

|  |  |  |   |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>505278 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>04/30/2013 |
|--|--|--|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>HEALTH AND REHABILITATION OF NORTH SEATTLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13333 GREENWOOD AVENUE NORTH<br>SEATTLE, WA 98133 |
|--|--|

| (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 Health and Rehabilitation of North Seattle on 04/22/13 and 04/30/2013 was the last day of data collection. A sample of 3 current residents were reviewed from a census 78 residents.</p> <p>The following complaints were investigated as part of this survey:</p> <p>complaint #2796776 and # 2794598</p> <p>The survey was conducted by:</p> <p>██████████, RD, MS</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services<br/>Aging &amp; Disability Services Administration<br/>Residential Care Services, Region 3, Unit B<br/>3906 172nd Street NE, Suite 100<br/>Arlington, WA 98223</p> <p>Telephone: (360) 651-6850<br/>Fax: (360) 651-6940</p> <p><i>[Signature]</i> 5-7-2013<br/>Residential Care Services Date</p> | F 000 | <p><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;"><i>RECEIVED<br/>MAY 03 2013<br/>DISHONORABLE</i></p> |  |
|-------|---|-------|---|--|

|   |                        |                      |
|---|------------------------|----------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>[Signature]</i> | TITLE<br>Administrator | (X6) DATE<br>5-17-13 |
|---|------------------------|----------------------|

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.

|  |   |  |  |                      |   |
|--|---|--|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                               |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>505278 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                      | (X3) DATE SURVEY COMPLETED<br><br>C<br>04/30/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HEALTH AND REHABILITATION OF NORTH SEATTLE |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13333 GREENWOOD AVENUE NORTH<br>SEATTLE, WA 98133   |                      |   |
| (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 157<br>SS=D  | <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview, and record review the facility failed to ensure they notified a</p> | F 157  | <p><b>Cited Residents</b><br/>A resident # 1 responsible party had been notified of the medication order.</p> <p><b>Other Residents</b><br/>A list of current medication for each resident has been created and mailed to each resident's responsible party.</p> <p><b>System Review/Education</b><br/>Appropriate licensed nurses were in-serviced on the facility policy for notifying and documenting notification of medication changes to resident responsible parties.</p> <p><b>Monitoring</b><br/>New medication orders will be read at the facility morning meeting and verified that the resident or resident's responsible party has been notified. Medical Records will keep an audit of notification and the results of the audits will be forwarded to the PI committee times 3 months to review for further educational opportunities.</p> <p><b>Responsibility</b><br/>The Director of Nursing will be responsible for the ongoing compliance.</p> | 5-31-13              |   |

RECEIVED  
MAY 13 2013  
DCHS/DUSA/RCS

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>505278</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>04/30/2013</b> |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HEALTH AND REHABILITATION OF NORTH SEATTLE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>13333 GREENWOOD AVENUE NORTH<br/>SEATTLE, WA 98133</b> |
|---|--|

| (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 157 | <p>Continued From page 2</p> <p>guardian when treatment changes were implemented. Failure to notify the guardian of a change in treatment resulted in Guardian not being informed the change in medication and potential side effects associated with it's use.</p> <p>Findings include:</p> <p>Resident #1 was readmitted to the facility on [REDACTED]/12, with multiple diagnoses, including [REDACTED] illness, [REDACTED] failure and [REDACTED].</p> <p>The behavioral section of the clinical record noted the resident experienced delusions, hallucinations and displayed behavioral symptoms. The behavioral symptoms included verbal and physical behavioral symptoms directed towards others and rejection of care.</p> <p>On 04/22/13 at 9:30 a.m., Resident # 1 was seated in the dining room with other residents. When greeted, Resident waved a hand and gestured, but did not respond verbally. Throughout the visit the resident remained in the dining room for meals and activities.</p> <p>The clinical record documented the physician ordered a new medication, "[REDACTED]" on 03/27/13. However there was no evidence in the clinical record indicating the Guardian was notified of the change in treatment. The initial order dated 3/27/13, was for the administration of one dose daily for the first seven days, and after that the medication was increased to two times, a day, every twelve hours.</p> <p>On 4/22/13 at 7:30 am, during an interview the Guardian reported the physician implemented the new drug, to assist with behavior management</p> | F 157 |  |  |
|-------|---|-------|--|--|

RECEIVED  
MAY 23 11:17  
DENVER, COLORADO

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

PRINTED: 05/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>505278</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>04/30/2013</b> |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HEALTH AND REHABILITATION OF NORTH SEATTLE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>13333 GREENWOOD AVENUE NORTH<br/>SEATTLE, WA 98133</b> |
|---|--|

| (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 157 | <p>Continued From page 3</p> <p>without any notification to her. The Guardian expressed concern about the change and explained that she did not find out about the change in medication until she attended a care conference on 04/04/13.</p> <p>On 04/22/13 at 11:45 a.m., the Director of Nursing Services and Administrator acknowledged the facility had not contacted the Guardian to discuss the change in medication before receiving a physician order. When asked why "consent" was not obtained prior to implementing the medication, the DNS stated the medication was not considered a psychotropic medication and did not feel it was necessary. However review of the facility policy noted that consent for mood stabilizers, (such as anticonvulsant medications) were obtained. In addition, there was no signed consent form by the Guardian for three psychotropic medications, the resident was administered. The facility form identifying the medications was found in the resident record but it was unsigned and undated.</p> <p>Not ensuring the Guardian was contacted when treatment changed and ensuring consent for a medications administered for behavior management was obtained left the Guardian without adequate information about the medications administered, potential adverse side effects and the change in the treatment.</p> | F 157 |  |  |
|-------|---|-------|--|--|

RELEASED  
MAY 23 2013  
COMSERVICES