

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

PRINTED: 11/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/12/2014
NAME OF PROVIDER OR SUPPLIER LEON SULLIVAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2611 SOUTH DEARBORN SEATTLE, WA 98144		
(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 Complaint Survey conducted at Leon Sullivan Health Care on 11/12/14. A sample of 9 current residents and 2 former residents from a total census of 138 residents was selected for review.</p> <p>The survey was conducted by: Katherine Ander, MN, RN, Complaint Investigator</p> <p>Complaints investigated include: 3046613; 3049138; 3042728</p> <p>The survey team is from: Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 2, Unit D 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253)234-6000 Fax: (253)395-5071</p> <p><i>Rob Roman 11/14/14</i></p>	F 000			

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

TITLE

(X6) DATE

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 ensure 1 of 8 residents (Resident #1) at risk for elopement from a census of 138 residents received adequate supervision to prevent elopement. Staff E failed to adequately intervene when the electronic alarm system (Wanderguard) sounded. This resulted in the resident leaving the facility without escort or supervision for over 24 hours. The resident was found by the police the following day in the parking lot of a fast food restaurant in a neighboring town.</p> <p>Findings include:</p> <p>Observation 11/12/14 at 10:40 a.m. noted a Wanderguard alarm system installed on exit doors, including the lobby entrance/exit. The lobby area consisted of a front desk and small couch with hall passage from the residence hallway to the outdoors. The Wanderguard alarm and key pad was located on the door frame entry from the residence hallway into the lobby.</p> <p>Facility Elopement policy states "If the wander guard goes off - never turn it off without knowing</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>the cause" and "Always walk outside and look around before turning off the alarm."</p> <p>Record review found Resident #1 was admitted to the facility [REDACTED] with medically disabling conditions, including Dementia. Resident #1 discharged to a secure Dementia unit on [REDACTED] prior to the department visit.</p> <p>The resident's minimum data set (MDS) assessment dated [REDACTED] identified the resident was unable to complete a brief interview for mental status (BIMS) assessment for cognitive function.</p> <p>An elopement risk assessment dated [REDACTED] identified the resident had exit seeking behavior consisting of wandering hallways without purpose or wandered in hallways looking for his room.</p> <p>The goal of Resident #1's elopement plan of care dated [REDACTED] was "Resident will not wander out of facility." Interventions included "Observe resident's location to ensure safety" and "Check Wanderguard all the time and redirect him when wandering."</p> <p>Facility incident report documented that at approximately 5:00 p.m. on 10/29/14 staff could not find Resident #1 when they went to assist him to the dining room. A search was unable to locate Resident #1 and a police report was made.</p> <p>The incident report documented that late in the evening of 10/30/14 (over 24 hours later) restaurant staff in a local neighboring city called police to report Resident #1 was loitering about the parking lot. Resident #1 was unable to express his needs, and was walking in an out of</p>	F 323		

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F 323	<p>Continued From page 3</p> <p>the restaurant. The restaurant staff called police when Resident #1 attempted to get into one of their vehicles. Police retrieved Resident #1 and returned him to the facility around midnight 10/30/14. "He did not appear to be harmed or injured but, cold, wet and hungry."</p> <p>Facility investigation found Resident #1 was last seen at approximately 3:00 to 3:30 p.m. on 10/29/14. According to the facility investigation, Resident #1 went to the 1st floor where his Wanderguard set off the lobby alarm. Facility investigation determined "It is unclear how he managed to make it past the front desk, but when the front desk staff got up to re-set the alarm he had his back turned and was distracted by the alarm and visitors in the lobby. There were multiple people in the area and (Resident #1) may have possibly been mistaken for a visitor and exited out the front door."</p> <p>On interview 11/12/14 at 2:30 p.m. Staff D stated she trains front desk staff regarding duties, including how to respond when the Wanderguard alarm sounds. Staff D stated if the alarm sounds, staff first attend to the resident who tripped the alarm to stop them from leaving. If the resident exits, staff is to retrieve the resident and escort back in. The alarm is not turned off until the resident is safely back in the building.</p> <p>On telephone interview 11/12/14 at 6:25 p.m. Staff E stated he was the front desk staff person on duty the day Resident #1 eloped from the building. According to Staff E, he mans the front desk one day per week. Staff E said his training was to identify the resident who tripped the Wanderguard alarm before turning it off.</p>	F 323		

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F 323	Continued From page 4 According to Staff E, the day Resident #1 eloped he was assisting multiple residents with banking while manning the front desk. Staff E said when the Wanderguard alarm sounded he got up and looked around and poked his head outside but did not see anyone leave. Staff E said he made some assumptions about the alarm. First, he assumed it was a "false alarm", triggered by a resident walking in the residential hall on the way to the secure courtyard at the back of the building, and "I assumed it was one of the residents I was helping at the time." Staff E turned off the alarm and resumed his duties without confirming which resident tripped the Wanderguard alarm and/or which resident was possibly attempting to exit the building. Staff E said in administrative staff told him in the future he should be more vigilant and "try to do better."	F 323			