

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

PRINTED: 01/15/2013
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 C 01/09/2013
NAME OF PROVIDER OR SUPPLIER KINDRED SEATTLE - NORTHGATE		STREET ADDRESS, CITY, STATE, ZIP CODE 10631 8TH AVE NE SEATTLE, WA 98125	
(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	
<p>F 000 INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Kindred Seattle- Northgate on 01/04/13-01/09/13. A sample of 3 residents was selected from a census of 27.</p> <p>The following complaint was investigated as part of this survey:</p> <p>2730014; 2735774</p> <p>The survey was conducted by:</p> <p>██████████, MN, R.N.</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 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>Delivered 1-15-2013</i> Residential Care Services Date</p>	<p>F 000 <i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <p>F-205 Corrective Action</p> <p>Bed hold was discussed with resident # 1 upon readmission and written notice given. Residents #2 and #3 have discharged and are not expected to return.</p> <p>For all other residents,</p> <p>The facility bed hold policy will be initiated upon admission and prior to any transfers a resident may make either to hospital, or for therapeutic leave. The facility will provide written information to the resident, and family member, or legal representative, that specifies the duration of the bed hold policy during which the resident may return and resume residence in the facility, regarding bed hold periods which are consistent with paragraph of 483.12 (b)(3) (F-205).</p> <p>Measures to be taken:</p> <p>The facility staff has been in-serviced on</p>	<p>01-22-2013</p> <p>RECEIVED JAN 24 2013 DSHS/ADSARCS</p>	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>		TITLE Executive Director	(X6) DATE 1-23-13

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: 505521	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/09/2013
NAME OF PROVIDER OR SUPPLIER KINDRED SEATTLE - NORTHGATE		STREET ADDRESS, CITY, STATE, ZIP CODE 10631 8TH AVE NE SEATTLE, WA 98125	
(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 205 SS=D	<p>483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR</p> <p>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide verbal notice of the facility Bed-Hold policy as required, to 2 of 3 residents transferred to the hospital from the facility, and failed to provide written notice of the facility Bed-Hold policy as required, to 3 of 3 residents reviewed, who transferred from the facility to the hospital for acute care needs. In addition, 5 of 5 facility staff confirmed the required written notice for facility Bed-Hold policy at the time of transfer, for residents transferring from the facility to the hospital was not done by the facility. This facility failure placed the residents at risk for having a</p>	F 205	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <p>the bed hold policy to include at admission and time of transfer of a resident for hospitalization or therapeutic leave. Ensuring the facility provides to the resident and a family member or legal representative written notice, which specifies the duration of the bed hold policy, to include sending a copy of the policy with the resident to the hospital or therapeutic leave.</p> <p>Monitoring :</p> <p>The ED or designee will monitor through observation and 24 hour report that residents have been provided a written notice of the bed hold policy at admission and transfer to hospital or therapeutic leave.</p> <p>The data will be reviewed monthly for three months and then quarterly at the Performance improvement meeting. With a subsequent plan of action developed and implemented as indicated. The ED is responsible for the overall compliance.</p>

DSHS/ADS/RCS

JAN 24 2013

RECEIVED

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

PRINTED: 01/15/2013
FORM APPROVED
OMB NO. 0938-0391

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 C 01/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED SEATTLE - NORTHGATE	STREET ADDRESS, CITY, STATE, ZIP CODE 10631 8TH AVE NE SEATTLE, WA 98125
--	--

(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 205	<p>Continued From page 2</p> <p>lack of knowledge about their rights for holding their beds and their possibilities of returning to the facility after hospitalization.</p> <p>Findings include:</p> <p>RESIDENT #1 According to record review on 01/04/13, Resident #1 was transferred to the hospital on [REDACTED]/12 for [REDACTED] care needs. According to the facility medical record, at the time of the transfer, Resident #1 was alert and oriented, responsible for self, and requested/agreed to the hospital transfer.</p> <p>In an interview on 01/04/13 at 11:40 a.m., Resident #1 stated the facility " Bed-Hold Policy " form was not given to the resident, or family member, at the time of the transfer to the hospital, and was not given to the resident or family member within 24 hours after the transfer. Resident #1 stated no knowledge of the resident ' s rights in regards to having a " Bed-Hold " at the nursing home for return after hospital treatment, which had the potential to result in anxiety about the ability to return to the facility after the hospitalization.</p> <p>Record review on 01/04/13 revealed, no documentation by the facility that a written notice of Bed-Hold policy was given to Resident #1 or a family member at the time of the transfer to the hospital, or within 24 hours after the transfer to the hospital.</p> <p>In an interview on 01/04/13 at 10:00 a.m., Staff A stated they had no knowledge of a written notice for Bed-Hold policy done in the facility for</p>	F 205		
-------	---	-------	--	--

RECEIVED
JAN 24 2013
DSHS/ADS/RCS

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

PRINTED: 01/15/2013
FORM APPROVED
OMB NO. 0938-0391

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 C 01/09/2013
--	---	--	--

NAME OF PROVIDER OR SUPPLIER KINDRED SEATTLE - NORTHGATE	STREET ADDRESS, CITY, STATE, ZIP CODE 10631 8TH AVE NE SEATTLE, WA 98125
--	--

(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 205 Continued From page 3

residents when they transfer to the hospital. Staff A stated they do not give a written notice to residents or families upon transfer out of the facility to the hospital, and Staff A had not seen a facility " Bed-Hold " written form used in the facility.

In an interview on 01/04/13 at 10:10 a.m., Staff B also stated no knowledge of a written notice for Bed-Hold, or a form to be given to residents or families when residents transfer out of the facility to the hospital.

In an interview on 01/04/13, Staff C also stated the Social Service department does not give any written notice for " Bed-Hold " to residents or families when they transfer to the hospital.

RESIDENT #2
According to closed record review on 01/04/13, Resident #2 was responsible for self, alert and oriented to person, place and time, and alert and able to make decisions during transfer from the facility to the hospital for acute care on 12/31/12. There was no documentation in the resident ' s record of any verbal or written notice of bed-hold policy when the resident was transferred to the hospital.

In an interview with Staff E on 01/04/13 at 10:20 a.m., Staff E, an administrative employee, stated documentation of verbal notice regarding Bed-Hold is placed in the medical record at the time of the resident transfer.

In an interview with Staff D on 01/04/13 at 11:55 a.m., Staff D stated a verbal notice is given to a resident or family for transfer but no written notice

F 205

RECEIVED
JAN 24 2013
DCHSI/ADS/ARCS

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

PRINTED: 01/15/2013
FORM APPROVED
OMB NO. 0938-0391

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 C 01/09/2013
NAME OF PROVIDER OR SUPPLIER KINDRED SEATTLE - NORTHGATE		STREET ADDRESS, CITY, STATE, ZIP CODE 10631 8TH AVE NE SEATTLE, WA 98125		
(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 205	Continued From page 4 is given at the time of transfer. Staff D also stated documentation of verbal notices of Bed-Hold policy is placed in the medical record at the time of transfer. RESIDENT #3 According to closed record review on 01/04/13, Resident #3 was sent to the hospital on 12/30/12 with no documentation of verbal or written notice of bed-hold policy given to the resident or the resident ' s family when the resident was transferred or in the days following the transfer. Failure of the facility to notify residents in writing of the facility Bed-Hold policy at the time of transfer as required, left residents at risk for having no knowledge of residents' rights to hold ther bed for return from the hospital.	F 205		

RECEIVED
JAN 24 2013
DSHS/ADSARCS