

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

PRINTED: 07/03/2013
FORM APPROVED
OMB NO. 0938-0391

1340

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LEON SULLIVAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2611 SOUTH DEARBORN SEATTLE, WA 98144
--	---

(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 INITIAL COMMENTS

F 000

7-23-12

This report is the result of an unannounced Abbreviated Complaint Survey conducted at Leon Sullivan Health Care on 06/26/13 and 06/27/13. A sample of 3 current residents from a total census of 132 residents was selected for review.

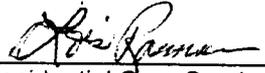
The survey was conducted by:
[REDACTED] MN, RN, Complaint Investigator

Complaints investigated include:
#2833626

The survey team is from:
Department of Social and Health Services
Aging and Long Term Support Administration
Residential Care Services, District 2, Unit D
20425 72nd Avenue South, Suite 400
Kent, Washington 98032-2388

Telephone: (253)234-6000
Fax: (253)395-5071

RECEIVED
JUL 12 2013
DSHS/ADSA/ROS

 7/3/13
Residential Care Services Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 7-12-13
---	------------------------	----------------------

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.

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

PRINTED: 07/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/27/2013
NAME OF PROVIDER OR SUPPLIER LEON SULLIVAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2611 SOUTH DEARBORN SEATTLE, WA 98144		
(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 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide medically-related social services to 3 of 3 sample residents (#1, #2, #3) in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This placed residents at risk for inadequate assessment and coordination of care.</p> <p>Findings include:</p> <p>RESIDENT #1: Record review found that Resident #1 was admitted to the facility [REDACTED] 13 with [REDACTED] and [REDACTED].</p> <p>On interview 6/26/13 at 4:00 p.m., Resident #1 reported she had not received [REDACTED] medication for a month after admission to the facility. Resident #1 stated she was discharging soon, but discharge had been delayed.</p> <p>Review of Resident #1's record found a mental health consultation report dated 4/22/13 documenting that Resident #1 feared her roommate was interfering with care, the resident felt unsafe and had [REDACTED]. The resident was</p>	F 250	<p>This plan of correction is submitted as required by Federal and State Laws.</p> <p>1. A) It is the policy and practice of Leon Sullivan Health Care Center to provide medically appropriate social services that help each resident attain or maintain the highest possible medical, mental, and psychosocial well-being. The policy further states that each resident should be provided with appropriate, safe (fear free) and secured environment.</p> <p>B) Discharge planning begins with admission and goes on until the resident is discharged or leaves the facility. The facility believes that residents should go back to their community as soon as possible and do all it can to make the discharge process go fast and well planned.</p> <p>C) It is also the policy of the facility that each residents is entitled to have an access to grievance procedures that protect their ability to speak up about issues that concerns them. All grievances are</p>	7-23-13	

RECEIVED

JUL 12 2013

DSHS/ADSA/RCS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LEON SULLIVAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2611 SOUTH DEARBORN SEATTLE, WA 98144
--	---

(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 2
diagnosed with [redacted] and [redacted] and was restarted on the [redacted] medication [redacted]. Medication record review found that due to a transcription error, the [redacted] was inadvertently discontinued in March 2013.

Review of progress, social service notes and social service referral book found that staff had not documented passing on information to the social worker about Resident #1's [redacted] or feeling unsafe. On review of the 4/22/13 note with Staff A 6/27/13 at 9:10 a.m., Staff A stated that generally staff reports resident [redacted] and feeling unsafe to the social worker and he did not know why this was not done. On interview at 6/27/13 at 12:10 p.m. Staff E said she knew that Resident #1 had mental health services but did not read any of the mental health note documentation (including the 4/22/13 note describing Resident #1's [redacted] and [redacted]).

Progress notes and social work referral records show that Staff A passed on a doctor's order for discharge planning on 5/2/13. Social work notes in the resident record found an initial discharge plan dated 3/7/13 and two sentences on a Care Conference form dated 5/16/13, which did not include the discharge plan. There was no documentation of ongoing social work coordination of care, or discharge planning.

