed over the fence this past weekend ... the gate in the back needs repair bad before someone knocks out some more slats & (and) makes for an easy exit, falls off the wall and breaks a hip or neck."</p> <p>Review of the facility's Safety Committee Meeting Minutes dated 6/29/12, 7/20/12, 8/23/12, 9/22/12, 10/19/12, and 11/12 staff wrote repeatedly the following "ALC courtyard needs to have trees trimmed, leaves swept, repairs to fence." There was no indication that the committee had discussed on how to address those safety concerns.</p> <p>Review of the facility's Grand Rounds Inspection Form, staff documented the following: 6/1/12 - "Pots in ALC close to fence?!" - "Fence Leaning on NW side , gaps on fence" 7/1/12 - "Fence in ALC still 0 (not) fixed; gaps @ (at)</p>	F 323	<p>To ensure that all facility residents at risk for elopement are and remain safe:</p> <ul style="list-style-type: none"> • All current residents identified to be at risk for elopement and newly admitted residents will be assessed to determine the risk of elopement, appropriate care plan will be developed and implemented. Elopement assessments will be reviewed and updated on a quarterly basis with the MDS and care conference, or as needed. To monitor and ensure compliance, facility will conduct ongoing monthly audits for elopement assessment and care plans for new admissions, those residents who had MDS due during that month and any resident who had a change in condition necessitating an elopement assessment. Additionally, as indicated, high elopement risk residents will be discussed in the weekly interdisciplinary At-Risk Meetings led by the DNS. • Monthly health and safety check results of the facility, including the ALC fence/patio/garden area will be reported immediately to the Administrator for corrective action as needed. <p>Administrator and Interdisciplinary Team to ensure compliance.</p>	

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F 323	<p>Continued From page 4 bottom C (not) safe" - "Patio (ALC) needs to be cleaned." 8/8/12 - "Courtyard to ALC needs branches trimmed" - "Fence is unlocked on patio side" - "Large gap under door" 9/2/12 "Trees throughout property need to be trimmed/cut away from building" 11/5 - "Keep door closed to patio" - "All courtyard full of leaves" - "Gaps in fence"</p> <p>In an interview with Staff A, Admissions Coordinator on 12/7/12 at 3:35 p.m., she stated "there had been ongoing concerns; the fence isn't really high enough." She indicated that there were discussions and plans related to replacing the fence but she wasn't sure if it was approved or if funds were allocated. When asked about the issues that she observed around ALC, she said "I had observed tree by the fence, numerous times reported to maintenance. Also bench along north side of fence. Just removed a tree in north east corner (since Wednesday 12/5/12). I was working with ... (former Administrator) on getting a new fence (for ALC area), then after he left, it didn't happen." On 12/7/12 at 3:35 p.m., Staff A, told the investigator that the door leading to the courtyard had a doorbell on it in the past. When asked what happened she said "the batteries died or it was turned off with switch". Staff A indicated that it wasn't the first time that the facility discussed on putting keypads on doors. When asked what happened with those discussions she stated "they said we will look into it."</p>	F 323	

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F 323

Continued From page 5

F 323

LACK OF MONITORING AND SUPERVISION:

According to the 12/4/12 Facility's Incident Report Statement "... (name of the resident) had been transferred to ... (facility) from another Skilled Nursing Facility after he succeeded in eloping from that facility earlier in 2012 ... repeatedly voiced his intent to leave ... (the facility) in the days preceding [REDACTED] (The day the resident eloped the facility and was hit by 2 cars and killed)."

According to the elopement risk tracking log dated 11/13/12 the Named Resident had "Hx of Previous elopements ... Verbalizes Desire to Go Home."

Review of the facility's MDS 3.0 Care Area Assessment Documentation notes dated 11/20/12, staff wrote "Per staff interview he (Resident #1) wanders in the ALC-secured unit where he has been admitted ... due to exit seeking at prior facility where he came from. He enters to other resident's rooms and has episodes of exit seeking, staff redirects him constantly. He continues to have exit seeking episodes ..."

