

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

PRINTED: 09/24/2013
FORM APPROVED
OMB NO. 0938-0391

1314

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2013
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NAME OF PROVIDER OR SUPPLIER SHUKSAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1530 JAMES STREET BELLINGHAM, WA 98225
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Shuksan Healthcare Center on 09/04/13, 09/06/13 & 09/10/13. A sample of 6 residents was selected from a census of 47. The sample included 3 current residents and 3 discharged residents.</p> <p>The following complaints were investigated as part of this survey:</p> <p>2845635, 2867081 & 2866522</p> <p>The survey was conducted by:</p> <p>██████████, R.N., B.S.N.</p> <p>The survey team was from: Department of Social and Health Services Aging and Long-Term Support Administration Residential Care Services, Region 2, Unit B 3906 172nd Street NE, Suite 100 Arlington, WA 98223 Telephone: (360) 651-6850 FAX: (360) 651-6940</p> <p><i>Shannon Richardson</i> 9/29/13 Residential Care Services Date</p>	F 000		
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RECEIVED
OCT 07 2013
ADSA/RCS
Smokey Point

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shannon Richardson</i>	TITLE Administrator	(X6) DATE 10/17/13
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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 223 483.13(b), 483.13(c)(1)(i) FREE FROM
SS=G ABUSE/INVOLUNTARY SECLUSION

The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review it was determined that the facility failed to recognize the signs of burn-out and failed to act on the verbalization of "burn-out" by the family member of 1 of 6 sample residents (1) who the facility was using as an intervention for the resident's problem behaviors. This failure resulted in the physical abuse of Resident 1 by the family member. Findings include:

Resident 1 was admitted to the facility [redacted] 1/13 with diagnoses that included a [redacted] with a [redacted] (). His Minimum Data Set (MDS) assessment, dated 6/6/13, indicated the resident was able to ambulate without assistance. The assessment also indicated he had behaviors that were directed towards others. The resident's behaviors significantly interfered with the resident's care; the resident intruded on the privacy of others, significantly disrupted the living environment and his behaviors had worsened since his last assessment.

Resident 1's current care plan for Psychosocial Well-Being was developed initially on 1/2/13 with a revision in 6/11/13 and goal dates set for

F 223

F223

Resident 1 no longer at facility.

All residents assessed and appropriate behavioral interventions in place, as necessary. All residents assessed for abuse risk, upon admission and with resident quarterly care plan conference. Social worker will conduct individual resident interview and provide or arrange the services identified through the interview process.

All staff in-serviced on resident safety related to abuse, specifically if there is an altercation involving residents, the parties must be separated and not left alone. All staff in-serviced on recognizing signs of burnout (family & staff). All staff educated on communicating any change in residents' mental, physical, and psychosocial status and any questionable interaction between family member and resident.

To monitor its performance, the facility will:

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F 223	<p>Continued From page 2</p> <p>9/13/13. An exit seeking care plan was developed on 7/8/13 when the resident began wandering in the facility and exit seeking. There were 4 interventions listed on the 7/8/13 plan: Bring the resident back in the building, 1:1 supervision, redirect the resident with food/activity and call the resident's family member.</p> <p>On 7/17/13, the family member took Resident 1 to a medical appointment. Following the appointment the resident refused to get into the car to return to the facility. The mental health professional (MHP) stated a colleague informed him there was a patient in the parking lot that was involved in an altercation. The MHP went to the parking lot to see if he could help. The MHP stated that the family member was "in hysterics." He wanted to defuse the situation so he called the facility, told them the resident was having a problem and asked if they could intervene by sending a van to pick up the resident. He was told "No" by the Social Worker. The MHP stated the facility Social Worker did not ask any further questions about the situation and he did not offer details. The resident became increasingly agitated and the police were called for assistance. The police got the resident into the family member's car and he was returned to the facility.</p> <p>When the family member returned with the resident she told the Social Worker that she no longer wanted to be the Power of Attorney (POA). The SW stated the family member stated she was "burned- out." The SW indicated the family member had a bad day with the resident. The SW gave the family member papers to fill out relinquishing her POA. The SW did not assess the situation and did not inform nursing staff of the family member's statement.</p>	F 223	<p>a.) All staff will report changes with resident and/or questionable interactions between resident and family member immediately to licensed nurse and/or DNS & Administrator if appropriate.</p> <p>b.) Monday-Friday day shift licensed nurse will communicate changes at daily stand up meeting with management team. At all other times DNS and Administrator available via phone.</p> <p>c.) If changes are made to the residents care plan, resident will be placed on alert so all nurses will be aware of changes within resident and will document as necessary.</p> <p>d.) "New Information" sheets placed in NAC flow sheets to alert NACs of changes with resident.</p> <p>e.) Facility will review safety and communication policies quarterly at all staff meeting and upon hire of new staff.</p>	