On interview at 6/27/13 at 12:10 p.m. Staff E stated that she kept notes in her computer (not a common electronic record) or in a personal spiral bound notebook where notes on all residents were kept. Review of Staff E's computer records included only notes from 4/17/13 and 6/3/13 about discharge planning, but nothing related to

F 250 immediately investigated, properly documented and directed to the responsible parties.
D) The facility believes that smooth, organized and timely communication between or among departments will help improve quality of services provided. There are folders/Note books on every unit to facilitate information exchange between nursing and social services.
E) The facility expects allemployees to be competent in their assigned areas and discourages guess works that do not reflect or address the actual issues.
2. A) Medication Error is considered serious at the facility. All medication should be transcribed correctly, administered safely in a timely manner per medication administration policy.
B) Omission of dosage, as with Resident #1 is treated as a medication Variance and thoroughly investigated immediately.

7-23-13

RECEIVED

JUL 12 2013

DSHS/ADSARCS

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

PRINTED: 07/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LEON SULLIVAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2611 SOUTH DEARBORN SEATTLE, WA 98144
---	---

(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 3
mental health coordination. These notes (desk computer and spiral notebook) were not accessible to other staff for coordination of care.

Staff E said that Staff F covered for her during Resident #1's Care Conference on 5/16/13 but could not stay for the whole meeting. Staff E acknowledged that documentation of the 5/16/13 Care Conference was not adequate and said that she did not speak to Staff F about the Care Conference or complete the documentation because she (Staff E) already knew the discharge plan.

RESIDENT #2:
Observation 6/27/13 at 9:00 a.m. found Resident #2 alert, awake and conversant. The resident stated that she had been in care since August of last year. The resident said that she received treatments for her medical condition but was very independent with activities of daily living generally, and thought she would just stay at the facility for now.

Record review found that Resident #2 was last admitted 12/12 with multiple medically disabling conditions. Review of social work notes found entries dated 8/28/12 (initial discharge plan), 11/9/12 (resident bored- given coloring book) and 3/14/13 (may go home soon per psychiatrist). There was no documentation of care coordination or ongoing discharge plan.

On interview 6/27/13 at 12:00 p.m. Staff E stated that she had no additional notes regarding Resident #2's care in her desk computer. Staff E said that social work notes are to be done every 30 days, but she did not write notes for Resident

F 250 Because all residents with Similar Situations are potentially affected by the cited deficiency on 6/26 & 6/27/2013, under the direction of the DNS, all Nursing staff will be in-serviced on:

- The Importance of correctly transcribing physicians' orders and follow up.
- Medication administration policies and procedures
- Potential or actual consequences of omitted medications and prevention of medication errors.
- Thorough assessment of resident's condition post dosage or medication omission
- The Importance of frequent medication review and interdepartmental communication.

Responsible:
Staff development
Compliance is monitored by the DNS and discussed in Monthly CQI meetings.

7-23-13

RECEIVED

JUL 12 2013

DSHS/ADSA/RCS

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

PRINTED: 07/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LEON SULLIVAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2611 SOUTH DEARBORN SEATTLE, WA 98144
---	---

(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 4
#2. According to Staff E, she had a computer list to keep track of who needs a note but "evidently I missed some people."

RESIDENT #3:
Observation 6/27/13 at 8:40 found Resident #3 lying in bed. The resident stated that she had been at the facility 2 1/2 weeks. The resident tearfully stated that she was told yesterday by staff that her insurance ran out and she had no place to go. "I guess I can go to a shelter."

Record review found that Resident #3 was admitted [redacted] 13 for care related to a medically disabling condition. Review of social work notes found no documentation of an initial assessment of social needs or documentation of discharge planning, or documentation of any conversation regarding benefits.

