

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

PRINTED: 06/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/17/2014
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - ARDEN			STREET ADDRESS, CITY, STATE, ZIP CODE 16357 AURORA AVENUE NORTH SEATTLE, WA 98133		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Kindred Arden Nursing and Rehabilitation on 06/16/2014-06/17/2014. A sample of 4 residents was selected from a census of 71.</p> <p>The following complaint was investigated as part of this survey:</p> <p>3011224; 3011252</p> <p>The survey was conducted by:</p> <p>Cathy Prentice, MN, R.N.</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 2, Unit C Creekside Two 20425 72nd Avenue South, Suite 400 Kent, WA 98032-2388</p> <p>Telephone: (253) 234 6003 Fax: (253) 395 5071</p> <p><i>Residential Care Services</i> <u>6-23-2014</u> Date</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

JMM

TITLE

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(X6) DATE

7.3.14

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: Based on observation, interview and record review, the facility failed to provide adequate supervision for safety of 1 of 2 residents at risk for elopement (Resident #1), when Resident #1 exited the facility without assistance and was found outside by a visitor on the sidewalk by a busy street and driveway in his wheelchair.</p> <p>Findings include:</p> <p>According to record review of facility medical records on 03/23/14, Resident #1 was admitted to the facility in 2012 and resided in the facility for long term care with conditions that included dementia and seizures.</p> <p>Review of the facility Wandering Assessment dated 11/27/2013 revealed, Resident #1 was at risk for unsafe wandering out of the facility due to impaired cognition, pacing, impaired decision making, a desire to leave, history of attempted elopement, and was to have frequent visual checks as well as an electronic Wanderguard</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <ol style="list-style-type: none"> As it pertains to the resident: <ul style="list-style-type: none"> Resident #1: Resident care plan has been updated. Resident fitted with a new wander guard bracelet and included in the updated elopement monitoring systems. As it pertains to residents in similar situations: <ul style="list-style-type: none"> Residents in similar situations care plans have been reviewed and residents have been updated with the elopement monitoring systems. Preventative Measures: <ul style="list-style-type: none"> Staff has been educated on elopement monitoring systems and identifiers put in place. Nurses educated on wander guard bracelet monitoring and placement validation. Validation that each medication carts has the wander guard test bracelets. Implementation of a new identifier system "red foot". Red foot symbol discreetly signifies a resident is an elopement / wander risk. Ongoing Monitoring: 		

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F 323	<p>Continued From page 2</p> <p>bracelet on his body to assist in adequate safety supervision.</p> <p>Further review of the facility Care Plan problem initiated in 10/02/2012 and updated 03/2014 revealed, Resident #1 had a problem with exit seeking and was to have the Wanderguard bracelet on at all times in addition to facility staff monitoring his location frequently.</p> <p>Additional record review of the Minimum Data Set (MDS) assessment dated 03/17/2014 revealed, Resident #1 had a BIMS score of 7/15 and needed assistance with all mobility as well as dressing and hygiene.</p> <p>Review of the facility investigation dated 05/18/2014 revealed, Resident #1 was seen outside of the facility on 05/18/2014 at 10:00 a.m. by another resident's visitor. According to the investigation documented by the facility, Resident #1 had exited the facility in his wheelchair without staff assistance or knowledge, and without a Wanderguard bracelet on, and Resident #1 was seen in the wheelchair on the sidewalk in front of the busy street at the end of the facility main driveway.</p> <p>Observation on 06/16/2014 at 2:00 p., revealed the main entrance of the facility opened to a large parking lot, and a main driveway with a downhill incline leading past a sidewalk that bordered a 4 lane busy street (Aurora Ave. N.).</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <hr/> <p>patients at risk to be completed weekly x4 weeks then Monthly x3 months and quarterly thereafter to assure resident's safety and staff compliance with the program.</p> <ul style="list-style-type: none"> • Follow up return demonstration validation with staff to be completed at random weekly x4 weeks, monthly x3 months and as needed thereafter. • Outcomes and concerns will be presented at the monthly PI Meeting. • The SDC, DNS & ED will be responsible for ongoing monitoring. 	DOC: 7.11.14	

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F 323 Continued From page 3
In an interview on 06/16/2014 at 4:25 p.m., Staff A, an administrative employee, stated the facility did not know why resident #1 did not have the Wanderguard bracelet on at the time of his unsafe and unattended exit from the facility and down the driveway to the sidewalk on 05/18/2014. Staff A also stated the facility nurses are to check the location of the Wanderguard bracelet that sets off an alarm at the facility exit, and the nurse had not checked it yet that morning when Resident #1 was found outside without the alarm sounding at the door.

