

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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
--------------------	--	---------------	---	----------------------

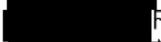
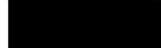
F 000

INITIAL COMMENTS

F 000

This report is the result of an unannounced Quality Indicator Survey conducted at Seattle Keiro on 09/23/13, 09/24/13, 09/25/13, 09/26/13, 10/01/13 and 10/02/13. A sample of 26 residents was selected from a census of 144. The sample included 24 current residents, the records of two former and/or discharged residents, and two supplemental residents.

The survey was conducted by:

 RN, MN
 MSW
 RN, MN
 RN, MN
 RN, BSN
 RD, MS

The survey team is from:

Department of Social and Health Services
Aging and Adult Services Administration
Residential Care Facilities Region 2, Unit E
20425 72nd Avenue South, Suite 400
Kent, Washington 98032-2388

Telephone: (253) 234-6000
Fax: (253) 395-5070

Mike Ambesse 10/07/13
Residential Care Services Date

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Randi Socha</i>	TITLE ADMINISTRATOR	(X6) DATE 10/18/2013
---	------------------------	-------------------------

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: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to actively seek resolution of grievances for two of three sample residents (#s 149 and 69) identified as having grievances of the eleven residents interviewed. Failure to resolve grievances, including those with respect to the behavior of other residents, and keep residents appropriately apprised of progress toward resolution, violated resident rights and had the potential to decrease quality of life.</p> <p>Findings include:</p> <p>RESIDENT #149 Review of the 07/11/13 quarterly Minimum Data Set assessment (MDS) revealed Resident #49 required care and services related to a stroke and heart disease. According to this MDS, Resident #149 was able to understand and be understood in conversation, had no cognitive deficits and had a preferred language which was not English.</p> <p>Observation on 09/24/13 at 8:59 a.m. revealed the resident was able to easily converse with the aide of an interpreter. In an interview at that time the resident indicated he had concerns/problems with a roommate. Resident #149 stated his roommate, Resident #86, "has visitors late at</p>	F 166	<p>F166 Right to prompt efforts to resolve grievances Residents #149 and #69 were interviewed and any concerns were addressed to both their expressed satisfaction. Staff also discussed roommate concerns with resident #86 and this resident agreed to accommodate roommates' requests for decreased noise (lower TV volume, limit visitors at night, use of headphones at night). Residents #149, 69 and 86's care plans have been updated. Staff G, J, L, and K have been in-serviced on the proper resolution of grievances, including those with respect to the behavior of other residents, and keeping residents appropriately apprised of progress toward resolution in addition to encouraging residents to voice any concerns to staff in a timely manner. Staff G, J, L and K have been in-serviced on how to address and follow-up on concerns and grievances specific to residents #149, 69 and 86 in a timely manner. All licensed staff has been in-serviced on proper handling, timely reporting, documentation and follow-up of concerns and grievances as well as updating of care plans. Administrator and/or designee is responsible for compliance.</p>	11/5/13	

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 166	<p>Continued From page 2</p> <p>night after 10:00 p.m. and are loud." Resident #149 indicated this interfered with his sleep. Resident #149 elaborated, "Sometimes the patients don't have control, but if you are working on your heath, if you don't rest well you can't get better."</p> <p>Resident #149 stated he had reported this issue to staff who spoke his language (Staff G), but when asked if staff addressed his concerns to his satisfaction, Resident #149 stated, "no... they seldom really talk to us, it could be the language barrier... I have reported it (the issue with Resident #86) many times; actually one time I was kind of frustrated and gave him the ultimatum, and told him if he continued (to be loud and disrespectful) I would have to call the police. For some people who don't come to self realization you have to give them some help; it wasn't just once or twice, I have reported many times." Resident #149 went on to explain that Resident #86's loud behaviors effected all the residents in the four resident room reporting, "It effects all three of us in here, originally there was a different neighbor in here. The person in bed D requested to be moved out because of this, and that doesn't solve the problem."</p> <p>Resident #149 further stated on 09/26/13 at 10:12 a.m., "I have reported a number of times my concerns to this person (Staff G), she claimed that she had talked to (Resident #86) two or three times but to me the situation has not improved... both the TV and visits late at night; last month and this month I have reported, because (Resident #86's) friend visits and stays up to 12:00 a.m. still chatting so I have to go out to tell the nurse then the nurse has to come in and tell him to leave... it interferes with my sleep and</p>	F 166		11/5/13
-------	---	-------	--	---------

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 166	<p>Continued From page 3</p> <p>rest... at 12 in the morning he will turn on the television; I told the guy, 'you should be mature enough to be considerate about neighbors...".</p> <p>In an interview on 09/26/13 at 10:33 a.m., Staff G (MDS coordinator) indicated the Social Worker (SW-Staff K) was aware of Resident #149's concerns and "we had talked to Resident #86." Staff G and Staff J (Resident Care Manager) elaborated at that time that another resident (Resident #156) had been moved out of the room related to concerns about Resident #86's behavior, stating, "(Resident #156) complained about (Resident #86) already and he moved to (another room)... it's been awhile now... we referred the concerns to the Social Worker who spoke to resident and then later, (Resident #149) had concerns."</p> <p>Record review revealed Resident #149 was transferred to his current four bed room on 09/09/13 09/09/13. Review of Resident #149's record revealed no mention of issues or concerns with his roommate. In an interview on 09/26/13, Staff G indicated that she did not make a note regarding Resident #149's concerns, "I just interpreted for the SW."</p> <p>When asked, in an interview on 09/26/13, if there were any indications in the record regarding Resident #149's complaints about his roommate or what the facility had done to resolve the concerns, Staff K said "Probably not, I am behind." Staff K elaborated, "He's (Resident #149) never come to me directly, I get reports from Staff G, he goes to her generally because of the language."</p> <p>Staff K then provided a Resident Grievance and</p>	F 166		11/5/13

RECEIVED

OCT 21 2013

DSHS/ADSARCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 166	<p>Continued From page 4</p> <p>Concern report dated 04/18/13 in which Resident #149 and Resident #156's wife had "complain about roommate (Resident #86) all night TV on (very loud), talking with family (by phone) midnight almost 2 hours. very noisy, can not sleep...".</p> <p>An email dated 04/26/13 from Staff L (third floor SW) to Staff K (second floor SW) identified, "I had a meeting with (Resident #86) in his room today. We talked especially about concerns of his watching TV and calling telephone loudly at late night. (Resident #86) said he used to turn off his TV at 9:00 p.m. and recently made a call... at 9:00 p.m. He denied the loudness of his TV sound and of his phone talking. He's suggested: 1/to use headphone if he watches TV late at night, especially after his roommates have gone to bed. 2/to make telephone calls at late hours in 2nd TV lounge. Resident #86 agreed with the suggestions...We spoke in his native language."</p> <p>Record review revealed that Resident #156 was subsequently moved to a different room on 06/14/13, "Family has been wanting a room change in the 2nd floor." There was no indication in the record why the family wanted a room change.</p> <p>In an interview on 09/26/13 at 1:00 p.m. (via interpreter), Resident #156's wife indicated she wanted a room change for her husband because "...a resident in the room (Resident #86) was turning on the fan and turning on the heat, and was very loud." When asked if the resident was speaking on the phone or to a visitor, she replied, "I don't know, I pulled the curtain, he was just very loud." This family member indicated she could not ask Resident #86 to change his behavior (quiet</p>	F 166		11/5/13
-------	--	-------	--	---------

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 166	<p>Continued From page 5</p> <p>down) because there was a language barrier. She also indicated she felt very lucky that another room had opened up and her husband could be transferred.</p> <p>When asked, on 09/26/13, if Resident #86's TV had the option of headphones, Staff K replied; "Yes" and "we can always get the wireless ones." However, Staff K then stated, "(Resident #86) declined to use headphone." There was no indication in either the resident's record or in the grievance system that Resident #86 was ever offered or declined the use of headphones.</p> <p>When asked in an interview on 09/26/13 how many times Resident #149 had voiced concerns regarding his roommate after the 04/18/13 grievance, Staff K indicated Resident #149 had made multiple complaints regarding Resident #86's behaviors. Staff K acknowledged there was no documentation of these complaints or any indication of what, if any, discussions were had regarding them. The only documentation was that of the 04/18/13 grievance completed and submitted by Resident #149. Staff K stated, "I think the last one (time Resident #149 voiced a concern) was a few weeks ago I think...". When asked the total number of times Resident #149 raised concerns, Staff K replied, "He's complained like two or three times." Staff K also stated, "The complaints Staff #149 made were both before and after (Resident #156's room change on [REDACTED] 13)."</p> <p>In an interview on 09/26/13 at 12:42 p.m. Staff K was asked to provide documentation of how facility staff worked to resolve concerns regarding Resident #86's continued negative impact on other residents, or considered that other</p>	F 166		11/5/13

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 166	<p>Continued From page 6</p> <p>roommates might have had the same concerns as Resident #s 149 and 156. No information was provided.</p> <p>RESIDENT #69 According to the initial 07/08/13 MDS, Resident #69 was admitted to the facility on [REDACTED]/13 with mild cognitive changes but exhibited no behavioral or mood issues. The resident's primary language was not English. The resident was placed in the same room as Resident #86.</p> <p>In an interview, via an interpreter, on 09/24/13 at 9:50 a.m., Resident #69 complained that one of his roommates, Resident #86, had visitors late at night that interfered with his sleep. Resident #69 stated Resident #86 was loud when visitors came. He further reported he was bothered by Resident #86's television and radio, which he often had on late at night at a loud volume.</p> <p>When asked if Resident #69 reported these concerns to staff, he stated no. He said he was not certain if the staff in the facility had the right to intervene. The resident then went on to explain that communicating with the staff was difficult because of the language barrier, and stated, "I don't speak English, how can I tell them?"</p> <p>On 09/26/13, during a follow up interview, Resident #69 reiterated that his sleep was frequently interrupted. He stated he was able to converse in his language with other residents in his room and he was aware that one of his roommates was also bothered by the noise Resident #86 made late at night.</p> <p>On 09/30/13 at 8:45 a.m., Staff K reported she was not aware of any concerns Resident #69 had</p>	F 166		11/5/13	

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 166	Continued From page 7 about the room or his roommates. Staff K stated she was not able to communicate with the resident directly and required an interpreter to facilitate communication. Staff K acknowledged that despite being aware of concerns expressed by Resident #s 149 and 156, she had never asked Resident #69 if he had similar concerns. Failure to address concerns related to a resident's behavior, and to facilitate resident's ability to voice those concerns, placed residents at risk to not have grievances addressed in a timely manner.	F 166		11/5/13	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to identify, thoroughly investigate and protect residents from other residents' acts of physical, verbal and psychological abuse involving Resident #s 120, 10, 179, 85, 38 & 22. The facility failed to ensure Resident #22 was free from witnessing ongoing abuse in her home. The facility failed to protect Resident #120 from ongoing fear of being hit by Resident #10 if he did not leave the area. The facility failed to recognize multiple incidents of resident to resident	F 226	F226 Develop/Implement abuse/neglect, etc policies Residents #120 and #22 were interviewed and a plan was established and documented to ensure that both residents are no longer fearful of other residents in their own home. Residents #120 and #22's care plans were updated to reflect the agreed upon plan and both deny being fearful of any other residents and exhibit no signs and/or symptoms of psychological or physical harm (cont)	11/5/13	

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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</p> <p>altercations involving Resident #179 as a form of potential abuse. In addition the facility failed to ensure that one (Staff W) of 12 employees reviewed was free of a disqualifying criminal conviction. These failures placed residents at risk for abuse being unrecognized and prevented the facility from immediately protecting residents.</p> <p>Findings include:</p> <p>The facility's undated Abuse and Neglect Prohibition and Reporting Policy and Procedure stated the facility would follow State and Federal guidelines to protect resident from mistreatment, neglect, and abuse. In addition, the procedure indicated conflicts between residents would be immediately investigated.</p> <p>The Department's Nursing Home Guidelines, dated February 2012, identified any action of hitting slapping or kicking could be classified as abusive even if there was no intent to cause harm. In addition, the guidelines indicate that Resident to Resident altercations may be considered abuse if the altercations involve the same resident(s) or may be considered neglect if the facility failed to protect residents from known threats.</p> <p>In an interview on 09/30/13 at 2:28 p.m. Staff B said "anytime there is a verbal, physical altercation of any sort" staff were to "separate" the residents and "provide safety". If it was a physical altercation, the facility was to notify the policy, call the Department and put interventions in place to ensure it did not happen again. Staff were also to monitor for psychological harm. "The main thing is safety and separation of the residents."</p>	F 226	<p>(cont) Residents #10, 179, 85 and 38 were re-assessed in terms of potential behavioral concerns and appropriate specific interventions were established and added to their care plans in collaboration with mental health services provider and interdisciplinary team. Staff GG, J, K were all in-serviced on how to identify potential and actual altercations and appropriate interventions (also specific to residents #10, 179, 85 and 38) to help prevent further altercations and to ensure that residents remain safe in an environment free from abuse and neglect. Additionally, these staff members were in-serviced on accurate and timely documentation of target behaviors.</p> <p>Staff W has been terminated. Staff X, Y, B and Z have been in-serviced on the facility protocol not to employ anyone with a disqualifying criminal conviction according to the Department of Social and Health Services' Secretary's List of Crimes and Negative Actions (cont)</p>	11/5/13

