| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505311 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Seattle Medical Post Acute Care | 555 16th Avenue<br>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) |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that two-person assistance was provided for bed mobility for 1 of 3 residents (Resident 1), reviewed for accident prevention. This failure to provide adequate supervision during repositioning in bed resulted in harm to Resident 1, who experienced an avoidable accident that caused a head injury requiring hospitalization and was found to have a new Left Frontal Intraparenchymal Hemorrhage (L F IPH - bleeding inside the left front part of the brain), leading to unintended health complications and a reduced quality of life.A past noncompliance was initiated on 01/18/2026 related to F689 Free of Accident Hazards/Supervision/Devices, for failure to protect Resident 1 from an avoidable accident. The facility implemented the following interventions that were initiated on 01/18/2026 and corrected by 01/21/2026:-Resident 1 was promptly transported to the hospital for medical evaluation and treatment.-The identified staff was suspended pending an investigation of the incident.-The identified staff was provided one on one reeducation regarding identifying and following plan of care for each resident before they returned to work.-Care observations of other residents were conducted to ensure staff provided care as determined by the residents' plan of care.-Audits were completed for a 30-day look-back on past falls and injuries to identify other residents affected by the failed practice.-Staff were educated on identifying and following plan of care for each resident as identified in their plan of care. -Periodic audits of resident care observations were initiated and will be conducted weekly for a duration of four weeks and then conducted monthly for a duration of two months to ensure compliance with the plan of correction. -Plan for reviewing and reporting to the facility's Quality Assurance and Performance Improvement Program meeting scheduled for 02/23/2026, for continued quality improvement.Findings included.Review of a face sheet showed Resident 1 admitted to the facility on [DATE] with diagnoses that included aphasia (a condition where a person has trouble speaking, understand words, read, or write) following cerebral infarction (a blocked blood vessel in the brain that causes brain damage), and encephalopathy (a condition that affects normal brain function).Review of Resident 1's Activities of Daily Living care plan, revised on 03/22/2023, showed she was two-person assist dependent for bed mobility due to limited/impaired mobility.Review of Resident 1's quarterly Minimum Data Set (an assessment tool), dated 12/26/2025, showed she was dependent (the assistance of two or more helpers was required for the resident to complete the activity) to complete the task to roll from lying on back to left and right side, and return to lying on back on the bed.Review of a facility provider acute care note dated 01/18/2026, showed Resident 1 chronically received anticoagulant (blood thinner) medication for valvular atrial fibrillation (a condition affecting heart valves and causes an irregular heartbeat).Review of Resident 1's nursing progress note dated 01/18/2026 showed, [Resident 1] fell from the bed and hit the back of her head resulting in a 2 cm [centimeter - a unit of measurement] laceration [cut in the skin], and that Resident 1 was sent to the hospital for further evaluation. It further<br><br>(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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | showed that the progressed note was written by Staff B, Weekend Nurse Manager.Review of hospital records titled, History and Physical - Critical Care, dated 01/18/2026, showed Resident 1 presented to the Emergency Department, after a fall from bed at SNF [Skilled Nursing Facility] found to have new L F IPH that increased slightly in size on 4hr [four hour] repeat scan [CT-Computed Tomography- medical imaging of the brain] with increased ventricles [four small, connected spaces inside the brain that hold and move fluid] size as compared to previous scan in 2019.Review of the facility's investigation summary report dated 01/18/2026, showed Staff B received a statement from Staff C, Certified Nursing Assistant (CNA), regarding Resident 1's incident on 01/18/2026. It further showed, Spoke with CNA about the event. I asked her if she had help while providing care for [Resident 1]. She said no. She stated that she had not turned her she was just trying to reposition her to the middle of the bed. She stated the patient [resident] slid off the side of the bed.Review of a training record, titled, CNA Competency Turning and Repositioning, dated 09/08/2025, showed that Staff C received training to lower head of bed, appropriate. Stand on the opposite side of the bed in which they will turn them. Lower bed rail, as a step in completing a turning and repositioning task.In an interview on 02/09/2026 at 12:52 PM, Staff B stated that Resident 1 was full dependence for bed mobility assistance and that repositioning her in bed required two-person assist to complete the task safely. When asked what contributed to Resident 1's fall out of bed on 01/18/2026, Staff B stated, [Staff C] said, when she went to pull [Resident 1] that's when [Resident 1] slid off the bed, and that I would expect [Staff C] to wait for second person to help. Staff B further stated that they expected staff would follow the resident's plan of care to make sure two-person assist is followed for bed mobility.In an interview on 02/10/2026 at 4:02 PM, Staff C was asked about the circumstances of Resident 1's incident on 01/18/2026, Staff C stated, I noticed she was at the edge of the bed on the left side.I pushed her upper body towards the middle of the bed, then I went around to the right side of the bed and used the draw sheet to pull her towards me. When asked what steps were taken to position the bed before repositioning Resident 1, Staff C stated, I didn't [did not] use any of the controls of the bed before repositioning [Resident 1], and that Resident 1's head of the bed was not lowered from a raised position prior to repositioning her. When asked when Staff C called for help from other staff, Staff C stated, I did not call for help at that moment, I called for help after the incident, when [Resident 1] slid out of the bed. Staff C further stated that Resident 1 slid off the bed from the left side while Staff C was standing on the right side of the bed. When asked if Resident 1's sliding off the bed could have been prevented, Staff C stated, If there was someone else there, then we would have been able to position her together and someone could have acted as a barrier on the side where she slid from, the left side.In a joint record review and interview on 02/11/2026 at 12:21 PM with Staff D, Nurse Practitioner, showed hospital records titled, History and Physical - Critical Care, dated 01/18/2026, showed Resident 1 presented to the Emergency Department, after a fall from bed at SNF found to have new L F IPH that increased slightly in size on 4hr repeat scan with increased ventricles size as compared to previous scan in 2019. Staff D stated, Because of the fall on 01/18/2026, the size of [Resident 1's] ventricles increased in size, showing swelling to the brain, and that Resident 1's anticoagulant medication was held [stopped] because [anticoagulant medication] can cause bleeding. When asked if the Resident 1's fall with a head injury caused the newly found bleeding in her brain, Staff D stated, From the notes, yes, after the fall, [Resident 1] was found to have new bleeding [in the brain].In an interview on 02/11/2026 at 12:32 PM, Staff A, Director of Nursing, stated [Resident 1] fell and ended up in the hospital with an injury, and that the incident happened when [Staff C] saw [Resident 1] sliding off the bed, came in and repositioned [Resident 1], however<br><br>(continued on next page) |

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| F 0689<br>Level of Harm - Actual harm<br>Residents Affected - Few | in the process of correcting [Resident 1's] position, [Resident 1] fell. When asked if Resident 1's 01/18/2026 fall was an avoidable accident, Staff A stated, Yes. Staff A further stated that Resident 1 was assessed to require two-person assistance with bed mobility. When asked if Staff C ensured Resident 1 received adequate supervision in accordance with their plan of care, Staff A stated, No she could have called for a second person.Reference: (WAC) 388-97-1060 (3)(g). |