

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Linden Grove Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 - 29th Street Northeast Puyallup, WA 98373	

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 - 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** 36854</p> <p>Based on interview and record review, the facility failed to accurately assess, identify, monitor, and adequately supervise residents at risk of elopement for 1 of 3 sample resident (Resident 1) reviewed for accident hazards. Resident 1, who had a cognitive impairment and lacked safety awareness, experienced harm when they exited the facility unsupervised, was subsequently observed by a bystander to fall on a freeway ramp, hit their head, and was transported by Emergency Services (EMS) personnel to a hospital for evaluation. This failure placed residents at risk for potential injury, negative outcome, and decreased quality of life.</p> <p>Findings included</p> <p>Review of a facility's policy titled, Elopements, dated 03/22/2022, noted the facility was to utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, that included identification and assessment of risk, identification and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.</p> <p>Resident 1 was admitted to the facility on [DATE] with multiple diagnoses, including stroke, dementia and encephalopathy (damage or disease that affects the brain that can cause confusion, memory loss, and other changes). The Minimum Data Assessment, dated 05/01/2025, noted that Resident 1 required staff assistance for activities of daily living.</p> <p>Review of Resident 1's care plan, dated 04/26/2025, documented the resident was at risk for falls and injury due to cognitive loss and lack of safety awareness. An addition to the care plan, dated 04/28/2025, documented Resident 1 had impairment or decline in their cognitive function or impaired thought processes related to dementia.</p> <p>Review of a nursing note, dated 05/01/2025 at 5:58 PM, documented Resident 1 wanted to leave and was upset that no one had checked on him. THE nursing note stated the resident started to fall, was assisted to a chair, assessed and taken to their room.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 505485
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note, dated 05/06/2025 at 4:57 PM, documented Resident 1 was last checked on at around 2:00 PM on 05/06/2025 and was not in the room when nursing checked on them around 4:00 PM. The nurse documented that they did not see the resident and was not aware of which resident was allowed to visit out or which one was not. The nurse noted the resident had previously attempted to leave, wanted to discharge, almost fell , and that the resident was very confused.</p> <p>Review of hospital documentation dated 05/06/2025, noted EMS was called at 3:41 PM after bystanders saw Resident 1 stumble while walking on a freeway ramp, fall, and hit their head. EMS arrived to find the resident sitting on the shoulder of the freeway on-ramp. EMS staff documented the resident was occasionally able to answer questions and talk in full normal sentences but then would say things that were not based in reality. The resident had abrasions and bruising on their body consistent with falls that were in different stages of healing. The resident was not able to give any medical history or say where they had come from. The resident told EMS staff that they had fallen because they had had a change in vision and their balance was off.</p> <p>Review of hospital notes, dated 05/06/2025, showed hospital staff contacted the facility due to the location of where Resident 1 was found. Hospital staff documented that facility staff were not aware that the resident was gone and, after several calls, it was determined the resident had not been seen at the facility since around 2:00 or 3:00 PM, when somebody had seen them walking down the hallway.</p> <p>Review of a nursing note, dated 05/06/2025 at 5:42 PM, showed facility staff received a call from the hospital that Resident 1 had been found on the ground outside the facility and had been taken to the hospital, and requested information regarding the resident, including their medication list. The provider was notified.</p> <p>Review of the facility investigation initiated on 05/06/2025, identified risks that included the accuracy of an elopement evaluation on admission; that nursing did not immediately look for the resident when they were not visualized in their room; and that staff in the Reception area did not notice the resident walk out the door.</p> <p>On 05/08/2025 at 1:30 PM, when asked, Staff C, a Licensed Practical Nurse and a Resident Care Manager, said if a resident was missing they would start looking, first indoors and then if not found they would look outside. When asked about Resident 1, Staff C said they had heard that the resident was missing and then they got a call from the hospital.</p> <p>On 05/22/2025 at 12:16 PM, Staff D, a certified nursing assistant, said when a resident is not in their room, they check the hall and the other rooms and then let the nurse know and then everyone checks and looks everywhere.</p> <p>On 05/22/2025 Staff D said they worked with Resident 1 on 05/06/2025, the night they left. Staff D said Resident 1 had been showered earlier and then their tray was brought in. Staff D said when they went back to get the tray, Resident 1 was not in the room and it was sometime later they figured out Resident 1 was not there.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/22/2025 at 3:04 PM, Staff B, the facility Director of Nursing Services, said they were shocked when the hospital called to say, we think we have one of your residents. Staff B said they had identified there was a problem with the risk assessment, and that Resident 1's assessment did not include factors from their history that would have triggered an elopement risk evaluation. Staff B also said they determined that there was a delay in beginning to look for the resident, and also that staff covering the reception area were not as familiar with the residents the day Resident 1 walked out of the facility.</p> <p>On 05/22/2025 at 3:50 PM, Staff A, the facility Administrator, said they have identified processes to focus on for improvement.</p> <p>Reference WAC 388-97-1060(3)(g)</p>		