STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505525	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lacey Post Acute & Rehabilitation	4524 Intelco Loop SE Lacey, WA 98503

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40916 Based on interview and record review, the facility failed to ensure consents for wanderguards, a device used for residents at-risk of elopement, were in place for 2 of 3 sampled residents (Residents 1 & 2) reviewed for informed consents regarding wanderguards. This failure placed residents and resident representatives at risk of inadequate knowledge of wanderguard use, decreased freedom of movement, and a decreased quality of life. Findings included . 1) Resident 1 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) assessment, dated 03/13/2024, documented the resident was cognitively intact and did not exhibit wandering behavior during the lookback period. A physician's order, dated 03/15/2024 and discontinued 03/19/2024, documented, Check placement of wander bracelet every shift. A review of Resident 1's electronic medical record (EMR) did not show an informed consent was completed for the wanderguard. On 04/08/2024 at 2:44 PM, Resident 1 said after her hospital stay she would walk in the facility to gain strength. Resident 1 said one day the facility staff asked her to wear an ankle monitor (wanderguard) because they were scared she was going to leave the facility. Resident 1 said she did not like wearing the wanderguard and did not remember signing a consent for the wanderguard. On 04/09/2024 at 10:25 AM, Staff C, Licensed Practical Nurse, said staff should obtain an informed consent prior to placing a wanderguard. On 04/11/2024 at 10:43 AM, Staff B, Director of Nursing Services and Registered Nurse, said residents were assessed for wanderguard needs if seen wandering the facility, exit-seeking, or talking about leaving the facility. Staff B said a consent would be needed prior to placing the wanderguard. Staff B said she could not locate Resident 1's consent for the wanderguard. 2) Resident 2 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], documented the resident was severely cognitively impaired and had wandering behavior for 1-3 days during the lookback period. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2's elopement care plan, dated 02/22/2024, documented an intervention to monitor for skin breakdown under wander bracelet. A review of Resident 2's EMR did not show an informed consent was completed for the wanderguard. On 04/11/2024 at 10:43 AM, Staff B said it did not look like there was a documented consent from the resident or their representative in the resident's EMR. Reference WAC 388-97-0300 (3)(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40916 Based on interview and record review, the facility failed to ensure wanderguard, a device used for residents at-risk of elopement, assessments were completed and in place for 3 of 3 sampled residents (Residents 1, 2 & 3) reviewed for accident hazards related to wanderguards. This failure placed residents at risk of improper wanderguard use, decreased freedom of movement, and a decreased quality of life. Findings included . 1) Resident 1 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) assessment, dated 03/13/2024, documented the resident was cognitively intact and did not exhibit wandering behavior during the lookback period. A physician's order, dated 03/15/2024 and discontinued 03/19/2024, documented, Check placement of wander bracelet every shift. A resident safety evaluation, dated 03/07/2024, documented, Not at risk for elopement at this time. No other safety evaluations were found in Resident 1's EMR (Electronic Medical Record). On 04/08/2024 at 2:44 PM, Resident 1 said after her hospital stay she would walk in the facility to gain strength. Resident 1 said one day the facility staff asked her to wear an ankle monitor (wanderguard) because they were scared she was going to leave the facility. Resident 1 said she did not like wearing the wanderguard and did not remember an evaluation being completed for the wanderguard. On 04/11/2024 at 10:43 AM, Staff B, Director of Nursing Services and Registered Nurse, said residents were assessed for wanderguard needs if seen wandering the facility, exit-seeking, or talking about leaving the facility. Staff B said residents were assessed for wanderguard needs via the safety evaluation. Staff B said there would then be a discussion with the resident or representative, a consent for the wanderguard obtained, and then orders placed in the resident's EMR and the resident's care plan updated. Staff B said Resident 1 was observed by facility staff near the lobby area of the facility, and staff came to her with a concern for elopement. Staff B said she talked to facility staff about performing an assessment for wanderguard placement. After reviewing Resident 1's EMR, Staff B said it did not look like a safety evaluation had been completed prior to wanderguard placement. 2) Resident 2 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], documented the resident was severely cognitively impaired and had wandering behavior for 1-3 days during the lookback period. Resident 2's elopement care plan, dated 02/22/2024, documented an intervention to monitor for skin breakdown under wander bracelet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 04/09/2024, documented, Elopement Risk Evaluation Completed. [Resident 2] is at risk for elopement. Wander bracelet applied. This evaluation was completed 47 days after the 02/22/2024 elopement care plan intervention to monitor for skin breakdown under wander bracelet. No prior elopement risk evaluations were found in Resident 2's EMR. On 04/11/2024 at 10:43 AM, Staff B said Resident 2 had orders placed for wanderguard monitoring on 04/09/2024 and the elopement risk assessment was completed on 04/09/2024. Staff B said she was not able to find a prior safety evaluation for Resident 2. 3) Resident 3 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], documented the resident wandered 1-3 days during the lookback period and the resident's cognition level was not assessed. Resident 3's safety evaluation, dated 07/15/2023, documented Resident 3 was not an elopement risk. A physician's order, dated 07/30/2023, documented, Check placement of wander bracelet every shift. every shift for exit seeking behaviors. A physician's order, dated 07/30/2023, documented, Wander Bracelet - Check function daily every night shift for exit seeking behaviors. On 04/11/2024 at 10:43 AM, Staff B said Resident 3's wanderguard was ordered on 07/30/2023. Staff B said there was a safety evaluation done on 07/15/2023 showing Resident 3 was not at risk for wandering. Staff B said there was no other safety assessments completed before placement of the wanderguard on 07/30/2024. Staff B said moving forward the facility was making sure safety assessments were completed prior to placement of wanderguards. Reference WAC 388-97-1060 (3)(g)