

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

PRINTED: 04/08/2013
FORM APPROVED
OMB NO. 0938-0391

8806

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505516	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/03/2013
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NAME OF PROVIDER OR SUPPLIER WASHINGTON SOLDIERS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1305 ORTING - KAPOWSIN HIGHWAY ORTING, WA 98360
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Washington Soldiers Home on 3/26/13 and 4/3/2013. The sample included 4 current residents out of a census of 95.</p> <p>The following are complaints investigated as part of this survey:</p> <p>#2775886 #2775437 #2779903</p> <p>The survey was conducted by:</p> <p>██████████, R.N, MSN ██████████, RN, MN</p> <p>The surveyor is from:</p> <p>Department of Social and Health Services Aging and Disability Services Residential Care Services, District 3, Unit B 1949 S. State Street Tacoma, WA 98405-2850</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>[Signature]</i> 4/19/13 Residential Care Services Date</p>	F 000	<p>APR 2 2013</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ADMINISTRATOR	(X6) DATE 4.23.13
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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.

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F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<p>The Director of Nursing will assign an Investigations Nurse to follow up on any investigations when the regular Investigations Nurse is out of the office. The community will thoroughly investigate discrepancies regarding documentation of 15 minute checks. Staff providing direct care will be re-trained by the Staff Development Coordinator regarding 15 minute checks. The Staff Development Coordinator will re-teach the specifics as to how to report change in location of a resident receiving checks.</p>	05/30/2013

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This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to complete a thorough investigation for 1 of 5 investigations (4 residents) reviewed for potential neglect. The facility did not thoroughly investigate Resident #1's elopement from the facility while care planned for every 15 minute safety checks.

Without a thorough investigation, the facility could not rule out neglect in their monitoring of Resident #1 which left Resident #1 at risk for recurrence of elopement.

Findings include:

Review of facility investigation dated 3/17/13 revealed Resident # 1 was observed by off-duty Staff P walking along a road beyond the facility. Staff P brought the resident back to the facility unharmed.

Review of the investigation revealed the incident occurred at 7:00 p.m. and the resident was last seen by staff in the facility walking in the hallway at 6:00 p.m.

Review of documentation of fifteen minute safety checks for Resident #1 dated 3/17/13 showed staff documented the resident was observed every fifteen minutes between 6:00 and 7:00 p.m. (6:00, 6:15, 6:30, 6:45 & 7:00).

There was no documented evidence of interviews with staff assigned to care for Resident #1 and no interviews with other staff that worked the evening

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shift to ensure adequate supervision was in place.

During exit interview on 4/3/13 at 4:15 p.m., the above information was shared with Staff A. Staff A stated she would investigate to determine if there was additional information available.

On 3/27/13, Staff A sent a written statement from Staff Q dated 3/26/13. Staff Q indicated he was assigned to Resident #1 during the evening shift on 3/17/13. Staff Q stated he checked the resident every 15 minutes except when he was assisting in the Crow's Nest dining room. Staff Q stated the resident was either in his room or out smoking. Staff Q stated "I didn't check him at dinner because he eats in the Rainier Room and I feed in the Crow's Nest, but the people at Station One serve his dinner".

There was no further evidence the facility investigated further to determine if staff from Station 2 communicated with staff on Station 1 that Resident #1 was on 15 minute checks.

On 4/3/13 at 10:00 a.m., interview with Staff P revealed she documented a late entry addition dated 4/1/13 to her statement regarding Resident #1's elopement. Staff P stated administrative staff subsequently asked at what time she observed Resident #1 on the road which was not part of the initial interview. Staff P stated she estimated the time to be around 5:30 p.m. and documented this for the record.

On 4/3/13 at 11:00 a.m. when interviewed, Staff B stated she did not interview staff caring for the resident on 3/17/13 because staff were not

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F 225	<p>Continued From page 4</p> <p>initialing the 15 minute check flow sheet and she did not know who was accountable for the checks. She asked the evening supervisor to provide training to nursing staff to ensure they initialed the flow sheet. Staff B did not conduct additional interviews until after the investigator requested additional information beginning on 3/26/13.</p> <p>The facility failed to thoroughly investigate discrepancies in the timeframes reported by staff of when the resident was discovered missing/last seen by staff as compared to continuous documentation that safety checks were completed. The investigation did not include interviews with staff on duty and/or with those caring for the resident until requested by the state investigator.</p> <p>Refer to F323 for details of failed facility practice related to lack of adequate supervision.</p>	F 225	<p>Refer to Page # 2</p> <p>Refer to Page # 6</p>
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 observations, record review, and interview, the facility failed to ensure adequate supervision of 2 of 3 residents (#1 & 2) reviewed</p>	F 323	

