

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505489	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/16/2014
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NAME OF PROVIDER OR SUPPLIER  SEA MAR COMMUNITY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 SOUTH HENDERSON STREET SEATTLE, WA 98108
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F 000 INITIAL COMMENTS

F 000

This report is the result of an Unannounced Abbreviated Survey conducted at Sea Mar Community Care Center on 09/26/2014, 10/08/2014 and 10/16/2014. A sample of 9 Residents were selected from a census of 95. The following complaints were investigated as part of this survey:

- 3037763
- 3043049
- 3040558
- 3044722
- 3045607

The survey was conducted by:

Diane Kirse, RN, BSN  
Nursing Home Complaint Investigator  
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Residential Care Services  
2042572nd. Ave S, Suite 400  
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*[Signature]*  
Residential Care Services      Date

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DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ADMINISTRATOR	(X6) DATE 11/10/2014
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A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.

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F 000	Continued From page 1	F 000			
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) <b>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b></p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p>	F 225	<p><b>F225 INVESTIGATE/REPORT ALLEGATION/INDIVIDUALS</b></p> <p>The facility gathered information needed to rule out abuse or neglect immediately following the incident with resident #1. Through interviews with the kitchen staff, Speech Pathologist, Nursing Staff and in reviewing the menu for the resident's prior meal and snack, it was determined that the resident aspirated on a piece soft pulled pork sandwich. This was on the menu AND within his prescribed diet. Therefore, abuse or neglect was ruled out. It was determined that the resident's aspiration was reasonably related to his medical and functional condition.</p> <p>The resident admitted to the facility with a diagnosis of [REDACTED]</p> <p>The facility ensured that the Speech Language Pathologist provided ongoing assessments and monitoring to include a specific care plan to prevent him from aspirating. The</p>	11/28/14	
	<p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the</p>				

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F 225	Continued From page 2 incident, and if the alleged violation is verified appropriate corrective action must be taken.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to recognize and investigate an event for one of one sampled resident (Resident #1) who suffered respiratory and cardiac arrest related to airway obstruction caused by food material. Failure to investigate this event, and implement a plan of corrective action to ensure residents received the correct diet placed residents at risk for aspiration and airway obstruction.  Findings include:  Resident #1 had been admitted with [REDACTED]. He had had multiple admissions into the facility and was well known to them. He had been assessed to be at risk for aspiration and was prescribed a altered diet of "mechanical soft, ground, with large portions and thin liquids". A review of his care plan dating back to 12/2013 showed he had a risk for choking due to a chewing and swallowing problem and needed a mechanically altered diet.  The nurse's notes for [REDACTED] 2014 revealed he had been found sitting in his wheelchair in his room, "unresponsive" and "disoriented X3". The record states he was cyanotic (blue in color) on his face. His vital signs were taken which showed an oxygen saturation level of 57 % (normal is above 90%) and a respiratory rate of 24. He was placed on oxygen. The doctor was	F 225	resident's medical record has evidence that the speech language pathologist assessed him for 1:1 cognition-language-swallowing and therapeutic diet needs, to include current diet tolerance on the following dates: 1/17/14, 1/20/14, 1/21/14, 1/22/14, 1/23/14, 1/24/14, 3/22/14, 3/27/14, 3/28/14, 3/25/14, 3/26/14, 3/27/14, 3/27/14, 3/31/14, 4/2/14, 4/2/14, 4/3/14, 4/4/14, 4/7/14, 4/8/14, 4/9/14, 4/10/14, 4/11/14, 4/14/14, 4/15/14, 4/16/14, 4/17/14, 4/18/14, 4/21/14, 4/21/14, 4/28/14, 4/23/14, 4/24/14, 4/25/14. Prior to the resident's aspiration he was assessed multiple times and had a care plan in place.  Recently on [REDACTED] 14, this resident was admitted to Harborview Medical Center for a fall with injury. After being under the care of Harborview Medical Center for 4 days the resident went into respiratory distress and was intubated. The doctor noted that he aspirated on a soft piece of chicken that the hospital served him for dinner. It is evident that the resident, due to his medical condition, continues to be at risk for		

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F 225	Continued From page 3 notified and 911 was called to transport him to the hospital.  The hospital records showed that when EMS arrived, they found the Resident wheezing and part of a "roast beef sandwich" was lodged in his throat. It was removed by EMS but the Resident suffered a cardiac arrest and required CPR. He was intubated (insertion of a tube into the trachea for breathing). He required admission to the intensive care unit. His stay was complicated by respiratory failure, sepsis and urinary tract infection.  In an interview with Staff B, RN (Registered Nurse), RCM (Resident Care Manager) on 11/16/2014 11:20 AM, she stated that when he was readmitted to the facility on [REDACTED] 2014 she found out about the obstruction. She stated "I think I read the discharge paperwork." Staff A, RN, RCM stated that no investigation had been done into the cause of the event. When asked what diet he had been on Staff B stated "mechanical soft." When asked how he might have gotten a roast beef sandwich she stated there was no way to know.  The facility failed to recognize and investigate this event. Staff failed to report the event when it occurred. When management staff finally learned of the event on 03/25/2014, they failed to initiate an investigation, thus did not formulate a preventative and ongoing plan and process to prevent similar events from occurring in the future.	F 225	aspiration despite being in the best trauma center in the Pacific Northwest.  On November 5, 2014 the facility initiated an incident report for the resident's aspiration on 3/25/14. Documentation in the incident report includes copies of the residents multiple assessments for swallowing by the speech pathologist, nursing assessments and care plans to prevent aspiration prior to the event on [REDACTED] 14, and after the event when the resident returned from the hospital.	
			The facility policy for investigating episodes of aspiration has been reviewed and updated to ensure documented investigations occur for all episodes aspirations. Staff will be in-serviced on 11/12/14.  A monthly QI audit of the investigation log will be audited to ensure compliance. The audit results will be reviewed by the monthly QI committee.  Administrator to ensure compliance.	

