

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

PRINTED: 01/22/2013  
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 09/21/2012
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NAME OF PROVIDER OR SUPPLIER  BALLARD CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 820 NORTHWEST 96TH STREET SEATTLE, WA 98117
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F 000 INITIAL COMMENTS

This report is the result of an unannounced Abbreviated Complaint Survey conducted at Ballard Care and Rehabilitation Center on 09/21/12 and 09/21/12. A sample of 3 residents was selected from a census of 137.

The survey was conducted by:

Katherine Ander, MN, RN, Complaint Investigator

Complaints investigated include:  
#2669502

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

Telephone: (253) 234-6000  
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F 000

IDR AMENDED

*[Handwritten Signature]*  
Residential Care Services Date 11/22/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE Administrator	(X6) DATE 1-28-13
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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.

Received Time Apr. 1. 2013 1:59PM No. 3601

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F 000	Continued From page 1	F 000		
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 ensure that 3 of 3 residents received adequate supervision and assistance devices to prevent elopement from the facility. The failure of systems to evaluate elopement risk and implement timely, appropriate prevention measures placed all 3 residents (#1, #2, #3) at risk of harm when they left the facility and were found unsupervised in the community.</p> <p>Findings include: Observation and interviews took place 9/21/12 unless otherwise noted.</p> <p>Observation 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 system (electronic alarm that sounds when a resident with a Wanderguard</p>	F 323	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Ballard Care and Rehabilitation</b> 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 Free of Accident Hazards/Supervision/Devices</p> <p>1. Elopement evaluations and care plans for residents #1, 2 and 3 have been updated on 10-15-12 by the Nursing Management team.</p> <p style="text-align: right;"><b>IDR AMENDED</b></p> <p>2. Elopement evaluations and care plans for current residents have been reviewed and revised by the Nursing Management team on 10-15-12.</p>	10-15-12

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F 323	<p>Continued From page 2 bracelet attempts to exit).</p> <p>On interview the administrator stated that the gate to the outdoor smoking area was not alarmed with a Wanderguard device until approximately 9/7/12, after two residents (#1, #2) who had a history of eloping from the facility and who wore Wanderguard bracelets were thought to have exited through the unalarmed gate.</p> <p><b>RESIDENT #1:</b> Facility records document that Resident #1 was admitted to the facility [REDACTED] 12 and re-admitted to the facility [REDACTED] 12 with medically and mentally disabling conditions. According to the resident's 2/6/12 Minimum Data Set (MDS - a standardized assessment tool), Resident #1 required extensive assistance for transfer, dressing, and toileting. The resident was continent of bowel and bladder and used a wheelchair for mobility. No wandering behavior was identified.</p> <p>Review of quarterly elopement assessments completed by facility staff found that sometimes Resident #1 was deemed a wander risk (4/10/12, 8/14/12) and other times was not a wander risk (1/10/12, 8/10/12).</p> <p>Review of quarterly smoking assessments determined that sometimes Resident #1 was safe to smoke without supervision (1/10/12, 7/10/12) and sometimes was not safe to smoke without supervision (2/8/12, 5/10/12). The 7/10/12 smoking assessment did address elopement risk from the smoking area with an un-alarmed outside gate.</p> <p>Review of Resident #1's care plan found on</p>	F 323	<p>3. Nursing Administration team has been re-educated in relation to the assessment, evaluation and care planning of elopement risk on 10-15-12 by the Director of Nursing. Licensed Nursing staff have been re-educated regarding elopement prevention practices on 10-15-12 by the Staff Development RN.</p> <p>4. Monthly reviews will be conducted by the Administrator and/or designee to validate elopement protocol in place for residents identified as at risk for elopement. Interdisciplinary team will review elopement assessment, evaluation and care planning for residents at risk in CARE (clinical at risk evaluation) meetings monthly.</p> <p>5. The Administrator and Director of Nursing will be responsible for compliance.</p> <p>6. 10-15-12</p>	

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F 323	Continued From page 3 2/2/12, staff identified that the resident was at risk for wandering related to confusion, new environment, and restless/agitated behavior. The resident was to have device mounted to wheelchair. The plan of care included assessing for triggers to wandering, attempt to divert attention when resident insistent on leaving the facility, electronic safety device left wrist, engage in activities, evaluate distress and care needs, if attempts to exit frequently observe for patterns such as time of day, etc.  Facility incident review found that on 4/22/12, during evening medication pass (5:00 to 6:00 p.m.), Staff K could not find Resident #1. A search of the facility by staff did not locate Resident #1. The facility alerted police that the resident was missing. Progress notes document that police found Resident #1 at 7:50 p.m. 10 blocks away. Staff drove to retrieve the resident and found him soaking wet, incontinent of urine. The facility placed a wrist Wanderguard on the resident at this time.  On interview, Staff A (resident care manager/supervisor) stated that Certified Nursing Assistants (NAC) should check assigned residents for care needs at the start of the shift. According to the facility incident investigation, Resident #1 was not in his room at the start of shift on 4/22/12 and Staff E (NAC assigned to Resident #1) thought the resident was in the building. Another resident 's family member documented that they saw Resident #1 several blocks away in the community at 2:00 p.m.  Facility incident review found that on 8/14/12 at approximately 4:15 p.m. Resident #1 was seen by	F 323			

