

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

PRINTED: 08/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

1445

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505521	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/30/2013
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NAME OF PROVIDER OR SUPPLIER  KINDRED SEATTLE - NORTHGATE	STREET ADDRESS, CITY, STATE, ZIP CODE 10631 8TH AVE NE SEATTLE, WA 98125
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F 000 INITIAL COMMENTS

F 000

This report is the result of an unannounced Quality Indicator Survey conducted at Kindred Seattle-Northgate on 07/23/13, 07/24/13, 07/25/13, 07/26/13, 07/29/13 and 07/30/13. The sample included 19 current residents from a census of 26, and the closed records of seven former/discharged residents.

The survey was conducted by:

 MSW  
 MSW  
 RN, BSN  
 RN, BSN

The survey team is from:

Department of Social and Health Services  
Aging and Long-Term Support Administration (AL TSA)  
Residential Care Services, Region 2, Unit C  
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*Delinda Valera 8-2-2013*

Residential Care Services Date

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DSHS/ADSA/RCS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Signature]*

Executive Director 8-16-13

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.

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F 156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal</p>	F 156	<p>F 156</p> <p>1) Resident # 49 is not longer a patient Seattle Northgate-SAU</p> <p>2)Seattle Northgate SAU will informs each resident, in the appropriate format, when services are no longer covered under Medicare. An audit was completed on all existing Medicare patients present in the unit. All existing Medicare patients will receive the denial notice pending outcome of each patient stay, as defined below.</p> <p>3)The SNF Determination on Continued Stay denial notice (NOMNIC) is being given and/or sent to residents and responsible party when resident no longer qualifies for Medicare benefits.</p>	8/30/2013

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F 156	Continued From page 2 funds, under paragraph (c) of this section;  A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.  A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.  The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.  The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156	4)Rationale for denial of benefits is determined by the Interdisciplinary Team. Social Services will complete the denial notice, obtain signature and file in the resident's record. The IDT will audit all Medicare residents at the weekly Medicare review meeting, for appropriateness of denial of benefits and make any recommendations, and request any denial letters to be sent. QAA/PI: The Social Worker /or designee, will present the results of the tracking form/denial letter compliance, to the Performance Improvement Committee for review monthly, for 3 months and quarterly thereafter.  6) The Administrator/Executive Director is responsible for overall compliance.	

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F 156	Continued From page 3  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the appropriate liability and appeal notice to Resident #49, 1 of 4 residents reviewed for this requirement. Failure to provide this notice placed the resident at risk for not having the opportunity to exercise her right to appeal this decision. Findings include: On 07/26/13 at 11:30 a.m., in an interview with Staff A, she stated liability notifications were given to residents after an interdisciplinary team meeting. On 7/29/2013 at 11:00 a.m. the closed records of four residents were reviewed to ensure each resident was given notice of their right to appeal discharge from Medicare skilled services. Resident #49 was re-admitted to the facility on [REDACTED]/13 and discharged to the community on [REDACTED] 13. No notice of Medicare decertification was found for this resident. Staff A stated the decertification notices were given to residents or their legal representative 48 hours prior to discharge. When Resident #49's closed record was reviewed with Staff A on 7/29/13, she acknowledged there was no evidence the resident received this notice.	F 156		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

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F 279	<p>Continued From page 4</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a written comprehensive care plan to address the use of several [REDACTED] medications for Resident #36, one of 10 residents for whom medications were reviewed. Failure to develop relevant goals and interventions placed this resident at risk for not attaining her highest level of psychosocial well-being.</p> <p>Findings include:</p> <p>Resident #36 was originally admitted to the facility on [REDACTED] 13 and was subsequently readmitted on [REDACTED] 5/13, [REDACTED] 1/13 and [REDACTED] 3/13. For each admission she had multiple diagnoses including [REDACTED] and [REDACTED]. For these diagnoses, she was receiving the following [REDACTED] medications: [REDACTED] a [REDACTED] used for [REDACTED], [REDACTED], an</p>	F 279	<p>F 279</p> <p>1) The Interdisciplinary Care Planning Team reassessed Resident #36 and complete a comprehensive care plan based on the assessment. Her care plans were updated and now reflect her usage of the psychoactive medications. Patient 36# is no longer a patient at the facility.</p> <p>2) The Interdisciplinary Care Planning Team has reassessed all residents care plans and completed a comprehensive care plan on each resident identified through the process.</p> <p>3) The Interdisciplinary Care Planning Team will assess each residents care plan during the weekly psychoactive medication review committee, and insure a complete comprehensive care plan on residents identified through the process.</p>	8/30/2013

