

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER Gig Harbor Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3309 45th Street Court Northwest Gig Harbor, WA 98335	

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** 40226</p> <p>Based on interview and record review, the facility failed to ensure 2 of 3 residents (Resident 1 and 2), reviewed for accidents, were assessed or re-assessed for elopement risk and care plans were revised to include interventions to mitigate risk for or prevent elopement. In addition, facility failed to ensure staff received education regarding prevention of elopement. These failures placed Resident 1 at risk for injury when the resident eloped to a potentially unsafe home setting and interventions to prevent elopement were not in place; and placed Resident 2 at risk for injury when the resident was not re-assessed for elopement risk and care plan was not revised after being moved from an alarmed unit to an unalarmed unit upon a change in medical condition and the resident was found attempting to leave the facility through an employee exit.</p> <p>Findings included .</p> <p>Facility policy, Elopement Prevention Guideline, dated April 2023, documented that residents would be evaluated by a licensed nurse for risk for elopement on admission/readmission, quarterly and when there was a change in condition.</p> <p>The Guideline stated that when a resident was identified at risk for elopement, the team would develop a plan of care that included interventions to reduce risk of elopement, maintain safety and a resident identification form with photo would be placed in the Elopement Risk Binder located at each nursing station. The Guideline's Flowchart showed that staff should monitor the resident and if there was a change in risk factors for elopement, a new risk assessment and care plan would be completed.</p> <p>The Guideline documented that elopement drills for staff would be conducted monthly on varying shifts.</p> <p>< Resident 1 ></p> <p>Resident 1 was admitted [DATE] with diagnoses including rib fractures, alcohol abuse and alcohol withdrawal.</p> <p>Nursing Admission Assessment, dated 03/03/2024, documented Resident 1 was able to walk, was confused and not at risk for elopement.</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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Care Plan, dated 03/03/2024, documented Resident 1 had impaired cognitive function/dementia and inability to recognize unsafe environment.</p> <p>Nursing Progress Note, dated 03/04/2024, documented Resident 1 had exit-seeking behavior and stated the desire to return home to spouse.</p> <p>Minimum Data Set (MDS), an assessment, dated 03/05/2024, documented Resident 1 had moderate cognitive impairment.</p> <p>Resident Safety Evaluation, dated 03/06/2024, documented Resident 1 had cognitive impairment, decreased safety awareness, disturbances in judgement, no verbal expressions of wanting to leave facility and was not at risk for elopement.</p> <p>Nursing Progress Note, dated 03/12/2024, documented Resident 1 was wandering throughout facility looking for a dog.</p> <p>Therapy Progress Note, dated 03/14/2024, documented Resident 1 was found walking to front door with bags packed.</p> <p>Nursing Progress Notes, dated 03/15/2024, noted at 12:17 AM, Resident 1 was confused and wandered in the halls.</p> <p>Nursing Progress Notes, dated 03/18/2024, noted at 7:21 AM Resident 1 wandered out of room, looking for family and at 4:45 PM, Resident 1 was lying in another resident's room.</p> <p>Nursing Progress Note, dated 03/25/2024 at 12:45 AM, documented Resident 1 had been missing since 5:00 PM the previous day, a search was conducted, the sheriff was called and Resident 1 was located at home with spouse who had taken resident from facility without notice. Nursing Progress Note documented that Resident 1's spouse did not intend to return the resident to the facility that day. Nursing Progress Note documented Resident 1 was a vulnerable adult whose spouse was unable to care for the resident.</p> <p>On 04/23/2024 at 1:56 PM, when Staff B, Director of Nursing, was asked if the facility conducted elopement drills for staff per its policy once per month, Staff B said, Not since I've been employed here the past year. Staff B indicated the facility policy would be to develop a care plan based on the risk for elopement and to place Resident 1's information sheet with photo in the Elopement Risk Binder.</p> <p>On 04/23/2024 facility Elopement Risk Binder was reviewed and did not contain an information sheet with photo for Resident 1.</p> <p>On 04/23/2024 at 3:06 PM, Staff A, Administrator, indicated that the facility should have reassessed Resident 1's risk for elopement as exit-seeking behaviors became obvious and the resident made statements about wanting to leave. Staff A stated that the regular receptionist was not on duty the day Resident 1 eloped and the substitute receptionist may not have recognized the resident when the resident and spouse exited through the front door. Staff A indicated that the staff members who cover for the regular receptionist may not have been trained on the use of the Elopement Risk Binder in the past year. Staff A stated, I am training on the binder today.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>< Resident 2 ></p> <p>Resident 2 was admitted [DATE] with diagnosis of Alzheimer's disease.</p> <p>Safety Risk Assessment, dated 09/08/2023, documented Resident 2 did not have a history of wandering and was not at risk for elopement.</p> <p>Wandering Care Plan, initiated 12/21/2023, documented Resident 2 was at risk for wandering. Care Plan stated the resident's triggers for wandering/eloping are (SPECIFY). Care Plan did not specify triggers.</p> <p>Quarterly MDS, dated [DATE], indicated Resident 2 had 4-6 days of wandering behavior. Quarterly MDS, dated [DATE], also indicated Resident 2 had 4-6 days of wandering behavior. No quarterly Elopement Risk Assessment was found to indicate reassessed risk per facility policy. Wandering Care Plan did not show revisions including new interventions to address increased wandering behavior or new risk presented by the move from an alarmed unit to an unalarmed unit.</p> <p>Nursing Progress Note, dated 04/22/2024 at 8:30 PM, documented Resident 2 was found out of room and off the unit, attempting to exit through an employee door near the kitchen.</p> <p>On 04/23/2024 at 1:56 PM, Staff B, Director of Nursing Services stated that Resident 2 was ordinarily a resident on the alarmed dementia unit but was moved to an unalarmed unit when it was determined that the resident had a change in condition that required management on a different unit. Staff B stated, I didn't think it was a good idea and explained that the resident did not have elopement attempts but that wandering behavior was a concern. Staff B indicated that when Resident 2 had a change in condition, that would have been the time to do a reassessment and update the plan of care.</p> <p>On 04/23/2024 at 3:06 PM, Staff A, when asked about the facility's policy to conduct elopement drills monthly, indicated the facility was preparing to conduct drills per policy.</p> <p>Reference WAC 388-97-1060 (1)(2)(3)(g).</p>