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	07/21/2025

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** Based on interview and record review, the facility failed to ensure physician and resident representative were notified for 1 of 2 residents (Resident 1), reviewed for notification of changes. The failure to notify the physician and the resident's representative when Resident 1 had significant weight loss placed the resident at risk for a delay in medical/nutritional treatment, and not having their representative involved in the health care decision making process for timely care and services.Findings included .Review of the facility's policy titled, Weights, revised on 10/12/2023, showed, The Center uses weights as one component of data collection needed to evaluate resident's nutritional status, fluid retention, or diuresis [excessive urination]. Significant weight loss/gain (five percent in 30 days, 7.5 % in 90 days, or 10 % in 180 days).The nurse records validated weights on the Weight Record in the resident's medical record.Licensed nurse will notify physician, resident/responsible party of significant change in weight and document notification in progress notes. Progress note to include responses. Resident 1 admitted to the facility on [DATE] with diagnoses that included traumatic brain injury and persistent vegetative state (also known as post-coma unresponsiveness, is a chronic disorder in which an individual with severe brain damage appears to be awake but shows no evidence of awareness of their surroundings).Review of Resident 1's admission Minimum Data Set (an assessment tool) dated 05/08/2025 showed Resident 1 was in a persistent vegetative state with no visible consciousness. The assessment further showed that Resident 1 had no significant weight loss during the assessment period. Review of Resident 1's weights and vitals summary dated 07/15/2025, showed the following documented weights: - On readmission on [DATE], they weighed 144.2 pounds (lbs.).- On 06/20/2025, they weighed 107.2 lbs. (25.6 % or 37 lbs. weight loss since readmission).- On 06/29/2025, they weighed 106.6 lbs. (26 % or 37.6 lbs. weight loss since readmission).- On 07/10/2025, they weighed 109.4 lbs. (24.1 % or 34.8 lbs. weight loss since readmission).Review of Resident 1's progress note dated from 06/20/2025 through 07/10/2025 did not show Resident 1's physician or representative was notified about Resident 1's significant weight loss. In a phone interview on 07/18/2025 at 8:23 AM, Resident 1's representative stated they were not notified about Resident 1's significant weight loss.In a phone interview on 07/21/2025 at 10:35 AM, Staff D, Registered Dietitian, stated that it was the responsibility of the Resident Care Manager (RCM) to notify resident's physician and their representative about significant weight loss. During an interview and a joint record review on 07/21/2025 at 10:55 AM, Staff B, Assistant Director of Nursing, stated that when there was a significant weight loss the resident physician and their representative would be notified by the RCM, and it would be documented in the resident's medical record. A joint record review of Resident 1's progress note dated from 06/20/2025 through 07/10/2025 did not show Resident 1's physician or their representative were notified about their significant weight loss. On 07/21/2025 at 1:15 PM, Staff A, Executive Director, stated that resident's physician and their representative should be notified when there is a significant weight loss. Reference: (WAC) 388-97-0320(1)(b).

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
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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS - an assessment tool) was completed for 1 of 2 residents (Resident 1), reviewed for SCSA. This failure placed the residents at risk for delayed care planning, unmet care needs, and a diminished quality of life. Findings included .Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.19.1, dated October 2024, showed that a SCSA is a comprehensive assessment for a resident that must be completed when determined that a resident meets the significant change guidelines for either major improvement or decline. The RAI manual showed a significant change is a major decline or improvement in a resident's status that impacts more than one area of the resident's health status. The RAI manual further showed emergence of unplanned weight loss problems (5% change in 30 days or 10% change in 180 days) and a worsening in pressure ulcer/pressure injury (PU/PI-an injury to skin and underlying tissue resulting from prolonged pressure on the skin) status are two areas of decline that required the completion of SCSA. The RAI manual defines PU/PI stages:- Stage 2 PU/PI is a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough (dead tissue, yellow/white material in the wound bed) or bruising.- Unstageable PU/PI is when the wound's anatomical (body structure) tissues are obscured such that the extent of soft tissue damage cannot be observed or palpated.- Stage 4 PU/PI is a full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (a dry, crusty scab or layer of dead tissue that forms on the surface of a wound) may be present on some parts of the wound bed. Often includes undermining (when the skin around a wound separates from the tissue underneath, creating a space or pocket beneath the wound's edges) and tunneling (an underground tunnel extending from a surface wound into the surrounding tissue). Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's admission MDS dated [DATE] showed Resident 1 had one stage 2 PU/PI present on admission. The assessment further showed that Resident 1 had no significant weight loss.Review of the wound consultant's note dated 05/15/2025 showed that Resident 1 had one unstageable PU/PI to their sacrum (the triangular bone at the base of the spine that connects the lower back to the pelvis [bony structure inside hip]).Review of the wound consultant's note dated 06/05/2025 showed that Resident 1's sacrum wound was a stage 4 PU/PI and was Deteriorating by overall clinical impression, tissue quality, dimension and with significant amount of palpable (able to be touched or felt) bone. The note further showed that Resident 1 had two unstageable PU/PI on their left lower leg. Review of Resident 1's weights and vitals summary dated 07/15/2025, showed the following documented weights:- readmission on [DATE], showed they weighed 144.2 pounds (lbs.).- On 06/20/2025, they weighed 107.2 lbs. (25.6 percent or 37 lbs. weight loss since readmission).Review of the MDS look-up page printed on 07/16/2025 showed there was no SCSA MDS completed for Resident 1. In an interview and joint record review on 07/21/2025 at 11:37 PM, Staff C, MDS Coordinator, stated that the facility followed the RAI manual. Staff C stated that an SCSA MDS would be completed within 14 days of the significant change in status. A joint record review of Resident 1's weight record showed Resident 1 had a significant weight loss. A joint record review of the wound consultant's note dated 06/05/2025 showed Resident 1 had a stage 4 PU/PI on their sacrum and two unstageable PU/PI on their left lower leg. Staff C stated Resident 1 had two areas of decline and an SCSA MDS should have been completed. On 07/21/2025 at 1:08 PM, Staff B, Assistant Director of Nursing, stated that they expected an SCSA MDS to be completed per the RAI manual. Reference: (WAC) 388-97-1000 (3)(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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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	505311	A. Building B. Wing	07/21/2025