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 9</p> <p>RESIDENT #22 In an interpreter supported interview on 09/24/13 at 10:43 a.m., Resident # 22 indicated she had seen other residents in the facility being abused, stating, "There have been residents yelling at each other and striking at each other. All the time. When people were eating at meal time they fight, they want to fight over something... I do not pay attention; they fight, that's their business, I don't even understand what they are saying (because they speak another language)."</p> <p>In an interview on 09/25/13 at 9:53 a.m. via an interpreter, when asked how often this behavior was observed Resident #22 replied, "it always happens even if they sit together they fight, I don't remember the last time it happened."</p> <p>RESIDENT #120 According to the Minimum Data Set assessment (MDS) dated 09/16/13, Resident #120 was was cognitively intact with no memory issues and had care needs related to dialysis.</p> <p>In an interview on 09/24/13 at 1:21 p.m. when asked, "Has staff, a resident or anyone else here abused you?" Resident #120 said "Yes" and indicated he had been physically abused by Resident #10 in the facility. Resident #120 indicated, "there are times when (Resident #10) will scold or hit you."</p> <p>During an interview with the aide of an interpreter on 09/25/13, Resident #120 stated he had a fistula in his [REDACTED] through which he received dialysis three times per week. He further elaborated that on 08/25/13, Resident #10 got angry and hit his fistula site. Resident #120 stated</p>	F 226	(cont) All licensed staff has been inserviced on the facility's Abuse and Neglect Prohibition and Reporting Policy. Administrator and/or designee is responsible for compliance.	11/5/13
-------	--	-------	--	---------

RECEIVED

OCT 21 2013

DSHS/ADS/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 10</p> <p>his [redacted] hurt so much that he had to be taken to the hospital for an x-ray. According to Resident #120 whenever Resident #10 got angry she would yell, hit, or throw objects at other residents.</p> <p>On 09/26/13 at 11:25 a.m. Resident #120 stated he didn't feel the staff did enough to protect him. "They saw her hit me and they did nothing to help me". Resident #120 stated, "I know that when (Resident #10), comes in the room, I stay away from her or leave the area..."</p> <p>Resident #120 stated Staff K (Social Worker) instructed him to avoid being close to Resident #10 and when seated in the dining room for meals or activities to ensure that he positioned himself away from Resident #10. Resident #120 stated that Staff K also instructed him to ensure his pocket talker was kept in the on position in the event Resident #10 became upset and was getting too close to him. In addition, in a report dated 08/28/13, Staff J documented that Resident #120 had been educated to keep his pocket talker on at all times, as he "often turned the device off" and therefore he did not hear Resident #10 yelling as she got closer to him. The facility failed to consider that Resident #120 had the right to be safe from physical harm even if he chose not to wear the hearing device.</p> <p>According to the facility's Incident Log, Resident #10 had a history of assaulting other residents. For example, on 06/08/13 Resident #10 grabbed a resident by the shoulders and began to shake that resident. On 07/04/13 Resident #10 had a resident to resident altercation in which she became angry and dug her fingernails into another resident's arm. Despite facility staff's awareness of Resident #10's repeated physical</p>	F 226		11/5/13
-------	---	-------	--	---------

RECEIVED

OCT 21 2013

DSHS/ADS/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 11</p> <p>altercations with other residents, on 08/25/13, according to investigative documents, Resident #10 again became angry and threw her left shoe at Resident #120. Resident #10 proceeded to hit Resident #120 on his left arm causing him pain.</p> <p>Facility failure to protect Resident #120 from physical harm, and failure to implement interventions to protect him in the future placed Resident #120 at risk for psychological harm as well as future physical harm.</p> <p>RESIDENT #10 According to the 08/13/13 MDS, Resident #10 had [REDACTED] with [REDACTED] symptoms. She was assessed with a deficit in both memory and cognitive ability. Resident #10's plan of care, dated 02/07/13, indicated that when Resident #10 became upset, staff should ensure that the path going to her room, dining room, toilet, sink or hallway was clear as she tended to get combative if other residents blocked her path. An 06/08/13 temporary care plan instructed staff "not to place residents in front of the doorway of resident room."</p> <p>Similar findings were noted in review of the facility's Incident Investigations. On 05/26/13 Resident #s 21 and 12 were sitting at separate tables, participating in an activity, when Resident #21 reached over and pushed the song book of Resident #12. Resident #12 then hit Resident #21, who hit Resident #12 in response. On 08/11/13 Resident #12 wheeled down the hallway towards Resident #21 and asked her a question, to which Resident #21 responded by hitting Resident #12. The facility's identified plan to protect the residents was for Resident #12 to avoid Resident #21 and stay away from her.</p>	F 226		11/5/13
-------	---	-------	--	---------

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 12</p> <p>Failure to consider whether that was an intervention that was likely to work or whether there were additional interventions the facility could implement in addition to asking Resident #12 to be responsible for avoiding another resident in the facility placed the resident at risk for future physical altercations.</p> <p>RESIDENT #s 179 and 85 During lunch on 09/23/13 Resident #179 was observed to walk over to where Resident #85 was sitting and reached for food on the resident's tray. Resident #85 hit and yelled at Resident #179. Although staff were observed to intervene and remove Resident #179 from the altercation, staff failed to redirect Resident #179 prior to the altercation to protect the residents.</p> <p>In an interview on 09/25/13 at 10:00 a.m. with the assistance of an interpreter, Resident #85 commented that Resident #179 "collects objects, things, and is selfish."</p> <p>During observation of lunch on 09/25/13 at 12:12 p.m. while pacing in the dining room, Resident #179 was observed to walk over to Resident #85 and placed her hands on the back of Resident #85's chair. Resident #85 started yelling and screaming in response. A staff member intervened and directed Resident #179 to a table and served her a tray. At 12:29 p.m. Resident #179 again walked over to Resident #85 and touched her right shoulder, at which time Resident #85 yelled at Resident #179. Staff K intervened and Resident #179 left the room.</p> <p>In an interview on 09/26/2013 at 10:21 a.m. Staff GG said of Resident #85, "she is very territorial, no one can occupy that space (referring to a</p>	F 226		11/5/13
-------	---	-------	--	---------

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 13</p> <p>place at the dining room table), sometimes bullying." Staff GG indicated the resident had instances of biting and hurting the staff. When asked if she had ever hurt another resident, Staff GG replied, "No, because the staff will intervene." The facility failed to intervene before Resident #85 hit Resident #179 and failed to identify the act as potentially hurtful.</p> <p>The facility identified a Target Behavior of "Verbal Aggression" for Resident #85. Review of behavior monitoring flow sheets revealed staff documented the resident had no episodes of verbal aggression on day shift of either 09/23/13 or 09/25/13. In addition, there were no progress notes regarding any of the above incidents.</p> <p>Review of Resident #85's record revealed a 10/25/10 Alteration in Thought Process and Behavior care plan related to a moderate level of Alzheimer's exhibited by "...occasional angry outburst or negative comments towards other residents." Interventions listed included "If another resident near resident is restless or is pacing, lead the other resident away from the resident." Staff failed to implement the plan of care to prevent resident altercations and protect the residents from harm.</p> <p>RESIDENT #s 179 and 38 During lunch on 09/23/13 at 12:43 p.m. Resident #179 was observed to walk over to Resident #38 and say something. Resident #38 was observed to hit Resident #179 with a terry cloth clothing protector, yell at her and call her a "Bastard". Although staff were observed to intervene and remove Resident #179 from the altercation, staff failed to redirect Resident #179 prior to the altercation to protect the residents. In an interview</p>	F 226		11/5/13

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 14 on 10/01/13 at 8:31 a.m. Staff GG said "She calls me that (Bastard) too."</p> <p>Review of Resident #38's record reviewed no progress note since 09/17/13 and no entry regarding the incident in the dining room. Review of Resident #38's behavior monitoring sheets revealed staff were instructed to document the number of episodes of screaming/yelling and had documented the resident experienced none on any shift of 09/23/13. Staff failed to identify the altercation as potential abuse and failed to implement the facility Abuse Prohibition Policy.</p> <p>In an interview on 09/26/13 at 10:21 a.m. Staff GG was informed of the observed conflict between Resident #179 and #38 and said, "yes that's a resident to resident altercation" and should have been dealt with as such.</p> <p>Review of Resident #179's care plan revealed a 06/27 entry "Resident is Combative, angry, would go around and suddenly would be so upset, takes protective clothing of other residents... be so upset. Difficult to redirect. When upset she would be flushed and she would pace. She was observed to have physically abusive tendencies with staff would fight verbally with other residents with no obvious provocations". Interventions listed include monitor resident, redirect gently, when appearing to be agitated provide space but monitor whereabouts, check other resident for safety when resident agitated - intervene immediately and separate/move other residents away.</p> <p>A 08/04/13 incident investigation regarding a resident to resident altercation involving Resident #179 was reviewed. The facility identified</p>	F 226		10/5/13	

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 15</p> <p>Resident #179 "easily gets angry and then yells at staff and residents. She would be seen talking to resident and if the other residents don't respond, she yells at them and at times would gesture hitting them." "She goes around table to table and speak to the residents and when not spoken to, would take it as an insult and get upset with them." "She could be observed minding other's business like when other residents are eating would go close to them and point at their food and pull their clothes protectors." The analysis included "Resident, with her behaviors that she continuously manifests may be seen in the same incidents in the future. Goal is to promote safety to other residents by preventing injury from her outbursts and staff to be able to redirect her safely." The interventions planned included, "Supervise resident and monitor whereabouts... intervene immediately when seen that resident gets into other residents' business, redirect the resident and ensure safety to all residents."</p> <p>In an interview on 09/26/13 at 10:21 a.m. Staff GG explained Resident #179 "provokes, comes to other residents" and gave an example, "yesterday, Resident #56 was reading and she would push him, he say no and she got upset with him. With other residents too she gets in shouting matches with other residents."</p> <p>In an interview on 09/30/13 at 2:28 p.m. Staff B described Resident #179 as "a highly mobile individual who likes to yell at people, sometimes I'll go into the unit and she is yelling at people, accusing others of things that are not true. The staff are trying to keep other residents away from her, or redirect her." Staff B said "Resident safety is a priority" and indicated that staff know Resident #179's tendencies to "bother other</p>	F 226		11/5/13

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 16</p> <p>residents" and commented staff "should have intervened before the incidents, to prevent the altercations."</p> <p>In an interview on 10/01/13 at 8:31 a.m. Staff GG said after speaking with Staff B on 09/30/13 she completed an investigation and reported the altercations between Resident #s 179 and 85 and #s 179 and 38 to the Department's hotline as directed by State regulation and facility policy.</p> <p>In addition the facility failed to implement their procedures regarding the screening of new employees. Failure to ensure that one (Staff W) of 12 employees reviewed was free of a disqualifying criminal conviction placed residents at risk for abuse.</p> <p>Review of personnel records found the facility hired Staff W on 07/29/13 as an on-call unit clerk. Review of the Criminal Background Inquiry (BGI) completed in May of 2013 revealed Staff W had a criminal conviction in 2012 which excluded them from having unsupervised access to vulnerable adults for three years after the date of the conviction. Additional records obtained on 9/30/13 indicated Staff W last worked in the facility on 08/30/13.</p> <p>On 09/25/13 at 10:00 a.m., Staff H, said the floor nurses did not supervise the unit clerks, and indicated the Health Information Manager, Staff X did. Staff H reported Staff X's office was located on the third floor.</p> <p>On 09/26/13 at 12:30 p.m., Staff X reported they were on medical leave when Staff W was hired, however they were aware of the results of Staff W's BGI. Staff X indicated Staff Y was acting</p>	F 226		11/5/13	

