

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

PRINTED: 03/06/2013
FORM APPROVED
OMB NO. 0938-0391

351

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505421	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WASHINGTON ODD FELLOWS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 534 BOYER AVENUE WALLA WALLA, WA 99362
---	--

(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 unannounced Abbreviated Survey conducted at Washington Odd Fellows Home on 03/04/2013 and 03/05/2013. A sample of 6 residents was selected from census of 95. The sample included 6 current residents.</p> <p>The following complaints were investigated as part of this survey:</p> <p>#2755606 #2725339 #2748338 #2748333 #2740997 #2727979</p> <p>The survey was conducted by:</p> <p>██████████ R.N. ██████████ R.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services District 1, Unit C 3611 River Road, Suite 200 Yakima, WA 98902</p> <p>Telephone: (509) 225-2800 FAX: (509) 574-5597</p>	F 000		
-------	---	-------	--	--

Received
Yakima RCS
MAR 13 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ██████████	TITLE ADMINISTRATOR	(X6) DATE 3/11/13
---	------------------------	----------------------

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.

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

PRINTED: 03/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505421	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2013
NAME OF PROVIDER OR SUPPLIER WASHINGTON ODD FELLOWS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 534 BOYER AVENUE WALLA WALLA, WA 99362	
(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>medication, which was to be given every eight hours as needed at bedtime for agitation.</p> <p>On 03/04/13 between approximately 11:00 a.m. and 12:00 noon the resident was sitting in a recliner in the room adjacent to the East wing dining room. The resident was unaware of where he was and he was unable to respond appropriately.</p> <p>On 02/11/13 at 6:30 p.m. the Medication Administration Record (MAR) noted the resident was given medication medication for increased restlessness/wandering with minimal effect. At 9:15 p.m. that evening the facility received a phone call that the resident was found at a college campus building not far from the facility. Staff were unaware of the resident's whereabouts for approximately 15 minutes, according to their investigation. Staff was sent to meet the resident and returned him to the facility unharmed. The investigation concluded the door alarm in the East Wing dining room was malfunctioning, thus when the resident left the building no alarm sounded.</p> <p>Review of the medical record revealed there was no assessment to determine the confused and wandering resident's risk for eloping from the facility. The plan of care did note the resident's tendency to wander throughout the care center and into other residents' rooms. An alarm bracelet was in place for safety. However, his risk for elopment from the facility was not identified on the plan of care.</p> <p>The facility had three doors which worked in tandem with the alarm bracelets. The door</p>	F 323	<p>F323</p> <p>The following corrections have been implemented to address the issues cited above:</p> <ol style="list-style-type: none"> 1. The facility revised the wrist sensor testing procedure and trained staff on how to test the sensors. 2. The facility instituted a wandering assessment for those residents who may have a propensity to wander. 3. The facility changed the cited door alarm to "Perimeter Door Mode", which locks the door 24/7 regardless of whether one is wearing a wrist sensor. 4. The facility installed a gate at the exit to the patio area where the resident exited the building. 5. The facility revised the policy to clarify and memorialize the above. <p>It should be noted that the manufacturer's documentation does not recommend replacing bracelets based on date. The manufacturer, however, does recommend testing the bracelets on a weekly basis – a recommendation far more liberal than the facility's practice of daily testing, and within the 7 days cited above.</p> <p>This will be monitored by the Charge Nurse and was completed on March 18, 2013.</p> <p style="text-align: right;">3/18/13</p>

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

PRINTED: 03/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505421	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/05/2013
NAME OF PROVIDER OR SUPPLIER WASHINGTON ODD FELLOWS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 534 BOYER AVENUE WALLA WALLA, WA 99362		
(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	Continued From page 4 resident's wandering behaviors and desires to go home, his increased agitation on the evening of his elopment, failure to monitor the bracelet battery, and knowledge of an exit door alarm malfunctioning intermittently, the facility failed to ensure adequate supervision to prevent his elopement.	F 323		