

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

1346  
PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505488	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/06/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  RICHMOND BEACH REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Federal Off-Hours Quality Indicator Survey conducted at Richmond Beach Rehabilitation on 12/01/13, 12/02/13, 12/03/13, 12/04/13, 12/05/13 and 12/06/13. A stage two sample of 52 residents was selected from a census of 138. The sample included 41 current residents and the records of 11 former and/or discharged residents.</p> <p>The survey was conducted by:   M.S., R.D.,   R.N., B.S.N.   R.N., B.S.N.   R.N., B.S.N.</p> <p>The survey team is from:                  Department of Social &amp; Health Services                  Aging &amp; Disability Services Administration                  Residential Care Services, District 2, Unit C                  20425 72nd Avenue South, Suite 400                  Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000                  Fax: (253) 395-5085</p> <p>                  Residential Care Services</p>	F 000	<p>This plan of correction is submitted as required under Federal and state regulations and statutes applicable to long term care providers for the survey conducted 12/2/2013 through 12/6/2013. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p> <p>Please accept this Plan of Correction as our credible allegation of compliance. Our compliance will be achieved by 01/13/2014.</p>	
-------	---	-------	---	--

RECEIVED  
JAN 03 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/30/2013
---	------------------------	-------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure two residents (#32 and #171) had a private place to meet. Additionally, the facility failed to ensure personal privacy was maintained for one resident (Resident #8) reviewed for personal privacy.</p>	F 164	<p>F 164</p> <p><u>How the nursing home will correct the deficiency as it relates to the resident:</u> Residents #32 and #171 were reminded how to reserve the Private Dining Room and Conference Room 7 days a week. Resident #8 is stable and improving.</p> <p><u>How the nursing home will act to protect similar residents in similar situations:</u> Residents and Staff were educated related to personal privacy during care, during therapy sessions, and where residents may meet privately with others.</p> <p><u>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</u> New residents will continue to receive a copy of their resident rights including their right to privacy, and information about where they may meet privately. Residents will also continue to be reminded of their rights in resident council and other resident meetings including but not limited to care conferences.</p>		

RECEIVED

JAN 03 2014

Durham, CA 94595

12/30/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505488	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/06/2013
NAME OF PROVIDER OR SUPPLIER  RICHMOND BEACH REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	<p>Continued From page 2</p> <p>These failures placed three residents out of 41 current Stage II residents at risk for anxiety for not having a public place to meet and exposure of body parts and public views.</p> <p>Findings include:</p> <p><b>RESIDENT # 32</b> Resident #32 was admitted to facility [REDACTED]/13 with multiple health care needs which included [REDACTED] and [REDACTED]. Review of the admission Minimum Data Set (MDS) dated [REDACTED]/13 and the quarterly MDS dated 10/24/13 revealed the resident was cognitively intact scoring 15 out of 15 on a Brief Interview Mental Status (BIMS)</p> <p>On 12/02/13 at 12:16 p.m., Resident #32 reported there was no private place to meet if she would have visitors. Resident #32 further reported that, in the past few months, there was a private room which was designated for residents to use if they needed, but it was taken and given to facility health care providers to use.</p> <p><b>RESIDENT #171</b> Resident #171 was admitted to facility [REDACTED]/13 with multiple health care needs which included [REDACTED]. Record review of the admission MDS dated [REDACTED]/13 and the quarterly MDS dated 09/05/13 revealed Resident #171 was cognitively intact and able to make needs known.</p> <p>On 12/02/13 4:16 p.m., in an interview Resident #171 verbalized concerns of not having a private place to meet with her visitors. Resident #171 further stated that she had used the dining room in the past, but there were always other residents</p>	F 164	<p>Residents will continue to be asked routinely if they feel their privacy needs are being met, and concerns will be acted upon when they are raised.</p> <p><u>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</u></p> <p>The results of the above audits shall be discussed in Quality Assurance Committee. Appropriate action shall then occur to assure compliance.</p> <p><u>Date corrective action will be completed:</u></p> <p>01/13/2014</p> <p><u>Title of the person responsible to ensure correction:</u></p> <p>Administrator</p>	