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 17</p> <p>supervisor while Staff X had been gone. When asked what kind of duties the unit clerks completed, Staff X reported the unit clerks maintained records, filing, coordinated outside appointments and arranged transportation. When asked about unsupervised resident contact, Staff X stated unit clerks did respond to simple requests from residents.</p> <p>On 09/26/13 at 12:40 p.m., Staff Y said she was aware of the findings of the CBI but thought the issue had been resolved when Staff W was hired for "on call". She then explained Staff W covered the second floor while the second floor unit clerk was gone for a two week vacation in August, 2013. When asked if Staff W was provided any additional supervision while working, Staff Y stated "no".</p> <p>On 09/26/13 at 1:10 p.m., the Director of Nursing Services, Staff B was interviewed about the results of the BGI. When asked about the conviction, she stated she thought it excluded staff from providing direct care to residents. She reported Staff Z, a Human Resource Specialist, was involved in the decision to hire Staff W. Staff B then obtained a copy of the list of disqualifying convictions and the guidelines established by the Department and reported she was not aware the conviction excluded the staff member from "unsupervised access" to vulnerable adults.</p> <p>On 8/30/13 at 9:15 a.m., Staff Z stated Staff W should have not been hired and explained unforeseen staffing needs contributed to the "wrong" decision of hiring the staff.</p>	F 226		11/5/13
F 241	483.15(a) DIGNITY AND RESPECT OF	F 241		11/5/13

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 241 SS=E	<p>Continued From page 18 INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure residents received care which upheld their right to dignity. Sensitive resident care information was posted for residents including #s 190, 153, 18, 113, 91, 84, 127, 102, 117 & 144 in areas visible to residents and visitors. Additionally, facility staff did not enhance the dignified dining experience of Resident #22, who was seated at a non language speaking table, and failed to ensure residents received dining assistance in a timely and dignified manner. These failures had the potential to negatively impact the resident's quality of life and dining experience.</p> <p>Findings include:</p> <p>DINING RESIDENT #22 In an interview on 09/25/13 at 9:53 a.m., with the aide of an interpreter, Resident #22 indicated the people at her table during meals, "don't talk to each other." When asked why, the resident replied, "because of the language, I can only speak [REDACTED] the other languages I cannot communicate." Resident #22 stated she sat at a table where [REDACTED] and [REDACTED] were spoken.</p> <p>When asked if she would be interested in sitting</p>	F 241	<p>F241 Dignity and respect of individuality DINING</p> <p>Resident #22 was interviewed and per this resident's wishes, moved to a different dining table with other Cantonese speaking residents that she can easily communicate with. Licensed staff was in-serviced on the importance of a dignified dining experience; including ensuring seating arrangements are acceptable to each resident, and how to ensure that residents are receiving dining assistance in a timely and dignified manner. DNS and/or designee are responsible for compliance.</p> <p>Staff EE, DD, U, and V was in-serviced on the requirement to serve and assist residents in a timely and dignified manner, specifically to serve residents at one table at a time, to sit down and feed a resident in a respectful and dignified manner without minimal disruption as able. Resident #121, #8, #131 are consistently assisted at meal time with minimal disruption in addition to other residents in need of assistance at meal time (cont)</p>	11/5/13
---------------	--	-------	---	---------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 241	<p>Continued From page 19</p> <p>at a table during meals with other people who spoke [REDACTED] the resident stated, "Maybe it would be kinda good to communicate with the people at the table... I would understand what it is being said... they can chat but I don't want to talk." Failure to ensure residents were seated with residents with whom they could communicate detracted from a dignified dining experience.</p> <p>DELAYS IN DINING / ASSISTANCE</p> <p>Review of the dining schedule revealed that the third floor lunch was to begin at 12:15 p.m. On 09/23/13 at 12:39 p.m. in the third floor dining hall seven of 16 tables had not yet been served.</p> <p>At 12:44 p.m., family of Resident #89 stated "It can take a long time to get served... this is typical."</p> <p>Observation of the lunch meal in the 3rd floor main dining room on 09/23/13 revealed at 12:27 p.m. Resident #8's tray was on her table, however the resident was not present. A CNA stated the resident had been taken back to her room, but would return soon. Two other residents sat at the table without their meals. At 12:33 p.m., Resident #8's tray was removed from the table. Her tablemates remained without their meals. At 12:35 p.m. Resident #8 was brought back to the dining room by staff and her food was returned. Her tablemates were served their meals immediately after.</p> <p>At 12:49 p.m., the Dietary Manager stated residents at one table should be served at approximately the same time. He stated delays can happen if residents move tables but staff were aware of the need to ensure residents do</p>	F 241	(cont)The Dietary Manager and dietary staff has been in-serviced on the importance of timely delivery of meals according to posted meal times.	11/5/13
-------	---	-------	--	---------

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 241	<p>Continued From page 20</p> <p>not have to watch tablemates eat for more than a few minutes before they were served.</p> <p>At 12:38 p.m., Resident #121's meal was placed in front of her. The resident sat without assistance until 12:53 p.m. when Staff EE began to feed her. At 12:55 p.m. Staff EE left Resident #121. A minute later, at 12:56 p.m., Staff DD sat and fed Resident #121 one bite then left her table at 12:57 p.m. At 12:59 p.m. Staff EE returned and sat next to Resident #121, said her name, then left the table before feeding her, to obtain a glass of milk for a resident at another table. She then returned to Resident #121 and began to feed her. At 1:01 p.m. Staff EE moved her stool to the opposite side of Resident #121 and began to feed her tablemate. An unidentified staff member then drug a chair across the DR, making a loud disruptive noise as it scraped the floor, and began to feed Resident #121. At 1:03 p.m., the unidentified staff left Resident #121 and Staff U sat down. At 1:10 p.m., Staff U moved to the other side of Resident #121 and stood while she fed both Resident #121 and her tablemate. At 1:16 p.m. Staff U left and Staff EE returned to feed the resident one bite before she removed her from the dining room.</p> <p>In an interview on 09/23/13 at 1:09 p.m., Staff Q indicated staff should remain with a resident they are assisting.</p> <p>In an interview on 09/23/13 at 1:35 p.m., Staff U stated Resident #121 required staff assistance to eat and she was not able to feed herself. She stated staff assisted her as quickly as they were able.</p> <p>During the lunch meal on 09/25/13 similar</p>	F 241		11/5/13
-------	---	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 241	<p>Continued From page 21</p> <p>observations were made of multiple staff assisting a resident in a short period of time. For example, at 12:46 p.m. a visitor of another resident stood next to Resident #131 and fed her a bite. Staff V asked the visitor to stop and sat to feed the resident. At 12:49 p.m., Staff V left Resident #131 to serve other residents trays. An unidentified staff member then sat down to assist Resident #131, but left after a minute. At 12:50 p.m. a third staff member sat to help Resident #131.</p> <p>In the main dining room on 10/01/13 at 8:43 a.m., Resident #121's tray was observed in front of the resident. It was not covered and the time it had been served was unknown. The resident was not assisted with her meal until 8:51 a.m.</p> <p>Failure to serve and assist residents in a timely manner with minimal disruptions placed residents at risk to not feel valued and respected.</p> <p>POSTINGS</p> <p>RESIDENT #190 Observation of Resident #190's room, which was shared with three other residents, on 09/24/13 at 8:52 a.m. revealed seven signs posted that contained specific care instructions. The signs included a turn schedule, direction to "keep HOB (head of bed) at 30 degrees", "Nothing by mouth, except ice chips", "Provide oral care 2x a shift", "sling prior to transfer", "bilateral hearing aides" and a positioning diagram.</p> <p>In an interview on 09/30/13 at 2:40 p.m., Staff E, Resident Care Manager, stated the signs were in resident's rooms to ensure all staff who provided care were aware of that resident's needs. She</p>	F 241	<p>POSTINGS</p> <p>Posting and/or signage specific to residents' plan of care in residents #190, 153, 18, 113, 91, 84, 127, 102, 117, 144, 141, 128 rooms have been removed. Staff E, O and J and all other licensed staff (including licensed therapy staff) has been in-serviced on the importance of maintaining an environment free of visible signage specific to directing staff on residents' plan of care. DNS and/or designee are responsible for compliance.</p>	11/5/13
-------	--	-------	---	---------

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 241	<p>Continued From page 22</p> <p>stated it was facility practice and resident's were not necessarily asked prior to the signs being hung. She stated while there was a care directive posted in each resident's closet, the information posted on the walls contained more "immediate concerns". She stated she had not considered any privacy or dignity issues, as the people who enter the rooms all "belong here", meaning they have family or friends in the facility.</p> <p>A sign posted on the outside of the door in which Resident #128 resided, and visible to all who passed the room in the hallway read "Must have 2 staff members together at all times. Thank you."</p> <p>During initial rounds on the morning of 09/23/13, posting of personal resident information was observed in numerous rooms, in all of which four residents resided. For example, in Resident #153's room were specific instructions to staff regarding dialysis care including "No bp, blood draws on right arm", "dialysis days Tuesday, Thursday, Saturday", "Please do not turn resident lying on his right side", "per family request please no toileting, change in bed", "no meal tray when resident is alone" and "eat in dining room for each meal for safety". In addition a turning schedule was posted.</p> <p>Similar findings were noted in Resident #18's room which had posted dialysis information and Resident #s 18, 113, 141 and 91 who had turning schedules posted.</p> <p>In addition Resident #91's room contained multiple instructions to staff regarding mobility including "Fall prevention", "bed to lowest position", "No wheelchair at bedside", "non skid</p>	F 241		11/5/13
-------	---	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 241	Continued From page 23 socks on while in bed", "Do not hoyer lift", "no crossing of legs", "no bending more than 70 degrees" and "No twisting of leg inward". Similarly posted above Resident #84's bed was instruction to staff to "Float heels while in bed" and above Resident #127's bed and posted on the closet were directions for use of a body jacket, or thoracic lumbar sacral orthotic brace. Similar care directives were noted above the bed of Resident #102. Above Resident #117's bed were instructions to staff including "npo nothing by mouth", and "keep head of bed elevated at 30-40 degrees at all times". Similarly, self-feeding strategies were posted above Resident #144's bed. The facility failed to maintain an environment in which there were no signs posted that were viewable by others which did not enhance each resident's dignity.	F 241		11/5/13	
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 practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide medically-related social services for three (#s 154, 89 & 22) of three residents reviewed who	F 250		11/5/13	

