

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 03/27/2025
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 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912</p> <p>Based on interview and record review, the facility failed to ensure the primary care physician was timely notified when medications were not administered for 1 of 4 residents (Resident 1), reviewed for notification of change. The failure to notify the primary care physician when the medication (clozapine-used to treat Schizophrenia [a chronic mental illness characterized by a combination of symptoms that significantly impair a person's thinking, feeling, and behavior]) were not administered caused harm for Resident 1 who had increased anxiety, behaviors, and suicidal ideation requiring hospitalization .</p> <p>A past noncompliance was initiated on 02/26/2025 related to F580 Notify of Changes (Injury/Decline/Room, Etc.) for failure to notify the physician when clozapine was unavailable and/or not provided to the resident resulting in increased behaviors, anxiety, and suicidal ideation requiring hospitalization .</p> <p>The facility implemented the following interventions that were initiated 02/26/2025 and corrected by 02/28/2025:</p> <ul style="list-style-type: none"> - Resident 1 was evaluated by the physician and was sent to the hospital for further evaluation. - The facility conducted an audit of medication errors from 01/01/2025 through 03/01/2025. No other issues identified. - In-services were held for licensed nurses related to medication administration and what to do if a medication was not available, including who to notify. - Weekly audits were completed weekly for four weeks and monthly for two months and the results will be reviewed through the facility Quality Assurance Performance Improvement Committee process. <p>Findings included .</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 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled, Medication Error Reporting and Adverse Drug Reaction Prevention and Detection, dated 01/2023, showed that Medication Error/Variance shall be defined as any preventable event that may cause or lead to inappropriate medication use or resident harm while the medication is in the control of the health care professional, resident or consumer. It showed that medication errors are considered significant if they require hospitalization . It further showed that In the event of a significant medication error .immediate action is taken, as necessary, to protect the resident's safety and welfare .the prescriber is notified promptly of any significant error.</p> <p>Resident 1 admitted to the facility on [DATE] with diagnosis that included Schizophrenia.</p> <p>Review of the annual minimum data set (an assessment tool), dated 12/11/2024, showed Resident 1 had a tracheostomy (a surgical procedure that creates an opening in the trachea (windpipe) and inserts a tube to provide an airway).</p> <p>Review of Resident 1's February 2025 Medication Administration Record (MAR) showed an order for clozapine with instructions to give 200 mg (milligrams-a unit of measurement) .one time a daily for Schizophrenia. It showed that on 02/22/2025, 02/23/2025, 02/24/2025 and 02/25/2025, clozapine was not marked as given and showed it was on order from pharmacy [indicating the medication was unavailable].</p> <p>Review of the facility's investigation report dated 02/26/2025, showed Staff H, Registered Nurse (RN), was the night nurse on 02/22/2025 and that was the first day the medication [clozapine] was not administered to Resident 1. It showed that Staff H did not notify the physician and did not place the resident on alert monitoring. It showed that Staff G, RN, was the nurse on 02/23/2025, 02/24/20225 and 02/25/2025 and that clozapine was not available on those days to be administered. It further showed that Staff G did not notify the physician or place the resident on alert monitoring.</p> <p>Review of a nursing progress note dated 02/24/2025, showed the resident [Resident 1] appeared anxious, PA [Physician Assistant] gave new order for Hydroxyzine [a medication used to treat anxiety].</p> <p>Review of a nursing progress note dated 02/26/2025, showed patient [resident] noted walking back and forth on unit new order for Ativan [medication to treat anxiety] 1 mg administered will continue to monitor. Review of another nursing progress note on 02/26/2025, showed patient noted to continue having more anxiety and notified new order for lorazepam [generic for Ativan] 4 mg x 1 [times one] only received medication obtained and administered will continue to monitor.</p> <p>Review of a social services progress note dated 02/26/2025 showed that SW [social work] met with resident this afternoon r/t [related to] reported anxiety. Resident was observed by this SW pacing down the hallway of 1st [first] floor throughout the day and resident endorsed feeling anxious by writing on his notepad when approached by this SW.</p> <p>Review of a social services note dated 02/27/2025 showed that resident was observed pacing down common areas of the facility. It further showed that Resident endorsed continuing to feel anxious at times.