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| 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 07/30/2012 |
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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 Survey conducted at Sea Mar Community Care Center on 07/27/2012 and 07/30/2012. A sample of 5 residents were selected from a census of 96.</p> <p>The following complaint was investigated as part of this survey:</p> <p>12-07-22686</p> <p>The survey was conducted by:</p> <p>Diane Kirse, RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Disability Services Administration Residential Care Services, Region 4 20425 72nd. Ave. South, Suite 400 Kent, WA. 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395- 5070</p> <p><i>[Signature]</i> 8/15/12 Residential Care Services Date</p> | F 000 | <p>RECEIVED</p> <p>AUG 24 2012</p> <p>DSHS/ADSA/RCS</p> | 7/14/12 |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> | TITLE Administrator | (X6) DATE 8/14/12 |
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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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| F 323 SS=D | <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure the safety and wellbeing of one (Resident #1) of 5 sampled Residents who had a high risk of elopement from the facility. The facility failed to monitor and supervise Resident #1. The facility failure to adequately monitor and supervise Resident #1 resulted in the Resident eloping from the facility and placed the resident at risk to experience cold or heat exposure, dehydration, medical complications, and injury.</p> <p>Findings Include:</p> <p>Resident #1 was admitted to the facility on [REDACTED] with [REDACTED]. The MDS (Minimum Data Set) dated 05/16/2012 revealed the Resident was at risk for wandering and demonstrated the behavior daily but the behavior did not place the resident "at risk of getting to a potentially dangerous place, (e.g., down stairs,</p> | F 323 | <p>F323 483.25(H) FREE OF ACCIDENT HAZARDS/SUPERVISION/ DEVICES</p> <p>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.</p> <p><u>Resident #1</u></p> <p>Resident's care plans were updated on 7/19, 7/24 and 7/29, 2012 respectively for Mood and Behavior, Cognitive Deficit and Chronic Confusion respectively. Behavior monitoring focused on anxiety and agitation so that nursing staff can intervene prior to resident's behavior escalating. Referral to psych was made on 7/29/2012 to review resident's medications due to his increased elopement risk and anxiety. Physician order for UA obtained on 7/29/2012 due to increased confusion. Rec. Therapy plan of care revised on 7/30/2012.</p> | 7/19/12 |

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| F 323 | <p>Continued From page 2 outside the facility.)"</p> <p>Per the care plan, the Resident was at risk for falls, dehydration, agitation, and elopement. The Resident lived on the dementia unit, which is a locked unit. The Resident could not be interviewed due to cognitive impairment.</p> <p>On 07/19/2012 at 12:30 PM, Staff E, CNA, (Certified Nursing Assistant) was returning to the facility with another Resident who had been out for an appointment. She observed Resident #1 on the side of the road, approximately 5 blocks away from the facility. She stated he was holding on to a tree, was sweating and was unstable on his feet. She transported Resident #1 back to the facility. In interviews with Staff A, C, E, and I, they were unable to determine how long the Resident had been gone or how he got out of the unit.</p> <p>On 07/27/2012 and 07/30/2012, multiple observations of Residents #2, 3, 4, and 5 revealed they made multiple attempts to exit the unit. All suffer from memory impairment and were identified to be at high risk for elopment. Observations revealed multiple staff and visitors coming in and out of the unit without ensuring the door closed properly behind them.</p> <p>In an interview with Staff J, RN (Registered Nurse) on 07/30/2012 at 8:30 AM, he stated that all the Residents on the unit are at risk for elopement and "it (elopement) happens all the time". He verified there was three staff assigned on the unit and when staff are in rooms, involved in the care of other Residents, there was no one in the area to observe the other Residents. He stated that Residents will exit behind someone</p> | F 323 | <p>To insure all secure unit residents have a decreased risk of elopement, and to address the issue regarding staff and visitors coming in and out of the unit without ensuring that the doors were properly closed behind them, notices were posted on 7/24/2012 to as a reminder to all persons entering and exiting the unit to do so.</p> <p>On 8/6/2012 we implemented a system where all staff taking and returning a resident to the secure unit will sign the resident in and out.</p> <p>By August 31, 2012 facility will have a policy and procedure for monitoring and managing residents at increased risk for elopement.</p> <p>By August 31, 2012, facility staff will be in-serviced on the policy and procedure.</p> <p>By September 7, 2012, the facility will initiate the system for resident monitoring and management via a 15 min checks/ rounding log - to be implemented in the secure unit, as per facility policy.</p> | |
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| F 323 | <p>Continued From page 3 when they open the door.</p> <p>On 07/27/2012 at 3:40 PM Staff A, the MDS nurse, stated that all the residents on that unit are ambulatory and most demonstrate exit seeking behavior.</p> <p>In an interview with Staff C, RN, on 07/27/2012 at 4:30 PM, she stated she was unable to determine how the Resident got out of the unit. When asked who supervises the wandering residents when staff are on break or in the rooms of residents, she stated "I don't know", "we don't have enough staff".</p> <p>A review of the medical record for Resident #1 revealed that between 07/01/2012 and 07/27/2012 the Resident made 53 attempts to elope from the unit.</p> <p>A review of the Resident's care plan revealed that he "hides from staff" and "wanders without regard for safety". According to the care plan, Resident #1 demonstrated wandering and exit seeking behavior from the time of admission. A review of the care plan revealed the Resident had an elopement by climbing over the fence on 09/18/2010, attempts to climb over fence on 03/17/2011. Under Problem date 9/27/11 (which was crossed out) and then written in was 12/10/12 showed "Hx (history) of elopement and cont. (continued) need of secured unit." The intervention was to "monitor Res whereabouts frequently at all time." On 10/31/2011 the care plan showed "NO EXIT SEEKING Noted: Res will cont. to-not have exit seeking behaviors." In the "Alteration in Mood and/or Behavior section of the care plan it was noted "Resident had elopement</p> | F 323 | <p>Facility will conduct monthly QI audit to ensure compliance with resident monitoring and management policy.</p> <p>Resident Care Manager, DNS and Administrator to ensure compliance.</p> | |
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| F 323 | Continued From page 4 7/19 from facility and hiding from staff 7/24. The care plan updated on 7/27/2012 stated "...staff will be aware of his location" but does not outline specific monitoring requirements. There was no specific plan in regard to how often the Resident should be checked and what interventions were implemented to reduce the risk for elopement. A review of the facility policy and procedures revealed no policy to address the procedures for monitoring and managing residents at risk for exit seeking behavior and elopement. | F 323 | | | |

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