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 24</p> <p>exhibited refusals. Failure to ensure staff identified reasons for continued refusals and considered alternatives to ensure resident's medical needs were met placed residents at risk for untreated medical conditions and impaired mobility status. Failure, through the assessment and care planning process, to identify and seek ways to support Resident #s 149 and 69's individual needs and concerns placed these residents at risk for decreased sleep and feelings of being disregarded.</p> <p>Findings include:</p> <p>Refer to CFR 483.10(f)(2), Facility resolve grievances, F-166</p> <p>RESIDENT #154 According to the 09/08/13 Minimum Data Set assessment (MDS), Resident #154 was assessed by staff to understand and be understood in communication and to have a BIMS score of 3, indicative of a memory deficit. According to the 03/28/13 and 06/18/13 MDS, the resident demonstrated no behaviors, but according to the 09/08/13 MDS, the resident demonstrated refusal of care on one to three of the past seven days and a new diagnosis of atrial fibrillation.</p> <p>In an interview on 09/23/13 at 12:56 p.m. Resident #154 stated, "I don't think I have any heart problems, there is a doctor that comes by he says I have a heart problem, I don't keel over, I don't think he's a real doctor but he told me to take the pill; I faked taking it and threw it out. Nobody ever told me why I need to take it, they gave me a pill to take..".</p>	F 250	<p>F250 Provision of medically related social services</p> <p>Residents #154, 89, and 22 have been assessed in terms of refusals. Resident #154 was educated on the importance of and rationale for consistently taking her cardiac medications, attending physician was notified and resident #154's care plan was updated. Resident #154 was also assisted with finding options which would meet her physical and emotional needs and specific interventions were implemented to better meet her treatment goals. Staff, including social services has been in-serviced on required documentation of refusals and proper notification of physician and responsible party. Staff was also in-serviced on alternatives should a resident continue to refuse medications when interventions and efforts to educate on risks and benefits have been provided. Resident #89 was reassessed by a dentist for the need for full dentures and nursing staff completed an assessment to identify the reason for resident's refusal to wear her upper dentures (cont)</p>	11/5/13
-------	---	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSARCS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 25</p> <p>Observation on 09/25/13 revealed the resident was independently ambulatory and often engaged with other residents and staff.</p> <p>Progress notes dated 08/26/13 indicated the resident had an EKG (cardiac test) and was diagnosed with "afib (atrial fibrillation, a cardiac condition which if not treated could result in stroke)". The resident was prescribed aspirin for "stroke prevention" and Toprol XL for "rate control" on 08/26/13.</p> <p>Review of Medication Administration Records revealed the resident refused these two medications on 08/29, 09/03, 04, 06, 07, 09, 10, 11, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24, and 25/13.</p> <p>According to a progress note dated 09/06/13, "(Resident #154) refused meds x 2 and took meds after 3 tries. The resident was noted to say, "I am okay, my heart is fine, I don't need any medicines like this. If I have a high blood pressure I will just die. I am already 90 yrs old."</p> <p>Care Conference notes dated 09/19/13 indicated the resident's diagnoses and medications included, "08/26/13 [redacted] for blood pressure and pulse management." The Care Area Assessment dated 09/12/13 indicated, "(Resident #154) is very alert to here and now. follows directions well. she refuses meds and other care by saying she does not need it. Proceed with Care Plan (CP)- Alteration in thought process and behavior." However, review of this CP revealed no indication that refusals of medications was an issue.</p> <p>In an interview on the morning of 09/26/13 the resident reiterated she didn't have any heart</p>	F 250	<p>(cont) Care plan was updated to reflect resident's wishes in terms of wearing dentures. Staff N and E, including social services has been in-serviced on required documentation of refusals and proper notification of physician and responsible party. Staff was also in-serviced on alternatives should a resident continue to refuse dentures when interventions and efforts to educate on risks and benefits have been provided. Resident #22 was assessed in terms of refusals of the restorative program and the reason for her refusals was identified. Resident #22 now participates in her restorative program per her own preference. Staff FF and all other restorative staff have been in-serviced on different approaches on identifying resident refusals of programs and potential interventions and notification of supervisor. DNS and/or designee are responsible for compliance (cont)</p>	11/5/13
-------	--	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 26 problem and didn't understand why they wanted her to take heart medication as she had never had heart problems before.</p> <p>There was no indication facility staff attempted to assist Resident #154 to find options which would most meet her physical and emotional needs or that social services provided interventions to assist the resident in meeting treatment goals or care alternatives. There was no evidence that social service interventions successfully addressed the residents needs by linking social supports with Resident #154's needs and individuality.</p> <p>Similar findings were identified for Resident #89 who was assessed to require upper and lower dentures but who was observed without the dentures throughout the survey. Record review revealed the resident's lower dentures were lost a month prior, and interviews with staff revealed the resident frequently refused to wear the upper dentures so they stopped being offered. There was no indication in the resident's record that she refused her dentures, nor that the facility had identified or assessed the reasons she might refuse them and attempt alternate interventions to ensure she received the care she was assessed to require.</p> <p>RESIDENT #22 According to the 08/08/13 MDS, Resident #22 was assessed by staff to understand and be understood in conversation and have a BIMS score of 15, which reflected the resident had no memory impairment and was cognitively intact.</p> <p>According to review of the resident's restorative flow sheets for September 2013, the resident had</p>	F 250	<p>(cont) Residents #149 and 69 have been interviewed and currently their individual need for sleep and preferences are met. Staff K has been in-serviced on timely response to resident complaints and appropriate implementation and follow-up of interventions. All staff has been in-serviced on the importance of honoring residents' preferences for a quiet home-like environment, customary routines, concerns and choices. Administrator and/or designee are responsible for compliance.</p> <p>11/5/13</p>

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 250	<p>Continued From page 27</p> <p>a restorative program which included upper extremity therapeutic exercises. Staff documented the resident participated in this program for 15 minutes on 9/04, 5, 10, 11, 14-18, 20, and 21/13, but refused on 09/01, 02, 03, 07, 22, 23, 24, 25, 26, 27, 28 and 29/13.</p> <p>An additional part of the program was, "ambulate with front wheel walker and contact guard assist ...". Staff documented the resident ambulated 20-23 feet on 11 days and refused nine days in September.</p> <p>Staff documented on the back of the restorative sheet that on 09/01/13, "the pt is refused exercise, she said she is tired." Staff documented the same for 09/02 and 06/13. On 09/07/13 "pt refused ex(ercise) program today" and on 09/08/13 "resident was in bed for most of the morning, I got her up and did ex(ercise) program with her but no ambulation she's weak today. it would have been her 3rd day no exercise if I did not reason with her." On 09/15/13 staff documented, "resident so sleepy today. I brought her down after lunch and she did some wall wts (weights) she did not want to do nustep, I did some ROM on LE but refused. she wanted to sleep"</p> <p>According to the restorative documents on 09/19, 22, 23, 24, 25, 26, 27, and 28 staff documented the resident refused to do therapy exercise, but didn't document why or attempt to determine why the resident was refusing.</p> <p>In an interview via an interpreter on 09/26/13 at 10:03 a.m. Resident #22 indicated she participated in a program, "a few days a week" and "does arm exercises on a machine". The</p>	F 250		11/5/13
-------	--	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 28</p> <p>resident indicated she didn't walk and staff didn't put a brace on her foot. The resident indicated she was not opposed to participating in the program, but liked to rest after breakfast.</p> <p>According to Staff FF (Restorative Aide), in an interview on 09/30/13 at 10:25 a.m., Resident #22 "works really hard" but had a decline after her stroke stating, "before she could walk 60 or 80 feet, but now declines to 20 or 30 feet." When asked why the resident was refusing, Staff FF indicated he didn't speak Resident #22's language but, "she told me, 'no good, no good'. She never say why no good no good." Staff FF indicated he reported to the Restorative Supervisor (Staff I) on 09/23/13 that Resident #22 "was not doing her program."</p> <p>In an interview on 09/30/13 Staff I stated, "if it was something we could do to change her mind, we would." When asked what the process was for resident refusal of therapy, Staff F stated, "Usually after one week we definitely try to see why she's not coming...".</p> <p>There was no indication facility staff attempted to determine the root cause of Resident #22's refusals or assisted Resident #22 to find options which would most meet her physical and emotional needs or that social services provided interventions to assist the resident in meeting treatment goals or care alternatives.</p> <p>RESIDENT #149 In an interview via an interpreter on 09/24/13 at 9:03 a.m., Resident #149 expressed frustration that he had reported, multiple times, concerns about a roommate's behavior, stating, "I have reported it many times; actually one time I was</p>	F 250		11/5/13
-------	--	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013	
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 29</p> <p>kind of frustrated." When asked if staff had addressed his concerns, Resident #149 replied, "No, they seldom really talk to us. It could be the language barrier." Additionally, the resident stated, "Sometimes the patients don't have control."</p> <p>In an interview on 09/26/13 at 10:12 a.m., Resident #149 stated that despite his voiced concerns, "the situation has not improved...". Resident #149 elaborated that another resident had requested and received a room change based on similar concerns, but, "...that doesn't solve the problem... it effects all three of us in here...".</p> <p>In an interview on 09/26/13 at 12:42 p.m., Staff K (Social Worker), confirmed Resident #149 had made multiple complaints about his roommate and that another resident had been transferred out of the room for similar concerns.</p> <p>Despite knowledge of ongoing roommate issues, the facility failed to identify and seek ways to support Resident #149's individual need for sleep and preferences for a quiet home-like environment after 10:00 p.m., customary routines, concerns and choices.</p> <p>RESIDENT #69 Review of Resident #69's record revealed he was admitted to the same room as Resident #s 149 and 89 on [REDACTED] 13 with multiple diagnoses. The resident's primary language was not English.</p> <p>On 09/24/13 at 9:50 a.m., Resident #69 complained that his roommate, Resident #89, had visitors late at night and it interfered with his sleep. Resident #69 also reported that Resident</p>	F 250		11/5/13

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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	Continued From page 30 #89 listened to the TV and radio loudly late at night. On 09/26/13 at 11:00 a.m., Resident #69 reiterated his concerns with Resident #89's behavior and reported his sleep was interrupted. On 09/30/13 at 1:45 p.m., Staff K said Resident #69 had not reported any concerns about other residents. She denied any awareness that Resident #69 complained about a loud roommate. Staff K admitted she had never discussed the issue with the resident despite an awareness regarding the complaints of the former resident and the current concerns expressed by Resident #149. The facility failed to provide social services to explore whether Resident #69 had issues with his roommate given their knowledge of ongoing concerns by others in the room. There was no consideration of each individual's need for sleep and preferences.	F 250		11/5/13	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information;	F 272	F272 Comprehensive Assessments Residents #89, 190, 116, 24, 154's MDSs were all modified to reflect accurate information. Staff D, G and K were in-serviced on the importance of accurate data entry and assessment. Staff J, K and licensed nursing staff were in-serviced on accurate documentation of target behaviors as observed and subsequent change or update of the care plan if indicated. DNS and/or designee is responsible for compliance.	11/5/13	

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 272	<p>Continued From page 31</p> <p>Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to accurately assess five (#s 89, 190, 116, 24 & 154) sampled residents of the 24 residents who were included in the Stage 2 review. Failure to accurately assess residents for dental status, weight loss, pressure ulcers, mental health status, behaviors, medication use and diagnoses placed these residents at risk for unidentified and/or unmet needs.</p>	F 272		11/5/13
-------	---	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 272	<p>Continued From page 32</p> <p>Findings include:</p> <p>RESIDENT #89 In an interview on 09/23/13 at 1:46 p.m., Resident #89's representative stated the resident had worn dentures due to being without teeth since prior to her admission to the facility several years earlier.</p> <p>An annual LTC Dental Screening, dated 03/08/12, noted the resident with "missing natural teeth. She used upper and lower dentures."</p> <p>Review of Minimum Data Set (MDS) assessments revealed on 03/19/13 she was assessed with no dental issues, however on the 06/16/13 and 09/09/13 MDS, she was identified with "no natural teeth / fragments (edentulous)".</p> <p>In an interview on 09/26/13 at 1:14 p.m., Staff D stated the 03/29/13 MDS "must have been a mistake" as it did not accurately identify the resident as edentulous. She stated the resident had no natural teeth "for a long time".</p> <p>In addition, the 01/27/13, 03/29/13, 06/16/13 and 09/09/13 MDS assessments all identified the resident with weight loss of 5% or more in the previous month or 10% in the previous six months. The 01/27/13 MDS identified the resident weighed 70 pounds and the 03/29, 06/16 and 09/09/13 MDS' all identified the resident weighed 68 pounds. These weights did not reflect a weight loss.</p> <p>In an interview on 09/26/13 at 1:16 p.m., Staff D stated she must have read the dietitian's forms wrong, as the resident had not had a weight loss over the past six months based on the weights</p>	F 272		11/5/13

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 272	<p>Continued From page 33 identified in each MDS. She acknowledged the assessments were inaccurate.</p> <p>RESIDENT #190 Review of Resident #190's weekly skin sheets revealed a Stage 2 pressure ulcer was identified by the facility on 08/18/13. The physician was notified and a treatment was ordered and administered until the pressure ulcer resolved. According to the 08/18/13 MDS, the resident did not have any unhealed pressure ulcers.</p> <p>In an interview on 09/26/13 at 1:02 p.m., Staff D stated she coded the pressure ulcer as "moisture associated skin damage". She acknowledged the resident's record identified the wound as a pressure ulcer and the MDS should have reflected that. She stated the skin sheet might not have been in the resident's record or she did not see it when she completed the MDS.</p> <p>Additionally, the 08/12/13 MDS identified the resident weighed 132 pounds. According to the 09/02/13 MDS, the resident weighed 110 pounds, however a weight loss of 5% in the last month was not identified.</p> <p>In an interview on 09/26/13 at 1:05 p.m., Staff D stated the 132 pounds was a data entry error and was not accurate.</p> <p>RESIDENT #116 Review of the resident's record revealed she admitted in 2010 with diagnoses including [REDACTED]</p> <p>The 09/30/10 Alteration in mood Care Plan included interventions for staff to "consult with [REDACTED] team". It was also noted the</p>	F 272		11/5/13

