

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

PRINTED: 01/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2012
NAME OF PROVIDER OR SUPPLIER BALLARD CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 820 NORTHWEST 95TH STREET SEATTLE, WA 98117	
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Complaint Survey conducted at Ballard Care and Rehabilitation Center on 12/27/12. A sample of 3 of 11 residents identified as Elopement risk was selected from a total census of 134.</p> <p>The survey was conducted by: Katherine Ander, MN, RN, Complaint Investigator</p> <p>Complaints investigated include: # 2724164; 2714262; 2729209; 2729490</p> <p>The survey team is from: Department of Social and Health Services Aging and Adult Services 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) 395-5085</p> <p><i>[Signature]</i> 1/4/13 Residential Care Services Date</p>	F 000	<p>RECEIVED</p> <p>JAN 14 2013</p> <p>DSHS/ADSA/RCS Kent</p>	

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

TITLE

(X6) DATE

[Signature]
NHA

Administrator

1-7-13

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=G	<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 ensure that 2 of 3 sample (#1, #2) residents received adequate supervision to prevent elopement from the facility. Failure to adequately evaluate elopement risk and implement timely, appropriate prevention measures: resulted in harm to Resident #1 who was hospitalized with hypothermia after being found on the ground 2 days after eloping from the facility; placed Resident #2 at risk of harm when she was found unsupervised outside the facility and placed current and future residents at risk for harm from inadequate care and supervision to prevent elopement.</p> <p>Findings include:</p> <p>RESIDENT #1: Facility records document that Resident #1 was admitted [redacted] 12 after being found unresponsive at home. Diagnoses included medically related conditions and Dementia. According to the resident's 09/27/12 Minimum Data Set (MDS - a standardized assessment tool), Resident #1 had a score of 9 on the Brief Interview for Mental</p>	F 323	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Ballard Care and Rehabilitation does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F323 - G Free of Accident Hazards/Supervision/Devices</p> <p>1) Resident #1 was re-assessed by the Resident Care Manager upon re-admission on [redacted] 12 as an elopement risk. Elopement evaluation and care plan reflect elopement risk. Resident #1 on re-admission was provided a wander guard bracelet on [redacted] 2 per plan of care. Resident #2 was re-evaluated on 12/23/12 by Unit Manager and continues to be an elopement risk related to exit seeking behavior. The Interdisciplinary Team reviewed and revised resident #2's plan of care on 12/23/12.</p>	12-25-12
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F 323	<p>Continued From page 2</p> <p>Status tool, indicating moderate cognitive impairment. The resident was continent of bowel and bladder and required minimal supervision for activities of daily living. No wandering behavior was identified.</p> <p>Review of Resident #1's Elopement/Wander Risk Evaluation dated 10/15/12 found that the resident had short term memory problems related to his medical condition, goal directed wandering (smoking), observable situational frustration, and was independent in walking off the unit. Resident #1 was determined by facility staff to have no elopement potential. No approaches addressing elopement potential were listed on the plan of care.</p> <p>Facility progress notes dated 11/29/12 to 12/15/12 document Resident #1 was very confused, forgetful, and had significant cognitive deficits. Staff documented Resident #1 frequently asked for cigarettes and at times become very agitated. On 12/03/12 Resident #1's agitation escalated after he temporarily ran out of cigarettes. Staff obtained a doctors order for Ativan (anti-anxiety medication) and a nicotine patch. No care changes were made recognizing the resident's behavior as elopement risk and alerting staff of the need for increased supervision.</p> <p>Facility progress notes dated 12/15/12 document at 7:30 a.m. after smoking a cigarette Resident #1 said his car was not in the parking lot and then paced up and down the hallway becoming increasingly agitated. At 9:00 a.m. the resident was given Ativan for his agitation and appeared to calm down. No additional or increased</p>	F 323	<p>2) Current residents in the Center with exit seeking behaviors were re-evaluated by Interdisciplinary team on 12/17/12 and 12/24/12. Resident Elopement risk criteria used by Nursing Administration team expanded to broaden elopement risk identification.</p> <p>3) Licensed Nursing Staff and Nursing Administration team re-educated by Regional Manager of Clinical Operations on 12-17-12 and by Director of Nursing on 12-24-12 regarding elopement risk criteria, documentation of elopement risk and the implementation of timely, appropriate elopement prevention measures. Licensed nurses received re-education by Nurse Managers on 12/17/12 and 12/24/12 on elopement evaluation of residents with exit seeking behaviors.</p> <p>4) Five random reviews of elopement evaluations will be conducted weekly times 4 weeks, then monthly times 2 months by Director of Nursing and/or designee and results tracked and trended for review in monthly Performance Improvement meeting monthly times 3 months.</p> <p>5) Director of Nurses will ensure compliance.</p> <p>6) 12/25/2012</p>	
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F 323	<p>Continued From page 3</p> <p>supervision was implemented after Resident #1 exhibited clear agitation, ambulation and statements about his car. Staff saw the Resident at the nurses' station at 11:30 a.m. At 1:00 p.m. staff could not find Resident #1 on the premises and implemented the missing resident protocol.</p> <p>Medical records document on 12/17/12 Resident #1 was found by a passersby unresponsive lying in a school field, cold and shivering. On admission to the hospital Resident #1 had wounds to his right arm and left hand. Resident #1 was placed in the intensive care unit. Doctors determined Resident #1 had life threatening failure of circulatory, neurologic, kidney systems, sepsis (total body infection), dehydration and severe hypothermia due to exposure. Medical records show that Resident #1 was re-admitted to the facility [REDACTED] 12.</p> <p>Observation 12/27/12 at 1:00 p.m. found Resident #1 lying in bed. On interview the resident did not know where he was, saying that it was hard to remember things because he wakes up for a day or two and then slips into a coma.</p> <p>On interview 12/27/12 at 11:50 a.m. Staff C (Staff RN) described Resident #1 as pleasant, occasionally confused but easily redirectable. The resident mostly talks about his car/keys "where is the car" and looks for cigarettes.</p> <p>On Interview 12/27/12 at 3:50 p.m. Staff A (Resident Care Manager) stated Resident #1 came to the nurses desk every morning asking why he is here, saying "I'm ready to go" and asking about his suitcase. Staff A stated he did not identify Resident #1 as an elopement risk</p>	F 323			

