

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

PRINTED: 07/29/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/16/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARK RIDGE CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1250 NORTHEAST 145TH STREET SEATTLE, WA 98155</b>		
(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><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Park Ridge Care Center on 07/08/2014-07/16/2014. A sample of 6 residents plus 3 closed records was selected from a census of 102.</p> <p>The following complaint was investigated as part of this survey:</p> <p>#3014752; 3015083; 3016519; 3017579; 3016515; 3021451</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>Dellan Lora</i> Residential Care Services      Date</p>	F 000	<p>Preparation and/or execution of this plan of correction does not constitute the provider's admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</p>		

RECEIVED  
AUG 08 2014  
DSHS/ADSA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Anna Manthey*

TITLE  
*Adminstrator*

(X6) DATE  
*8/5/14*

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.

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

PRINTED: 07/29/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/16/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARK RIDGE CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1250 NORTHEAST 145TH STREET SEATTLE, WA 98155</b>		
(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 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 to prevent unsafe elopement for 1 of 4 residents sampled who were at risk for elopement (Resident #1). This failure led to Resident #1 leaving the facility unsupervised into a parking lot, and walking one tenth of a mile from the facility on a busy city street without supervision, and placed the resident at risk for serious injury.</p> <p>Findings include:</p> <p>According to record review of facility medical records on 07/08/2014, Resident #1 was admitted to the facility in [REDACTED] 4 from the hospital, with diagnoses of dementia with behaviors, Alzheimer's, [REDACTED] and cognitive impairment. Review of the hospital records in the facility record dated 05/19/2014 revealed, Resident #1 had independent mobility, confusion with aggression, impaired judgement, wanders and needs direction. Further review of the hospital History and Physical revealed, resident</p>	F 323	<p>This facility does and will continue to ensure each resident is receiving adequate supervision and assistance devices to prevent accidents.</p> <p>All deficiencies related to F323 have been corrected.</p> <p>Resident #1 no longer resides at this facility.</p> <p>All other residents with cognitive impairment that are independently mobile have been reviewed and care plans have been updated to accurately reflect the level of supervision and assistance devices required to prevent accidents.</p> <p>The facility has implemented and staff have received in-service training on new standards for Resident Safety which include elopement/wandering assessments completed upon admission, quarterly and with any significant change in condition.</p>	8/25/14	

AUG 06 2014  
DSHS/ADSNBOS

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

PRINTED: 07/29/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/16/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARK RIDGE CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1250 NORTHEAST 145TH STREET SEATTLE, WA 98155</b>		
(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 323	<p>Continued From page 2</p> <p>#1 had a history of exit seeking at a prior facility, and a history of falls.</p> <p>Additional record review of the facility medical records on 07/08/2014 revealed, a facility assessment for Resident #1 dated [REDACTED] 2014, day of admission to the facility, noted Resident #1 was confused and forgetful, and able to ambulate independently, with a high fall risk. Additional Minimum Data Set (MDS) assessment dated 05/26/2014 noted Resident #1 had cognitive impairment with a BIMS score of 4/15.</p> <p>Review of the facility Wandering Unsafe Resident procedure on 07/08/2014 revealed, the facility staff will institute an individualized supervision plan as indicated for residents who are assessed to have high risk for elopement.</p> <p>Review of the facility Risk of Elopement/Wandering Review dated 05/19/2014 revealed, Resident #1 was at risk for elopement from the facility and indicated an intervention for frequent monitoring, check every 30 minutes.</p> <p>Review of the facility Care Plan dated 05/19/2014 revealed, interventions for Resident #1's risk for elopement to include Resident Observations, and Distract resident away from exit doors, with a Goal of: resident will not wander outside of facility.</p> <p>In an interview on 07/08/2014 at 1:26 p.m., Staff</p>	F 323	<p>All licensed nurses have been retrained on the principals of supervision and team responsibility for resident care.</p> <p>Additionally, the interdisciplinary team is reviewing the 24 hour report to identify any changes in status including changes to the resident environment and equipment that require an overall safety evaluation. All accidents and incidents are also reviewed daily at the stand-up meeting.</p> <p>Incidents and accidents are tracked and trended by the Director of Nursing. Results are presented to the Quality Assurance and Assessment Committee quarterly.</p> <p>The Director of Nursing shall assure ongoing compliance.</p>	

RECEIVED  
AUG 08 2014  
DSHS/ADSA/RCS

RECEIVED  
AUG 08 2014  
DSHS/ADSA/RCS

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

PRINTED: 07/29/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/16/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARK RIDGE CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1250 NORTHEAST 145TH STREET SEATTLE, WA 98155</b>		
(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 323	<p>Continued From page 3</p> <p>B, a caregiver at the facility, stated the staff check residents every 30 minutes if they are at risk and some people every 15 minutes.</p> <p>In an interview on 07/08/2014 at 1:35 p.m., Staff C stated, the facility staff usually check residents at risk of elopement every 30 minutes.</p> <p>Review of the facility Progress Notes dated 05/22/2014 revealed, Resident #1 was confused with occasional delusions, and required close supervision for safety; 05/27/2014 noted ambulates freely and requires frequent redirection; 06/02/2014 noted wandering hallways most of day, and had confusion.</p> <p>According to record review of the facility Progress Notes on 07/08/2014, Resident #1 eloped from the facility on 06/02/2014 in the evening, and was last seen in the building at 8:15 p.m. The licensed nurse note dated 06/02/2014 further noted, Resident #1 was brought back to the facility 45 minutes later by police who were called by a passer who saw the patient down the street at an intersection. Further review revealed, the nurse noted Resident #1 said "I got lost".</p> <p>According to review of the facility investigation dated 06/02/2014, the facility staff did not see Resident #1 exit the building on the evening of 06/02/2014. Review of the investigation also revealed Resident #1 did not remember how he got out of the facility.</p>	F 323		

AUG 08 2014  
DSHS/ADSARCS

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

PRINTED: 07/29/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>07/16/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARK RIDGE CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1250 NORTHEAST 145TH STREET SEATTLE, WA 98155</b>		
(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 323	<p>Continued From page 4</p> <p>In an interview on 07/08/2014 at 12:19 p.m., Staff A, an administrative employee, stated the facility staff did not know Resident #1 was missing from the facility on the evening of 06/02/2014, until 45 minutes after he was last seen, when the police returned him to the building after a call from a passerby who saw Resident #1 at a busy street intersection.</p> <p>Observation on 07/07/08/2014 at 1:07 p.m., revealed: a facility exit at the rear of the building with two large swinging doors on an alarm. The exit opened out to a large parking lot. Approximately 60 steps led to a drive through coffee shack, a sidewalk and a 4 lane busy street. Further observation revealed, the intersection where Resident #1 was found by police at 150th and 15th NE was, one tenth of a mile from the facility, and required crossing a street, about 6 driveways, and passing several parking lots with driveways to businesses and apartment complexes. The street had no street lighting along this observed route to where Resident #1 was found at 9:00 p.m. on 06/02/2014.</p> <p>Failure to provide adequate supervision for Resident #1, who was at high risk for unsafe wandering/elopement, contributed to Resident #1's unsafe elopement from the facility property onto a busy city street, and placed the resident at high risk for serious injury.</p>	F 323		

RECEIVED  
AUG 08 2014  
DSHS/ADSA/RP

AUG 08 2014  
DSHS