STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seattle Medical Post Acute Care	555 16th Avenue Seattle, WA 98122

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619 Based on interview and record review the facility failed to provide necessary/adequate supervision for 1 of 1 resident (Resident 1) reviewed for elopement. The resident was allowed to exit the facility unnoticed and was placed at risk for serious injury and a diminished quality of life. A past noncompliance was initiated on 08/28/2024 related to F689 Free of Accident Hazards/Supervision/Devices for failure to provide necessary supervision for a resident at risk for elopement. The facility implemented the following interventions that were initiated 08/28/2024 and corrected by 09/03/2024: - Assisted Resident 1 with returning to the facility from the kidney center [which was located across the street from the facility]. - Audits were completed for current residents for risk for wandering and elopement. - Elopement Risk evaluations were updated/completed. - Resident educated on signing in/out and informing staff of intent of leaving the facility. - Staff education on policies and procedures for wandering and elopement. Findings included . Review of the facility policy titled, Missing Resident/Elopement Procedures, dated September 2016, showed elopement occurred when a resident left a safe area without staff knowledge or when the resident entered an unsafe area without staff knowledge or presence. Resident 1 admitted to the facility on [DATE] with diagnoses that included Encephalopathy (a condition that affects the nervous system due to a lack of thiamine [vitamin that helps to keep the nervous system healthy] with symptoms such as confusion, ataxia (loss of muscle coordination), and vision changes such as abnormal eye movements. Other diagnoses included muscle weakness and pain in right hip. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505311	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seattle Medical Post Acute Care	555 16th Avenue 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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's admission Minimum Data Set (an assessment tool), dated 08/13/2024, showed Resident 1 had moderate cognitive impairment. Review of Resident 1's elopement/exit seeking evaluation dated 08/14/2024, showed the resident was at risk for elopement. Review of Resident 1's falls care plan initiated on 08/07/2024, showed the resident was at risk for falls related to gait/balance problems. Review of Resident 1's pain care plan initiated on 08/07/2024, showed the resident's pain was aggravated by movement. Review of Resident 1's elopement care plan initiated on 08/14/2024, showed the resident was an elopement risk/wanderer related to their cognition and ability to ambulate independently. Review of the facility's reporting log dated August 2024 showed Resident 1 was a missing person/eloped on 08/28/2024. Review of the facility's Elopement investigation for Resident 1 dated 08/28/2024, showed the resident left the facility to get cigarettes from the store down the street. The resident stated they were not able to get up the hill so they asked for help from the kidney center. Further review of the investigation showed the resident would remain on the elopement risk for safety concerns related to the resident's ability to self propel/locomotion [movement] outside the center. Review of Resident 1's nursing progress note dated 08/28/2024, showed Resident 1 had wandered to the kidney center and needed help coming back to the facility. The provider had ordered an x-ray of the resident's right hip due to pain and a onetime order for ibuprofen (anti-inflammatory medication used to treat mild to severe pain). Further review of Resident 1's clinical record showed the right hip x-ray result dated 08/28/2024, showed no injuries. On 09/11/2024 at 11:50 AM, Staff C, Licensed Practical Nurse, stated Resident 1 was confused and had issues with their memory. Staff C stated Resident 1 tended to stray and was on the elopement list. Staff C further stated that the facility should not have let the resident go outside unsupervised. On 09/12/2024 at 1:55 PM, Staff B, Director of Nursing stated Resident 1 had gone to the grocery store to buy cigarettes and had last received their medication at 4:00 PM on 08/28/2024 and was last seen around that time according to their investigation and was gone for about three hours. Staff B stated the Kidney Center notified them the resident needed assistance getting back to the facility. Staff B stated Resident 1's orientation fluctuated due to their diagnosis of Encephalopathy. Staff B further stated that the facility identified Resident 1 was at risk for elopement and should not have left the facility unattended/unsupervised and that they initiated a plan to correct the situation. On 09/18/2024 at 1:42 PM, Staff A, Administrator stated Resident 1 was at risk for elopement and should not have left the facility unsupervised on 08/28/2024. Reference: (WAC) 388-97-1060 (3)(g)