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F 223	Continued From page 3 LN 1 documented that from the beginning of the shift the resident had been exit seeking. Documentation went on to say the LN called the family member and the family member stated "that she can't come in, she's too burned out." The resident continued to be agitated and the LN called the family member again and informed the family member that "we can't keep watching him and she needed to come in." Resident 1's family member had now told 2 facility staff that she was "burned-out" they continued to use her presence as a behavioral intervention for Resident 1. The family member came to the facility at LN 1's request. A Nursing Assistant (NA) documented that she walked past the resident's room and found the resident with blood on arm, the family member was crying and saying "He hit me and I hit him back." The NA documented that she "left the room, shutting the door behind me and alerted" the LN. LN 1 documented that she was called into the resident's room by the NA because there was an altercation. When she entered the resident's room, the resident was "extremely agitated," appeared to be "still violent" and he was bleeding from his nose and left forearm. The family member was crying, was very upset and was bleeding from her eyebrow. The LN documented that she left the room to call local law enforcement. LN 2 documented that the NA told her that LN 1 needed her. When she arrived at the room the door was closed, when she entered the room the	F 223	DNS and Administrator to monitor compliance. Corrective action complete 10-8-13. <i>10/8/13</i>

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F 223 Continued From page 4

resident was clinging to the curtains. The family member was standing behind the resident when the resident began to sit on the bed the family member grabbed his arm and told him no. The resident began swinging his elbows to get her hands off him. The family member balled up her fist and began to swing at the resident. The LN blocked the family member's swing with her arm.

The family member wrote a statement for the facility incident investigation. She stated that after the resident had become physically assaultive she grabbed him by his belt and physically restrained him from leaving the room. The family member also documented that she told LN1 that she needed to leave the area or the resident was going to "kill me or I was going to kill him."

Both the NA and LN 1 failed to protect Resident 1 from further physical abuse when they left the family member alone in the room with the resident, knowing that she had hit him.

Review of Resident 1's medical record revealed the resident's family member had exhibited signs of burn-out prior to 7/17/13 including:

- Returning on multiple occasions from appointments and/or outings with the resident and immediately requesting that staff give him "as needed" Ativan (an antianxiety/sedative medication).
- Documentation that the resident either became agitated upon seeing or talking to the family member.
- Documentation that the family member was called 3 times in one shift to assist the facility with the resident and the family member "hung up phone in apparent frustation one time."
- Documentation that the resident and family were

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F 223	Continued From page 5 noted to have raised voices in the resident's room. The resident left the room and went to the courtyard and "appeared agitated." The family member reported to staff "that she may not be helping." There was no evidence staff recognized these situations as precursors to abuse, attempted to determine what had occurred and if any other interventions would have been appropriate. The facility continued to rely on Resident 1's family member to intervene when the resident displayed problem behaviors culminating in the physical abuse on 7/17/13.	F 223	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	

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F 225 Continued From page 6

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to conduct complete investigations of allegations of abuse/neglect for 4 out of 4 sampled residents (#1, 2, 3, & 4) reviewed for abuse/neglect. Resident 4 was identified to have two fractures of unknown cause, Residents 2 & 3 exited the building and received injuries and Resident 1 was harmed by a family member. Failure to perform thorough investigations in timely manner placed residents at risk of abuse/neglect.