</p> <p>Review of a physician note dated 02/27/2024 showed Pt [patient] did not receive his PM [night] clozapine x 4 [four] days and having symptoms of anxiety, insomnia, racing thoughts, and confusion, irritability, pacing up and down the hallways. It showed Medications did not reach until 2/26 [02/26/2025] PM.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a nursing progress note dated 03/01/2025, showed Resident has expressed suicidal ideation with altered mental status. On call PCP [Primary Care Physician] notified with order to send to hospital for evaluation and treatment.</p> <p>Review of a hospital note dated 03/01/2025, showed that Resident 1 presents [to the] emergency department with suicidal ideation. It showed, He did express that he was suicidal without a plan.</p> <p>Review of a hospital psychiatry (the branch of medicine focused on the diagnosis, treatment and prevention of mental, emotional and behavioral disorders) note dated 03/02/2025, showed Spoke with nursing staff via phone at [the facility]. Per staff, due to a medication error patient went without Clozapine from 2/22 [02/22/2025] to 2/26 [02/26/2025] so staff psychiatrist restarted Clozapine titration. It showed Resident 1 was requiring Ativan .for agitation including pulling at trach [tracheotomy], psychomotor agitation, thought to be due to decreased Clozapine dose.</p> <p>In an interview on 03/27/2025 at 11:19 AM, Staff E, Licensed Practical Nurse, stated that if a resident's medication was unavailable, they would notify the doctor, call the pharmacy and notify the resident.</p> <p>In an interview and joint record review on 03/27/2025 at 12:00 PM, Staff B, Physician, stated that missing four doses of clozapine would be a big cause for concern. Joint record review of Resident 1's hospital records showed Resident 1 was sent to the hospital on 03/01/2025 for low oxygen, self-decannulation (removal of the tracheostomy) and suicidal ideation. Staff B stated it was very unfortunate those doses were missed. Staff B further stated that they would expect staff to notify the provider as soon as discovered that a medication was missed and no one was notified about the missing doses until [Resident 1] was having behaviors.</p> <p>In an interview on 03/27/2025 at 12:06 PM, Staff C, PA, stated they were notified that Resident 1 was having behavior changes such as not sleeping well, pacing up and down the hallway and he was anxious and agitated and they ordered hydroxyzine starting on 02/24/2025. Staff C stated that nursing called me that morning [02/26/2024] to say [Resident 1] was not getting better, I ordered lorazepam. Staff C said when they got to the clinic on 02/26/2025, the Resident Care Manager (RCM) told me about the missing doses [of clozapine] and then I went to see him. Staff G stated they were not notified about the missing doses of clozapine until 02/26/2025 [four days after missing the first dose]. Staff C further stated that Resident 1 had to go to the hospital because the day he left I was told he had suicidal thoughts and they did tell me he attempted self-decannulation.</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview and joint record review on 03/27/2025 at 1:39 PM, Staff D, RCM, stated they expected medications to be available for residents and you can't just not give it [the medication] if there's an order, there's steps to take, call pharmacy, have to make the doctor aware. Joint record review of the Resident 1's February 2025 MAR showed clozapine was not given from 02/22/025 through 02/25/2025. Staff D stated that clozapine was not given on 02/22/2025, 02/23/2025, 02/24/2025 and 02/25/2025 and showed that the medication was on order from the pharmacy. Staff D stated they expected licensed nurses to notify the pharmacist and the doctor to ask what to do. Joint record review of Resident 1's progress notes from 02/22/2025 through 02/25/2025 showed no documentation that the physician was notified of the missing doses of clozapine. Staff D stated, if it wasn't documented it didn't happen. Further joint record review of Resident 1's progress notes, showed that Resident 1 had increased behaviors and Staff D stated that most likely because he missed 4 [four] doses of clozapine. Joint record review of a nursing progress note dated 03/01/2025 showed that Resident 1 was sent to the hospital for suicidal ideation. Staff D stated, I didn't know about him having suicidal ideation before, so based off of that it would be a new behavior and that it happened after Resident 1 missed four doses of their clozapine. Staff D further stated Resident 1 had a change in condition due to missed doses of clozapine and stated that suicidal ideation was a negative outcome.</p> <p>In a phone interview on 03/27/2025 at 3:32 PM, Staff A, Director of Nursing, stated that Resident 1 went to the hospital because the facility couldn't manage Resident 1's behaviors and it would be better handled at the hospital. When asked if Resident 1 was having suicidal ideation, Staff A stated, I believe that was mentioned. When asked if Resident 1 experienced a negative outcome due to missing four doses of clozapine, Staff A stated that Resident 1 had increased behaviors. When asked if being hospitalized was a negative outcome, Staff A stated Resident 1 had actively increased behaviors and out of abundance of caution he was sent to the hospital. When asked if this was after Resident 1 missed four doses of clozapine, Staff A stated, yes. Staff A further stated that staff should have notified the provider after the first dose was missed.