Staff documented multiple episodes of resident #1 wandering into other residents' rooms. Staff also documented resident behaviors of agitation and exit seeking, including:
- [REDACTED] (resident's date of admission) staff wrote "Admitting Dx of Advanced Dementia ...hx of agitation ...Current issues to watch ...exit-seeking behavior."
-11/16/12 "...walk to exit door x 1"

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F 323 Continued From page 6

- 11/17/12 "Resident was wandering and ambulating ..."
- 11/17/12 at 1230 "...confusion and wandering ... with increasing agitation toward the staff members."
- 11/17/12 at 10:30 p.m. "...ambulating ...out into the garden area in the rain ... he became increasingly agitated and wanting to exit."
- 11/18/12 at 1300 "...he was actively exit seeking, taking about ... 'leaving here', agitated and was very difficult to redirect."
- 11/19/12 "... active seeking didn't sleep until midnight ..."
- 11/.../12 "Patient wanders in courtyard looking at fence. Verbally states 'I want to leave this place' ...appears agitated. Brought back inside and again patient return to courtyard seeking exit."
- 12/1/12 5:30 p.m., "Pt states 'I got to leave this place' continuously talking to staff unsuccessful to have him sit."
- 12/3/12 0550 "Resident on alert charting r/t have exit seeking."
- ██████ 2240 "Resident could not be found for dinner at 5:30 p.m. last seen at 4:40 PM ... administrator is (was) informed by the police the resident is (was) involved in an accident while walking on 509 highway and is deceased ..."

F 323

Resident #1's Plan of Care dated 11/12 instructed staff to "Monitor behaviors ... Encourage resident to participate in daily activities ... Redirect resident to conversation or activities ...". No other directions of interventions of Resident's agitation wandering and exit seeking was found and when to place the resident for a 15 minute check. Additionally there was no indication that the resident's care plan was revised or updated after the resident was actively seeking for exit.

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F 323	<p>Continued From page 7</p> <p>In an interview with Staff C, RN, RCM (Residential Care Manager) on 12/5/12 at 4:30 p.m. she indicated that if a resident is observed to be exit seeking "they can be monitored or even put on every 15 min checks ...".</p> <p>Further review of records revealed the resident was not placed on 15 minute checks when the resident was actively seeking for exit and agitated.</p> <p>In an interview on 12/7/12 at 12:55 p.m., Staff B, RN (Registered Nurse) assigned to care for ALC residents told the investigator that the facility did not train her regarding resident elopements. Staff B indicated that the facility "...need a process tree" to direct staff when to go to the next higher level of supervision for a resident at risk for elopement. When asked how they would know that a resident needs a 15 minute check, staff B indicated that the Nurse decides when a resident is in need of 15 minute checks and said "If they say I gotta get out of here, if they try to push door ... if they try to leave, if they attempt to leave ... if agitated and talking about leaving..."</p> <p>In an interview with the DNS (Director of Nursing) on 12/7/12 at 3:15 p.m., regarding her expectations related to use of 15 min. checks, she stated "We don't have an appropriate tool for elopement risk ... it's not clear when resident are at risk.. How do we define elopement? Without defining elopement- they haven't really begun to identify levels of risk. They identify some risk factors on page 1 of policy, but are meeting now to look at a revision of risk assessment."</p> <p>According to the 12/4/12 Facility's Incident Report Statement, the resident eloped and "...the victim (Resident #1) ...had not survived the impact of two (2) collisions from different motor vehicles when he apparently had walked into oncoming</p>	F 323		

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F 323	Continued From page 8 traffic on Highway 509 while in a disoriented state." Observation on 12/18/12 at 3:10 p.m., revealed the ALC unit had a fence around it (looked like a plastic coated chain link fence). There were 2 trees inside the fence, two wooden posts within the fence that measured about 12 feet x 3.5 inches and a bench that measured L=71.5 x W=17.5 x H 18 inches right next to the fence. In an interview with the Administrator on 12/18/12 at 3:50 p.m., she indicated that on 12/4/12 alarms on the ALC door exits were added and staff were in serviced regarding residents not having unsupervised access to the ALC garden area. The administrator told the investigator that there was only one staff assigned to the ALC unit at night time and another back up staff that will check the unit from time to time. The Administrator was unable to answer when asked how could they ensure that residents who will go out through the exit door get supervision if the only staff assigned in the unit is busy assisting and/or taking care of another resident. The facility was notified of the immediate jeopardy on 12/18/12 at 4:05 p.m. Before exiting the facility on 12/18/12, the facility had provided a safety plan to ensure supervision was increased and the monitoring of the patio area. An on-site visit on 12/21/2012 to complete the partial extended survey confirmed the immediate jeopardy had been abated.	F 323			
F 490 SS=K	483.76 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial	F 490			