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F 323	<p>Continued From page 4</p> <p>Staff L on the busy thoroughfare heading toward a grocery store. Staff L alerted the facility who was unable to locate Resident #1. Facility staff retrieved Resident #1 from the community. Facility incident investigation concluded that the resident was suspected of eloping from the facility but did not say how.</p> <p>On interview, the Director of Nursing (DON) and Administrator stated that it was suspected that on 8/14/12 Resident #1 exited through the non-alarmed gate in the resident's smoking area. Both stated that Resident #1 was safe to smoke unsupervised but after the 8/14/12 incident, it was determined that smoking supervision was necessary due to elopement risk.</p> <p>According to the Administration and DNS, at the time of Resident #1's 8/14/12 elopement a sign had been placed on the un-alarmed gate stating that the gate was an Emergency Exit only. The Administrator stated that the sign was placed because another resident (#2) who was also wore a Wanderguard bracelet had eloped through the un-alarmed gate a few weeks before.</p> <p>RESIDENT #2: Facility records document that Resident #2 was admitted to the facility [REDACTED] 12 with medically and mentally disabling conditions. According to the resident's 3/29/12 MDS assessment, Resident #2 required extensive assistance for transfer, dressing, toileting and walking with a walker. According to the resident's 6/17/12 MDS, the resident required only limited assistance and could walk independently or used a wheelchair. No wandering behavior was identified on either assessment.</p>	F 323	IDR AMENDED	

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F 323	Continued From page 5  Staff determined that on 03/23/12 Resident #2 was not at risk for elopement but on 4/24 and 7/12/12 Resident #2 was at risk of elopement.  Review of quarterly smoking assessments determined that sometimes Resident #2 was safe to smoke without supervision (7/5/12) and sometimes was not safe to smoke without supervision (5/3/12, 3/7/12, 9/12/12). The 7/5/12 smoking assessment did address elopement risk from the smoking area with an un-alarmed outside gate.  Facility incident review found that on 4/24/12 between 4:30 and 5:00 p.m., Staff L found Resident #2 at a local grocery store several blocks from the facility. The resident was retrieved by facility staff. The resident's care plan was updated to implement a Wanderguard alarm. The care plan did not address where the Wanderguard was located (on body, belongings or assistive device).  Facility incident review found that on 8/3/12, at approximately 11:50 a.m., two neighbors notified the nurse on duty that the resident fell outside the facility. Staff documented that Resident #2's Wanderguard was on but staff was not aware of the resident leaving the facility. The facility documented that the door alarm did not sound off, possibly because Resident #2 was not carrying her back-pack where the Wanderguard is located. Therapy records document that on 8/3/12 Resident #2 was found on the ground after eloping in her wheelchair from the smoking area.  The corrective action documented by the facility	F 323			

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F 323	<p>Continued From page 6</p> <p>was that maintenance would fix the exit door for added security. The facility re-assessed Resident #2 as a dependent (supervised) smoker.</p> <p>Therapy records document that on 8/25/12 Resident #2 eloped again from the smoking area and was found in the parking lot. " She may need to have supervised smoking to prevent elopement from smoking area. " On review 9/21/12, Resident #2 ' s care plan still did not address where the Wanderguard would be located and was not updated for supervised smoking until 8/14/12.</p> <p>On interview, the Administrator stated that while waiting for the Wanderguard to be installed on the gate in the smoking area, the facility posted a sign that the gate was to be used as an Emergency Exit only and this was considered sufficient to protect residents from wandering through that exit.</p> <p>RESIDENT #3: Facility records document that Resident #3 was last re-admitted to the facility [REDACTED] 12 with medically and cognitively disabling conditions. According to the resident ' s 1/15/12 MDS Resident #3 required limited assistance for transfer and dressing. The resident could walk and toilet with supervision. No wandering behavior was identified.</p> <p>Review of sequential elopement assessments completed by facility staff found that sometimes Resident #3 was deemed a wander risk (4/15/11, 2/25/12, 7/17/12) and other times was not a wander risk (7/25/11, 8/2/12).</p>	F 323	<p style="text-align: right;">IDR AMENDED</p>	
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F 323	Continued From page 7 Review of Resident #1 's care plan dated 5/22/12 found " use of Wanderguard for safety/elopement risk ". Facility records document that on 7/31/12, staff determined that the Wanderguard was no longer required and it was discontinued.  Facility records document that on 8/25/12 the NAC assigned to Resident #3 during evening shift could not find him. The NAC documented that he was late checking on assigned residents and did not note that Resident #3 was missing until 3:15 p.m. Facility staff was unable to locate Resident #3 and alerted family and police. Facility records document that Resident #3 was found 7 blocks away at 12:15 a.m., cold and asking for tea. Police returned Resident #3 to the facility.  On interview, DON and Administrator stated that the elopement assessment used by the facility clearly identified elopement risk and alternately identified risk of wandering or no risk of wandering without indicating what information was used to reach the conclusion about risk.	F 323	
<b>IDR AMENDED</b>			