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F 323	<p>Continued From page 5 for elopement and/or suicide attempt.</p> <p>This placed the residents at risk for potential harm related to the risk of injuries associated with elopement and /or self-harm.</p> <p>Findings include:</p> <p>1. Review of Resident #2's record revealed nursing progress note entries dated 3/9/13 at 10 p.m. revealed Resident #2 called 911 and told the dispatcher he was going to cut himself with a razor. Review of care directives (undated) revealed they included removal of sharp objects from the resident's room and instituted monitoring of the resident every 15 minutes.</p> <p>Review of nursing notes dated 3/26/13 at 11:00 a.m. revealed the resident dismantled a pencil sharpener and cut his arm, inflicting a 4.0 centimeter (cm) by 1.0 cm superficial cut to the front of the resident's right elbow area. Review of safety monitor check flowsheet revealed the resident was last observed by staff 15 minutes earlier at 10:45 a.m.</p> <p>During interview at 8:50 a.m., Staff F (licensed nurse assigned to Resident #2) stated she was aware Resident #2 was on every 15 minute checks; however, she was not sure why. Staff F looked up the resident's care directives to determine the reason for frequent safety checks.</p> <p>Interview with Staff M at 10:25 a.m. on 4/3/13 revealed Staff B provided activity staff with a list of residents that were on frequent safety checks. Staff M stated she assumed Residents #2 & 3 were being monitored for elopement; Staff M was</p>	F 323	<p>The Staff Development Coordinator will re-train regarding 15 minute checks by May 30, 2013 to assure the community practices adequate supervision. Training will include specifics as to how staff informs someone outside the normal duty station who receives 15 minutes checks, i.e., staff in the dining room, activities or therapy locations. In addition to retraining, the community added a notebook listing anyone receiving 15 minute checks (with a photograph) and the reason for the 15 minute check. The community implemented email notification to departments outside of the nursing department in an effort to allow anyone on the 188 acre campus to be aware of those receiving 15 minute checks and see their photograph. The Quality Assurance Registered Nurse or designee will email all departments each time a resident has 15 minutes checks (including a photo) and the reason for the 15 minute check. The Quality Assurance Registered Nurse or designee will audit those receiving 15 minute checks and the reasons for those checks for 90 days to assure continued compliance and safety.</p>	05/30/2013

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not sure why Resident #2 was on every 15 minute checks.

On 4/3/2013 at 12:00 p.m., Resident #2 was observed eating lunch in the Crow's Nest dining room. Certified nursing assistants J, K, L and registered nurse I staffed the dining room.

Interviews revealed the four staff were assigned to Station 2; Resident #2 resided on Station 1. Each staff identified two residents in the dining room from station 2 that were on every 15 minute checks for elopement risk; they were not aware Resident #2 was on 15 minute checks for suicide attempt.

Staff D was assigned to Station 1 in the morning and was then floated to Station 2; Staff D was aware Resident #2 was on every 15 minute checks; however, was not aware of the resident's self inflicted injury. Staff D stated she was not asked by staff on Station 2 to monitor the resident during lunch.

2. Record review revealed Resident #1 was found off facility grounds on 3/17/13 and was seen by an off duty staff and returned unharmed to the facility.

Subsequent investigation by the facility determined the resident left the facility during the dinner hour at approximately 5:30 p.m. Investigation showed the resident was on every 15 minute safety checks at the time of the elopement. Resident #1 resided on Station 2 and dined in Rainier dining room which was located on Station 1. Facility investigation determined the staff assigned to care for Resident #1 was

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assigned to the Crow's Nest dining room while Resident #1 was eating in Rainier dining room.

On 4/3/13 at 12:20 p.m., Resident #1 was observed seated in Rainier dining room. Interview with Staff N revealed she did not know which residents were on every 15 minute checks since she usually worked in another building. Staff O was aware of the 2 residents on fifteen minute checks, including Resident #1. Staff O stated she worked on both stations, otherwise she would not have known.

During interview earlier on 4/3/13 at 10:10 a.m., Staff H stated Staff C was aware of the residents in the independent dining room (Rainier) that were monitored every 15 minutes and he monitored them while they were in the dining room.

At 11:30 a.m. in Rainier dining room, Staff C was observed setting up for lunch. Staff C stated he supervised in the dining room every morning for the breakfast meal. Staff C stated he did not know which residents were on every 15 minute checks. He stated staff from Station 1 were assigned to Rainier dining room; Staff from Station 2 would be responsible for monitoring residents from Station 2 while those residents were in Rainier dining room. He was not aware if staff from Station 2 communicated to staff on Station 1 or if they found out from another source.

Observations and interviews revealed there was a lack of consistent communication between staff and respective stations to ensure residents received adequate supervision to prevent accidents associated with potential elopement

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