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F 279	Continued From page 5 [REDACTED] also used for [REDACTED] and, [REDACTED], another [REDACTED] used for [REDACTED]  Review of Resident #36's care plan originally initiated 04/08/13 and updated to reflect her readmissions, revealed no goals or objectives for the resident's use of the three [REDACTED] medications. Further, there was no indication of the possible use of non-pharmaceutical interventions, no indication of the behaviors for which the medications were being received. There was no monitoring of the frequency of the behaviors described as [REDACTED] and [REDACTED]  On 07/30/13 an interview was conducted with administrative nursing Staff C at 12:30 p.m. She acknowledged there was no care plan and said she did not know how the facility failed to initiate a care plan for the use of [REDACTED] medications.	F 279	The Staff Development Director has completed an in-service with nursing staff, and the Interdisciplinary Care Planning Team, on the development and completion of comprehensive care plans, specifically with regard to care planning the use of psychoactive medications.  4) The Director of Nursing/designee will randomly monitor on at least a monthly basis to assure comprehensive care plans are developed for all residents. The Director of Nursing /designee, will monitor through resident record review (care plans), monthly for three months, then at least quarterly, to assure each resident has a comprehensive care plan. The Director of Nursing will report to the QA/QI PI compliance data monthly x 3months, then quarterly.  6) The Administrator/Executive Director is responsible for overall compliance.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a	F 329		

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F 329	<p>Continued From page 6</p> <p>resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to implement a system to identify and monitor specific target behaviors, as well as use of non-drug interventions for six of ten sample residents for whom prescribed medications were reviewed. For Residents #24, 91, 76, 36, 41, and 25, the facility failed to ensure prescribed medications were monitored for efficacy and attaining therapeutic goals. Additionally, the facility failed to identify and implement non-drug interventions to ensure residents received medications only when necessary.</p> <p>Findings include:</p> <p>RESIDENT #24: Resident #24 was admitted [REDACTED]/13 with care needs related to cancer and symptoms of [REDACTED]. Review of her initial Minimum Data Set (MDS) assessment dated 06/27/13 did not identify the use of an [REDACTED] medication. However, MDS</p>	F 329	<p>F tag 329</p> <p>1) The Interdisciplinary Team including the MD and consultant Pharmacist, reassessed Resident #'s: 24, 36, 91, 76, 41 and 25 and completed/reviewed a comprehensive care plan, initiated monitoring of specific target goals, behaviors and non-drug interventions based on the recommendations of the IDT /MD/ Consultant Pharmacist.</p> <p>2) The Interdisciplinary Team, during the weekly Psychoactive medication review committee, has reviewed all resident psychoactive medication usage, review MD and Pharmacist consultant reports; in order to develop non-medication interventions, target behaviors, goals, efficacy and attainment of therapeutic goals.</p>	8/30/2013