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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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely provide necessary care and services to prevent the worsening of pressure ulcer/pressure injury (PU/PI-an injury to skin and underlying tissue resulting from prolonged pressure on the skin) and ensure nutritional supplements and recommendations were followed for 1 of 2 residents (Resident 1), reviewed for pressure ulcers. Resident 1 experienced harm when their sacrum (the triangular bone at the base of the spine that connects the lower back to the pelvis [bony structure inside hip]) and left lower leg pressure ulcers worsened/deteriorated due to the delayed implementation of recommended treatments and nutritional supplements. These failures placed the residents at risk for further skin breakdown, worsening pressure ulcers, infection, medical complications, and a diminished quality of life. Findings included .The October 2024 Resident Assessment Instrument (RAI) User's Manual defines PU/PI as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The PU/PI can present as intact skin or an open ulcer and may be painful. The RAI manual defines PU/PI stages:-Stage 1 PU/PI is an observable, pressure related alteration of intact skin with a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury may appear with persistent red, blue, or purple hues. -Stage 2 PU/PI is a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough (dead tissue, yellow/white material in the wound bed) or bruising. -Unstageable PU/PI is when the wound's anatomical (body structure) tissues are obscured such that the extent of soft tissue damage cannot be observed or palpated. -Stage 4 PU/PI is a full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (a dry, crusty scab or layer of dead tissue that forms on the surface of a wound) may be present on some parts of the wound bed. Often includes undermining (when the skin around a wound separates from the tissue underneath, creating a space or pocket beneath the wound's edges) and tunneling (an underground tunnel extending from a surface wound into the surrounding tissue). The RAI manual further showed that PU/PI at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, more frequent dressing changes, and treatment that is more time-consuming than with routine preventative care.Review of the facility's policy titled, Skin Integrity, updated in June 2025, showed, In an effort to maintain the resident's optimal level of skin integrity and promote healing of skin ulcers/pressure ulcers/wounds, the facility has a systematic approach and monitoring process for evaluating and documenting skin integrity. In the event that a resident is admitted with or develops a skin ulcer/pressure ulcer/wound, care is provided to treat, heal, and prevent, if possible, further development of skin ulcers/pressure ulcers/wounds. Resident 1 admitted to the facility on [DATE] with diagnoses that included traumatic brain injury and persistent vegetative state (also known as post-coma unresponsiveness, is a chronic disorder in which an individual with severe brain damage appears to be awake but shows no evidence of awareness of their surroundings).Review of the facility's admission - readmission Nursing Evaluation dated 05/02/2025, showed Resident 1 was readmitted to the facility with one stage 2 PU/PI on their sacrum measuring 1.5 centimeter (cm - unit of measurement) by 1 cm by 0 cm. The assessment further showed that Resident 1 had two stage 1 PU/PI on their left lower leg.Review of Resident 1's admission Minimum Data Set (an assessment tool) dated 05/08/2025 showed Resident 1 was in a persistent vegetative state with no visible consciousness and that they had one stage 2 PU/PI present on admission. The assessment further showed that Resident 1 was at risk of developing PU/PI and was dependent on staff with all aspects of care. Review of the wound consultant's note dated 05/15/2025 showed that Resident 1's physical examination indicated malnutrition. The note showed that Resident 1 had one unstageable PU/PI to their sacrum measuring 5 [cm] by 4.5 [cm] by 0 [cm]. The note further showed the goal of care was for wound healing, an intervention for daily wound dressing change, and recommendation for 30 mL (milliliters - unit of measurements) of protein supplement twice a day until wound closure. Review of the wound consultant's note dated 05/29/2025 showed that Resident 1's sacrum unstageable PU/PI wound showed, Deteriorating by overall clinical impression, tissue quality. The note showed Resident 1 had two other wounds of unknown origin on their left lower leg. The note further showed a treatment to apply Dakin's (a special cleaning solution that helps kill the germs in a wound) soaked gauze to the sacrum wound daily and recommendation for 30 ml protein supplement twice a day until wound closure. Review of Resident 1's May 2025 Medication Administration Record (MAR)/Treatment Administration Record (TAR) showed there

