

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 12/06/2024
NAME OF PROVIDER OR SUPPLIER Seattle Medical Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787</p> <p>Based on interview and record review, the facility failed to ensure residents were free from misappropriation of property for 1 of 7 residents (Resident 1), reviewed for abuse investigations. This failure placed the residents at risk for pain, unmet care needs, on-going misappropriation of medication, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, dated October 2022, showed, Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Examples of misappropriation of resident property included, missing prescription medications or diversion of a resident's medications, including, but not limited to, controlled substances for staff use or personal gain.</p> <p>Review of the admission Minimum Data Set (MDS-an assessment tool) dated 10/17/2024 showed Resident 1 admitted to the facility on [DATE] with a diagnosis that included pain, multiple fractures (broken bones) to the right pelvis, hip and lower back.</p> <p>Review of an incident investigation dated 11/10/2024 showed the floor nurse reported missing one [Bingo] card (medication package) of narcotic medication that contained 42 tablets of Oxycodone (narcotic pain reliever) 5 milligrams (mg-a unit of measurement) Immediate Release that belonged to Resident 1. The incident investigation showed Staff D [Licensed Practical Nurse (LPN)] stated that they may have misplaced a bingo card of Oxycodone for Resident 1 and that they gave the resident their medication in the morning and did not realize it was missing until counting narcotics at the end of the shift and then searched for the missing narcotics with other nurses. Further review of the investigation showed the missing narcotics were not found.</p> <p>In an interview on 11/19/2024 at 12:17 PM, Staff C, LPN, stated that the narcotic medications were always counted at the beginning and at the end of the shift with the nurse that was ending the shift and the nurse that was starting the shift. Staff C further stated that two nurses had to be present to dispose of narcotic medications and that it was required for them to sign and date each time the medication was administered to the residents, when the medication was counted and/or disposed of.</p> <p>(continued on next page)</p>

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
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/19/2024 at 12:54 PM, Staff D stated that narcotics should never be left unattended or unsecured by a nurse, and that they did not know what happened to the missing narcotic medication and when they could not find the medication, they reported it to the nursing management staff.</p> <p>In an interview on 12/06/2024 at 2:09 PM, Staff E, Registered Nurse/Resident Care Coordinator, stated that Staff D notified them when they could not find the 42 tablets of Oxycodone for Resident 1. Staff E further stated that the nurses searched for the medication, but it was never found.</p> <p>In an interview on 12/06/2024 at 3:36 PM, Staff B, Director of Nursing Services, stated that they found out about the missing narcotic medication for Resident 1 when Staff D called them and informed them and that they could not find the Oxycodone for Resident 1. Staff B stated that the medication was the property of Resident 1 and that the nurses searched for the medication, but it was never found. Staff B further stated that their expectation was for the nurses to count the narcotic medications at end of the shift with the nurse that was starting the shift and to keep the narcotic medications secure and never leave them unattended.</p> <p>In an interview on 12/06/2024 at 3:43 PM Staff A, Administrator, stated that the medication was the property of Resident 1 and that the medication was replaced by the facility pharmacy when the narcotic medication could not be found by the nurses.</p> <p>Reference: (WAC) 388-97-0640 (3)(d)</p>		