Findings include:

1. Resident 1 was admitted to the facility 1/13 with diagnoses that included a [REDACTED] with [REDACTED]. His Minimum Data Set (MDS) assessment dated 6/6/13 indicated the resident was able to ambulate without assistance.

On 07/17/13 a LN 1 documented on a "Resident Incident Report" that there was a physical

F 225

F225

Resident 1, 2, 3, 4 no longer at facility.

All incidents will be thoroughly investigated to rule out abuse and neglect. As applicable, witness statements will be included with incident reports. Any resident that poses a threat to themselves or others, will be kept safe by implementing interventions specific to resident, medication management as prescribed by doctor, and/or 1:1 staff. If facility unable to ensure resident safety, transfer to alternate living facility or hospital will be initiated.

All staff will be educated on facility policy and procedure on incident investigations, including writing witness statements. All staff educated on communicating any change in residents' mental, physical, and psychosocial status to licensed nurse, social worker, DNS, and/or Administrator.

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F 225	<p>Continued From page 7</p> <p>altercation between the Resident and a family member. The resident sustained an injury to his nose and left forearm that were bleeding.</p> <p>The investigation was reviewed and incomplete. The investigation did not address why Nursing Assistant 1 (NA 1) and Licensed Nurse 1 (LN 1) both entered the room and saw there was an incident and both parties had injuries that were bleeding. Neither of the two staff members immediately separated the parties to protect Resident 1 from further assault.</p> <p>The investigation did not address why LN1 insisted that a family member come to the facility to sit with the resident after the family member stated that she was too burnt out. The investigation did not identify if staffing may have been a possible problem. They did not address why other interventions had not been attempted (including medications or calling the MD) or what the resident's response was to any interventions that had been attempted. They did not look at why the care plan had not been updated or revised if interventions were not working.</p> <p>There was no interview of the Social Worker as to why she did not intervene when she was contacted by a Mental Health Professional or when the family member informed her that she no longer wanted to be the POA. Why Social Services had not assisted staff in understanding and dealing with the resident's behaviors.</p> <p>The investigation included an in-service to all staff members that included the topic "Safety for Residents and Staff."</p> <p>2. Resident 2 was admitted to the facility on</p>	F 225	<p>To monitor it performance the facility will have all incident reports reviewed by Administrator and DNS; any incident report requiring mandated call to state hotline will be reviewed by sister facility DNS. Facility will refer to state "Purple Book" to complete investigations.</p> <p>Corrective action complete 10-8-13.</p> <p>DNS and Administrator to monitor compliance.</p>	10/8/13

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F 225	<p>Continued From page 8</p> <p>8/11/13 with diagnoses that included [REDACTED] and poor safety awareness.</p> <p>On 8/21/13, documentation showed that staff were unable to locate the resident. Staff searched the neighborhood and found the resident about 1 1/2 to 2 blocks away lying on the ground with paramedics on the scene assessing and tending to the resident. The resident received 2 abrasions from the fall.</p> <p>Per documentation, prior to the resident eloping the resident was agitated, self-propelling his wheel chair throughout the facility and stating that he wanted to go home. He was refusing care and was not easily redirected.</p> <p>The investigation was reviewed and lacked enough information to rule out abuse and or neglect. The report did not include whether the care plan had been reviewed to determine whether staff were following the care plan. There was no documentation where staff was at during the time of the incident that was responsible for his supervision and care. Why a care plan had not been created to minimize his behaviors. There was no documentation that justified that it was an unpreventable incident.</p> <p>3. Resident 3 was admitted to the facility with diagnoses that included [REDACTED]. The Minimum Data Set (MDS) assessment dated 8/26/13 indicated the resident was severely impaired in his cognitive thinking.</p> <p>On 8/24/13, documentation on a "Resident Incident Report" indicated a pedestrian reported Resident 3 was found lying on the ground at the bottom of the cement stairs in the front of the</p>	F 225	

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building. LN 1 documented that the resident was last seen at the nursing station (close to the front door). There was lots of activity, visitors and residents at that time.

