

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

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/25/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122	<i>Amended</i> 11/14/12
--	---	----------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Seattle Medical and Rehabilitation Center on 10/22/12 and 10/25/12. A sample of 4 residents was selected from a census of 91. The sample included 4 current residents.</p> <p>The survey was conducted by: Katherine Ander MN, RN</p> <p>The survey team is from: Department of Social and Health Services Aging and Disability Services Administration Residential Care Services, Region 4, Unit B Creekside Two 20425 72nd Avenue South, Suite 400 Kent, WA 98032-2388</p> <p>Telephone: (253) 234 6003 Fax: (253) 395 5071</p> <p><i>[Signature]</i> 11/14/12 Residential Care Services Date</p>	F 000	<p>DISCLAIMER CLAUSE</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>RECEIVED NOV 19 2012 DSHS/ADSA/RCS</p>	
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rachael Abdala</i>	TITLE <i>Executive Director</i>	(X6) DATE 11/16/12
--	------------------------------------	-----------------------

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.

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

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/25/2012
NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122 <i>amended 11/14/12</i>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to thoroughly investigate and protect residents after allegations of sexual activity or unwanted touching for two of two sample residents (#1, #2). The facility's policy for identifying situations that could be abusive was not complete as it did not include the complete state definition of situations that represented sexual abuse. The facility did not follow it's concern policy to identify if a concern involves abuse and immediately inform the administrator and begin an investigation for Resident #2. This potentially placed all 91 residents at risk for abuse going unrecognized and prevented residents from being immediately protected.</p> <p>Findings include:</p> <p>Interviews and observations were conducted 10/22/12 unless otherwise noted.</p> <p>Facility policy stated that the facility conducts a thorough investigation of allegations of mistreatment, neglect or abuse. Policy stated the facility protects residents from harm during investigation, including suspension of staff involved as an alleged perpetrator. Policy stated</p>	F 226	<p>F226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES</p> <p><u>Plan of Correction</u></p> <p>Investigations were completed for resident #1 and # 2.</p> <p>The facility policy for identifying situations that could be abusive has been updated to include the complete state definitions of situations that represent sexual abuse.</p> <p>Staff have been in-serviced on the updated Abuse Prohibition Policy.</p> <p>Staff have been in-serviced on the facility Concern Policy including immediate notification of Executive Director.</p> <p>Concerns will be announced in detail and reviewed daily at the Department Manager morning meeting by the Executive Director and the IDT.</p> <p>Random audits of staff knowledge of the Abuse Policy and Concern Policy will be performed by the Staff Development Coordinator and or designee for three months and quarterly thereafter.</p> <p>Audit results will be forwarded to Quality Assurance Committee.</p> <p>Executive Director will ensure compliance.</p>	11/30/12

RECEIVED

NOV 19 2012

DSHS/ADSA/RCS

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

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/25/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122 <i>Amended 11/14/12</i>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 226	<p>Continued From page 2</p> <p>the facility reports allegations of abuse to the state survey agency and law enforcement in accordance with state regulation.</p> <p>Facility policy defined sexual abuse as including but not limited to sexual harassment, sexual coercion or sexual assault. Unwanted touching was not specifically identified as possible sexual abuse. Revised Code of Washington (RCW) 74.34 (2)(a) defines "Sexual abuse" as "any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment." The facility's policy was not inclusive of the state law definitions of situations of sexual abuse.</p> <p>RESIDENT #1: On observation 10/22/12 at 3:40 p.m. Resident #1 was lying on his back in a hospital bed wearing a hospital gown. The resident responded slowly to yes/no questions but did not respond further when asked open ended questions. Resident #1 was able to spontaneously lift his head off the pillow but could not use his arms to make any adjustments to his clothing or bedding.</p> <p>Review of the resident face sheet found that Resident #1 was admitted to the facility [REDACTED] with medically disabling conditions.</p> <p>Resident #1's Minimum Data Set (MDS - an assessment tool) dated 9/11/12 identified the resident had unclear speech (slurred or mumbled words) and sometimes understands (responds adequately to simple direct communication only). The MDS identified Resident #1 had severely</p>	F 226		11/30/12
-------	--	-------	--	----------

