

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Fir Lane Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2430 North 13th Street Shelton, WA 98584	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49451</p> <p>Based on interview and record review the facility failed to follow their policy to prevent resident elopement for 1 of 3 residents (Resident 4) reviewed for accidents. This failure placed residents at risk of elopement, accidents and a decreased quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy, titled Elopement Prevention, dated 11/2022, showed elopement prevention included completing an admission assessments, elopement evaluations, identifying risk factors and hazards and could have included previous elopements, desire to leave the center and cognitive impairments. The policy included completing an elopement care plan and developing individualized interventions which may have included the electronic monitoring/alarm system to be used and to check through observation that the resident was wearing the device, if one was applied by indicating this on the Treatment Administration Record (TAR).</p> <p>Resident 4 was admitted to the facility on [DATE] with diagnoses including hepatic encephalopathy (brain disorder that occurs when toxic substances build and reach the brain due to liver dysfunction) and cirrhosis of the liver (permanent scarring that damages the liver and interferes with its functioning). The Minimum Data Set (MDS), an assessment tool, dated 08/12/2024 showed the resident had cognitive impairment and required staff assistance for bathing and staff supervision for transfers and ambulation.</p> <p>Resident 4's progress note, dated 08/13/2024, showed the resident left the building unattended and the resident returned to the facility with police.</p> <p>Resident 4's progress note, dated 08/14/2024, showed the resident has made no further attempts at elopement.</p> <p>Resident 4's progress note, dated 08/15/2024, showed the resident has made no further attempts at elopement.</p> <p>Resident 4's progress note, dated 08/15/2024, showed a wander guard (monitoring system worn by an at-risk resident to alert caregivers when resident exits or enters designated areas) was applied to Resident 4's left ankle.</p> <p>(continued on next page)</p>

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Fir Lane Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2430 North 13th Street Shelton, WA 98584	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 4's record showed no physicians order for a wander guard.</p> <p>Review of the facility accident and incident logs showed no documentation of Resident 4's elopement on 08/13/2024.</p> <p>Resident 4's progress note, dated 08/26/2024, showed an elopement code was overheard at 11:00 AM that Resident 4 was missing from the facility and had been observed at a traffic light down the street.</p> <p>Resident 4's care plan did not indicate the resident was at risk for elopement.</p> <p>On 11/05/2024 at 12:50 PM, the Staff A, Administrator, acknowledged Resident 4 left the facility against medical advice (AMA) on 08/26/2024. Staff A acknowledged the resident had eloped from the facility for a short period of time previously and the resident returned to the facility and a wander guard was applied to the resident. Staff A acknowledged the resident's care plan did not indicate the resident was at risk of elopement or had eloped and there was not a physician's order for the wander guard. Staff A acknowledged the facility did not follow their policy.</p> <p>At 1:20 PM, Staff C, Resident Care Manager (RCM) said she was on duty when Resident 4 eloped from the facility on 08/15/2024. Staff C said she called the elopement drill, called the police and notified the next of kin. Staff C said, I don't know what happened, I thought I put an order in for a wander guard. Staff C said the wander guard alarm had not been functioning properly. Staff C acknowledged there was not a physician's order in the medical record for the wander guard and the care plan did not indicate the resident was at risk for elopement. Staff C said the resident eloped from the facility on 08/26/2024, returned to the facility and then Resident 4 left against medical advice on 08/26/2024.</p> <p>Reference WAC 388-97-1060 (g)</p>