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LISA M. SAAROS

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F 329	<p>Continued From page 7</p> <p>assessments dated 07/07/13 and 07/21/13 both documented the resident was receiving [REDACTED] medications on a daily basis. Review of the Medication Administration record (MAR) for July 2013 also showed Resident #24 was receiving an [REDACTED] medication once or twice each day, as needed.</p> <p>Her care plan, dated 7/16/13, identified a "mood problem", without specifying a problem of [REDACTED]. The only intervention identified for this mood problem directed staff to "administer medication, monitor and doc (document) side effects". No specific target behaviors, or factors which precipitated [REDACTED], or non-medication based interventions were identified as part of her care plan or on a "Behavior Monitor Flow sheet", or in the July 2013 MAR.</p> <p>On 07/29/13 at 12:10 p.m., the Resident Care Manager (RCM), Staff D, was interviewed regarding the regular use of the [REDACTED] medication by Resident #24. Staff D was asked for documentation of target behavior monitoring which necessitated use of the [REDACTED] medication. She reviewed the resident's chart, but was not able to locate it. When asked about non-drug interventions to be used by staff either prior to or in conjunction with use of the antianxiety medication, she could not locate this information.</p> <p>On 07/30/13 at 8:20 a.m., interview with the Director of Nursing Services (DNS), Staff C, and a Corporate Nurse consultant (Staff E), a copy of the facility's current policy regarding monitoring and use of [REDACTED] medications was requested. Staff C said the interdisciplinary team met on 07/29/13 to review all current residents'</p>	F 329	<p>3) The Staff Development Nurse/designee, has conducted an in-service for the IDT regarding the system of monitoring/reviewing psychoactive medications in the review committee, with concern for non-drug interventions, target behaviors, goals, efficacy and attainment of therapeutic goals.</p> <p>4)The Director of Nursing/designee will monitor through resident record review, attendance at psychoactive medication review committee, monthly for three months, and then at least quarterly, to assure each resident has a behavior monitor with target goals, non-drug interventions, GDR and efficacy and that specific target goals are included for the usage of those drugs.</p>	
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F 329	<p>Continued From page 8</p> <p>use of psychoactive medications. She acknowledged monitoring of target behaviors related to Resident #24's use of the [REDACTED] medication had not been completed prior to her discharge on 07/26/13 and non-drug interventions had not been identified.</p> <p>RESIDENT #91: Resident #91 was admitted on [REDACTED]/13 with care needs related to [REDACTED] and [REDACTED]. On 07/29/13, review of the July 2013 MAR revealed Resident #91 had been receiving an [REDACTED] since her admission. A "Monthly Behavior Monitoring Flow sheet" intended to document monitoring of target behaviors related to [REDACTED], was in the MAR, but had not been completed since the resident's admission on 07/6/13. The only entries on the form were the resident's name and room number. No non-drug interventions to help the resident had been identified on the form, in the resident's care plan or the MAR.</p> <p>On 07/29/13 at 12:10 p.m., Staff D was interviewed regarding Resident #91's use of an [REDACTED]. She confirmed the resident was receiving this medication since admission. Staff D was asked about monitoring of target behaviors by staff related to the resident's daily use of the [REDACTED]. She was not able to provide evidence the facility was monitoring specific target behaviors or had identified non-drug interventions for this resident. On 07/30/13 at 8:20 a.m., during an interview with Staff C and Staff E, the lack of monitoring of target behaviors and use of non-drug interventions for Resident #91, was acknowledged.</p> <p>RESIDENT #76:</p>	F 329	<p>The Director of Nursing/designee will report to QA/QI PI monthly x 3 months, and then on a quarterly basis to address areas identified through the RAI process.</p> <p>6) The Administrator/Executive Director is responsible for overall compliance.</p>	

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F 329	Continued From page 10  RESIDENT #36: Resident #36 was originally admitted to the facility on [REDACTED] 13 and was subsequently readmitted three times with the last readmission occurring on [REDACTED] 13. For each admission she had [REDACTED] diagnoses of [REDACTED] and [REDACTED]. For these [REDACTED] diagnoses, she was receiving [REDACTED] (a [REDACTED] used for [REDACTED]), [REDACTED] (an [REDACTED] also used for [REDACTED] a) and [REDACTED] (a [REDACTED] used for [REDACTED].)  Review of Resident #36's care plan originally initiated 04/08/13 and updated to reflect her readmissions, revealed no goals or objectives for the resident's use of the three [REDACTED] medications. (Refer to F279 for additional information.) Further, there was no indication of the use of non-pharmaceutical interventions, no indication of the behaviors for which the medications were being received, and no monitoring the frequency of the specific behaviors such [REDACTED] or [REDACTED].  Review of the facility's records found no documentation in the progress notes of behaviors, [REDACTED] manifestations. There were no social work interventions related to her [REDACTED] diagnoses and use of [REDACTED] medications. Additionally, there was no documentation of the number of hours of sleep for which she was receiving the [REDACTED].  RESIDENT #25: Resident #25 was admitted to the facility in [REDACTED] 2013. Her initial MDS dated 03/05/13 did not indicate any [REDACTED] disorders	F 329		

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F 329	<p>Continued From page 11 and did not reflect she received any [REDACTED] medications. However, her next Quarterly MDS dated 06/05/13 identified both [REDACTED] and [REDACTED] for which she was prescribed [REDACTED] and [REDACTED] medications.</p> <p>Review of the resident's care plan indicated a number of psychosocial care needs including [REDACTED], extended hospitalization, and [REDACTED]. Specific interventions were not identified in the care plan, except to state "Monitor for effectiveness and side effects" of the medications.</p> <p>An additional problem related to "[REDACTED] behaviors ineffective coping skills" listed an intervention of "Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document." A review of the MAR, all facility progress notes did not reveal any information related to this intervention. During an interview with Staff C on 07/30/13 at 12:30 p.m., she confirmed there was no monitoring as specified in the care plan.</p>	F 329			

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