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 272	<p>Continued From page 34</p> <p>resident took medications "to manage her mood, insomnia and appetite. Monitor for side effects and target behaviors and document..."</p> <p>Review of the 02/21/12 Preadmission Screening and Resident Review (PASRR) indicated the resident had a mood disorder and a psychotic disorder and therefore required a Level II evaluation. A 03/06/12 Level II invalidation statement was present in the record indicating the resident was "Stable per social services".</p> <p>According to the 04/21/12 Annual MDS, the resident was assessed with a serious mental illness. The 03/15/13 Annual MDS, Section A1500, assessed the resident was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition.</p> <p>In an interview on 09/30/13 at 10:27 a.m. Staff K indicated the resident still had depression, which would be considered a mental illness, but because she had received a Level II invalidation statement, she had answered the MDS question as no rather than yes, and commented "I checked that wrong, in error."</p> <p>In an interview on 09/30/13 at 10:56 a.m. when asked how Resident #116's behaviors had been over the last couple of months, Staff J reviewed the behavior monitoring flow sheets and said "better."</p> <p>Review of Target Behavior monitoring revealed staff noted no episodes of the resident exhibiting "angry outburst/yelling" in the months of July and August 2013.</p>	F 272		11/5/13

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 272	<p>Continued From page 35</p> <p>According to the 08/26/13 MDS, staff noted no potential indicators of psychosis, no behavioral symptoms, no rejection of care and no wandering. However, the facility indicated on this MDS the residents's behavior was worse compared to the prior assessment. Review of the prior assessment, the 06/05/13 MDS, revealed the resident exhibited no behaviors during the prior observation period as well.</p> <p>The 08/28/13 Social Service Assessment Quarterly Review of Behavior issues indicated there were "No reports of paranoia from resident or staff. No complaints came in from other residents and other resident's family member regarding resident's foul/derogatory language this past quarter again, however she has episodes of this behavior a few times this past quarter, but not during the observation period. Resident has, generally, been very quiet, just going about her daily routine."</p> <p>In an interview on 09/30/13 at 10:33 a.m. Staff K said "She didn't exhibit it (behaviors) during the observation period, but from when I talked to the staff they were saying they were seeing it more often then before." When asked what behaviors staff reported, Staff K replied "Specifically her yelling. I asked one specific aid who speaks (her language)... I asked her if she was speaking foul language, and she said yes."</p> <p>The assessor failed to ensure the assessed change in behavior was based on behaviors exhibited during the observation periods of two MDS' as instructed.</p> <p>RESIDENT #24 Review of the resident's record revealed a</p>	F 272		11/5/13
-------	---	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 272	<p>Continued From page 36</p> <p>05/30/13 physician's order for the anti-depressant [REDACTED] to be given at bedtime, which was documented as administered daily from 07/01 through 07/31/13. According to the 07/29/13 MDS, the resident received no anti-depressant medications. In an interview on 09/30/13 at 9:55 a.m. Staff D said, "I must have missed that."</p> <p>RESIDENT #154 Similar findings were identified for Resident #154 whose 06/18/13 MDS indicated a diagnosis of [REDACTED] Disease, which was changed to [REDACTED] on the 09/08/13 MDS, without supporting documentation.</p> <p>In an interview on 09/30/13 at 11:08 a.m., when asked about the changes in diagnosis, Staff G indicated the 06/18/13 MDS was incorrect stating, "maybe I hit the wrong button."</p>	F 272		11/5/13
F 279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</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</p>	F 279		11/5/13

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 279	<p>Continued From page 37</p> <p>§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 observation, interview, and record review it was determined that the facility failed to develop and/or revise comprehensive care plans for seven (#s 122, 89, 151, 22, 85, 116, & 117) sampled residents of the 24 residents who were included in the Stage 2 review. Failure to establish care plans that accurately reflected assessed care needs and provided direction to staff on the residents' care related to device use, dental status, nutrition, vision, and behaviors placed residents at risk to receive less than adequate care.</p> <p>Findings include:</p> <p>RESIDENT #122 Resident #122 was admitted to the facility on [REDACTED] '13 after being treated for [REDACTED] fractures sustained during a fall.</p> <p>Review of Care Plan (CP) directives, dated 06/12/13 and "Nursing Kardex" (a document that communicates care plan directives to the nursing assistants) indicated the resident wore a lumbar corset (or a splint device) for the compression fractures in the lumbar region of the spine.</p> <p>On 09/30/13 at 1:45 p.m., Staff J, the Resident Care Manager, was asked about the use of the splint device. He stated the device was</p>	F 279	<p>F279 Develop Comprehensive Care Plans</p> <p>Residents #122, 89, 151, 22, 85, 116 and 117's care plans and care directives ("kardex") were all updated to reflect the correct assessed care needs. Staff E, GG, O, P and J, T and S were in-serviced the updated information pertaining to residents #122, 89, 151, 22, 85, 116 and 117 and on the importance of timely and complete assessment of a resident; including correctly updating a resident's care plan and nursing assistants' care directive ("kardex"). All licensed staff were in-serviced on required assessment and care planning of every resident. DNS and/or designee is responsible for compliance.</p>	11/5/13
-------	--	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 279	<p>Continued From page 38</p> <p>discontinued by physician's order on 07/22/13. Staff J stated the care plan and Kardex should have been updated when the splint was discontinued and acknowledged they had not been.</p> <p>RESIDENT #89 Review of the resident's record revealed a CP, updated June 2013, that identified the resident "has indwelling Foley cath for urinary retention". Interventions included "has indwelling Foley cath(eter), follow facility protocols for cath care." In addition, the Nursing Assistant Documentation Record (NADR) for August, 2013 included direction that the resident "Has indwelling Foley cath, follow facility protocols for cath care."</p> <p>In an interview on 09/26/13 at 10:09 a.m., Staff E stated the resident had not had a catheter "for several years". She stated the CP should have been updated to reflect the resident's current status. She also stated the NADR was a part of the care plan and it should be accurate as well.</p> <p>The August NADR indicated the resident was "On PSFP program". The Weight Loss CP, dated 05/03/13, identified the PSFP program was discontinued on 06/20/13. Staff E acknowledged the NADR should have been updated to reflect the change in the resident's dining program.</p> <p>An annual Dental Screening, dated 03/08/12, noted the resident with "missing natural teeth. She used upper and lower dentures."</p> <p>The 05/18/11 CP, updated June 2013, identified the resident required assistance with Activities of Daily Living (ADLs). Interventions included</p>	F 279		10/5/13	

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 279	<p>Continued From page 39</p> <p>"Hygiene and oral care: Hygiene with extensive 1 person assist, Encourage independence. Oral care in (morning and bedtime)." This CP did not identify that the resident had no teeth and wore upper and lower dentures.</p> <p>A 03/23/12 Temporary Care Plan identified "denture partial, upper and lower, full upper and lower". The care plan was not individualized to identify the type of dentures Resident #89 used.</p> <p>Additionally, a 08/15/13 progress note indicated the resident's lower denture was missing. In an interview on 09/30/13 at 11:13 a.m. Staff E acknowledged the care plan had not been updated to reflect the missing denture, nor was there specific, individualized direction to staff regarding the resident's oral care needs.</p> <p>RESIDENT #151 According to a 09/05/13 Annual Nutrition Assessment, Resident #151 received a regular diet. A nutrition review, dated 06/06/13, included a plan to add sweets to the resident's diet. On 07/18/13 the dietitian included a plan to add ice cream to the resident's lunch tray.</p> <p>The Nursing Kardex, dated 08/05/13, indicated the resident received a regular diet with no concentrated sweets.</p> <p>In an interview on 09/30/13 at 11:31 a.m., Staff E stated the resident did not receive a non concentrated sweets diet and the Kardex was inaccurate.</p> <p>Similar findings were identified for Resident #22, whose 08/08/13 MDS indicated the resident required the use of glasses for vision, but whose</p>	F 279		11/5/13
-------	--	-------	--	---------

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 279	<p>Continued From page 40</p> <p>Kardex did not reflect the resident required glasses. In an interview on 09/30/13, Staff J indicated the Kardex was inaccurate and should reflect the assessed need for glasses.</p> <p>RESIDENT #85 Review of the resident's record revealed the resident received the anti-depressant [REDACTED] daily since 2/12/09. In addition, the resident was restarted on the [REDACTED] on 04/20/13 for dementia with behavior disturbance, the dose of which was increased on 09/25/13 with the instructions to document signs and symptoms of psychosis, depression and anxiety not responsive to behavior management.</p> <p>The 09/10/13 MDS indicated the resident had mild depression. In addition the resident exhibited verbal behavioral symptoms directed towards others that included threatening and screaming or cursing at others on one to three days which significantly disrupted care or the living environment. The resident rejected care on one to three days, and the resident's overall behaviors were worse compared to prior assessment.</p> <p>An 11/28/12 Psychiatric Progress Note listed treatment recommendations including "If at any time during this nursing home stay, (Resident #85) develops acute onset suicidal/homicidal ideations, initiate every 15-minute checks for safety and remove any items in her immediate environment which could possibly be utilized to harm herself or others."</p> <p>A 10/25/10 Potential Alteration in Mood CP related to depression did not include the above psychiatric recommendations. In an interview on</p>	F 279		11/5/13
-------	--	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 279	<p>Continued From page 41</p> <p>10/01/13 at 9:13 a.m. Staff GG verified the recommendations were not care planned.</p> <p>A 09/09/13 Behavior Management at Psychotropic Medication Review Form listed issues of "shows outburst of anger more; becoming more territorial; fighting with new roommate and others." The recommendations listed included rule out UTI (Urinary Tract Infection).</p> <p>A 05/17/13 (Patient to Patient) Altercation CP did not include a goal. In addition the CP did not include the approach to conduct a urine analysis to rule out a UTI.</p> <p>In an interview on 10/01/13 at 9:13 a.m. Staff GG acknowledged te recommendations of the Psychotropic Medication Review were not included in the resident's plan of care.</p> <p>RESIDENT #116</p> <p>The 08/26/13 MDS indicated the resident had a diagnosis of [REDACTED] and received [REDACTED] medication daily. Review of POs revealed on 11/15/12 the [REDACTED] dose had been decreased to 50mg at bedtime from the prior dose of 75mg.</p> <p>The 04/24/12 episodes of insomnia CP listed the intervention of [REDACTED] 100mg at bedtime for insomnia since 08/17/10. On the back of the CP staff wrote "Care plan reviewed and updated" for dates of 03/19/13 and 06/05/13, but only the goal date was changed with the last date of 09/05/13.</p> <p>In an interview on 09/30/13 at 10:49 a.m. Staff J indicated CPs were reviewed and revised on a quarterly basis according to the MDS schedule.</p>	F 279		11/5/13
-------	--	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 279	<p>Continued From page 42</p> <p>Staff J confirmed the CP should have been reviewed and revised as scheduled to accurately reflect the resident's current status.</p> <p>RESIDENT #117 Resident #117 was admitted to the facility in 2011. According to the 04/29/13 annual MDS this resident had diagnoses which included a previous [REDACTED], [REDACTED], [REDACTED] (an acquired language disorder) and dysarthria (difficulty saying words).</p> <p>Record review revealed due to the usage of an anti-depressant, Resident #117 was being monitored for behaviors and mood. One intervention on the care plan was to "monitor mood and document target behaviors." One of the target behaviors monitored was to "Document # of negative statements (hopeless/helplessness)." Review of the August and September MAR (Medication Administration Record) revealed this resident did not have any episodes of this target behavior.</p> <p>On 09/25/13 at 11:00 a.m. Resident #117 was observed in an activity called "Sing along." Resident #117 shook a tambourine, but was not observed singing or talking.</p> <p>Review of the Nursing Kardex, updated 05/13, stated "no speech r/t (related to) CVA (stroke)."</p> <p>Interviews with staff revealed conflicting answers about communication with this resident. On 09/26/13 at 10:06 a.m. Staff P stated "He doesn't communicate with us but we talk to him... shakes his head and we can tell things by the look on his face." Staff P indicated that at one point previously this resident was verbal but stated "not now."</p>	F 279		11/5/13
-------	---	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 279	<p>Continued From page 43</p> <p>On 09/26/13 at 11:03 a.m. Staff T stated that the resident would shake his head to respond when they spoke to him.</p> <p>On 09/26/13 at 2:40 p.m. Staff S explained the family was relied on often since the resident was mostly non-verbal. When asked about the target behavior of negative statements Staff S stated that "it is up to the nurse to assess."</p> <p>On 09/26/13 at 1:23 p.m. Staff O stated Resident #117 did not talk but communicated with facial expressions. When asked about the intervention of monitoring the number of negative statements Staff O explained that the intent was to be interpreted as "more of negative gesturing than anything." When Staff O was informed of the varying opinions from staff as to what this meant Staff O stated "I can see why that's confusing."</p> <p>On 10/01/13 at 9:08 a.m. Staff O stated "Instead of saying verbal it should be about expressions instead. We should have termed it in a different word."</p> <p>The failure of the facility to have an appropriate care plan intervention put the resident at risk for inadequate monitoring and/or unmet needs.</p>	F 279		11/5/13
-------	--	-------	--	---------