The investigation was incomplete and lacked documentation from LN 1 as to why if LN 1 knew there was a lot of commotion why the resident with dementia was not removed from the area.

A staff person documented that he was sitting in his car in the front of the building and saw two people walk outside the building "followed shortly" by the resident. The staff member assumed they were together so he took a nap. There was no documentation as to why the staff member did not question the people even though the resident was following them instead of the people pushing him in his wheel chair.

4. Resident 4 was admitted to the facility on [REDACTED]/13 with diagnoses that included [REDACTED]

On 8/28/13, resident documentation showed that the resident had a seizure at 4:15 a.m. Observations of seizure revealed the resident's arms were bent tightly upwards. There was no thrashing or flailing of his arms observed.

On the same evening, the resident was being transferred by a sit to stand mechanical machine. The resident became unresponsive and his body went "flaccid". After staff got the resident back to bed and the LN assessed him he showed signs of pain to his left side. There was no bruising noted at that time.

On 8/29/13, the next day, documentation showed that the resident's right elbow and shoulder were

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F 225 Continued From page 10 F 225

tender and he was medicated for pain at 1:00 p.m. By evening shift there was bruising noted to his left armpit. The pain continued until 8/31/13 when x-rays were taken. The x-rays showed that the resident had a right head fracture with impaction of the right arm shaft and a left hip displaced fracture with bone chip.

The investigation was reviewed and showed that it was incomplete and did not have enough information to determine the cause of the two fractures or rule out abuse and or neglect.

The investigation lacked witnesses statements from all of the parties involved in the transfer when the resident became unresponsive, was transferred back to bed, bruising was discovered and the resident began having pain in his left side.

There were no witness statements from the private care giver that comes into the facility that provides hygiene and range of motion services even though the care giver stated that that the more she moved his are it seemed to loosen up and not bother him.

F 250 SS=G 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE F 250

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

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F 250 Continued From page 11

Based on observation, interview and record review, the facility failed to provide medically related social services to attain the highest level of physical, mental and psycho-social well-being for 2 of 4 residents (#1 & 2) investigated for social service support. The failure to aggressively identify the need for medically-related social services related to behaviors, and pursue the provision of these services placed the residents at risk for worsening behaviors and increased the likelihood they would display behaviors that could cause injury. Failure to address the reasons for Resident 1's behaviors led to escalating assaultive behaviors and Resident 2 leaving the building and obtaining injuries. These patterned failures resulted in harm for Resident 1 & 2 and caused residents to be at risk for the high likelihood of behaviors needs not being addressed.

Findings Include

Resident 1 was admitted to the facility [REDACTED] 13 with diagnoses that included a [REDACTED]. His Minimum Data Set (MDS) assessment dated 6/6/13 indicated the resident was able to ambulate without assistance. The assessment also indicated he had behaviors that were directed towards others. The resident's behaviors significantly interfered with the resident's care; the resident intruded on the privacy of others, significantly disrupted the living environment and his behaviors had worsened since his last assessment.

Staff documentation revealed that Resident 1 had escalating behaviors between the months of April 2013 to July of 2013. Examples included: The resident was wandering, cussing at staff,

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F250

Resident 1 and 2 no longer at facility.

Upon admission and with resident quarterly care plan conference, Social worker will conduct individual resident and family interviews and provide or arrange the services identified through the interview process. All resident care plans individualized to specific resident behaviors as appropriate.

Social worker and all staff educated on communicating any change in residents' mental, physical, and psychosocial status or questionable interaction between family member and resident and reporting it to licensed nurse. Licensed nurse will notify DNS, Administrator and outside mental health services, as appropriate. Social worker will conduct resident "well check" interviews in accordance with the residents MDS schedule and as needed. Social Worker and licensed nurses educated on aggressively assessing and revising care plans for residents who present with behaviors to ensure resident safety.