F 323 *This Plan of Correction is the center's credible allegation of compliance.*

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

Faiulre of the facility to provide adequate supervision and safety on 05/18/2014 led to Resident #1's unsafe and unattended elopement outside of the facility in his wheelchair onto the sidewalk of a busy street of traffic and the potential for injury.

F 456 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE SS=F OPERATING CONDITION

F 456
F 456 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION

The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to maintain essential resident care equipment in safe operating condition when an electrical cord to a resident's bed caught fire due to a split in the cord with exposed wires that were wrapped with medical paper. In addition, the facility found another electric bed cord in the same unsafe condition in

1. As it pertains to the resident:
 - Resident #1: Resident bed cord has been replaced.
2. As it pertains to residents in similar situations:

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F 456	<p>Continued From page 4</p> <p>another resident room, as well as 2 resident electric bed control boxes with exposed wires. This failure placed residents at risk for injury from unsafe resident care equipment.</p> <p>Findings include:</p> <p>Record review of the facility investigation dated 05/23/2014 revealed, on 05/19/2014 at 2:00 p.m., a facility caregiver observed an electrical bed cord in Resident #2's room that "had a flame and was melting". The facility investigation noted the caregiver removed the resident from the room and there was no resident injury.</p> <p>In an interview on 06/17/2014 at 1:45 p.m., Staff B, a facility maintenance employee, stated the electrical cord in Room 5 that was on fire had a split in the cord with exposed wire and medical paper tape around the split, indicating that someone had attempted to repair the split incorrectly and had not notified maintenance about the damage prior to the fire.</p> <p>Observation on 06/17/2014 at 2:10 p.m., revealed a black bed cord about 10 feet long with a frayed and split area about mid-cord that had burned and melted and had old white medical paper tape on the split area. In addition, another electrical bed cord was observed with a split, exposed wires and white medical tape wrapped around the split in the cord. Further observation of damaged resident equipment found by Staff B after the fire revealed, 2 electric bed control boxes with about 1 inch of exposed wires at the entry point to the</p>	F 456	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <ul style="list-style-type: none"> • As it pertains to resident in room 5, bed safety repairs have been completed. • As it pertains to resident in room 8, bed safety repairs have been completed. • As it pertains to resident in room 14, bed safety repairs have been completed. • As it pertains to resident in room 48, bed safety repairs have been completed. <p>3. Preventative Measures:</p> <ul style="list-style-type: none"> • Staff has been educated proper reporting of broken equipment and taking it out of use. • Facility provided electrical tape should the need arise among staff to secure wires for the protection of the resident if absolutely necessary. • Facility has purchased back up cords to be available for quick repair. • General orientation has been modified to include staff training regarding bed safety with observation of damaged cord for emphasis as well as return demonstration of reporting broken equipment. 	DOC: 7.11.14

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F 456	Continued From page 5 boxes. Further interview on 06/17/2014 at 1:45 p.m. revealed Staff B checked all other resident electric beds in the facility after the fire in Room 5, and found another resident bed electrical cord with the same damage and incorrect attempt at repair with white medical paper tape in another resident room. In addition, Staff B stated he found 2 electric bed control boxes with exposed wires on resident beds in the facility as well. According to the facility investigation dated 05/23/2014, the maintenance staff found that all of the rooms with damaged wires on electric beds had residents living in the rooms: Room 5, 8, 14, 49. Although the facility had a system in place for checking resident care equipment on a routine basis, and a system for facility staff to communicate damaged equipment to maintenance for repair, the facility failed to ensure resident care equipment was maintained in safe operating condition on 05/18/2014, which placed residents at risk for injury.	F 456	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> 4. Ongoing Monitoring: <ul style="list-style-type: none"> • Monthly Audits to be completed verifying bed safety x3 months by Maintenance Team. • Follow Up return demonstration validation will be completed monthly x3 months and as needed thereafter. • Random audits of bed safety to be completed by assigned managers monthly x 3 months. • Outcomes and concerns will be presented at the monthly PI Meeting. • The Maintenance Director, DNS & ED will be responsible for ongoing monitoring		

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L. J. BARRIOS