On interview 6/27/13 at 12:10 p.m. Staff E stated that she spoke to the resident yesterday, but had not written documentation yet. Staff E stated that she was gone from [redacted] to [redacted]/13 when Resident #3 was first admitted, so one of the other staff should have done the admission assessment and documentation. Staff E did not follow up to be sure the work was done for the benefit of the resident.

INACCURATE ASSESSMENT:
The standardized tool to evaluate cognition for the MDS is called "Brief Interview for Mental Status" or BIMS. Residents can attain a maximum of 15 points if all items are scored at the highest level.

Review of Resident #2's BIMS tool completed by

F 250

Social Services
Under the direction of the director Social services, all the Social workers will be in-serviced on:

- Thorough and resident specific assessment and care plans
- Discharge planning and care conferences
- Organizational skills and documentation.
- inter departmental communication /information exchange
- Coordinated and accurate grievance log- each unit should have its own grievance log.
- Quarterly, annual and as needed assessment and documentation that reflect specific resident's physical, mental, psycho social needs. The director of social services will also identify the

7-23-13

RECEIVED

JUL 12 2013

DSHS/ADSA/RCS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LEON SULLIVAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2611 SOUTH DEARBORN SEATTLE, WA 98144
---	---

(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 5
Staff E on 3/14/13 found that the resident score was 17 (two points higher than the maximum score for an alert, awake, oriented person).

On interview 6/27/13 at 12:20 p.m. Staff E stated that she did not know the maximum score for a BIMS test. Staff E said that she thought the score was used to tell the nurse or doctor at the pharmacy meeting so they would know if medication doses needed to be reduced. Staff E said the higher the score, the more medications need to be adjusted.

MISSING BELONGINGS:
Facility policy stated that residents or representatives may file a grievance at any time. The social worker assigned grievances to the appropriate department which investigated grievances and developed solutions. The social worker was responsible to maintain a log and report on resolution of grievances (such as missing belongings).

On interview 6/26/13 at 4:00 p.m., the resident reported she was missing clothing items and reading glasses. Resident #1 stated that she was working with Staff E on getting reimbursed for the glasses but this had not happened.

Review of Resident #1's record found no documentation regarding missing belongings. Record review found there was no separate grievance log for the 3rd floor residents. Review of all facility grievance logs found no documentation of Resident #1's missing belongings.

On interview 6/26/13 at 5:00 p.m. Staff E stated

F 250

educational needs of each social worker in general and in the area of cognitive assessment tools, their interpretations and appropriate application in particular. The indentified needs will be addressed immediately – will educate the social services employees.
Responsible: Social services director

Compliance will be monitored by the Administrator and discussed in a monthly CQI Meetings.
Actions being taken/already taken
Resident #1 is being assessed by DSHS and will be discharging soon. Medication variance, missing items and fear of safety (resident #1) are being investigated. The Investigation of alleged verbal abuse by the roommate has been completed. Resident #2 is independent with activities of daily living but has some critical medical issues that require

7-23-13

RECEIVED
JUL 12 2013
DSHS/ADSA/KC

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

PRINTED: 07/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LEON SULLIVAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2611 SOUTH DEARBORN SEATTLE, WA 98144
--	---

(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 6
that she did not keep a grievance log for 3rd floor residents, but if she did have a grievance, she wrote on the floor 2 grievance log. Staff E said that the purpose of the grievance log was to provide a paper trail for missing items.

Staff E said that she knew about Resident #1's missing clothing but the resident told her that the clothing was old and she did not know the value so she did not log them. Staff E said that she knew about Resident #1's missing reading glasses and replaced them but did not log the loss per facility policy.

F 250 24 hours care. She is scheduled for a surgical procedure.
Resident #3 will be assessed for possible Medicaid eligibility or other benefits that can help facilitate the discharge process or pay her bill.
Completion Date. 7/23/2013

7-23-13

RECEIVED
JUL 12 2013
DSHS/ADSA/RCS