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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 07/21/2025

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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 0692 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure acceptable parameters of nutrition were maintained, provide nutrition per physician order, maintain accurate documentation of nutritional intake, and recognize significant weight loss for 1 of 2 residents (Resident 1), reviewed for nutrition/weight loss. Resident 1 experienced harm when they had a significant weight loss of 24.1 percent (%) in two months. This failure placed the residents at risk for further decline in their weight, unintended consequences of poor nutrition, unmet care needs and decreased quality of life.Findings included.Review of the facility's policy titled, Nutrition Risk Monitoring and Evaluation guidelines, updated in November 2017, showed that residents nutritional risk factors are evaluated by the Interdisciplinary Team (IDT) on an ongoing basis. Among the guideline's listed nutrition factors to consider are significant weight loss or weight gain, poor skin integrity, unresponsiveness, and enteral feedings (also known as tube feeding, is a way of delivering nutrition to the stomach). The policy further showed that the IDT determines appropriate interventions with ongoing monitoring and evaluation by the Nutrition Hydration Skin Committee.Review of the facility's policy titled, Weights, revised on 10/12/2023, showed, The Center uses weights as one component of data collection needed to evaluate resident's nutritional status, fluid retention, or diuresis [excessive urination]. The policy further showed that residents with significant weight loss/gain (five percent in 30 days, 7.5 % in 90 days, or 10% in 180 days) and residents with multiple pressure ulcers may need to be weighed weekly. The policy further showed, The nurse records validated weights on the Weight Record in the resident's medical record. Review of the facility's policy titled, Enteral Feeding Tube, updated in May 2025, showed, It is the policy of this center that residents receiving tube feedings receive appropriate treatment and services to prevent complications and restore, if possible, normal eating skills.Intake is completed on those residents who are receiving enteral nutrition. This is done by checking the total infused via the enteral feeding pump. This is cleared after the total is evaluated and documented on the MAR [Medication Administration Record] or TAR [Treatment Administration Record]. Resident 1 admitted to the facility on [DATE] with diagnoses that included traumatic brain injury and persistent vegetative state (also known as post-coma unresponsiveness, is a chronic disorder in which an individual with severe brain damage appears to be awake but shows no evidence of awareness of their surroundings).Review of Resident 1's admission Minimum Data Set (an assessment tool) dated 05/08/2025 showed Resident 1 was in a persistent vegetative state with no visible consciousness. The assessment showed that Resident 1 was on a feeding tube and was dependent on staff with total calorie (measurement of the energy content of food) and fluid intake by tube feeding. Review of Resident 1's admission nutrition evaluation dated 05/16/2025 showed, Resident is NPO [nothing by mouth], dependent on enteral nutrition to meet 100% nutrition/hydration needs.Review of May 2025 MAR and TAR showed that Resident 1 had an order for tube feeding of Jevity 1.5 (brand name- a tube feeding formula) at a rate of 65 cubic centimeter (cc - a unit of measurement) per hour for 20 hours which equals to 1300 cc total per 24 hours. Review of the MAR/TAR showed no documentation of the total amount of tube feeding formula infused from 05/02/2025 through 05/16/2025. Further review of the MAR/TAR showed that Resident 1 received a daily total of 520 cc of tube feeding formula from 05/17/2025 through 05/31/2025 (780 cc less formula was administered daily).Review of June 2025 MAR and TAR showed that Resident 1 received a daily total of 520 cc of tube feeding formula from 06/01/2025 through 06/05/2025 (780 cc less formula was administered daily). Review of Resident 1's weights and vitals summary dated 07/15/2025, showed the following documented weights:- On readmission on [DATE], they weighed 144.2 pounds (lbs.).- On 06/20/2025, they weighed 107.2 lbs. (25.6 % or 37 lbs. weight loss since readmission).- On 06/29/2025, they weighed 106.6 lbs. (26 % or 37.6 lbs. weight loss since readmission).- On 07/10/2025, they weighed 109.4 lbs. (24.1 % or 34.8 lbs. weight loss since readmission).Review of the Nutrition Hydration Skin Committee Review dated 07/11/2025 (which was completed 21 days after Resident 1's documented weight loss) showed Resident 1 was reviewed for pressure injuries and weight loss. The review showed Resident 1 had a significant weight loss of 25.5 percent in one month.Review of the progress note dated 07/11/2025 showed that Resident 1 was sent to the hospital due to abnormal laboratory results. Review of the hospital progress note dated 07/13/2025 showed Resident 1 looked cachectic [a state of severe physical wasting and malnutrition. It is characterized by significant loss of body weight, particularly muscle mass] during admission to the hospital. In an interview on 07/21/2025 at 10:11 AM, Staff E, Licensed Practical Nurse, stated that for