| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505334 | A. Building<br>B. Wing | 09/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Kirkland | 10101 Northeast 120th Street<br>Kirkland, WA 98034 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619<br><br>Based on interview and record review the facility failed to provide necessary/adequate supervision for 1 of 1 resident (Resident 1), reviewed for elopement. This failure allowed Resident 1 to exit the facility unnoticed and placed the resident at risk for serious injury and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility policy titled, Unsafe Wandering and Elopement Prevention, revised 08/22/2022, showed the facility must ensure that each resident receives adequate supervision .to prevent accidents. The policy further showed elopement is when a resident leaves a safe area without the necessary supervision to do so and places them at risk of heat/cold exposure, dehydration, and/or being struck by a motor vehicle.<br><br>Resident 1 admitted to the facility on [DATE] with diagnoses that included dementia (a progressive condition that causes a decline in cognitive abilities, such as thinking, remembering, and reasoning, that interferes with daily life), muscle weakness, and unsteadiness on feet.<br><br>Review of Resident 1's quarterly Minimum Data Set (MDS-an assessment tool), dated 09/12/2024, showed Resident 1 had severe cognitive impairment.<br><br>Review of Resident 1's Elopement Risk Evaluation dated 04/11/2023, showed Resident 1 was at risk for elopement, as they were wandering around, pushed the front door but failed.<br><br>Review of Resident 1's Elopement Risk Evaluation dated 09/10/2024, showed Resident 1 was cognitively impaired, able to ambulate independently or without the use of an assistive device (including a wheelchair), and had a history of elopement. The evaluation further showed the resident was at risk for elopement.<br><br>Review of Resident 1's elopement care plan initiated on 04/11/2023, showed the resident wandered around the facility, liked to walk outside of the facility at times supervised by the resident representative or staff. The care plan further showed a goal for the resident not to leave the facility unattended.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 1's falls care plan initiated on 04/11/2023, showed the resident was at risk for falls due to weakness/impaired mobility, and had poor safety awareness, combative and impulsive behavior.<br><br>Review of the facility's reporting log for September 2024, showed Resident 1 was a missing person/eloped outside on 09/10/2024.<br><br>Review of the facility's undated elopement investigation for Resident 1 showed that on 09/10/2024 at approximately 6:30 PM, staff were unable to find Resident 1 in their room or common areas and initiated a search. Resident 1 was last seen by staff at 6:00 PM. The investigation also showed police were notified, found the resident around 6:48 PM, and assisted bringing the resident back to the facility around 7:15 PM. Further review of the investigation showed it was highly likely that resident exited the facility with a visitor as the alarms did not go off.<br><br>Further review of the elopement care plan interventions initiated on 09/10/2024 and 09/12/2024 showed the following:<br><br>-Offer the resident walks around the facility<br><br>-Sit and talk about their past and share stories<br><br>-Provide frequent safety checks<br><br>-Reduce noise and confusion<br><br>-Turn off the TV, close the blinds when resident is ready for bed<br><br>-When resident becomes exit seeking or seems anxious, provide coffee and snacks to calm them down<br><br>-When resident is overstimulated provide visits to support calm the resident down, at times too many people can become overestimating for them.<br><br>Review of the facility's document titled, Safety checks-15 minute, dated 09/14/2024, showed Resident 1 had one on one monitoring (sitter whose role is to provide one to one nursing or constant observation care for a period). Further documentation showed the following:<br><br>- at 8:15 AM, Resident 1 was mad and not wanting to be here.<br><br>- at 1:30 PM, Resident 1 was in the hall looking out the door.<br><br>- at 2:45 PM, Resident 1 was in room upset wanted to leave.<br><br>- at 3:00 PM, Resident 1 was in the courtyard wanted to leave.<br><br>- at 3:15 PM, Resident 1 was in the lobby exit seeking.<br><br>- at 4:00 PM, Resident 1 was exit-seeking.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 09/16/2024 at 4:07 PM, showed signage on the exit doors that said, Visitors and staff please turn around and make sure that a resident isn't trying to leave the building with you!<br><br>Observation on 09/25/2024 at 3:21 PM, showed Resident 1 following this surveyor out of their room.<br><br>Observation on 09/25/2024 at 3:30 PM, showed Resident 1 walked around the facility to the [NAME] exit door, looked out of the window, and stated, It is pretty out there. Resident 1 stated they had to go to the bathroom and staff assisted them back to their room after attempting to go into another resident room.<br><br>On 09/26/2024 at 1:39 PM, Staff D, Licensed Practical Nurse, stated Resident 1 had dementia, was ambulatory, and was at risk for elopement.<br><br>On 09/26/2024 at 1:40 PM, Staff C, Registered Nurse Unit Care Coordinator, stated that the resident was independent with ambulation. Staff C stated that Resident 1 did wander, and they had found the resident trying to leave several times. Staff C stated Resident 1 was at risk for elopement and had eloped on 09/10/2024 and was found by police down by 405 [freeway] and 116th in the parking lot. Staff C stated that this placed the resident at risk of getting hurt, lost, or injured. Staff C further stated that Resident 1 was pretty tired when they returned to the facility and was ready to lie down.<br><br>On 09/26/2024 at 3:15 PM, Staff B, Director of Nursing, stated that Resident 1 had severe cognitive impairment and that they wandered. Staff B stated that when the resident had eloped on 09/10/2024, someone outside of the facility had called the police and they had already picked her up and was found up the street by the car lot and they were not familiar with the area. Staff B stated that Resident 1 was at risk for elopement and should not have left the facility unattended/unsupervised and that it placed the resident at risk for harm.<br><br>On 09/26/2024 at 3:31 PM, Staff A, Executive Director, stated that Resident 1 was at risk for elopement and should not have left the facility unattended/unsupervised and that this placed the resident at risk of getting lost or injured. Staff A stated that based on their investigation they concluded Resident 1 left with visitors as the alarms did not go off, and that they had placed signage for visitors and staff to check behind them when exiting the facility. When asked if it was the visitors' responsibility to ensure resident safety, Staff A stated, it is a request. Staff A further stated that additional interventions in the care plan were put in place to prevent the resident from further elopement.<br><br>Reference: (WAC) 388-97-1060 (3)(g) |