RECEIVED

NOV 19 2012

DSHS/ADS/RCS

gms

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

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/25/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122 <i>Amended 11/14/12</i>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 226	<p>Continued From page 3</p> <p>impaired decision making, inattention and was unable to participate in a basic interview for mental status screening. According to the MDS, Resident #1 had daily behavioral symptoms not directed toward others (hitting, scratching, screaming, disruptive sounds) that disrupted his care. Resident #1 required extensive 1-2 person assist for bed mobility, transfer, personal hygiene, and required total dependence of 2 staff for toileting. The resident was fed through a tube inserted into his stomach through the abdomen. According to the MDS, staff assessed the resident's pain through non-verbal sounds like crying, gasping or moaning and facial expressions like wincing or furrowed brow.</p> <p>The department received a report dated 10/12/12 that Resident #1 had a sexual encounter with a Significant Other (S.O.) who was a S.O. prior to being admitted to the facility. The report referenced Staff C and Staff I as having specific knowledge related to the report.</p> <p>Review of facility August-September-October 2012 investigation log on 10/22/12 found that there was no listing or investigation of an alleged sexual encounter. Review of Resident #1's progress notes found no reference to a sexual encounter. No staff reported a sexual encounter to administration.</p> <p>Social service notes documented on 10/15/12 the social work director (Staff D) met with Resident #1 related to a report that he and his S.O. engaged in physically sexual behaviors. The resident was able to answer yes/no questions and responded "yes" when asked about consent to sexual activity. A care plan was written identifying</p>	F 226		11/30/12
-------	---	-------	--	----------

RECEIVED

NOV 19 2012

DSHS/ADSA/RCS

Grub

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

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/25/2012
NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 4</p> <p>that staff would provide a private non-confrontational environment for sexual activity.</p> <p>Social Service notes document that on 10/17/12 Resident #1's legal representative/decision maker was contacted and stated that the sexual activity was "okay". A referral was made to mental health to formally evaluate Resident #1's capacity to consent to sexual activity. Social service notes was the only documentation (other than the care plan) related to the alleged sexual contact between the resident and S.O. See findings under F514.</p> <p>On 10/18/12 a mental health professional documented "I cannot assess if mentally competent or not, but I can assess whether he has the capacity to render a decision." The mental health provider determined that Resident #1 consented to sexual activity by asking the resident to speak and nod his head yes/no when asked if he was engaged in consensual sexual activity.</p> <p>On interview 10/22/12 and 10/25/12 both the director of nursing (DNS) and administrator (ADM) stated that the initial report made to the state hotline was not reported to them by staff as an allegation of sexual abuse. They both said that they found out about the hotline call when the state called the facility and requested more information on 10/16/12.</p> <p>Both the DNS and ADM said that prior to the 10/16/12 state request for additional information, there had been a report of sexual activity between Resident #1 and his S.O. which was addressed</p>	F 226		11/30/12	

RECEIVED

NOV 19 2012

DSHS/A VRCS

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

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/25/2012
NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 5</p> <p>by social services. The DNS and ADM stated that the information about a report of sexual contact was not identified or investigated as an allegation of sexual abuse. Both the DNS and ADM identified the resident's S.O. is very involved and caring, and the person who called may have made a personal judgement about Resident #1 or not had all of the information.</p> <p>On interview 10/26/12 Staff D stated that he did not know exactly specific information about the alleged sexual activity. According to Staff D, the DNS told him on Monday 10/15/12 to determine if Resident #1 had the capacity to consent to sexual activity. According to Staff D, there was no reason or need to protect Resident #1 while sorting things out because this was done the same day as reported to him by the DNS. Staff D stated that the S.O. was not interviewed as this would be an invasion of privacy.</p> <p>On interview 10/26/12 the resident care manager (Staff C) stated that prior to the 10/16/12 state request for additional information there had been rumors "flying around" that someone had seen something that could have been sexual activity between Resident #1 and his significant other. Staff C stated that he "asked around" but no one saw anything. Staff C stated that he did not write down staff interviews because it was hearsay and there was no specific allegation. Staff C could not say for certain which day the rumors were heard, but it was probably 10/15/12 (Monday). According to Staff C, there was no reason to implement protection of the resident because Resident #1's S.O. does not come in on Mondays, and that was the day that Staff D determined that the resident could consent to</p>	F 226		11/30/12	