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F 250	<p>Continued From page 12</p> <p>becoming "extremely agitated", having angry violent outbursts including trying to put fist through a wall, displaying finger gestures, throwing things at staff, banging on walls, using profanities and increased exit seeking.</p> <p>A care plan was developed on 1/2/13 that was not specific to each behavior. The interventions were bring animals into his room, call the daughter, encourage the resident to attend an activity of interest. (According to the DNS, daughter and the Administrator the resident was not interested in the facility's activity program), offer the resident to take a walk and use medications as ordered.</p> <p>Interventions on the MAR included interaction with the facility dog or distraction with activities. If those interventions failed then call the daughter.</p> <p>One LN documented that they called the daughter to see if "she could talk some sense into the resident", another time, the "daughter showed up and took over the situation" and the "daughter was called to sit with him"</p> <p>On multiple occasions the daughter instructed staff to give the resident "as needed" medications including Ativan (an Anti-anxiety medication)</p> <p>In an interview with the daughter on 09/05/13, she stated that she had noticed a gradual change in the resident's mood and behaviors in about April of 2013. He became more physical where he was never physical prior. On 7/17/13 the daughter took the resident to an appointment. The resident became agitated at the appointment and took a swing at her.</p>	F 250	<p>Social worker educated on assisting staff in understanding and managing resident behaviors.</p> <p>Licensed nurse and social worker to report plan of care for residents with behavioral concerns at daily stand up meeting. Residents receiving medications for behavior management will be reviewed at monthly psychotropic meeting.</p> <p>Corrective action complete 10-8-13.</p> <p>Administrator to monitor compliance.</p>	10/8/13

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F 250 Continued From page 13

A Mental Health Worker from the clinic came out to the parking lot and attempted to get the facility to come and help the daughter. The facility declined to do so the local law enforcement was called. They got the resident into the car and she got him back to the facility. Upon entering the facility she spoke with the Social Worker (SW) who told her that she heard that the resident was having a problem at his appointment. She informed the SW that she did not want to be the Power of Attorney (POA) anymore, was burnt out and did not want to come back to the facility. Facility staff called her regardless of her statements, without attempting any interventions including medications, and when the daughter came to the facility there was an altercation.

There was no documentation that the facility assessed the behaviors, revised the care plan, and was actively involved in assisting staff in understanding and dealing with the resident's behaviors. There was no evidence that the SW provided the staff with any type of support. There was only documentation on admission, during the MDS review and during a care conference dated 6/19/13 where the resident's behaviors were discussed. There was no change in the care plan at that time.

2. Resident 2 was admitted to the facility on [REDACTED] 13 with diagnoses that included [REDACTED] and poor safety awareness.

On 8/18/13, documentation in the progress notes showed that the resident was self-ambulating in his wheel chair and was looking for his mother.

On 08/19/13, there was documentation that the resident was moved closer to the nurses' station

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F 250	<p>Continued From page 14</p> <p>due to safety concerns. The resident was looking for his wife and "wanted to go home". Staff attempted multiple times to redirect the resident but was unsuccessful. The resident circled the facility in his wheel chair multiple times.</p> <p>On 8/20/13 an assessment was done by a Licensed nurse (LN) for Mood and behaviors. The LN determined that he had a new chronic wandering behavior.</p> <p>On 8/20/13 a LN contacted the physician because the resident seemed restless and agitated. The physician documented that the LN informed the physician that on 8/19/13 the resident " had to be redirected a number of times as he tried to leave the building"</p> <p>There was no evidence of a care plan being developed for behaviors to prevent the resident from leaving the building.</p> <p>On 8/21/13, documentation showed that at 3:00 am the resident was ambulating about the building and staff was providing 1:1 supervision during the night shift. There was no care plan developed even though night shift was providing 1:1 supervision.</p> <p>At approximately 6:30 pm. the facility discovered the resident was missing. Staff searched the neighborhood and found the resident about 11/2 to 2 blocks away lying on the ground. By the time the facility staff arrived the paramedics were already on scene assessing and tending to the resident.</p> <p>There was no documentation that the SW aggressively assessed the behaviors, revised the</p>	F 250		