F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p>	F 282		11/5/13
---------------	---	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 282	<p>Continued From page 44</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review it was determined that the facility failed to ensure care plan interventions were consistently implemented for four (#s 48, 122, 24 & 116) of the 24 residents who were included in the Stage 2 review. Failure to ensure interventions were consistently implemented placed residents at risk for health complications associated with dehydration, accidents and a decline in mobility, urinary status and pain.</p> <p>Findings include:</p> <p>RESIDENT #48 Resident #48 was admitted to the facility in 2009 with multiple medical conditions including [REDACTED]. Review of the Minimum Data Set (MDS) assessment dated 06/27/13 noted the resident experienced a decline in the ability to participate in activities of daily living.</p> <p>Review of the Care Plan (CP) revealed directives, dated 10/04/10, that the resident was at risk for dehydration. Interventions included to monitor the resident for symptoms of dehydration, encourage fluids as tolerated, provide beverages at each meal and directed staff to cue or assist the resident to drink all fluids.</p> <p>On 09/30/13 during observation of breakfast between 8:00 and 8:30 a.m., the resident remained in the dining room with a tray before her on the table. The tray contained a glass of juice and a glass of milk, however the lids remained on the two glasses throughout the meal. The resident also had a mug filled with a hot beverage.</p>	F 282	<p>F282 Services provided by qualified persons/per care plan</p> <p>Residents #48, 122, 24 and 116's care plans and care directives ("kardex") were all updated to reflect the correct assessed care needs. Staff JJ and all other licensed staff were in-serviced on accurate documentation and provision of food and fluid intake for resident #48 and all residents in general. Staff LL and KK were in-service on accurate provision of care according to a resident's care plan (also specific to resident #48). Resident #122 has been re-assessed in terms of an individualized "walk-to-dine" program and care plan has been updated to reflect changes. Staff KK was in-serviced on the requirement to follow this resident's and all other residents' care plans. Resident #24's bowel and bladder assessment has been updated and care plan has been updated to reflect any changes. Staff O has been in-serviced on the requirement of timely and complete quarterly assessment of resident #24 and all other residents. Resident #116's pain assessment has been completed and care plan has been updated to reflect any changes. Staff J has been in-serviced on the requirement of timely and complete quarterly assessment of resident #116. All licensed staff has been in-serviced on the requirement of timely and complete assessment of all residents. DNS and/or designee is responsible for compliance.</p>	11/5/13

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 282	<p>Continued From page 45</p> <p>At the time the staff removed the tray from the resident, the two beverages remained untouched with the lids in place, and the mug was noted to be half full. Although the resident was served 600 cubic centimeters (cc) of fluid with the meal, she only consumed 120cc from the mug. Staff in the dining room were not observed to cue or assist the resident with the beverages nor did they remove the lids from the juice or milk glass to facilitate the resident's consumption.</p> <p>Staff noted on the meal monitor the resident consumed 240 cc of fluids with the meal. During a follow up interview at 10:40 a.m., when asked how she determined how much fluid the resident consumed with the meal, Staff JJ stated she visualized the tray. The amount documented on the meal monitor did not match what the resident was observed to consume.</p> <p>During an additional observation of breakfast on 10/01/13 the resident was observed to sit for an extended period of time with her food before her but did not eat. Although on this occasion the lids had been removed from the glasses, the resident did not drink the beverages served during the meal. The resident did drink half a cup of the coffee offered with breakfast. Staff JJ, who was seated at the table with the resident, reported the resident was "confused" that morning and was not eating. The tray was removed and the milk and juice on the tray remained untouched.</p> <p>Failure to implement care plan interventions to encourage/cue and assist the resident with fluid intake placed the resident at risk for health complications associated with poor fluid intake such as dehydration. Additionally, not accurately</p>	F 282		10/5/13
-------	--	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 282	<p>Continued From page 46</p> <p>documenting the amount of fluid consumed left the facility without information to monitor and assess the resident's fluid intake.</p> <p>Further review of the CP revealed the CNA directives indicated the resident should not be left alone in the bathroom. On 09/30/13 at 8:28 a.m., a Licensed Nurse, Staff LL, assisted Resident #48 to transfer to the toilet. Staff then exited the room, leaving the resident alone in the bathroom. Within two minutes the resident turned the call light on. Staff LL and Staff KK responded to the call light and then exited the room, again leaving the resident alone in the bathroom. Within four minutes the call light was turned on again to alert the staff the resident needed help. Staff KK responded to the call light and transferred the resident back to her wheelchair.</p> <p>Staff failed to follow the care plan that directed staff to not leave the resident alone in the bathroom, which increased the risk of an accidental injury.</p> <p>RESIDENT #122 Resident #122 admitted to the facility on [REDACTED]/13 after being treated for [REDACTED] fractures sustained during a fall in a community setting. Record review revealed the resident participated in skilled therapy services until 07/07/13 when therapies were discontinued and the resident was referred to a restorative nursing program.</p> <p>The CP, dated 06/12/13, indicated the resident was to walk to and from the dining room with a walker and assistance from the staff for all meals. A therapy referral form, dated 06/25/13, noted the resident was to ambulate with care giver assistance and a walker "to/ from" the dining</p>	F 282	<p>RECEIVED OCT 21 2013 DSHS/ADSA/RCS</p>	10/5/13
-------	--	-------	---	---------

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 47 room for all meals.</p> <p>On 09/30 and 10/01/13 the resident was observed eating breakfast in the dining room. A wheelchair was observed next to her dining room chair. Staff were observed to propel the resident from the dining room after breakfast back to her room in the wheelchair. On 10/01/13 when asked about the walking program, Staff KK stated the resident had walked to the dining room and that she had taken the walker back to the resident's room and brought the wheelchair out. She was unable to explain why the resident was not assisted to walk back to her room as the care plan directed.</p> <p>The CP identified the goal of the intervention was to assist the resident with maintaining the ability to walk. Failure to implement the care plan intervention to walk with assistance to and from the dining room placed the resident at risk for a decline in this ability.</p> <p>RESIDENT #24 Resident #24 admitted to the facility on [REDACTED] 13. According to the 05/17/13 MDS, Resident #24 was always continent of urine and according to the 07/29/13 MDS the resident was occasionally incontinent of urine.</p> <p>Review of the Bowel and Bladder Assessment revealed the only assessment was dated 05/11/13 and did not include an assessment of the resident's identified decline in urinary status, according to the MDS.</p> <p>The resident's record contained instructions regarding the Quarterly Assessment that read "complete the bowel and bladder assessment" as</p>	F 282	<p style="text-align: center;">RECEIVED OCT 21 2013 DSMS/ADSARCS</p>	10/5/13
-------	---	-------	--	---------

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 282	Continued From page 48 well as others, with the criteria "please complete the above assessments if applicable to each resident." The August Treatment Administration Record (TAR) listed "Quarterly Assessment due: please complete... Bowel and Bladder Assessment and care plan review every 3 months (may, august, nov, feb)", which was highlighted to be completed on 08/03/13. Staff initialed the TAR, indicating the assessment was completed, but had not completed the assessment. In an interview on 09/25/13 at 9:23 a.m., Staff D said the quarterly assessments should be done as scheduled. Staff O said the Quarterly Assessments were scheduled on the TAR, which was part of the resident's plan of care. After review she stated the Bladder Assessment "should have been done in August." RESIDENT #116 Similar findings were noted for Resident #116 for whom the Quarterly Pain Assessment was not performed as planned on 08/18/13. According to the resident record the resident experienced a fall on 08/04/13 at 1:55 p.m. and had complaints of pain for which she received Tylenol over the next week. In an interview on 09/30/13 at 1:04 p.m. Staff J noted the pain assessment was not done as care planned.	F 282		11/5/13	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		11/5/13	

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 312	<p>Continued From page 49 and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of three dependent residents reviewed for Activities of Daily Living received necessary care. Failure to ensure Resident #89 received oral hygiene services placed her at risk for poor nutritional intake, inadequate hygiene and dissatisfaction with care.</p> <p>Findings include:</p> <p>RESIDENT #89 In an interview on 09/23/13 at 1:44 p.m., Resident #89's representative stated the resident's lower dentures were recently lost however the resident still had upper dentures that she typically wore. The representative stated she noticed at lunch on 09/23/13 Resident #89 did not have her upper dentures in place, but she did not know why. The representative further explained she had discussed replacing the lost dentures with the facility and they were assisting the resident to do so.</p> <p>The resident was observed on 09/25/13 at 10:57 a.m. in an activity at which she ate some applesauce. She was observed without her upper dentures, which were noted in her bedside drawer. At 12:19 p.m. Resident #89 was observed in the dining room, prior to lunch. She was not wearing her dentures and they were observed in the same location in her bedside drawer. At 10:36 a.m. on 09/26/13, the resident</p>	F 312	<p>F312 ADL Care Provided for dependent residents Resident #89 was reassessed by a dentist for the need for full dentures and nursing staff completed an assessment to identify the reason for resident's refusal to wear her upper dentures. Care plan and care directive ("kardex") was updated to reflect resident's wishes in terms of wearing dentures. Staff E, M, N were in-serviced on timely notification of physician and responsible party, assessment, intervention and documentation of resident's refusal to wear dentures. All licensed staff has been in-serviced on different approaches on identifying resident refusals of dentures and adaptive equipment and potential interventions and notification of supervisor, physician and responsible party. DNS and/or designee is responsible for compliance.</p> <p style="text-align: right;">RECEIVED OCT 21 2013 DSHS/ADSA/RCS</p>	10/5/13
-------	---	-------	---	---------

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 312	<p>Continued From page 50</p> <p>was again observed without her upper dentures in place. They were located in the denture cup in her bedside drawer.</p> <p>Review of the resident's record revealed her lower denture was determined to be missing on the afternoon of 08/15/13.</p> <p>Review of the resident's record revealed a care plan, updated June 2013, that identified the resident required assistance with ADLs. Interventions included "Hygiene and oral care: Hygiene with extensive 1 person assist... Oral care in (morning and bedtime)." Review of August and September 2013 Nursing Assistant Documentation Records revealed staff signed they provided the oral care the resident required daily, with no indication she had refused or did not receive care.</p> <p>The Nursing Kardex, located in the resident's closet and used by staff to determine what care the resident required, indicated "Oral Care: Daily Cleaning of teeth/dentures: Yes; Dentures/removable bridge: Yes". While there were boxes to indicate whether the resident had Upper, Lower, Partial, or Full dentures, none of the boxes were checked.</p> <p>Review of the resident's record revealed a dental Patient Report dated 08/22/13. It revealed the resident was seen for a dental exam and that she was "not cooperative." The dentist noted the resident was not wearing her upper denture during the exam and had lost her lower denture, but that she was reportedly having no problems without either denture.</p> <p>In an interview on 09/26/13 at 10:17 a.m., Staff E,</p>	F 312	<p style="text-align: center;">RECEIVED OCT 21 2013 DSHS/ADSA/RCS</p>	11/5/13
-------	--	-------	---	---------

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 312	<p>Continued From page 51</p> <p>Resident Care Manager, stated the resident's lower denture was lost and that she was on the dentist's list to have it replaced. She stated the resident was still wearing the upper denture. Staff E stated she was not aware the resident was observed the past several days without the upper denture in place and she was not sure why that would be the case. She reviewed the resident's chart and stated there were no progress notes or care plan entries that identified the resident was refusing the upper denture or that she should not be wearing it.</p> <p>In an interview on 09/26/13 at 10:45 a.m., Staff M, the CNA assigned to care for the resident, explained the resident lost her bottom denture and "didn't seem to want the top ones". He stated the resident would historically open her mouth when staff showed her the dentures, but in the past few weeks she "sort of stopped doing that" and since her diet was in a form that did not require she have teeth and it did not seem to impede her speech, staff stopped offering them to her. He stated he thought the dentures were "sort of hidden away" in her drawer. Staff M stated his understanding was that the resident no longer wore the upper dentures.</p> <p>In an interview on 09/26/13 at 10:52 a.m., Staff N, Licensed Nurse, stated the resident did not wear her upper denture because she "refused". She stated the resident threw it on the floor so staff stopped offering it. She stated while the resident varied from day to day as to whether she would be cooperative with care or not, staff no longer offered the denture as they felt she would not wear it. She stated she thought the resident's refusal to wear the denture was due to her dementia. Staff N also stated while the resident's</p>	F 312		11/5/13	