RECEIVED

NOV 19 2012

DSHS/ADSA/RCS

gerado

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

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/25/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122	<i>Amended</i> 11/14/12
--	---	----------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 226	Continued From page 6 sexual activity. RESIDENT #2: Facility grievance (concern) procedure states that if any concern brought forward involves abuse, the executive director is notified immediately and an investigation is begun per the abuse prohibition policy (including state notification if applicable). Concerns are resolved immediately when possible by the individual receiving the concern. If resolution is not possible, the concern is routed to social services or designee within 24 hours and a form is completed and logged. Within 48 hours the department manager reviews the concern. Resident #2 was re-admitted to the facility [REDACTED] with medically disabling conditions affecting mobility and mood. The resident's MDS dated 8/15/12 identified that the resident was cognitively intact, without memory impairment or symptoms of depression. The resident was independent with toileting. Observation at 11:05 a.m. noted the resident dressed in shorts and tee shirt seated in a wheelchair. The resident was fully conversant. On interview Resident #2 stated that in July/August 2012, he was going through a time when he was exhausted and slept heavily. The resident said his nurse (Staff B) was concerned that he had an infection so called the doctor who ordered a urine test. Resident #2 stated that he woke to find a new employee (Staff A) standing over him with her hand on his penis. The resident stated that the urine specimen cup was	F 226		11/30/12
-------	---	-------	--	----------

RECEIVED

NOV 19 2012

DSHS/ADSA/RCS

Jardas

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

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/25/2012
NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 7</p> <p>across the room, nowhere near the nurse "she saw a guy asleep and tried to take advantage."</p> <p>Resident #2 said that the resident care manager (Staff C) filed an internal complaint for him. Resident #2 stated that he asked to have no contact with Staff A, but she still works almost every weekend. "I feel trapped in my room." Resident #2 stated that he has to go to Staff A to receive his pain medication and insulin which causes a whole mix of emotions. "I am embarrassed and angry about the whole situation."</p> <p>Review of facility incident investigation found a narrative written by the Director of Nursing (DNS) on 8/30/12 documenting that Resident #2 called Staff A "pervert" and told her to "Get the F--- Out" of his room. The DNS documented Resident #2 declined to talk to her 8/30/12, five residents interviewed reported no concerns and other nurses besides Staff A would care for Resident #2. The DNS documented there was no reason for an incident report and no reason to remove Staff A from the schedule or report possible abuse because there was no specific allegation and it was a customer service issue. The DNS kept the narrative in the incident log. No concern/comment form (CCF) was filed at the time.</p> <p>Facility records show that Staff A worked 29 shifts as the licensed nurse on all 3 floors of the facility between 8/30/12 and 10/22/12. Twelve shifts were on the 3rd floor, responsible for Resident #2's care. Staff A had unrestricted access to all 91 residents at the facility. There was no written directive in Resident #2's record regarding</p>	F 226		11/30/12	