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F 250	Continued From page 15 care plan, or was actively involved in assisting staff in understanding and dealing with the resident's behaviors. There was no evidence that the SW provided the staff with any type of support.	F 250		
F 323 SS=G	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, record review, and interview, the facility failed to identify and provide sufficient supervision for 2 of 4 residents with dementia to prevent the residents from exiting the building and falling. (#2 & 3) reviewed. Residents 2 & 3 experienced actual substantial harm as a result of a fall down the cement steps outside of the building. Findings include: 1. Resident 3 was admitted to the facility on 8/20/13 with diagnoses that included Senile Dementia. The record indicated that the resident used a wheel chair for ambulation and was able to self-propel the chair.	F 323	F323 Resident 2 and 3 no longer at facility. All residents will be assessed upon admission, after 72 hours, as needed, and in accordance with their quarterly MDS schedule for wandering behaviors. If it is deemed appropriate, facility will use a wanderguard device that alerts staff that resident is moving towards door. All resident environments to remain as free of accidents or hazards as possible. Facility will maintain an "elopement risk" book with pictures and brief description of residents identified as elopement risks. A gait was in place on 9-4-13 to decrease the likelihood of further falls at this site (outdoor stairs).	

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F 323 Continued From page 16

F 323

On 8/24/13, documentation on a Resident Incident Report indicated a pedestrian reported Resident 3 was lying at the bottom of the cement stairs in front of the building. A Licensed Nurse (LN) documented that the resident had last been seen in the front of the building where there was lots of activity, visitors and residents.

A staff person documented that he was sitting in his car in the front of the building and saw two people walk outside the building "followed shortly" by the resident. The staff member assumed they were together so he took a nap. The staff member did not question the people even though the resident was following them instead of the people pushing him in is wheel chair.

The resident fell down the stairs and received abrasions to knees and forehead, subdural hematoma and a left femur fracture. The resident passed away 2 days later.

The medical record revealed multiple entries that the resident had confusion, agitation and mild anxiety related to new environment. There was no wander or risk assessments completed to determine if the resident had the potential to exit the building even though the resident had dementia.

The care plan indicated the resident had impaired cognition, needed assistance with all of his activities of daily living and the goal was for the resident to remain oriented to person. The care plan did not address increased supervision to ensure the resident was safe.

All staff in-serviced on the policy and procedure for wander assessments and wanderguard devices. All staff in-serviced on elopement prevention.

Facility will monitor its performance by completing admit and quarterly audits to ensure wander assessment completed. Facility will educate at quarterly all staff meeting, new hires, and as needed regarding prevention of resident elopement.

Corrective action complete 10-8-13.

DNS and Administrator to monitor compliance.

10/8/13

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F 323	<p>Continued From page 17</p> <p>2. Resident 2 was admitted to the facility on 8/17/13 with diagnoses that included dementia and poor safety awareness.</p> <p>On 8/21/13, an LN documented that the resident returned to the facility after a medical appointment. The resident was agitated and not easily redirected.</p> <p>At approximately 6:30 pm. staff were unable to locate the resident. Staff searched the neighborhood and found the resident about 1 1/2 to 2 blocks away lying on the ground with paramedics on the scene assessing and tending to the resident. The resident received 2 abrasions from the fall.</p> <p>On 8/18/13, documentation in the progress notes showed that the resident was self-ambulating in his wheel chair and was looking for his mother.</p> <p>On 08/19/13, there was documentation that the resident was moved closer to the nursing station due to safety concerns. The resident was looking for his wife and "wanted to go home". Staff attempted multiple times to redirect the resident but was unsuccessful. The resident circled the facility in his wheel chair multiple times.</p> <p>On 8/20/13 an assessment was done and for Mood and behaviors it was determined that he had a new chronic wandering behavior</p> <p>On 8/20/13 a Licensed nurse (LN) contacted the physician because the resident seemed restless and agitated. The MD documented that the LN informed the MD that on 8/19/13 the resident "had to be redirected a number of times as he tried to leave the building" There was no</p>	F 323		