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F 323	<p>Continued From page 4 because the resident was easily redirectable and had made no attempt to elope.</p> <p>On Interview 12/27/12 at 4:30 p.m. administrator and Director of Nursing (DON) stated that the Elopement/Wander Risk Evaluation tool used by the facility only identified potential risk of elopement. The DON said that elopement risk or determination of the need for electronic alert systems (like Wanderguard) was based on professional opinion of staff. According to the administrator, someone wandered (Resident #1) so clearly the assessment needed to be different and perhaps the facility could broaden their perspective/evaluation to identify more clearly elopement risk.</p> <p>RESIDENT #2: Facility records document Resident #2 was admitted to the facility [REDACTED] 12 with medical conditions and mild cognitive impairment. Medical records document that 10 days prior to admission on [REDACTED] 12 Resident #2 was found down on a sidewalk by a bystander, unable to supply any history. The resident was admitted to the hospital as Jane Doe and then transferred to the facility once her identity was established.</p> <p>According to the resident's 06/06/12; 09/02/12; 12/02/12 MDS assessments, Resident #2 had no identified wandering behavior.</p> <p>Resident #2's Elopement/Wander Risk Evaluation dated 05/30/12 identified elopement potential as the resident was very confused and had poor judgment. The plan of care was to "evaluate for wandering" and provide a supportive environment.</p>	F 323		
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F 323	<p>Continued From page 5</p> <p>Resident #2's 09/05/12 Elopement/Wander Risk Evaluation identified concerns in cognition, behavior/mood and mobility but no elopement potential as there was no history of elopement.</p> <p>Facility records show that on 09/20/12 Resident #2 eloped to a local grocery store. The Elopement/Wander Risk Evaluation for 09/20/12 and 10/15/12 identified that there was elopement potential but the resident refused to wear a Wanderguard. A wander risk care plan was implemented 09/20/12.</p> <p>Progress notes document 12/23/12 around 2:00 p.m. Resident #2 was found by Staff D standing outside, unsupervised. Staff D opened the door to let Resident #2 inside. The facility treated the incident as an elopement and implemented 1:1 monitoring after Resident #2 again adamantly refused to wear the Wanderguard.</p> <p>Observation 12/27/12 at 11:00 a.m. found Resident #2 standing in the hallway at the medication cart fully clothed and groomed. On interview the resident spoke in partial or incomplete sentences saying that she was going back to to where she lived before in the city "sometimes I stay, sometimes not."</p> <p>On interview 12/27/12 at 3:50 p.m. Staff A stated that the 09/20/12 elopement was thought to be related to a recent re-connection with family and a family outing. Staff A said that he thought the 12/23/12 elopement occurred when a temporary outside smoking area was implemented during an infectious gastrointestinal outbreak and Resident #2 followed other residents outside. Staff A</p>	F 323		

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F 323	<p>Continued From page 6.</p> <p>stated that social services are working on getting a place where the resident can be safe. Increased supervision was not implemented when the facility practice changed (temporary outside smoking area) increasing the resident's elopement risk.</p> <p>On interview 12/27/12 at 4:30 p.m. the administrator stated that Resident #2's photo was in the "wander alert" notebook at the front desk and she was sure there were other wander prevention measures in place even though the resident refused the Wanderguard.</p> <p>FACILITY PRACTICE: Observation 12/27/12 at 9:00 a.m. noted that Ballard Care and Rehabilitation Center is located in the city of Seattle in a residential neighborhood 4 blocks from a busy thoroughfare. The building has a Wanderguard departure alert system (electronic alarm that sounds when a resident with a Wanderguard bracelet attempts to exit).</p> <p>The facility Elopement/Wander Risk Evaluation tool directed that if a resident had a single factor related to mobility, behavior/mood, cognition or factors in all 3 areas (mobility, behavior/mood or cognition) it "raises the potential for elopement." If any factors were present (regardless of area or amount) staff was directed to complete the Evaluation Risk Identification Form. Nowhere on the form or in the facility policy was staff given direction about how to assess the level of elopement risk in light of identified risk factors or when/if to use a Wanderguard or implement increased supervision. The form did not include and staff did not identify that Resident #1 making statements about being ready to go, or looking for</p>	F 323			

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F 323	Continued From page 7 suitcases/car indicated a desire or possible intent to leave. Previous department investigation in September 2012 related to elopement events identified the facility Elopement/Wander Risk Evaluation tool did not assist staff to analyze information in order to determine elopement risk. On 12/27/12, Staff B identified 11 residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11) as wearing Wanderguard devices due to risk of elopement from a census of 134. Review of current facility practice found the same Elopement/Wander Risk Evaluation Form from September 2012 was in use without modification.	F 323			

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