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

PRINTED: 12/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505489	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/21/2012
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F 490	<p>Continued From page 9 well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to administer services effectively and efficiently in order to attain, and/or maintain, each cognitively impaired resident's optimal physical, mental and psychosocial well-being. Failure to provide safe and secured environment, and ensure adequate monitoring and supervision of cognitively impaired residents with known elopement risks, resulted in the Resident #1's avoidable accident that caused his death when he was hit and killed while walking on a highway after eloping from the facility. This potentially placed all other cognitively impaired residents with eloping and exit seeking behaviors residing at the facility's "secured" ALC (Alzheimer's Living Center) unit at risk.</p> <p>Findings include:</p> <p>Observation on 12/5/12 at 12:23 p.m. of the Alzheimer's Unit Walking Garden revealed a tree with lower branches next to South fence was present and could be used by a resident to steady self and climb the fence. In the South East corner of the fence was a clay pot for plants approximately 18-24 inches tall reducing the height needing to be scaled to approximately four feet. A bench was also observed next to the North side of the fence that could provide approximately 18 inches step up to help climb through the fence. Additionally, a gap</p>	F 490 F 490	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>The facility administration initiated safety steps immediately and has continued to make changes to ensure that facility residents are safe.</p> <p>A dedicated staff person has been assigned to monitor the door from the ALC unit to the patio/garden area to ensure that ALC residents do not have unsupervised access to the patio/garden area until such time as the doors leading to the patio/garden area are secured with a keypad. ALC programming has been changed such that no ALC resident will have unsupervised access to the ALC patio/garden area. Staff has been in-serviced on revised programming, to include dedicated person on ALC door to patio, supervised resident outside time, additional resident engagement/activities. A taller and sturdier fence has been built for the ALC patio/garden area. It was completed on 1/3/2013. Trees and shrubs have again been trimmed back; trees and bushes close to the fence have been removed; all flower pots have been removed from the patio/garden area</p> <p>1/9/2013</p>

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F 490	Continued From page 10 of 8-9 inches between the ground and the lower edge of the fence was also observed which could potentially be used for an exit or could entrapped a cognitively impaired resident. Review of the facility's work order dated 6/4/12 staff wrote "Patio fence ... ALC unit patio ... The wooden post on fence ... is very wobbly (wobbly) since resident climbed over the fence this past weekend ... the gate in the back needs repair bad before someone knocks out some more slats & (and) makes for an easy exit, falls off the wall and breaks a hip or neck." Review of the facility's Safety Committee Meeting Minutes dated 6/29/12, 7/20/12, 8/23/12, 9/22/12, 10/19/12, and 11/12 staff wrote repeatedly the following "ALC courtyard needs to have trees trimmed, leaves swept, repairs to fence." There was no indication that the committee had discussed how to address those safety concerns. The DNS reported that she notified the AIT (Administrator In Training) about the tree and the gap by the fence on November 2012 but observation on 12/5/12 at 12:23 revealed no changes. In an interview with the Administrator on 12/18/12 at 3:50 p.m., she indicated that on 12/4/12 alarms on the ALC door exits were added and staff were in serviced regarding residents not having unsupervised access to the ALC garden area. The administrator relayed that she was aware of the ongoing safety concern in the ALC garden area. The administrator was also unable to answer what had been done to the unsecured environment discussed on multiple occasions in the safety committees to immediately fix the concerns in the ALC garden area prior. The administrator told the investigator that there was only one staff assigned to the ALC unit at	F 490	An audible door alarm has been installed Keypads are being installed on the door from the ALC to the patio/garden area and on the stairwell door; as approved by DOH Construction Review. it is anticipated that this will be completed by Jan. 9, 2013. (there was some delay in getting the request response from the DOH). All facility residents, including ALC unit residents will be assessed for elopement risk upon admission and quarterly with MDS review or as needed. To ensure timely corrective action to facility safety check findings, the process has been revised to include immediate discussion with the Administrator when safety issues are identified. Administrator will continue to take continuing education courses including those relevant to resident care and safety. Administrator to ensure compliance.		

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F 490	Continued From page 11 night time and another back up staff that will check the unit from time to time. The Administrator was unable to answer when asked how could they ensure that residents who will go out through the exit door get supervision if the only staff assigned in the unit is busy assisting and/or taking care of another resident. The Administration failed to provide safe and secured environment, and ensure adequate monitoring and supervision of cognitively impaired resident's with known elopement risks. This potentially placed all other cognitively impaired residents with eloping and exit seeking behaviors residing at the facility's "secured" ALC (Alzheimer's Living Center) unit at risk for potential harm. Refer to F 323 CFR 483.25(h) (2) Prevention of accidents.	F 490			

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