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F 323	Continued From page 18 evidence of a care plan being developed to prevent the resident from leaving the building. On 8/21/13, documentation showed that at 3:00 am the resident was ambulating about the building and staff was providing 1:1 supervision during the night shift. There was no care plan developed even though night shift had been providing 1:1 supervision. A care plan for elopement was not created until 8/22/13 after the resident eloped and had fallen.	F 323		
F 490 SS=G	483.75 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 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the facility's administration failed to effectively and/or efficiently use its resources to attain or maintain the highest practicable well-being of each resident. Failure of the Administrator to ensure a thorough and effective abuse prevention program was implemented or to recognize resident behaviors that constituted abuse resulted in harm for 3 of 4 residents (#1, 2 & 3) and placed all other residents at risk for experiencing unrecognized abuse. Failure to provide supervision for residents 2 & 3 who had dementia lead to both residents eloping from the facility and Resident 3 sustaining substantial injuries.	F 490		

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F 490 Continued From page 19

Findings include:
The Administration failed to assess and recognize that using a family member as a behavioral intervention for a resident's behaviors created family burn out. The facility insisted the family member take care of Resident 1 who was agitated and resulted in actual harm due to an altercation between Resident 1 and the family member.

Refer to F 223, CFR 483.13(b) Abuse

The Administration failed to thoroughly investigate allegations of abuse. The Administration took no actions to protect residents from further potential abuse by not providing supervision to prevent exit seeking behaviors in two residents (2 & 3) which resulted in actual harm for Resident 3.

Refer to F 225 CFR 483.13(c)(3)
Investigate/Report Allegations/Individuals

The Administration failed to provide medically related social services to attain the highest level of physical, mental and psycho-social well-being for 2 of 4 residents who exhibited behaviors (#1 & 2) investigated for social service support.

Refer to F 250 CFR 483.15(g)(1) Social Services

The Administration failed to provide safe and secured environment, and ensure adequate monitoring and supervision of cognitively impaired resident's. This potentially placed all other cognitively impaired residents with eloping and exit seeking behaviors residing at the facility at risk for potential harm.

F 490

F490

Resident 1,2,3 no longer at facility.

The facility will use the resources available to provide residents with a living environment where they will be assessed, monitored, and provided cares in a manner that offers them the ability to attain or maintain the highest physical, mental, and psychosocial well-being.

Staff educated on maintaining the safest living environment for residents, including education related to caregiver burnout (family & staff); in-servicing staff, reviewing and updating policies and procedures; auditing assessments, monitoring and updating care plans, and communicating between all staff to ensure resident safety.

The facility will monitor its performance by conducting surveys for residents, families and staff. Employee surveys will be asked questions as they relate to

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F 490	Continued From page 20 Refer to F 323 CFR 483.25(h) (2) Prevention of accidents.	F 490	<p>safety in the workplace & resident safety; communication with residents, co-workers, and families; familiarity with facility policies and procedures including: abuse and neglect, elopement, incident investigations; behavioral management.</p> <p>The facility has begun conducting resident surveys on topics that include: resident safety, communication with staff, abuse and neglect. Family members will be given surveys as it relates to family support from facility, feelings towards having loved one in a care facility, communication with staff, and resident safety. Facility mailed surveys to family members who were otherwise unavailable.</p> <p>Survey results will be the catalyst in directing change, education, and implementation as the facility moves forward and maintains the safest living environment for all residents. The survey results will be discussed during quarterly QA meeting.</p> <p>Corrective action complete 10-8-13.</p> <p>Administrator to monitor compliance.</p>	10/8/13