RECEIVED

12/30/13

JAN 03 2014

DSHS/ADSWALS

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 164	<p>Continued From page 3 in the dining room.</p> <p>On 12/05/13 at 2:10 p.m., in an interview, Staff O admitted the private room for the residents was taken away. Staff O further stated that there was a private dining room available for the residents to use, but not all residents were informed about its availability for use. Staff O reported that on 09/13/13, an interview was conducted with Resident # 32 where she expressed similar concerns but no interventions were initiated to address resident's concerns. Staff O continued and stated " We will find a way to notify all our residents about the availability of the private dining room."</p> <p>Observation of the private dining room on 12/03/13 at 3:30 p.m., 12/04/13 at 11:35 a.m. and 12/05/13 at 1:20 p.m., the dining room was noted to be used by facility staff for meetings. No residents were observed using private dining room.</p> <p><b>RESIDENT #8</b> Resident #8, was admitted to the facility on [REDACTED]/2010, with multiple medical diagnoses including [REDACTED] and [REDACTED]. The resident's most recent annual MDS Assessment dated 10/01/13, documented the resident needed limited assistance or supervision with the activities of daily living.</p> <p>On 12/03/13 at 10:55 a.m., the resident was observed in the hallway in her wheelchair. The resident was accompanied by a therapy staff through the 300 hallway. The resident was seated in her wheelchair wearing a hospital gown, however the back of the gown was open</p>	F 164		
-------	---	-------	--	--

RECEIVED

JAN 03 2014

JSR/ADS, RLS

12/30/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 164	Continued From page 4 exposing the skin on the resident back. The therapy staff cued the resident let go see the gym, and walked beside the resident as she propelled her wheelchair slowly towards the area. Other resident and staff were present in the area.  At 11:05 a.m., a similar observation occurred as the resident propelled herself back to her room, again she was not to be accompanied by staff while in the hall way. Not ensuring the resident was covered or clothed appropriately in a common area violated the resident personal privacy.	F 164			
F 272 SS=D	<b>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b>  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;	F 272	<b>F 272</b>  <u>How the nursing home will correct the deficiency as it relates to the resident:</u>  Residents #252 was assessed related to weight [redacted] and appropriate clinical action was taken, her care plan was updated.  <u>How the nursing home will act to protect similar residents in similar situations:</u>  An audit of similar residents occurred and residents who triggered for weight loss were appropriately assessed and action was taken where warranted including care plan modification.		

RECEIVED 12/30/13

JAN 03 2014

DSHS/ACQUAN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	<p>Continued From page 5</p> <p>Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to complete assessments for one of the 41 current Stage II residents (Resident # 252). Failure to assess one resident's refusal of care and identify and assess significant weight loss for another resident increased the risk of health complications associated with unmet care needs.</p> <p>Findings include:</p> <p><b>RESIDENT #252</b></p> <p>Resident 252 was admitted to the facility on [REDACTED]/13 for [REDACTED] after the [REDACTED] repair. The resident was assessed to be alert and able to make her needs known.</p> <p>On 12/02/2013 at 11:25 a.m., the resident reported the food was "not good" and commented</p>	F 272	<p><u>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</u></p> <p>The RCMs will audit resident weights frequently and assure that residents are weighed according to their plan of care. Weight audits shall be presented in the Nutrition at Risk Meeting.</p> <p><u>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</u></p> <p>The results of the above audits shall be discussed in Quality Assurance Committee. Appropriate action shall then occur to assure compliance.</p> <p><u>Date corrective action will be completed:</u></p> <p>01/13/2014</p> <p><u>Title of the person responsible to ensure correction:</u></p> <p>Director of Nursing Services.</p>	

RECEIVED

12/30/13

JAN 03 2014

DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505488	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/06/2013
NAME OF PROVIDER OR SUPPLIER  RICHMOND BEACH REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	<p>Continued From page 6</p> <p>that "everything tastes the same." The resident stated she was aware that she was losing weight, and indicated it was not intentional.</p> <p>Review of the nutrition care plan dated 11/19/13 included directives to obtain weekly weight and notify Registered Dietitian (RD) of significant changes. The care plan goal was to "maintain weight [REDACTED] lbs."</p> <p>Review of the resident's electronic record revealed a pattern of continued weight loss. On 11/15/13 the resident's documented weight was [REDACTED] pounds (lbs), on 11/22/13 [REDACTED] lbs, and on 11/20/13 [REDACTED] lbs. Although the care plan noted that weekly weights were obtained, no additional weights were noted in the clinical record on 12/05/13.</p> <p>On 12/05/13 at 11:48 a.m., during an interview, Staff J, was asked about the resident's current weight. She then located an additional weight on 11/30/13 of [REDACTED] lbs. Staff J did not why a December weight was not taken and then directed a nursing assistant to check the resident's weight which was [REDACTED] lbs.</p> <p>On 12/05/13 the RD was interviewed about how she received referrals for residents with weight loss. She stated the clinical data base system would cue her if a resident experienced a weight loss if the weight was entered into the electronic record. She also reported RCMs also provided information about weight loss during meetings she attended. The RD said she was not aware the Resident #252 was actively losing weight, and had not assessed the weight loss.</p> <p>Failure to identify Resident #252 was actively</p>	F 272			

