

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2014
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NAME OF PROVIDER OR SUPPLIER FOSS HOME & VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 13023 GREENWOOD AVENUE NORTH SEATTLE, WA 98133
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(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
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F 000 INITIAL COMMENTS

F 000

This report is the result of an unannounced Abbreviated Survey conducted at Foss Home and Village on 08/26/2014-08/29/2014. A sample of 5 residents plus 3 closed records was selected from a census of 160.

The following complaint was investigated as part of this survey:
#3028793; 3033568; 3029730; 3030243;
3029744

The survey was conducted by:

Cathy Prentice, MN, R.N.

The survey team is from:

Department of Social and Health Services
Aging and Long Term Support Administration
Residential Care Services, District 2, Unit C
Creekside Two
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Deloris Urea 9/11/2014
Residential Care Services Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Deloris Urea</i>	TITLE Administrator	(X6) DATE 9/25/2014
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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.

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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 to provide adequate supervision to prevent unsafe elopement for 1 of 4 residents reviewed (Resident #1), when Resident #1 unsafely left the facility premises, unassisted and unsupervised out of the facility, in a wheelchair and up a busy street without the knowledge of the facility staff. This failure placed Resident #1 at substantial risk for injury.</p> <p>Findings include:</p> <p>Review of facility medical records on 08/26/2014 revealed, Resident #1 resided in the facility for long term care since late [REDACTED] with dementia, major depressive disorder, and a history of falls. The facility Minimum Data Set (MDS) assessment dated 03/03/2014 noted, resident #1 had a memory problem and disorganized thinking, as well as hallucinations. The facility medical record also revealed Resident #1 had a history of "exit seeking" behaviors since admission to the facility, as noted below.</p>	F 323	<p>F-323: Resident #1 was moved to the secured unit on 8-18-14.</p> <p>Clinical Care Managers conducted an audit to identify all potential wanderers.</p> <p>An elopement/wandering risk assessment form was developed to assess all residents routinely. A new protocol was written for elopement prevention.</p> <p>Licensed nurses were in-serviced on the new protocol and form.</p> <p>Clinical Care Managers will monitor for completion of assessment forms. Director of Nursing will assure compliance.</p>	10-1-2014	

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F 323	<p>Continued From page 2</p> <p>Record review of the facility Multi-Disciplinary Progress Notes revealed, on 02/25/2014, facility staff noted Resident #1 was confused, agitated and self-propelled her wheelchair independently "wanting to go home". The facility note dated 02/25/2014 further revealed, Resident #1 "almost got out" of the facility exit doors by the loading dock, and was assisted back to her room.</p> <p>Further review of the facility Progress Notes revealed, on 04/18/2014, about seven weeks after the first elopement attempt, Resident #1 was "exit-seeking" and "tried to get out" from the northend hall door, an alarm sounded, and Resident #1 was brought back to the unit crying that she was not able to do her job of driving kids on a bus.</p> <p>Additional record review revealed a Mental Health Services assessment note dated 04/18/2014 that stated, Resident #1 had previously been treated in another facility by the same Mental Health Services, and Resident #1 presently had dementia, depression and some paranoia and delusions that put her as a potential "flight and safety risk". The Mental Health recommendation was an antipsychotic medication for delusions and sleep difficulty.</p> <p>Review of the facility Care Area Assessment dated 06/03/2014 revealed, the facility noted no other attempts to leave the facility since 04/18/2014, about a six week timeframe, and did not include exit seeking risk on the Plan of Care dated 06/02/2014, and subsequent Care Plan</p>	F 323			

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F 323	<p>Continued From page 3 dated 07/09/2014.</p> <p>Review of the facility Progress Notes dated 07/22/2014 revealed, about 3 months after the second elopement attempt, Resident #1 eloped out the front entrance of the facility in her wheelchair unsupervised, and was brought back to the facility almost an hour later by staff from a building up the street.</p> <p>The facility Progress Note dated 07/22/2014 noted, Resident #1 had tried to leave the facility that evening at 7:20 p.m., then was next seen by facility staff at 8:15 p.m. when an employee of another building up the street brought Resident #1 to the facility after seeing the name of the facility on Resident #1's wheelchair. The facility note also noted Resident #1 had been "looking for a male friend" during the evening shift in the facility.</p> <p>According to review of the Facility Investigation dated 07/24/2014, Resident #1 did try to exit the facility on 07/22/2014 around 7:20 p.m., and was brought back by a facility employee at that time (Staff A), who notified a caregiver nearby (Staff B), then went on her break. The facility investigation further noted, the caregiver (Staff B) also went on a break after the exit attempt, and Staff C, the caregiver assigned to Resident #1, was on a break after the first exit attempt by Resident #1 at 7:20 p.m.</p> <p>The facility investigation dated 07/24/2014 noted, Resident #1 was able to exit from the facility</p>	F 323	<p>RECEIVED</p> <p>SEP 26 2014</p> <p>DSHS/ADSRCS</p>	

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F 323	<p>Continued From page 4</p> <p>premises after the 7:20 p.m. attempt, because the main entrance receptionist was on a break without coverage at the front desk.</p> <p>In an interview on 08/26/2014 at 4:20 p.m., Staff D, an administrative employee, stated there were no facility staff who knew Resident #1 had eloped from the facility after the 7:20 p.m. attempt, and no facility staff knew Resident #1 was missing from the facility until 8:15 p.m., when someone from a building up the street brought her back because they saw the facility name on her wheelchair when they saw her in their parking lot.</p> <p>In an interview on 08/26/2014 at 3:10 p.m., Staff A, a facility receptionist, stated on 07/22/2014, she was at the front desk and at about 7:20 p.m., Resident #1 was observed by Staff A to exit through the first set of facility doors at the front entrance in her wheelchair, and was halfway out the second set of doors to the front parking lot, when Staff A intervened and assisted her back inside and to the nearby dining room. Staff A also stated Resident #1 was confused, and Staff A notified a nearby staff caregiver (Staff B), then left for her evening break.</p> <p>In an interview on 08/26/2014 at 3:05 p.m., Staff B stated, he did not know Resident #1, he assisted her into the dining room after she tried to leave the facility. Staff B did not know if there was another staff member in the dining room since dinner was over, and Staff B did not notify any other staff about Resident #1's exit attempt. Staff B then went on his evening break.</p>	F 323		

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F 323	Continued From page 5 In an interview on 08/26/2014 at 3:25 p.m., Staff C, the caregiver assigned to Resident #1 on the evening of 07/22/2014, stated she was on her break when the elopement attempt occurred, and she did not know Resident #1 eloped until after she was brought back to the facility after 8:15 p.m. Staff C also stated Resident #1 was self-propelling her wheelchair that evening before she left the building premises, and was looking for a man in her mind. Observations on 08/26/2014 at 3:20 p.m., and 4:30 p.m., revealed, the front entrance to the facility included two sets of glass doors, with the second set opening into the driveway and parking area, then approximately 20 feet to the sidewalk that borders a 4 lane busy street (Greenwood Ave. North). Further observations revealed, the building where Resident #1 was found in a parking lot, was approximately one tenth of a mile from the facility, and across at least 5 driveways and across one street. The facility failure to provide adequate supervision for Resident #1 after an attempted elopement on the evening of 07/22/2014, contributed to an unsafe elopement from the facility when Resident #1 left the facility in a wheelchair, along a busy street to a building parking lot north of the facility, placing the resident at substantial risk for injury.	F 323			

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