STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505527	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Post Acute	21008 76th Avenue West Edmonds, WA 98026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787 Based on observation, interview, and record review, the facility failed to revise an elopement care plan for 1 of 1 resident (Residents 1), reviewed for care plan revision. This failure placed the resident at risk for additional elopements, unmet care needs, and a diminished quality of life. Findings included . Review of the quarterly Minimum Data Set assessment (MDS-a required assessment) dated 01/16/2025 showed Resident 1 admitted to the facility on [DATE]. The MDS assessment further showed the resident had moderately impaired thinking and used a wheelchair for mobility. Review of the admission elopement risk assessment dated [DATE] showed the resident was at risk of elopement. Review of the facility's investigative report dated 02/24/2025 showed that on 02/24/2025 at 3:00 AM, the local law enforcement called the facility and informed the nurse on shift that Resident 1 was found at a store approximately 11/2 miles away from the facility in a gown and with a wheelchair that had the name of the facility on it. Resident 1 was returned to the facility at 3:30 AM by the local law enforcement. A device (wander alarm) was then placed on Resident 1 to alert staff when Resident 1 approached the monitored doors that exit the facility. Review of the care plan initiated on 02/24/2025 showed, Check placement of the wander alarm every shift. Location: Left Ankle. Observation and interview on 03/10/2025 at 4:17 PM with Staff D, Licensed Practical Nurse, showed the wander alarm was not on the left ankle of Resident 1, the wander alarm was observed fastened to the left arm of the wheelchair that Resident 1 sat on. Interview with Staff D at this time stated the wander alarm was checked every shift to make sure it was still in place and worked properly. Staff D then stated that the wander alarm had been moved from the left ankle to the arm of the wheelchair because Resident 1 did not want it on their ankle anymore. Staff D further stated that the care plan should have been updated when the wander alarm was moved from Resident 1's left ankle to the arm of their wheelchair. (continued on next page)

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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/10/2025 at 4:28 PM, Staff E, Resident Care Manager, stated the care plan should have been updated when the wander alarm was moved from Resident 1's left ankle to the arm of Resident 1's wheelchair. In an interview on 03/10/2025 at 4:45 PM, Staff B, Assistant Director of Nursing Services, stated the care plan and the location of the wander alarm should be the same, the care plan should have been updated when the wander alarm was removed from Resident's 1 left ankle. Reference (WAC): 388-97-1020 (5)(b)

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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** 35787 Based on interview and record review, the facility failed to provide the necessary supervision resulting to an elopement for 1 of 1 resident (Resident 1), reviewed for accident hazards. This failure placed the resident at risk for additional elopements, injuries and pain. Findings included . Review of the quarterly Minimum Data Set assessment (MDS-an assessment tool), dated 01/16/2025 showed Resident 1 admitted to the facility on [DATE]. The MDS assessment further showed the resident had moderately impaired thinking and used a wheelchair for mobility. Review of the admission elopement risk assessment dated [DATE] showed the resident was at risk of elopement. Review of the care plan dated 10/15/2024 showed Resident 1 was at risk of elopement/exit seeking/wandering related to mild thinking impairment, a history of elopement attempts, mood or behavior disorders and noncompliance. Review of the facility's investigative report dated 02/24/2025 showed that on 02/24/2025 at 3:00 AM, the local law enforcement called the facility and informed the nurse on shift that Resident 1 was found at a store approximately 11/2 miles away from the facility in a gown and with a wheelchair that had the name of the facility on it. Resident 1 was returned to the facility at 3:30 AM by the local law enforcement. The investigative report documented that Resident 1 reported that they used their wheelchair to go to a local store, went down a curb near the store, fell and was helped up by a couple that wheeled them to the store, the local law enforcement was notified. Resident 1 was assessed for injuries when they returned to the facility and a bruise/scratch was noted on their left knee, pain medication (Tylenol) was administered for pain relief. A device (wander guard) was then placed on Resident 1 to alert staff when Resident 1 approached the monitored doors that exit the facility. In an interview on 03/10/2025 at 3:09 PM Resident 1 stated they left the facility alone and went to the store. Resident 1 stated that they tried to roll their wheelchair over a curb next to the store, fell over the curb, out of their wheelchair and a man and a woman that they did not know helped them to get back into their wheelchair and then pushed them in their wheelchair the rest of the way to the store, then the local law enforcement was called who brought them back to the facility. Resident 1 further stated they hurt their knee when they fell out of their wheelchair, and the nurse gave them pain medication to stop the pain. In an interview on 03/14/2025 at 1:01 PM, Staff C, Certified Nursing Assistant, stated they thought Resident 1 was at risk for elopement because they would sit by the door of the facility, and it looked like they wanted to leave the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/14/2025 at 4:17 PM, Staff D, Licensed Practical Nurse, stated Resident 1 was at risk for elopement and that they had recently eloped from the facility, a wander guard had been placed on Resident 1 to notify the staff when Resident 1 got close to the doors that exit the facility. In an interview on 03/14/2025 at 3:39 PM, Staff E, Resident Care Manager, stated Resident 1 was at risk for elopement and was not safe to leave the facility unsupervised. In an interview on 03/14/2025 at 3:41 PM, Staff B, Assistant Director of Nursing Services, stated that Resident 1 had a decline in their thinking ability but was able to enter the code that opened the door and left the facility. Staff B stated that the investigation dated 02/24/2025 showed when the staff reviewed the facility's surveillance camera Resident 1 was seen leaving the facility at 12:47AM unsupervised, and that they were not safe to be out in the community unsupervised. In an interview on 03/14/2025 at 4:04 PM, Staff A, Administrator stated that Resident 1 was not safe to leave the facility unsupervised, especially at 1:00 AM. Reference: (WAC) 388-97-1060 (3)(g)