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F 323 F 323 SS=D	Continued From page 4 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to establish a process to ensure that alarms used for resident safety were placed correctly and were in proper working order. The facility failed to fully assess and revise the plan of care for one resident (Resident #1) of 5 sampled residents who had alarms in use. Failure to ensure that alarms used were appropriate for the resident, placed correctly, and checked for function, placed residents at risk for injury if an alarm failed to sound.  Findings include:  Resident #1 had been admitted to the facility multiple times. He suffered from [REDACTED]. [REDACTED] He had a Foley catheter (a tube inserted into the bladder to drain urine) due to [REDACTED]. His care plans, dating back to 11/2013 showed he had been assessed to be at risk for falls and had suffered numerous falls at the facility. He was to have equipment, personal items, and call light within his reach and was to be reminded to call when he needed assistance.	F 323 F 323	<b>F223 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b>  The resident was admitted with [REDACTED] was admitted due to history of falls and decrease function in swallowing due to advanced [REDACTED]. The resident was assessed upon admission and as needed with his change of condition. An extensive care plan specific to the resident's needs was in place to meet the resident's ADL needs, prevent him from falling, and prevent him from aspirating/choking.  On 12/23/13, the facility Physical Therapist initiated two types of fall prevention alarms. A pad (bed) alarm and a Wheelchair alarm. The resident was assessed for these two alarms, a specific fall prevention care plan was in place, and the resident signed the consent for them.  On 5/21/14, the Physical Therapist received a referral from resident #1's	11/28/14	

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F 323	Continued From page 5 He was assessed to require one person with use of a walker and gait belt for ambulation. He had a known history of removing his alarm devices.  On 08/20/2014, the Resident suffered a fall. The investigation showed he was found on the floor of the bathroom. His Foley catheter had come out and there was blood on the floor. The Resident stated he slipped in the blood. 911 were called and he was taken to the hospital where a [REDACTED] (fracture) was discovered. The incident investigation showed that neither his bed alarm nor call light sounded. There was no information that showed if the facility attempted to determine if the equipment was functional at the time, if it had been removed from his bed or if he had just failed to use it.  On 10/16/2014 at 09:50 AM, the Resident was observed to be in bed in his room. There were three signs posted in his room that stated "call, don't fall." Observation of the room showed he had a sensor pad bed alarm that was turned off and draped over the head of his bed. His call light was observed to be draped over his TV, which was located at least 24 inches away from his bed, on a bedside stand. His personal items and remote control was also located there. All items were out of reach of the Resident and would have required him to get out of bed and walk to get these items. Staff C, CNA (certified nursing assistant) was asked to come into his room and find his call light. She searched for it and finally found it on his TV. When asked about his call light, she stated he never used it. When asked about the pressure bed alarm that was at the head of the bed, she stated "he takes it off." The Resident was given the call light and when asked, was able to demonstrate how to use it.	F 323	nurse requesting an evaluation on better placement of the alarm since this resident kept removing the alarm.  On 10/23/14, the nurse made a 3 <sup>rd</sup> referral to the physical therapist to evaluate for a different type of alarm that resident would not remove. The physical therapist evaluated the resident and ordered a sensor alarm. This is evidence that the facility did in fact evaluate resident for different types of alarms. Documentation to support this is in resident's medical record.		
			Effective 11/14/14, all facility resident's that have fall prevention alarms will have their alarms checked for proper function daily. Nurses will be sign the each resident's MAR daily for checking function of fall prevention alarms.  On 11/10/14, the facility policy and procedure for fall prevention alarms was reviewed and updated. An in-service to train staff on the new procedure for checking bed alarms will be held on 11/12/14.		

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F 323	Continued From page 6  In an interview with Staff A and B on 10/16/2014 at 11:15 AM, Staff B stated the resident knew how to use his call light but did not use it most of the time. When asked what type of alarm the resident had she stated a sensor pad. Staff B stated he "gets the pad out himself" and puts it on the floor. She stated the resident was able to turn the alarm off by himself and that this had been observed by the CNA staff. When asked if other types of alarms had been considered, she stated "no." When asked who is responsible for checking the alarms for placement and function, she stated "we are, nurses and CNA's." When asked where these checks are documented, she stated they don't document the checks. When asked if the facility has a policy or process for checking alarms for function, she stated the facility did not have one.	F 323	An audit will be conducted monthly on the nurses checking alarms. Audit results will be reviewed by the QI committee.  DNS to ensure compliance.	
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