RECEIVED

12/30/13

JAN 03 2014

DSHS/ADBAK 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	Continued From page 7 losing weight resulted in the facility not assessing and/or identifying interventions to assist the resident to maintain body weight. This placed the resident at risk for health complications associated with malnutrition and weight loss.	F 272			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE  A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to identify a significant change in condition for Resident #50, one of 41 current Stage II residents reviewed. Failure to identify the need for a significant change assessment due to this resident's improvements in ADLs (Activities of Daily Living) along with the decline in behaviors, placed this resident at risk for unmet care needs.  Significant change: According to the Resident	F 274	F 274  <u>How the nursing home will correct the deficiency as it relates to the resident:</u>  Resident #50 was assessed for a significant change MDS and the MDS document was completed.  <u>How the nursing home will act to protect similar residents in similar situations:</u>  An audit of similar residents occurred and residents who triggered for a significant change, those residents were assessed and when appropriate the MDS document was completed.  Education was provided to the Interdisciplinary team members who complete the MDS tasks related to identification of a change in condition as defined by the RAI manual.		

12/30/13  
RECEIVED

JAN 03 2014

DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 274	<p>Continued From page 8</p> <p>Assessment Instrument (RAI: used to code the Minimum Data Set, an assessment tool) a significant change is a facility assessment of the resident's condition, which must be completed 14 days after determination that significant change in the resident's condition occurred.</p> <p>Findings include:</p> <p>Resident #50 was admitted to the facility [REDACTED]/13 with diagnoses that included [REDACTED], [REDACTED], [REDACTED] and [REDACTED] (difficulty [REDACTED]). According to the [REDACTED]/13 admission MDS (Minimum Date Set) this resident needed extensive assistance with several ADLs to include locomotion off the unit and dressing.</p> <p>Review of the 11/12/13 MDS revealed the resident's status changed to only needing limited assistance with locomotion off the unit and only needed one person assistance for dressing. Both of these were improvements, and therefore changes. This MDS, however, did not reflect the resident's current wandering behavioral status and a significant change assessment was not completed.</p> <p>The 11/12/13 MDS indicated the resident was not displaying any wandering behavior. Review of a Nursing Progress Note (NPN) 11/07/13 revealed a wanderguard (a device the resident wears for protection against elopement) was being implemented. Continued review of NPN from 11/12/13, 11/16/13, 11/18/13 and 12/05/13 all included documentation describing the resident's wandering behavior, to include instances Resident #50 wandered into other resident's rooms uninvited.</p>	F 274	<p><u>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</u></p> <p>The MDS Coordinator will review each MDS prior to signing and transmitting to assure compliance with the completion criteria for the significant change MDS as required by the RAI manual.</p> <p><u>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</u></p> <p>The results of the above audits shall be discussed in Quality Assurance Committee. Appropriate action shall then occur to assure compliance.</p> <p><u>Date corrective action will be completed:</u></p> <p>01/13/2014</p> <p><u>Title of the person responsible to ensure correction:</u></p> <p>RN MDS Nurse.</p>		

12/30/13  
REC'D [REDACTED]

JAN 03 2014

DSHS/ADULT [REDACTED]

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 274	Continued From page 9 On 12/02/13 at 9:18 a.m., Resident #50 was observed entering another resident's room and received a negative reaction from the resident who resided in that room.  Review of the care plan revealed the resident's wandering behavior was not addressed. The resident had the ability to wander due to her improvement in mobility. Staff had not updated the care plan to reflect the resident's current care needs.  On 12/06/13 at 2:49 p.m., Staff K reviewed the changes on the MDS with ADLs and also identified the wandering behavior was not coded. Staff K indicated a significant change assessment should have been done at that point to reflect the current status of Resident #50.	F 274			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure care directives for two of the 41 current Stage II sample residents (#252 & 17) were consistently implemented. Failure to ensure that services were provided as care planned placed the resident at risk for health complications associated with poor oral hygiene and weight	F 282	<u>How the nursing home will correct the deficiency as it relates to the resident:</u>  Resident #252 was assessed for weight loss and her care plan and Kardex were updated.  Resident # 17 was re-assessed to determine her wishes related to oral care. Her wishes are consistent with the wishes that she has expressed for more than 10 years, and her care plan and Kardex were updated to reflect her right to refuse oral care.		

