

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

PRINTED: 08/09/2013
FORM APPROVED
OMB NO. 0938-0391

679

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 C 08/02/2013
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NAME OF PROVIDER OR SUPPLIER SEATTLE KEIRO	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 EAST YESLER WAY SEATTLE, WA 98122
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Seattle Keiro on 08/02/2013. A sample of 5 residents were selected from a census of 145.</p> <p>The following complaints were investigated as part of this survey:</p> <p>2847752</p> <p>The survey was conducted by:</p> <p>██████████, RN, BSN</p> <p>The surveyor is from:</p> <p>Department of Social and Health Services Aging & Disability Services Administration Residential Care Services 20425 72nd. Ave. S, Suite 400 Kent, WA 98032</p> <p>Phone: (253) 234-6000 Fax: (253) 395-5070</p> <p><i>[Signature]</i> Residential Care Services Date</p>	F 000	<p>RECEIVED</p> <p>AUG 22 2013</p> <p>DSHS/ADS/RCS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Randi Saeb</i>	TITLE ADMINISTRATOR	(X6) DATE 08/20/2013
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to accurately assess, and</p>	F 278		08/28/13

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F 278	<p>Continued From page 2</p> <p>develop a plan of care for one resident (Resident #1) of 5 sampled residents who suffered a fall. Failure to accurately assess for fall risk and implement a plan of care for fall prevention resulted in the Resident suffering a fall on 07/15/2013 which resulted in bruising to his shoulder.</p> <p>Findings include:</p> <p>Resident #1 was admitted in 2012 with multiple diagnoses including [REDACTED] with [REDACTED] hypertension (high blood pressure), decreased cognitive ability, and [REDACTED] (a [REDACTED] problem resulting in [REDACTED]). The Resident also had a history of wandering and had a "WanderGuard" alarm on his right wrist.</p> <p>On 08/02/2013 the Resident was observed ambulating with a cane. He was noted to have some foot drag on the left side and used the cane for stability with walking. He stated he has trouble walking from time to time and that his feet just "slipped out from under me" at the time of the fall on 07/15/2013.</p> <p>A review of the fall investigation showed the Resident suffered an observed fall on 07/15/2013 when he was in the dining room. The Resident was assessed by the nurse after the fall and no injuries were found. He was provided with a cane after the fall. Prior to that, he was not using any assistive devices.</p> <p>On 07/20/2013, the Resident's wife came to visit</p>	F 278	<p>F-278: Assessment Accuracy/Coordination/Certified</p> <p>Resident #1 remains a resident of the facility and has suffered no falls or injuries since the fall on 07/15/2013. Resident #1's fall assessment has been updated to accurately reflect fall risk. The care plan and care directive have been updated to accurately reflect the resident's status. The nursing assistant has been re-educated on the requirement of timely reporting of a bruise and other injuries to a licensed nurse. The nurses who completed the fall assessments on 05/06/2013 and 07/15/2013 have been in-serviced on how to accurately complete a fall assessment. All licensed staff has been in-serviced on the updated facility fall protocol. Director of Nursing and/or designee is responsible for compliance.</p>	08/28/13
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F 278	<p>Continued From page 3</p> <p>him and found a large bruise measuring 14X13 CM (centimeters) on his right shoulder. The staff was not aware of this bruise. The facility investigation showed that one of the CNA (certified nursing assistant) staff found the bruise but did not report it to the nurse.</p> <p>In an interview with Staff A, the Director of Nursing on 08/02/2013 at 01:00 PM, she acknowledged the facility utilizes a "Fall Risk Assessment" form to assess for fall risk. The assessment done for Resident #1 on 05/06/2013 revealed a fall assessment score of 3. Per the form, the resident is considered high risk for falls with a score of 10 or greater. A review of the documentation on this form revealed the Resident was not accurately assessed. The Resident had a history of wandering and decreased muscular coordination. He was on four medications (insulin, metformin, losartan, and chlorthalidone) which had the potential to cause low blood glucose levels and low blood pressure. The Resident also had three or more medical diagnoses that placed him at risk for falls. Had the fall risk assessment been accurate, his fall score would have been 14, which would have placed him at high risk for falls. On 07/15/2013 following the fall event, he was assessed for fall risk with a score of 5, which again did not include the medications, coordination, wandering, and medical conditions which would have made him high risk for falls.</p> <p>The Resident's plan of care was revised after the fall and he was provided with a cane for ambulation assistance. Staff A provided the Resident's care plan dated 07/31/2013. Review of the care plan revealed the Resident was to have a mat to the floor, bed alarm, wheelchair alarm,</p>	F 278	<p>RECEIVED</p> <p>AUG 22 2013</p> <p>DSHS/AE SAF CS</p>	08/28/13
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F 278	<p>Continued From page 4</p> <p>high low bed, and bed in low position. On 08/02/2013, these interventions were not observed to have been implemented. The CNA Care Directive dated 05/09/2013 was found inside the Resident's closet. The Care Directive indicated that he required a cane for ambulation/mobility. There was no information on the form indicating a diagnosis of diabetes or high blood pressure. There was no information related to the use of the Wanderguard or the fact that the Resident had a recent fall. There was no information related to the other fall interventions that were listed on the updated care plan dated 07/31/2013.</p> <p>On 08/02/2013 at 01:00 PM, in an interview with Staff A and Staff B, the Administrator, both verified that Resident #1's fall assessments had not been accurate. Both acknowledged that the Resident would have been at high risk for falls if the assessment had been accurate. When asked how staff know about the residents they are caring for, Staff A stated they get this information in report. When asked if the CNA care directive is part of the care plan and is a tool for the CNA staff to use to know the needs of the residents. She acknowledged care directives were part of the care plan and the Resident's plan of care was not up to date.</p> <p>Failure to accurately assess the Resident for fall risk and to formulate a comprehensive plan of care based on that assessment placed the Resident at risk for falls and injury.</p>	F 278	<p>RECEIVED</p> <p>AUG 22 2013</p> <p>DSHS/ADSARCS</p>	08/28/13
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