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 312	<p>Continued From page 52</p> <p>representative visited often, she had not spoken to her about the resident's failure to wear her denture.</p> <p>In an interview on 09/30/13 at 11:13 a.m. Staff E stated the resident had thrown the denture and that was likely why staff stopped assisting her to wear it. She acknowledged there was no indication in the resident's record staff stopped providing the resident the assistance with her upper denture she was assessed to require, nor had she been re-assessed once staff stopped providing the assistance required. Failure to provide the resident assistance with her denture placed her at risk for less than adequate nutrition and potential weight loss or dissatisfaction with her care.</p>	F 312		11/5/13
F 329 SS=E	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>Based on a comprehensive assessment of a 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</p>	F 329	<p>RECEIVED OCT 21 2013 DSHS/ADSARCS</p>	11/5/13

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 329	<p>Continued From page 53</p> <p>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 observation, interview and record review it was determined that the facility failed to ensure residents had adequate indications for use of, monitoring, or gradual dose reductions of medications for three (#s 87, 85 & 117) of five residents reviewed for unnecessary medications and one (#22) supplemental resident reviewed. These failures caused Resident #22 to experience adverse side effects, including increased sedation and placed residents at risk to receive unnecessary medications.</p> <p>Findings include:</p> <p>CFR 483.15(g)(1), F-250, Social Services</p> <p>RESIDENT #22 Resident #22 was admitted to the facility on [REDACTED]/13 with care needs related to [REDACTED] and [REDACTED]. According to the 03/06/13, 05/20/13, and 08/08/13 Minimum Data Set assessments (MDS) the resident had no psychiatric or mood disorders and took no anti-anxiety medications. According to the resident's original Preadmission Screening (a screen to determine mental health needs) dated 03/04/13, Resident #22 had no mental illness.</p>	F 329	<p>F329 Drug regimen is free from unnecessary drugs</p> <p>Residents #87, 85, 117 and 22 have been re-evaluated for the use of unnecessary drugs. Resident #22's anti-anxiety medication has been discontinued and she is participating in her restorative program. Restorative staff has been in-serviced on timely reporting and documentation of residents' refusal to participate in their restorative programs to supervisor. Resident #87, #85 and #117 have been evaluated for GDR and physician's orders are followed. Staff J, O, P, E, GG, L, K, T and all licensed staff were in-serviced on federal regulation for gradual dose reduction (GDR) in long-term care and on the importance of identifying, monitoring and documentation of potential adverse reactions to psychotropic medications in addition to timely notification of attending physician and responsible party. DNS and/or designee is responsible for compliance.</p>	11/5/13

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 329	<p>Continued From page 54</p> <p>According to the 08/08/13 MDS, Resident #22 was assessed by staff to understand and be understood in conversation, had no memory impairment and was cognitively intact.</p> <p>According to progress notes dated 08/08/13 staff, "talked to (family member who lived out of state) and recommended giving resident [REDACTED] (an [REDACTED] medication with side effects including drowsiness, sedation, dizziness) 0.5 (milligrams at noon) and [REDACTED] (also with side effects of drowsiness) for Dizziness. (Advice physician) for order." The physician subsequently wrote an order for "[REDACTED] 0.125 mg... for [REDACTED] and "[REDACTED] 25 mg (twice a day)..."</p> <p>Further record review revealed no indication Resident #22 ever experienced anxiety and no Target Behaviors were identified for this resident which might establish the resident required this medication.</p> <p>In an interview on 09/26/13 at 9:30 a.m., Staff J (Resident Care Manager-RCM) indicated as part of the process of starting residents on psychotropic medications, "...we check to see if the psychotropic medication is appropriate, they have to have symptoms or signs that they are depressed or something, then if sometimes depending on the situation we need to refer them to our mental health team, we want to make sure the behavior is identified, for example sad facial expression we need to monitor for that behavior." Staff J elaborated that for residents already admitted who were started on a psychotropic medication, the interdisciplinary team would ensure behaviors were identified and the resident was monitored.</p>	F 329		11/5/13	

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 329	<p>Continued From page 55</p> <p>When asked if Resident #22 had an [REDACTED] disorder which would require the use of [REDACTED] medication, Staff J replied, "I don't think she does." When informed the resident received [REDACTED]. Staff J queried, "Is it a routine [REDACTED]? We (Interdisciplinary team) never talked about her..."</p> <p>In an interview on 09/26/13 at 10:27 a.m., Staff J, after reviewing the resident's record, indicated there was no clinical justification for Resident #22 to receive an [REDACTED] medication. Failure to ensure adequate indication for use of [REDACTED] constituted the use of an unnecessary drug.</p> <p>Additionally, facility staff failed to identify Resident #22 refused restorative therapy multiple times in September due to sedation (a side effect of [REDACTED]). On 09/01,02, and 03/13 staff documented the resident refused services because she was, "tired." On 09/15/13 staff documented, "Resident so sleepy today...refused she wanted to sleep." Failure to monitor for side effects of medications placed the resident at risk for falls and deconditioning due to decreased therapy participation.</p> <p>RESIDENT #87 Review of physician's orders revealed Resident #87 received the [REDACTED] [REDACTED]. It was initiated 10/28/12 at a dose of 25 milligrams (mg) twice a day for [REDACTED] with [REDACTED]. On 03/13/13, the dose was decreased to 12.5mg in the morning and 25mg at night.</p> <p>Review of the Behavior Management Psychotropic Medication Review Form (BMPMRF), dated 04/23/13, indicated "(Psychiatrist) in to see on 03/13/13 with</p>	F 329	<p style="text-align: right;">RECEIVED OCT 21 2013 DSHS/ADSA/RCS</p>	11/5/13
-------	---	-------	--	---------

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013	
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 329	<p>Continued From page 56</p> <p>recommendation to decrease Seroquel... Mood stable, appetite improving... Have (psychiatrist) re-assess in June for another GDR (gradual dose reduction)." The BMPMRF, dated 07/18/13, noted the resident "... with stable mood et effect. No adverse effect of GDR of [REDACTED] Will request GDR of hs (night) dose."</p> <p>A 06/17/13 nursing progress note indicated the "[REDACTED] was decreased in March without adverse reaction or changes in mood intrusion."</p> <p>Review of the physician's progress note, dated 08/01/13, identified the resident was "stable. She joins activities. Reads bible." He noted her agitation was "relatively stable".</p> <p>Behavior monitors for August and July, 2013 indicated the resident had no episodes of sad, worried facial expression; refusal of care; suicidal ideation; paranoia/ hallucinations; anxiety or worriedness. She was noted to call out on three occasions in July and none in August.</p> <p>In an interview on 09/30/13 at 2:09 p.m., Staff E, Resident Care Manager, stated she spoke to the psychiatrist regarding a dose reduction for Resident #89 and she had been seen recently. She was unable to locate any notes that reflected the discussion, nor were there any notes from the psychiatrist regarding a visit since March, 2013. When asked what the rationale was for continuing the [REDACTED] [REDACTED] Staff E stated the resident exhibited some attention seeking behaviors in August. She reviewed the chart and acknowledged no behaviors had been recorded by staff. She also acknowledged attention seeking was not a behavior monitored, nor was it the rationale for why the [REDACTED] was</p>	F 329	<p>RECEIVED OCT 21 2013 DSHS/ADSA/RCS</p>	11/5/13

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 329	<p>Continued From page 57</p> <p>administered. Staff E stated the resident exhibited some [REDACTED], but it was "her baseline" so staff typically did not record it on the behavior monitors.</p> <p>On 10/01/13 at 8:34 a.m., Staff E stated she spoke to the psychiatrist and determined the resident had not been seen since March, 2013. She provided a physician's note that indicated he "reviewed" medications on 06/21/13, although he did not specifically mention anything about the Seroquel or a consideration of dose reduction.</p> <p>In an interview on 10/01/13 at 10:18 a.m., Staff E provided a fax that was sent to the resident's physician on 07/08/13 requesting a consideration of a GDR of the Seroquel. No response was noted and Staff E stated there was no indication the physician responded nor was there follow-up by the facility to ensure the physician received and reviewed the request.</p> <p>Failure to provide an on-going rationale for the use of an anti-psychotic medication and to institute GDRs when identified as appropriate placed this resident at risk to receive an unnecessary medication.</p> <p>In addition, review of Resident #89's record revealed a 06/16/10 physician order (PO) for [REDACTED] 300mg at bedtime for GERD. A 06/19/12 Pharmacy recommendation indicated "the manufacturer recommends giving 150 mg once a day if the creatinine clearance is < 50ml/min. This resident's creatinine clearance is 42ml/min Please consider reducing the dose." The form was noted as faxed to the physician on 06/26/12, however there was no indication of a response, nor was the dose changed.</p>	F 329		11/5/13	

RECEIVED
OCT 27 2013
DSHS/ADS/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 329	<p>Continued From page 58</p> <p>In an interview on 09/30/13 at 10:30 a.m., Staff E stated the resident sometimes complained of stomach problems and that was the reason for the medication. She was unable to locate any indication the physician had considered the pharmacy recommendation or had provided any rationale for the continued use at the dose beyond the manufacturer's recommendation. Failure to ensure rationale for the ongoing use of this medication placed the resident at risk to receive an unnecessary medication.</p> <p>RESIDENT #85 Review of physician's orders revealed Resident #85 received the [REDACTED] sertraline [REDACTED] 50 mg daily for [REDACTED] since [REDACTED]/09.</p> <p>The 09/09/13 BMPMRF indicated the resident exhibited "no expressions of sadness, verbally and through her facial expression." The BMPMRF did not consider a GDR or dose change for the Zoloft.</p> <p>The 09/10/13 MDS staff assessment of resident mood (PHQ-9) listed a total severity score indicating minimal depression which was attributed to poor appetite half or more of the days. Similarly on the 07/27/12 and 01/08/13 MDS the resident was assessed with minimal depression and on the 10/13/12 MDS the resident exhibited no indicators of depression.</p> <p>The facility identified target behavior for continued use of the sertraline was "sad fretful expression." Review of the monitoring sheets revealed the resident did not exhibit the target behavior in July 2013, exhibited the behavior once on the evening shift of 08/28/13, and not at all September 1-25,</p>	F 329		11/5/13
-------	---	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 329	<p>Continued From page 59 2013.</p> <p>In an interview on 09/30/13 at 9:02 a.m. Staff K provided a 06/20/12 Psychiatric Progress Note in which the physician documented "Recommend no changes in [REDACTED] at lowest effective dose." Staff K said "We took it as referring to both the [REDACTED] and the [REDACTED]" but was unable to say why. Documentation of a failed GDR or other evidence supporting the continuation of the [REDACTED] at a "lowest effective dose" was requested, but none was provided.</p> <p>RESIDENT #117 Resident #117 was admitted to the facility [REDACTED] 11. The 04/28/13 annual MDS revealed the resident needed care and services related to [REDACTED] and [REDACTED]. The Care Area Assessment for psychotropics indicated the resident had no behavior issues at that time.</p> <p>Record review of the Medication Administration Record (MAR) revealed Resident #117 received [REDACTED] 25 mg for depression and [REDACTED] 0.375 mg for [REDACTED].</p> <p>After admission to the facility, on [REDACTED] 11 Resident #117 started taking [REDACTED] 125 mg and [REDACTED] 0.25 mg. The 02/13/12 BMPMRF indicated the [REDACTED] was increased to 0.5 mg on 01/12/12. No reasoning was listed for the increase on this review, however, the 03/12/12 BMPMRF indicated the increase had taken place "due to agitation/aggressive behaviors."</p> <p>The 06/11/12 BMPMRF indicated on 08/05/12 the [REDACTED] was decreased to 0.375 mg. On 09/26/13 at 1:23 pm. Staff O stated that was a</p>	F 329		11/5/13	

