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	01/06/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on interview and record review, the facility failed to ensure responsible parties were notified for 1 of 1 (Resident 1), reviewed for notification of changes. The failure to notify the resident's representative when Resident 1 went missing placed the resident at risk of not having their representative make decisions for timely care and services. Findings included . Review of Resident 1's face sheet printed on 12/12/2024 showed Resident 1 admitted to the facility on [DATE]. Further review of the face sheet showed that Resident 1's representative was listed as their Power of Attorney (a designated person to make decisions about another person's medical care) with their cell phone number listed on the face sheet. Review of the nursing progress note dated 12/11/2024 at 6:42 AM, showed Resident 1 left the faciity on [DATE] around noon and did not return to the facility and that law enforcement was notified. Further review of the nursing progress note did not show Resident 1's representative was notified. Review of the social services note dated 12/12/2024 at 11:56 AM, showed Resident 1's apartment residential councilor spoke with the resident and stated that the resident did not want to return to the facility. Another social service notes at 2:20 PM that day showed Resident 1 left the facility against medical advice, and it was reported to adult protective services. Further review of the note did not show that Resident 1's representative was notified. During a telephone interview on 12/19/2024 at 12:08 PM, Resident 1's representative stated they were not informed about Resident 1's admission to the facility and they unaware when Resident 1 went missing. Resident 1's representative stated, With [Resident 1's] recent diagnosis of stroke [happens when blood flow to the brain stops] and not having a cellphone, I would like to know what was going on with [Resident 1]. During an interview on 01/06/2025 at 10:48 AM, Staff C, Infection Preventionist/Resident Care Manager, stated if Resident 1's face sheet showed they had a representative, then the representative should have been notified when the resident went missing from the facility. (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/06/2025 at 10:55 AM, Staff D, Social Services, was asked if they called or notified the resident's representative when Resident 1 went missing. Staff D stated they did not call the resident's representative and that they should have been notified. During an interview on 01/06/2025 at 1:21 PM, Staff B, Director of Nursing, stated Resident 1's representative should have been notified when the resident went missing from the facility. On 01/06/2025 at 2:28 PM, Staff A, Executive Director, stated that they expected all responsible parties should have been notified for changes in the resident's care. Reference: (WAC) 388-97-0320(1)(b)

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on interview and record review, the facility failed to ensure enteral nutrition (the delivery of nutrients through a tube feeding [TF] directly into the stomach or small intestine) was administered in accordance with physician's orders and professional standards of practice for 1 of 2 residents (Resident 2), reviewed for tube feeding management. The failure to clarify enteral nutrition orders to include route of administration and/or follow physician's orders on the amount of formula to administer placed the resident at risk for adverse health outcomes, related complications, and a diminished quality of life. Findings included . Review of the facility's policy titled, Enteral Feeding, updated in April 2017, showed, Enteral feeding parameters are ordered by a physician. The nutritional value is calculated and documented in the medical record by the Registered Dietitian (RD). The licensed nurse administers the enteral feeding and medications per physician order using best practice. The policy further showed that the enteral feeding order to include access route (e.g. G [Gastric - stomach]-tube, J [Jejunum - section of the small intestine] tube.) Resident 2 admitted to the facility on [DATE] with diagnosis that included persistent vegetative state. Review of the quarterly Minimum Data Set (an assessment tool) dated 11/14/2024, showed for the entire seven days of the assessment period, Resident 1 received 51% or more of their calorie (a measurement of the energy content of food) intake and 501 milliliters (ml-a unit of measurement) of fluid per day from enteral feeding. Review of the facility's investigation dated 11/23/2024 showed that Staff F, Licensed Practical Nurse (LPN), found Resident 1 was receiving enteral feeding formula via G-tube not J-tube on 11/23/2024. Review of the nutrition note dated 10/25/2024 and 11/18/2024 showed Resident 1 was placed on enteral feeding regimen of Nutren (a tube feeding formula brand 2.0 at 30 ml per hour for 20 hours with a total of 600 ml per 24 hours. Review of the October 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed Resident 1 had a tube feeding order with a start date of 10/12/2024, Formula: Nutren 2.0 @ [at] 30 cc [cubic centimeter]/HR [hour] x 20 HRS/24 HRS = 600 CC/24HRS . Access ROUTE: G Tube. Further review of the MAR/TAR showed Resident 1 received 1200 cc formula on 10/12/2024, 10/13/2024, 10/15/2024, and 10/16/2024 (a double amount of tube feeding formula was given to the resident). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the November 2024 MAR and TAR showed that Resident 1's tube feeding order with a start date of 11/09/2024, Formula: Nutren 2.0 @[at] 30 cc /HR x 20 HRS/24 HRS = 600 CC/24HRS . Access ROUTE: G/J Tube. The MAR and TAR showed that the order was not clear whether the formula should be administered through G tube or J tube. Further review of the MAR/TAR showed Resident 1 received 1200 cc formula from 11/09/2024 to 11/18/2024. During an interview and joint record review on 01/06/2025 at 12:03 PM, Staff E, LPN, stated that they would follow the physician order to administer tube feeding formula through feeding tube and they would document the amount administered. Joint record review of the November 2024 MAR and TAR with an order start date of 11/09/2024 showed Resident 1's tube feeding formula administration access route was G/J tube. Staff E stated the tube feeding access route order was not clear and should have been clarified. During an interview and joint record review on 01/06/2025 at 1:01 PM, Staff B, Director of Nursing, stated that tube feeding administration access would be included in the order, and they expected staff to follow the physician order and document the amount of formula administered. Joint record review of Resident 1's November 2024 MAR/TAR showed Resident 1 received 1200 cc formula from 11/09/2024 to 11/18/2024. Further review of the MAR and TAR showed the formula administration access route was via, G/J tube. Staff B stated that the order for TF access should have been specified, and the order should have been clarified. Staff B further stated that Resident 1 should have received 600 cc per 24 hours as ordered. Reference: (WAC) 388-97-1060 (3)(f)