</p> <p>Reference: (WAC) 388-97-0320</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912</p> <p>Based on interview and record review, the facility failed to provide an ordered medication, significant to the health of 1 of 4 residents (Resident 1), reviewed for medication administration. This failure caused harm to Resident 1 when their medication (clozapine-used to treat Schizophrenia [a chronic mental illness characterized by a combination of symptoms that significantly impair a person's thinking, feeling, and behavior]) were not administered resulting in increased anxiety, behaviors, and suicidal ideation requiring hospitalization .</p> <p>A past noncompliance was initiated on 02/26/2025 related to F760 Residents Are Free of Significant Medication Errors for failure to provide a medication significant to the health of the resident.</p> <p>The facility implemented the following interventions that were initiated 02/26/2025 and corrected by 02/28/2025:</p> <ul style="list-style-type: none"> - Resident 1 was evaluated by the physician and was sent to the hospital for further evaluation. - The facility conducted an audit of medication errors from 01/01/2025 through 03/01/2025. No other issues identified. - Staff educations were held for licensed nurses related to medication administration and what to do if a medication was not available, including who to notify. - Weekly audits were completed weekly for four weeks and monthly for two months and the results will be reviewed through the facility Quality Assurance Performance Improvement Committee process. <p>Findings included .</p> <p>Review of the facility's policy titled, Medication Administration General Guidelines, dated January 2024, showed that Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices.</p> <p>Review of the facility's policy titled, Medication Error Reporting and Adverse Drug Reaction Prevention and Detection, dated 01/2023, showed that Medication Error/Variance shall be defined as any preventable event that may cause or lead to inappropriate medication use or resident harm while the medication is in the control of the health care professional, resident or consumer. It showed that medication errors are considered significant if they require hospitalization .</p> <p>Resident 1 admitted to the facility on [DATE] with diagnosis that included Schizophrenia.</p> <p>Review of the annual Minimum Data Set (an assessment tool) dated 12/11/2024, showed Resident 1 had a tracheostomy (a surgical procedure that creates an opening in the trachea (windpipe) and inserts a tube to provide an airway).</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's February 2025 Medication Administration Record (MAR) showed an order for clozapine with instruction to give 200 mg (milligrams-a unit of measurement) .one time a daily for Schizophrenia. It showed that on 02/22/2025, 02/23/2025, 02/24/2025 and 02/25/2025, clozapine was not marked as given and showed it was on order from pharmacy [indicating the medication was unavailable].</p> <p>Review of the facility's investigation report dated 02/26/2025, showed Staff H, Registered Nurse (RN), was the night nurse on 02/22/2025 and that was the first day the medication [clozapine] was not administered to Resident 1. It showed that Staff H did not notify the physician and did not place the resident on alert monitoring. It showed that Staff G, RN, was the nurse on 02/23/2025, 02/24/2025 and 02/25/2025 and that clozapine was not available on those days to be administered. It further showed that Staff G did not notify the physician or place the resident on alert monitoring.</p> <p>Review of a nursing progress note dated 02/24/2025, showed the resident [Resident 1] appeared anxious, PA [Physician Assistant] gave new order for Hydroxyzine [a medication used to treat anxiety].</p> <p>Review of a nursing progress note dated 02/26/2025, showed patient [resident] noted walking back and forth on unit new order for Ativan [medication to treat anxiety] 1 mg administered will continue to monitor. Review of another nursing progress note on 02/26/2025, showed patient noted to continue having more anxiety and notified new order for lorazepam [generic for Ativan] 4 mg x 1 [times one] only received medication obtained and administered will continue to monitor.</p> <p>Review of a social services progress note dated 02/26/2025 showed that SW [social work] met with resident this afternoon r/t [related to] reported anxiety. Resident was observed by this SW pacing down the hallway of 1st [first] floor throughout the day and resident endorsed feeling anxious by writing on his notepad when approached by this SW.</p> <p>Review of a social services note dated 02/27/2025 showed that resident was observed pacing down common areas of the facility. It further showed that Resident endorsed continuing to feel anxious at times.</p> <p>Review of a physician note dated 02/27/2024 showed Pt [patient] did not receive his PM [night] clozapine x 4 [four] days and having symptoms of anxiety, insomnia, racing thoughts, and confusion, irritability, pacing up and down the hallways. It showed Medications did not reach until 2/26 [02/26/2025] PM.