STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505417	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anne Nursing and Rehabilitation Center	3540 Northeast 110th Street Seattle, WA 98125

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47130 Based on interview and record review, the facility failed to ensure a safe discharge process were implemented for 3 of 3 residents (Residents 1, 2 & 3), reviewed for discharge planning. The failure to ensure residents who discharged against medical advice (AMA) were provided risks and benefits prior to leaving the facility placed the residents at increased risk for hospital readmission, injury, and a diminished quality of life. Findings included . Review of the facility's policy titled, Discharging A Resident without a Physician's Approval, revised in October 2022, showed that should a resident, or their representative request an immediate discharge, the resident's attending physician is promptly notified. If the resident and/or their representative requests discharge without the approval of the attending physician, the resident and/or their representative will be asked to sign a release of responsibility form. Should either party refuse to sign the release, such refusal must be documented in the resident's medical record and witnessed by two staff members. RESIDENT 1 Resident 1 admitted to the facility on [DATE] with a diagnosis of fractures (broken) of the right humerus (upper arm) and right ulna (forearm). Review of the admission progress notes dated 02/22/2024, showed Resident 1 had a sling to their right arm requiring substantial (maximal) two person assist for transfer and mobility. Review of the Minimum Data Set (MDS- an assessment tool) dated 02/26/2024 showed Resident 1 had restricted mobility and required moderate assistance with activities of daily living. Review of the progress notes dated 02/26/2024, showed Resident 1 left the facility with a friend, would not be returning to the facility, and left the facility without medical advice. Further review of the progress notes showed no documentation that risks and benefits were discussed with Resident 1, their attending physician was notified of the unplanned discharge, inquired if the resident was safe after leaving the facility with an unknown person, and if Resident 1 was offered other options regarding any concerns they may have. (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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/2024 at 2:12 PM, Staff C, Medical Records, stated they were able to contact Resident 1's representative dated 02/26/2024, and Resident 1's representative stated that they did not know in advance about Resident 1's leaving with a friend. Staff C stated that Resident 1's representative stated that the resident had multiple concerns about the care at the facility, one of which was waiting for a long time in the bathroom and that no one helped them. On 03/04/2024 at 3:50 PM, Resident 1 stated that they were home and having difficulty moving around due to their broken right arm. On 03/11/2024 at 10:31 AM, Staff B, Interim Director of Nursing, stated that the facility was aware Resident 1 left the facility with a friend and that the facility did not contact the resident to check their safety. When asked regarding risks and benefits with Resident 1 prior to leaving AMA, Staff B stated that no one in the facility called Resident 1 and that the interdisciplinary team (IDT) was aware of the discharge but did not discuss the need for referral to other state entities. RESIDENT 2 Resident 2 admitted to the facility on [DATE]. Review of the admission progress notes dated 09/15/2023 showed Resident 2 required extensive assist for dressing. The progress notes showed Resident 2 was crying and wanted to go home. Resident 2 and their representatives left the facility and did not sign the AMA form. Further review of the progress notes showed no documentation that risks and benefits were discussed with the resident, their representatives, and/or their attending physician was notified of the unplanned discharge. RESIDENT 3 Resident 3 admitted to the facility on [DATE]. Review of Resident 3's progress note dated 01/15/2024 showed Resident 3 left AMA without discharge plan stating that it was freezing in the facility, and was not happy. Further review of the electronic health record on 03/11/2024 at 9:45 AM, did not show documentation that the facility inquired why the resident was not happy with the care and/or if the facility offered the resident other options regarding any concerns they may have. The clinical record showed no documentation that risks and benefits were discussed with the resident and/or that the attending physician was notified of the unplanned discharge. On 03/11/2024 at 10:31 AM, Staff B stated that the facility's process was for nursing to notify the attending physician and that the resident and/or their representatives would be asked to sign a release of responsibility form. Staff B stated that the facility should have ensured Resident 1, Resident 2, and Resident 3's safety was discussed with IDT. Staff B further stated that the physician notification should have been documented on the progress notes. Reference: (WAC) 388-97-0080 (5)