RECEIVED
OCT 21 2013
DSHS/ADS/IRCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 329	<p>Continued From page 60</p> <p>typo and the date for reduction of the [REDACTED] was actually 03/15/12. The 06/11/12 review read "Behavioral issues stable."</p> <p>The next BMPMRF, dated 11/12, revealed the doses remained the same: [REDACTED] at 0.375mg and [REDACTED] 25mg. This review read "Pt. (patient) behavior improved."</p> <p>The BMPMRF, dated 12/12/12, revealed the doses of both the [REDACTED] and [REDACTED] remained the same. Noted under the [REDACTED] was "Lowest effective dose." The review indicated continued stable mood and behavior. There was no evidence of a failed GDR attempt nor any indication of why staff now considered the Risperdal to be at the lowest effect dose.</p> <p>The 07/08/13 BMPMRF indicated the medication doses remained the same, despite the continued lack of behavior and mood issues. The review also indicated again that the Risperdal was at the "lowest effective dose" without evidence of a failed GDR.</p> <p>On 09/26/13 at 10:06 a.m. Staff P indicated Resident #117 was not exhibiting any behaviors and stated "Lately he's been fine."</p> <p>On 09/26/13 at 11:03 a.m. Staff T stated "I haven't noticed any behaviors lately."</p> <p>On 09/26/13 at 1:23 p.m. Staff O was asked how it was determined Resident #117 was on the "lowest effective dose" of Risperdal. Staff O stated "His behaviors were better... if there are no behaviors we don't have to do a GDR quarterly." Staff O referenced physician notes which declared the Risperdal was at the lowest effective</p>	F 329		11/5/13

RECEIVED
OCT 27 2013
DSHS/ADS/ROS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 329	Continued From page 61 dose, however, there was still no evidence of a failed GDR. When asked about the time elapsed between reviews Staff O acknowledged they were not done quarterly as planned. On 09/30/13 at 1:40 p.m. Staff L was asked about the [REDACTED] GDR for Resident #117, noting one had not been done since 03/15/12. Staff L stated "We need to consider... when we can make that lower reduction we need to do that." Staff L added the interdisciplinary team convened once a month to do reviews and stated anti-psychotics should be looked at every three months (quarterly) and anti-depressants every six months to consider whether residents continued to require them.	F 329		11/5/13
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425		11/5/13

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 425	Continued From page 62 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure medications were available and/or administered according to pharmacy protocol for three (#s 11, 22 & 144) of eleven residents reviewed during medication pass. Failure to ensure Intramuscular medications were administered according to policy, site rotation documented and safety of medication administration was assessed placed Resident #11 at risk for altered medication absorption, tissue damage and choking. Failure to ensure medications were available placed Resident #22 at risk for eye discomfort. Failure to clarify and/or follow Physician's Orders placed Resident #144 at risk for medication errors. Findings include: RESIDENT #11 Observation of medication pass on 09/25/13 at 8:55 a.m. revealed Staff H prepare and administer medications to Resident #11, including seven oral medications (cardiac, [REDACTED] medications to treat [REDACTED] and supplements) and an Intramuscular (IM) injection of an antibiotic. Staff H was observed to administer the IM injection into the resident's right buttock, without aspirating prior to depressing the plunger. When asked if it was her practice to administer IM injections in this manner, Staff H replied, "I don't	F 425	F425 Pharmaceutical services – accurate procedures, RPH Resident #11 was assessed and determined to be able to receive medications in crushed form as needed per physician's orders. Resident #11 had no adverse side effects from the incorrect administration of an IM injection. Staff H and all licensed staff have been in-serviced on the proper administration and documentation of IM injections according to facility policy. Staff H and all licensed staff were in-serviced on on-going assessment of resident changes and the potential need for an alternate form of medications, timely notifications of physician and documentation. Resident #22 is receiving eye drops per physician's orders. Licensed staff was in-serviced on proper procedures to assure accurate acquiring and receiving of drugs and biologicals as well as required documentation. Resident #144's Sinemet order was clarified with the attending physician. Staff O and all licensed staff were in-serviced on timely notification of physician upon resident readmission to facility in addition medication reconciliation. DNS and/or designee is responsible for compliance.	11/5/13

RECEIVED

OCT 21 2013

DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 425	<p>Continued From page 63</p> <p>aspirate, in school they said to aspirate, here they say no."</p> <p>According to the facility policy on IM injections, facility staff were instructed to "pull back on plunger to see if needle is in a blood vessel." Staff were also directed, according to this pharmacy policy to "document the injection on the MAR (Medication Administration Record) along with site used." Record review revealed staff did not document the injection sites, detracting from their ability to rotate sites.</p> <p>Observation of the oral medication administration revealed Staff H give Resident #11 one to two pills at a time via a spoon. The resident was offered and took sips of fluid in between, but was observed to have difficulty taking the medication. After taking all the oral medications the resident put a napkin to her mouth and spit out all medications except the liquid medication which was swallowed. According to Staff H at that time, "sometimes yes sometimes no (having difficulty taking her medications)... she (usually) gets them down, the husband says he sometimes see some pills in there (resident's mouth)... I heard yesterday the evening shift crushed them (oral medications)."</p> <p>According to the Pharmacy policy on preparation guidelines, "If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed...". This policy further directed staff that, "the need for crushing medication is indicated on the resident's orders and the MAR so that all personnel administering medications are aware of this need and the consultant pharmacist can advise on safety issues and alternatives, if</p>	F 425		11/5/13	

RECEIVED
OCT 21 2013
DSHS/ADSARCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 425	<p>Continued From page 64 appropriate during medication reviews."</p> <p>Review of MAR revealed the resident did not receive her morning medications on 09/07/13 "not given... refuse.. too drowsy." Similar entries were made on 09/19/13 and 09/20/13. While staff documented the resident also did not receive medications on the morning of 09/25/13, there was no record that staff notified the primary physician the resident didn't receive her medications. There was no documentation in the record to support staff crushed medications on 09/24/13 nor was there any consideration the resident had a change and now required medications to be crushed.</p> <p>In an interview on 09/26/13 at 2:29 p.m., Staff H stated Resident #11 took the medications that morning, "I crushed them and she took them." In an interview at that time Staff B (Director of Nursing) explained directions to crush medications were on a nursing form and that nurses have to assess if the resident is having difficulties to determine if the medications need to be crushed. Review of this nursing form revealed Resident #11 was to receive medications whole. Staff B further indicated she would want her staff to assess the residents needs and consistently administer the medication in a form that best suited the resident, rather than different shifts attempting to administer the medications in a different form.</p> <p>There was no progress note that indicated the physician was notified the resident didn't receive the morning medications as ordered on 09/25/13. There was no indication facility staff reattempted administration after identifying the resident was having difficulty swallowing the pills whole.</p>	F 425		11/5/13
-------	---	-------	--	---------

RECEIVED
OCT 21 2013
DSHS/ADSARCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 425	<p>Continued From page 65</p> <p>According to Staff B, interviewed on 09/26/13, "I would say if (the resident) missed it (medication) here or there the doctor should be notified so we can adjust if needed."</p> <p>RESIDENT #22 Record review revealed facility staff failed to procure the necessary medications to administer to the resident. According to MAR, on 09/23/13 and 09/24/13 staff documented, "Artificial tears 0.5% oph(almic) drops not available not given." Failure to ensure pharmaceutical services (including procedures that assure the accurate acquiring and receiving of all drugs and biologicals) resulted in Resident #22 not receiving intended medications.</p> <p>RESIDENT #144 During medication pass observation on 09/24/13 at 12:47 p.m. Staff H was observed to prepare and administer medications to Resident #144, including one tablet of [REDACTED] 25-100. Review of the resident's record revealed a 11/21/12 physician's order for [REDACTED] 25-100 mg three times a day, and a Medical Center after visit instructions dated 09/11/13 which instructed staff to administer two tablets of Sinemet three times a day.</p> <p>In an interview at 1:11 p.m. Staff O said the resident had an emergency room visit on 09/11/13 and upon the resident's return to the facility nursing staff should have reviewed the after visit instructions, called the primary doctor and written an order. Review of the progress notes revealed a 09/12/13 note indicating the resident had returned to the facility, but did not include a note indicating the physician had been</p>	F 425	<p style="text-align: center;">RECEIVED OCT 21 2013 DSHS/ADSARCS</p>	11/5/13
-------	---	-------	--	---------

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 425	Continued From page 66 contacted for a clarification regarding the Sinemet dosage.	F 425		11/5/13
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431	<p>F431 drug records, label/store drugs & biologicals</p> <p>Residents #95, 189, 161, 177, 29, 13, 117, 186's expired and/or medications were removed and destroyed per facility policy. Residents #13, 189, 177 and 186 have been discharged from the facility. Staff CC, G, P, R and all licensed staff have been in-serviced on proper dating, labeling and storage of medications/ supplies in the medication storage room/ refrigerator/medication carts as well as timely removal and destruction of discontinued and expired drugs per facility policy. DNS and/or designee is responsible for compliance</p>	11/5/13

RECEIVED
OCT 21 2013
DSHS/ADSARCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 431	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure medications were dated and discarded according to facility policy and pharmacy standards. Failure to date and discard medications as indicated on two of two floors, three of six medication carts, one of two medication rooms and one overflow cabinet placed residents at risk to receive medications that were expired and placed residents at risk for accidental ingestion of medication for which they were not intended. Findings include: In an interview on 09/26/13 at 1:59 p.m., Staff B (Director of Nursing) stated, "we date med(ications) when we open them" and indicated facility staff were expected to follow the guidelines for expirations posted at the nurse's station. Staff B indicated expired medications should be returned to the pharmacy or destroyed in a timely manner. Staff B stated, "...we would like them to give it back to pharmacy at the end of the day; but it could be the next shift. I just don't want meds piling up in the med room... IV (Intravenous) medications like oral medications destroy as soon as we can...". SECOND FLOOR WEST CART Observations during initial rounds on 09/23/13 at 9:05 a.m. revealed the following: Antibiotic eye medications for Resident #95 which were open but not dated; a box of laxative suppositories with an expiration date of 09/12; and medication for	F 431		11/5/13	

RECEIVED
OCT 21 2013
DSHS/ADS/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 431	<p>Continued From page 68 Resident #189, who was [REDACTED] from the facility.</p> <p>SECOND FLOOR CART III Observations during initial rounds on the morning of 09/23/13 revealed the following: Steroidal eye drops for Resident #161 which were open but not dated. According to the pharmacy policy posted at the nurse's station, "other ophthalmic" medications expire after 28 days. This policy directed staff that "The following items must be dated and initialed when opened. These items should not be used after the recommended expiration dates listed below or the manufacturers expiration date on the container."</p> <p>SECOND FLOOR MEDICATION ROOM Observations during initial rounds on 09/23/13 at 9:20 a.m. revealed the following: liquid oral antibiotics which were open and not dated; six bags of IV antibiotics for Resident #177 which expired on 08/07/13; and 10 bags of IV antibiotics which expired on 08/08/13 for a resident Staff G stated discharged from the facility on 07/25/13.</p> <p>SECOND FLOOR 2 SOUTH MEDICATION STATION Observation of the over the counter medication cabinet during initial rounds on 09/23/13 at 9:30 a.m. revealed the following expired, unopened over the counter medications: Rena vit expired on 04/11; Anti diarrheal expired on 07/12; Ferrous glucante expired on 07/13; Buffered aspirin expired on 2/13; Vitamin b complex expired on 07/13; Liquid pain reliever expired on 10/12; and Cough syrup expired on 12/12. Staff CC verified all of the medications listed above had expired on the dates listed. Staff CC stated, "usually medications are thrown out when they expire."</p>	F 431		9/5/13
-------	---	-------	--	--------

RECEIVED
OCT 21 2013
DSHS/ADSA/RCS

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2013
NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY 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 431	<p>Continued From page 69</p> <p>THIRD FLOOR TEAM ONE MEDICATION CART On 09/23/13 at 9:10 a.m. Lantus Insulin was found to have expired 09/20/13 for Resident #s 29, 13 and 117. All were dated as opened 08/22/13. Staff P was present and confirmed they were expired and should have been removed from the cart.</p> <p>THIRD FLOOR MEDICATION ROOM On 09/23/13 at 9:52 a.m. Calcitonin for Resident #186 was found to have been opened 07/17/13. Staff R stated per facility policy, "Calcitonin expires 28 days after opening", however, facility policy indicated Calcitonin expired 35 days after opening. Additionally, Staff R elaborated the Calcitonin was discontinued 07/25/13, but was not removed.</p>	F 431		11/5/13

RECEIVED
OCT 21 2013
DSHS/ADSARCS

RECEIVED
OCT 21 2013
DSHS/ADSARCS