</p> <p>Review of a nursing progress note dated 03/01/2025, showed Resident has expressed suicidal ideation with altered mental status. On call PCP [Primary Care Physician] notified with order to send to hospital for evaluation and treatment.</p> <p>Review of a hospital note dated 03/01/2025, showed that Resident 1 presents [to the] emergency department with suicidal ideation. It showed, He did express that he was suicidal without a plan.</p> <p>Review of a hospital psychiatry (the branch of medicine focused on the diagnosis, treatment and prevention of mental, emotional and behavioral disorders) note dated 03/02/2025, showed Spoke with nursing staff via phone at [the facility]. Per staff, due to a medication error patient went without Clozapine from 2/22 [02/22/2025] to 2/26 [02/26/2025] so staff psychiatrist restarted Clozapine titration. It showed Resident 1 was requiring Ativan .for agitation including pulling at trach [tracheotomy], psychomotor agitation, thought to be due to decreased Clozapine dose.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 03/27/2025 at 9:30 AM, Staff F, Consultant Pharmacist, stated that clozapine was a powerful anti-psychotic used to treat schizophrenia. Staff F stated that Clozapine should be taken daily. When asked what would happen if a resident missed four doses, Staff F stated, that would be an issue and would see symptoms like hallucinations, agitation, and delusions in a resident. When asked if missing four doses would be considered a significant medication error, Staff F stated, I think for the most part that would be significant.</p> <p>In an interview on 03/27/2025 at 11:19 AM, Staff E, Licensed Practical Nurse, stated that if a resident's medication was unavailable, they would notify the doctor, call the pharmacy and notify the resident.</p> <p>In an interview and joint record review on 03/27/2025 at 12:00 PM, Staff B, Physician, stated that missing four doses of clozapine would be a big cause for concern. Joint record review of Resident 1's hospital records showed Resident 1 was sent to the hospital on 03/01/2025 for low oxygen, self-decannulation (removal of the tracheostomy) and suicidal ideation. Staff B stated it was very unfortunate those doses were missed.</p> <p>In an interview on 03/27/2025 at 12:06 PM, Staff C, PA, stated they were notified that Resident 1 was having behavior changes such as not sleeping well, pacing up and down the hallway and he was anxious and agitated and they ordered hydroxyzine starting on 02/24/2025. Staff C stated that nursing called me that morning [02/26/2024] to say [Resident 1] was not getting better, I ordered lorazepam. Staff C said when they got to the clinic on 02/26/2025, the Resident Care Manager (RCM) told me about the missing doses [of clozapine] and then I went to see him. Staff C further stated that Resident 1 had to go to the hospital because the day he left I was told he had suicidal thoughts and they did tell me he attempted self-decannulation.</p> <p>In an interview and joint record review on 03/27/2025 at 1:39 PM, Staff D, RCM, stated they expected medications to be available for residents and you can't just not give it [the medication] if there's an order, there's steps to take, call pharmacy, have to make the doctor aware. Joint record review of the Resident 1's February 2025 MAR showed clozapine was not given from 02/22/025 through 02/25/2025. Staff D stated that clozapine was not given on 02/22/2025, 02/23/2025, 02/24/2025 and 02/25/2025 and showed that the medication was on order from the pharmacy. Joint record review of Resident 1's progress notes, showed that Resident 1 had increased behaviors and Staff D stated that most likely because he missed 4 [four] doses of clozapine. Joint record review of a nursing progress note dated 03/01/2025 showed that Resident 1 was sent to the hospital for suicidal ideation. Staff D stated, I didn't know about him having suicidal ideation before, so based off of that it would be a new behavior and that it happened after Resident 1 missed four doses of their clozapine. Staff D further stated Resident 1 had a change in condition due to missed doses of clozapine and stated that suicidal ideation was a negative outcome.</p> <p>In a phone interview on 03/27/2025 at 3:32 PM, Staff A, Director of Nursing, stated that Resident 1 went to the hospital because the facility couldn't manage Resident 1's behaviors and it would be better handled at the hospital. When asked if Resident 1 was having suicidal ideation, Staff A stated, I believe that was mentioned. When asked if Resident 1 experienced a negative outcome due to missing four doses of clozapine, Staff A stated that Resident 1 had increased behaviors. When asked if being hospitalized was a negative outcome, Staff A stated Resident 1 had actively increased behaviors and out of abundance of caution he was sent to the hospital. When asked if this was after Resident 1 missed four doses of clozapine, Staff A stated, yes.</p> <p>(continued on next page)</p>		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Reference: (WAC) 388-97-1060 (3)(k)(iii)		