NOV 19 2012
DSHS/ADSA/RCS

gnd

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

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/25/2012
NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 8 contact between Resident #2 and Staff A.</p> <p>A facility incident report dated 10/17/12 identified a report was made and investigation initiated after Resident #2 told Staff E during a monthly customer service interview he was angry about waking to find Staff A's hand on his penis. The incident report did not document that Staff A was suspended during investigation.</p> <p>The 10/17/12 incident report documentation included an undated narrative written by Staff C and an unsigned CCF dated 10/5/12. The incident report included progress notes dated 8/30/12 written by Staff A and Staff B and a more detailed written statement by Staff A dated 10/8/12.</p> <p>On interview, the Administrator (ADM) identified that the undated narrative, 10/8/12 note and the CCF were "recreated" when Resident #2 told her about the incident on 10/5/12. From 8/31/12 to 10/17/12 none of the staff documented in progress notes or on the facility investigation notes about circumstances related to Resident #2's allegation. According to the ADM, Resident #2 reported that a CCF was completed in mid-September, but this CCF could not be found.</p> <p>The ADM and Director of Nursing (DNS) stated that Staff A was not removed from the schedule pending investigation for the following reasons: a) The issue was already investigated on 8/30/12 and found to be related to customer service and b) The resident did not identify that waking to find Staff A's hand on his penis was sexual when reported to Staff C in mid-September. According to the ADM and DNS, the 10/17/12 report of</p>	F 226		11/30/12	

RECEIVED

NOV 19 2012

DSHS/ADSA/ROS

g...

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

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/25/2012
NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 9 possible abuse was made because Resident #2 had received a 30 day notice. "We know Mr. (Resident #2)." The DNS stated that she distinguished a grievance from an allegation requiring investigation. According to the DNS, there was no specific allegation initially so the 8/30/12 event was considered a grievance. However, because Resident #2 used the word "pervert" on 8/30/12, she felt the need to talk with other residents about Staff A. On interview, Staff C stated that he completed a CCF regarding Resident #2's concern in in mid-September but this form could not be found. According to Staff C after the 8/30/12 event Staff A would have no contact with Resident #2 when assigned to Resident #2's floor. Medications were to be given by Staff G. This was communicated verbally to both Staff A and Staff G. On interview Staff G stated that on 10/21/12 he did not give medications to Resident #2 for Staff A because he was busy with treatments on another floor. Staff F (nursing assistant certified) stated she delivered medications to Resident #2 and left them on the table for the resident. See findings under F281.	F 226		11/30/12	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest	F 250			

RECEIVED
NOV 19 2012
DSHS/ADSARCS

gndw

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

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/25/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122	<i>Amended</i> 11/14/12
--	---	----------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 250	Continued From page 10 practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility failed to provide medically related social services to one of 2 sample residents (Resident #1) whose diagnoses reflected he had severe medical, physical, mental, and functional challenges. The facility failed to anticipate and meet timely the social needs of this resident. Findings include: Resident #1 was admitted to the facility [REDACTED] with multiple medically disabling conditions. Resident #1's Minimum Data Set (MDS - an assessment tool) dated 9/11/12 identified the resident had unclear speech (slurred or mumbled words) and sometimes understands (responds adequately to simple direct communication only). The MDS identified Resident #1 had severely impaired decision making, inattention and was unable to participate in a basic interview for mental status screening. According to the MDS, Resident #1 had daily behavioral symptoms not directed toward others (hitting, scratching, screaming, disruptive sounds) that disrupted his care. Resident #1 required extensive 1-2 person assist for bed mobility, transfer, personal hygiene, and required total dependence of 2 staff for toileting. The resident was fed through a tube inserted into his stomach through the abdomen. According to the MDS, staff assessed the resident's pain through non-verbal sounds like	F 250	F250 PROVISION OF MEDICALLY RELATED SOCIAL SERVICE <u>Plan of Correction</u> Resident #1 plan of care has been updated to meet their social needs. All residents have been re-assessed by Social Services to ensure that their social needs are or can be met according to their wishes. Care Plans have been updated. Social Services Department have been re-educated on F250 requirements and meeting resident social needs timely significant to the residents. Random monthly audits will be conducted for three months by Regional staff to assure Social Service documentation meets social needs requirements and are timely. Audit results will be forwarded to Quality Assurance Committee Executive Director will ensure compliance.	11/30/12
-------	---	-------	---	----------

