

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

PRINTED: 10/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505311</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/10/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SEATTLE MEDICAL &amp; REHAB CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>555 16TH AVENUE SEATTLE, WA 98122</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Seattle Medical and Rehabilitation Center on 10/08/12 and 10/10/12. A sample of four residents were selected from a census of 90 in house residents.</p> <p>The survey references the following complaint: # 2689434</p> <p>The survey was conducted by: Robin Windhausen, RD, MS</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Disability Services Administration Residential Care Services, Region 4, Unit B 20425 72nd Avenue South, Suite 400 Kent Wash. 98032 Telephone: (253) 234-6000 Fax: (253) 395-5805</p> <p><i>[Signature]</i> 10/22/12 Residential Care Services Date</p>	F 000	<p style="text-align: center;"><b>DISCLAIMER CLAUSE</b></p> <p>PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.</p> <p style="text-align: right;"><b>RECEIVED</b> NOV 13 2012 DSHS/ADSA/RCS Kent</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <b>Executive Director</b>	(X6) DATE <b>11/7/12</b>
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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.

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F 201 SS=D	<p><b>483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT</b></p> <p>The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;</p> <p>The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;</p> <p>The safety of individuals in the facility is endangered;</p> <p>The health of individuals in the facility would otherwise be endangered;</p> <p>The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or</p> <p>The facility ceases to operate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure one Resident issued a 30 day discharge notice was issued in accordance with the federal requirements. The requirements identified five reasons for</p>	F 201	<p><b>F201 REASONS FOR TRANSFER/DISCHARGE OF RESIDENT</b></p> <p><u>Plan of Correction</u></p> <p>Resident # 1 Discharge Notice has been rescinded</p> <p>Staff has been educated on clearly identifying reasons for discharge on "30 Day Notice of Discharge" notifications in accordance to the 5 statues.</p> <p>Staff has been educated on appropriate assignments of discharge location to ensure a safe discharge location.</p> <p>All Resident Smokers have been given and have reviewed the Facility Smoking Policy and Rules.</p> <p>All newly admitted smokers will be given Facility Smoking Policy and Rules upon admissions assessments.</p> <p>30 Day Discharge notifications will be reviewed randomly by regional staff for appropriateness and forward results to Executive Director</p> <p>Quality Assurance Committee will ensure compliance.</p>	11/16/12
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F 201	<p>Continued From page 2</p> <p>discharging a resident, including endangering the safety of residents. Failure to ensure the discharge notice clearly identified the reason behind the issuance of the notice and identified an appropriate safe discharge location placed the resident at risk for health complications associated with unmet care needs.</p> <p>Findings include:</p> <p>Resident # 1 was issued a 30 day discharge notice dated [REDACTED] 12. The notice indicated the safety or health of persons in this facility is endangered as a result of "Consistently and purposefully smoking outside smoking policy of facility." The discharge location identified was a shelter, which is not equipped to meet the medical needs of the resident.</p> <p>Review of the initial Minimum Data Set assessment (MDS) revealed the resident was admitted to the facility [REDACTED] and had multiple medical diagnoses including [REDACTED] which was currently being managed with insulin injections and was wheelchair dependent. The assessment noted the resident was alert and oriented and had no cognitive impairments. The initial assessment for smoking indicated the resident could obtain smoking supplies from the Nurse and leave the facility property to smoke independently.</p> <p>Resident's clinical record and care plan were reviewed. The care plan accurately reflected the assessment information. Two additional documents related to smoking were in the record. One was entitled "Scheduled Safe Smoking Policy," listed the numbers 1-9, # 4 stated " all smoking materials needed to be kept in a locked</p>	F 201		11/16/12

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F 201	<p>Continued From page 3</p> <p>area on the first floor, it also stated the failure to comply will result in option listed in # 14, but no bullet point # 14 was found.</p> <p>The other was entitled "Acknowledgment of Smoking Risks." indicated residents smoked only in designated areas, and if the activity did not endanger the health and safety of others. This document also stated that if the policy was violated it may result in an involuntary discharge. The two pages found in the record were signed and dated by the resident on [REDACTED]/12.</p> <p>On 10/08/12 at 1:30 pm the resident was interviewed. The resident reported Staff A approached the entrance to the facility and found him smoking in the designated staff smoking area with a Nurse who was on a break. He stated the Staff A directed him down the alley to the sidewalk adjacent to the facility, which was a level path to maneuver his wheelchair across. He stated that he did not feel the street in the area was safe. When asked if he could maneuver his wheelchair up the incline to the other street adjacent to the facility, which may offer a more secure environment he stated, no.</p> <p>On 10/08/12 at 1:07 p.m., Staff B the residents social worker was asked about the discharge notice issued. He stated Staff A, had written the notice. On 10/08/12 at 2:00 p.m. Staff A was asked how the resident smoking in the designated staff area placed other residents at risk she stated, " by having paraphilia, he could drop his lighter and someone else gets it. " Staff A reported the resident broke the rules " over and over again. "</p>	F 201		11/10/12

