

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 03/03/2025
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912</p> <p>Based on observation, interview, and record review, the facility failed to take timely action and ensure a urology (a surgical specialty that focuses on the urinary tract) referral, and urine analysis (UA- test for UTI [Urinary Tract Infection or bladder infection]) were conducted for 1 of 1 resident (Resident 1), reviewed for urinary care management. These failures placed the resident at risk for urinary associated infections, other health related complications, and diminished quality of life.</p> <p>Findings included .</p> <p>UROLOGY REFERRAL</p> <p>Review of the facility's policy titled, Clinical and Support Services, updated in July 2015, showed, The Social Services Department assists residents in obtaining needed clinical and support services.</p> <p>Resident 1 admitted to the facility on [DATE] with diagnoses that included neuromuscular dysfunction of bladder (lack of bladder control due to brain, spinal cord or nerve problems).</p> <p>Review of the admission Minimum Data Set (an assessment tool) dated 07/15/2024, showed Resident 1 had an indwelling urinary catheter (a flexible tube inserted into the bladder to drain urine).</p> <p>Review of the catheter care plan, revised on 01/08/2025, showed Resident 1 had an indwelling urinary catheter and an intervention to monitor/record/report to MD [Medical Doctor] for s/sx [signs and symptoms] UTI including symptoms such as cloudiness, foul smelling urine, and no output.</p> <p>Review of the physician note dated 10/14/2024, showed ongoing concerns noted on foley [type of catheter] catheter blockage needing ongoing flushing and replacements. It further showed under the heading Assessment/Plan, Urology follow up to eval [evaluate] and make recommendations.</p> <p>Review of the physician note dated 12/05/2024, showed per staff, [Resident 1] had a cloudy foley cath [catheter], UA was sent last night. Foley was changed with yellowish urine output. It further showed under the heading Assessment/Plan, referring to urology, awaiting appointment still.</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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 03/03/2025 at 11:10 AM, showed Resident 1 with an indwelling catheter in a privacy bag. Resident 1 stated that they have had cloudy urine from August [2024] until now. Resident 1 stated that a referral to urology was finally made in December [2024]. Resident 1 further stated, I still don't think the appointment has been made.</p> <p>In an interview on 03/03/2025 at 12:02 PM, Staff E, Licensed Practical Nurse, stated that Resident 1 had ongoing concerns with [their] catheter and it was getting clogged. Staff E further stated that it was recommended that [they] see urology and they were unsure if Resident 1 had seen urology yet.</p> <p>In an interview on 03/03/2025 at 12:20 PM, Staff D, Resident Care Manager, stated that after a physician puts in an order to refer a resident for a specialty service (like urology), the process was that the Social Services Assistant (SSA) would send the referral to the hospital and then the hospital would call to schedule the resident. Staff D further stated that after an order was placed for a resident to be referred to a specialty service, the referral should happen as soon as possible.</p> <p>In an interview and joint record review on 03/03/2025 at 12:26 PM, Staff C, Social Services Director, stated that once the SSA [Staff F] was made aware of a provider wanting to refer a resident, it's an immediate process and the referral would be right away. Joint record review of the physician notes from 10/14/2024, showed Urology follow up to eval [evaluate] and make recommendations. Staff C stated, looks like there was a referral for urology and I will look and get back to you. In a follow up interview and joint record review at 2:46 PM, Staff C stated, we can't find that the referral was made in October [2024]. Joint record review of a telephone conversation from 10/15/2024 showed the following documentation from the hospital to the facility, LVM [left voicemail] to send referral, gave our fax number. Staff C stated, the SSA would have immediately sent the referral. [We are] missing that piece. Staff C further stated that they asked the hospital, and they did not have documentation of a referral that happened after that last message. Joint record review of a progress note dated 01/02/2025 written by the SSA showed, called the urology clinic regarding the referral that was faxed over on 12/18/2024. Staff C stated the referral was followed up in December and Resident 1 has an appointment on April 14th [04/15/2025] with urology.</p> <p>In an interview and joint record review on 03/03/2025 at 3:16 PM, Staff B, Director of Nursing, stated that they expected staff to refer as soon as we are able after a physician ordered a referral. Staff B stated that they expected a follow up on the referral within the week and document that. When asked if they expected the referral to be made two months after the physician had ordered it for Resident 1, Staff B stated, no, we should have done a follow-up before that. Staff B further stated that there should be documentation that the referral was followed up on for Resident 1 and should not have been two months later.</p> <p>In an interview on 03/03/2025 at 3:39 PM, Staff A, Executive Director, stated they expected referrals to be sent in a timely manner and within one to two weeks. Staff A stated that they would expect a follow-up. Staff A further stated that the referral process was not followed for Resident 1 when the referral from October was not followed up on until December.</p> <p>UTI MANAGEMENT</p> <p>Review of a nursing progress note dated 12/05/2024, showed Resident 1's urine was cloudy with a strong smell. Called On-Call MD and on call ordered a UA with culture. Sample collected at 0545 [5:45 AM] and sent out to lab [laboratory].</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Lab Results Report dated 12/13/2024, showed Resident 1's UA result as test not performed. Improper specimen submitted.</p> <p>Review of the nursing progress note dated 12/18/2024, showed the results of Resident 1's UA was reviewed and that lab results incomplete D/T [due to] inadequate specimen. Staff will collect another specimen today.</p> <p>Review of Resident 1's clinical/electronic health record showed no documentation that another urine specimen was collected.</p> <p>During a joint record review and interview on 03/03/2025 at 3:16 PM with Staff B, showed a nursing progress note dated 12/18/2024, revealed that the UA and culture were incomplete. Staff B stated that the note said that staff would submit another specimen. Joint record review of Resident 1's clinical record showed no documentation that another UA was collected. Staff B stated there's no follow up. They should have documented if no need to collect another sample. Staff B further stated that there should be documentation that there was a follow up and there was not anything documented.</p> <p>Reference: (WAC) 388-97-1060 (3)(c)</p>