RECEIVED
NOV 19 2012
DSHS/ADSA/RCS

gpr

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

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/25/2012
NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 250	<p>Continued From page 11</p> <p>crying, gasping or moaning and facial expressions like wincing or furrowed brow.</p> <p>The MDS documented that daily routines and preferences meaningful to the resident were identified by family, close friend or other representative. One note in the resident record dated 6/21/12 identified that staff could share information with Resident #1's significant other (S.O.) during the absence of the resident's power of attorney. There was no documentation in social work notes regarding the nature of the continued relationship with the S.O. or the residents choice or ability to consent or engage in intimate relations. There was no documentation of domestic partnership determination.</p> <p>On observation 10/22/12 at 3:40 p.m. Resident #1 was lying on his back in a hospital bed wearing a hospital gown. The resident responded slowly to yes/no questions but did not respond further when asked open ended questions. Resident #1 was able to spontaneously lift his head off the pillow but could not use his arms to make any adjustments to his clothing or bedding.</p> <p>The department received a report on 10/12/12 that Resident #1 had a sexual encounter with a S.O. who was a S.O. prior to being admitted to the facility.</p> <p>Social service notes documented on 10/15/12 the social work director (Staff D) met with Resident #1 related to a report that he and his S.O. engaged in physically sexual behaviors. The resident was able to answer yes/no questions and responded "yes" when asked about consent to</p>	F 250		11/30/12	

RECEIVED

NOV 19 2012

DSHS/ADSA/RCS

Handwritten signature

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

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/25/2012
NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122 <i>Amended 11/14/12</i>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	<p>Continued From page 12</p> <p>sexual activity. A care plan was written identifying that staff would provide a private non-confrontational environment for sexual activity. There was no indication that the facility social worker reconciled the information that just a month earlier documented on the MDS that the resident was severely impaired in decision making so was unable to participate in a mental status screening. Although the resident could slowly answer what sounded like yes or no direct questions there was no real determination if the resident comprehended things like risks or benefits of a medication or treatment or a decision that may affect his health or his desire to be intimate with his S.O.</p> <p>Social Service notes document that on 10/17/12 Resident #1's legal representative/decision maker was contacted and stated that the sexual activity was "okay". There was no information to verify that the resident 's decision maker had an opportunity to talk with a physician about the risks of various intimate contacts for the resident given his current physical conditions. A referral was made to mental health to formally evaluate Resident #1's capacity to consent to sexual activity. Social service notes was the only documentation (other than the care plan) related to the alleged sexual contact between the resident and S.O. See findings under F514.</p> <p>On 10/18/12 a mental health professional documented "I cannot assess if mentally competent or not, but I can assess whether he has the capacity to render a decision." The mental health provider determined that Resident #1 consented to sexual activity by asking the resident to speak and nod his head yes/no when</p>	F 250	<p>RECEIVED NOV 19 2012 DSHS/ADSA/RCS</p>	11/30/12

gurb

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

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/25/2012
NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 250	<p>Continued From page 13</p> <p>asked if he was engaged in consensual sexual activity.</p> <p>On interview 10/26/12 Staff D stated that he did not know exactly specific information about the alleged sexual activity. According to Staff D, the DNS told him on Monday 10/15/12 to determine if Resident #1 had the capacity to consent to sexual activity. According to Staff D, there was no reason or need to protect Resident #1 while sorting things out because this was done the same day as reported to him by the DNS.</p> <p>Staff D stated that the S.O. was not interviewed as this would be an invasion of privacy. There was no recognition on the part of social service staff D that the facility's primary responsibility was to protect the resident. To accomplish that and allow the resident the opportunity for intimate contact with a person of his choice it was necessary to find out some information from the S.O. as well as the resident.</p> <p>Resident # 1 had been a resident in the facility for well over a year and the S.O. had been visiting regularly the entire time. Social service failed to ensure that the resident's social needs for intimacy were anticipated and worked out with the resident, his family and his S.O. in advance so the facility could ensure that the resident was protected as well as allowed to continue social choices significant to the resident.</p>	F 250		11/30/12	

RECEIVED
NOV 19 2012
DSHS/ADSARCS

grest