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F 201	Continued From page 4 During the interview Staff A, clarified the facility document " Scheduled Safe Smoking Policy " should be a three page document and provided a copy of the complete document. Review of the document found the second page included information about potential consequences for not following the smoking policy. When asked about the document found in Resident # 1 ' s record she acknowledged it was missing information.  At 2:45 p.m., Staff A was informed that two other residents (#2 and # 3) were observed with smoking paraphilia at 12 p.m. She stated all residents were supposed to give the nursing staff their smoking materials, and was not aware that there were any other residents who did not comply with the facility policy. (See F 323 for more information concerning failure to provide adequate supervision,)  On 10/10/12, Staff A reported the previous day (10/09/12) Resident #1 verbally expressed concerns about safety while on the street adjacent the facility. When asked about the residents medical conditions, both Staff A and Staff C stated the resident was not an insulin dependent diabetic, but reported the resident took oral medications to manage diabetes. When asked about the discharge location identified in the notice, both indicated the resident could safely be discharged to the shelter. Not ensuring a discharge notice provided an appropriate discharge location and was issued for one of the five reasons identified in statutes placed the resident at risk for harm related to lack of care.	F 201		11/16/12
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323 Continued From page 5

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 ensure that two of five residents (Residents # 2 and # 3) observed in the designated resident smoking area were supervised. Failure to ensure the residents were supervised during smoking placed the residents at risk for injury from burns.

Findings include:

Review of the facility policy found each resident 's ability to safely smoke was assessed and that the facility staff kept smoking supplies (cigarettes and lighting materials). The policy stated each resident was assessed to determine their ability to safely smoke. All residents needed to smoke in the designated area located on the patio of the first floor with supervision. The policy indicated some residents could obtain smoking materials from the nursing staff if leaving the facility grounds to smoke independently.

On 10/08/12 at 12 p.m. , Resident # 2 was observed smoking a filter less cigarette. Residents in the area stated they were waiting for the staff to arrive with their smoking supplies for a scheduled smoking session. Resident # 3 who

F 323

**F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES**

Plan of Correction

Resident #2 Smoking Assessment has been updated.

Resident #3 is no longer a resident of the facility

All current Resident smokers have had Smoking Assessment updated. Care Plans have been updated to reflect assessment outcomes.

Resident Smoking Assessments will be updated quarterly and as needed to reflect resident's improvement or decline in abilities.

Staff has been re-in-serviced on Facility Smoking Policy, Rules and Smoking Session Supervision responsibilities.

Executive Director and or designee will perform random audits of smoking areas to ensure supervision compliance and perform random resident interviews to ensure residents compliance to the facility policy and rules.

Audit results will be forwarded to the Quality Assurance Committee who will ensure compliance

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F 323

Continued From page 6

was also present in the area was clutching a lighter in his fist. At 12:08 p.m., a staff member arrived in the supervised smoking area and passed out smoking materials and assisted residents with a lighter as stated in the policy. The staff was not aware that Resident #2 was smoking prior to her arrival or noticed that Resident # 3 was clutching a lighter in his fist.

On 10/08/12 at 2:45 p.m., the observation was shared with the Staff A, the facility Administrator. On 10/10/12 at 11:00, Staff A was interviewed about actions taken after the observation was reported. Staff A reported the facility was not able to verify where Resident # 2 obtained the cigarette he was observed smoking and reported when Resident # 3 was asked he denied having any lighter.

Review of the clinical record for these two residents revealed the following:

RESIDENT #2 was admitted to the facility on [REDACTED] with multiple diagnoses including a [REDACTED]. The smoking assessment in the clinical record, dated [REDACTED] 12, indicated the resident had "cognitive delay, and a lit cigarette sometimes lingers above the lap."

The assessment concluded the resident needed supervision of staff to safely participate in smoking. The assessment indicated the resident needed assistance with storage and lighting tobacco products; and a "smoking apron" when participating in the activity. Review of the care plan found it did not identify any of the interventions identified in the assessment, the only information provided to the direct care staff

F 323

*11/10/12*

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F 323	<p>Continued From page 7 simply states the resident smoked.</p> <p>During the observation of supervised smoking on 10/08/12 at 12:10 p.m., Resident # 2 was not observed to wear a "smoking apron," Staff F simply provided a cigarette and light to the resident. On 10/10/12 at 10:00 a.m., Staff G did the same. Only one resident, not Resident # 2, was observed wearing a "smoking apron." When asked who needed the protective covering Staff G did not identify Resident # 2.</p> <p>RESIDENT # 3 was admitted to the facility on [REDACTED] with multiple medical diagnoses including [REDACTED]. On 10/08/12 at 12:00 p.m., Resident # 3 was observed clutching a lighter in his hand while seated in the supervised smoking area but no staff were present.</p> <p>On 10/08/12 at 12:30 p.m. Staff D, a nurse, was not able to find any assessment of the residents ability to smoke safely in the clinical record. Review of the care plan found it was updated on 10/08/12 indicating the resident smoked. Staff D, the resident's social worker, who was also present, reported the smoking activity was added to the care plan on 10/08/12. Both staff said Resident # 3 should not have any smoking materials in his possession.</p> <p>On 10/10/12 at 11:00 am, the Administrator was asked about what steps had been taken to ensure that Residents # 2 and # 3 did not have smoking materials. She reported they were unable to verify that either of the residents had any smoking supplies in their possession.</p> <p>Failure to ensure adequate supervision was</p>	F 323		10/14/12

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F 323	Continued From page 8 provided to Resident # 2 and # 3, to ensure they complied with the facility policy for smoking placed the residents at risk for harm from a burn injury or an accidental explosion	F 323		11/10/12

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