12/30/13

JAN 03 2014

DSHS/AUS/1/3/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 10 loss.</p> <p>Findings include:</p> <p><b>RESIDENT #17</b></p> <p>Resident #17 had multiple medical conditions including a progressive [REDACTED] disease. The record documented the resident was re-admitted to the facility on [REDACTED]/13. The Minimum Data Set (MDS: an assessment tool) assessment completed on re-admission, [REDACTED]/13 indicated the resident was alert and oriented and noted the resident needed extensive assistance with hygiene.</p> <p>Review of the resident care plan indicated staff provided the assistance with oral care twice a day, in the morning and evening. During an interview on 12/02/13 at 11:00 a.m., Resident #17 was noted to have poor dentition. Her upper and lower teeth appeared stained, broken and decayed. She stated that staff did not provide assistance with oral care unless "she requested" assistance.</p> <p>On 12/05/13 at 11:45 a.m., during an interview Staff J, the Resident Care Manager (RCM), reported the resident frequently refused assistance with oral care from staff. She stated the physician orders, included a directive for the Nurses to monitor the provision of oral care and refusals, but was not able to find the directive on the resident's current Medication administration or treatment record. She stated she did not know why the directive was not on the resident treatment sheet or why the care was not being monitored.</p>	F 282	<p><u>How the nursing home will act to protect similar residents in similar situations:</u></p> <p>An audit occurred for residents with alteration in oral care and residents who are at risk for weight loss. Where issues were identified, they were corrected and the care plan was updated.</p> <p>The licensed nursing staff were in-serviced related to care planning, updating the Kardex and the use of the care plan in general.</p> <p><u>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</u></p> <p>The MDS nurse will audit the care plans in accordance with the standards posed in the RAI manual and the requirements related to the review and coordination of the plan of care; at least every 92 days.</p> <p><u>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</u></p> <p>The results of the above audits shall be discussed in Quality Assurance Committee. Appropriate action shall then occur to assure compliance.</p>	

RECORDED  
12/30/13  
JAN 03 2014  
DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 11</p> <p>Not ensuring the physician order to monitor the provision of oral care was followed, placed the resident at risk for poor oral hygiene and dental caries.</p> <p>RESIDENT #252</p> <p>Resident #252 was admitted to the facility on [REDACTED]/13 for [REDACTED] after the [REDACTED] repair of a [REDACTED]. The resident was hospitalized and then re-admitted to the facility on [REDACTED]/13. The resident was assessed to be alert, oriented and able to make her needs known.</p> <p>During the initial admission, an assessment of the residents nutritional status was completed and the Registered Dietitian (RD) noted the resident goal weight was [REDACTED] pounds.</p> <p>When asked about the care plan directive to complete weekly weight, Staff J, the RCM reported all residents are placed on weekly weights at the time of re-admission. She stated the Licensed Nurses are asked to document the weights for four weeks after admission. She then stated it should be identified on the treatment sheet, but was not able to find the directive on the resident current Medication administration or treatment record. She then commented the resident weight should have been taken on tuesday, which was 12/03/13.</p> <p>Although the weights should have been monitored and entered in the record, they were not. The last weight found documented in the clinical record was dated 11/24/13. There was no evidence the weekly weights were obtained after that date. On 12/06/13, Staff J asked a NAC to obtain the resident's weight and it was discovered</p>	F 282	<p><u>Date corrective action will be completed:</u></p> <p>01/13/2014</p> <p><u>Title of the person responsible to ensure correction:</u></p> <p>RN MDS Nurse.</p>	

**12/30/13**  
RECEIVED  
**JAN 03 2014**  
DSHS/SAL/SK/LS

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 12 the resident had lost additional weight.  During a follow up interview the Registered Dietitian stated the electronic record would alert her if a resident had experienced significant weight loss, if the weights after 11/24/13 had been entered into the clinical record.  Not ensuring the care plan to monitor the resident weights weekly to identify the significant weight loss contributed to the resident losing █ % of body weight in less than thirty days, which according to the Centers for Medicare is considered severe weight loss.	F 282		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329	F 329  <u>How the nursing home will correct the deficiency as it relates to the resident:</u>  Resident #91 was re-assessed by her physician in December, 2013, and a Gradual Dose of her █ was ordered.  Resident #255 has discharged.  <u>How the nursing home will act to protect similar residents in similar situations:</u>  An audit occurred for residents who are prescribed psychotropic	

12/18/2013  
JAN 03 2014

OSASIA LAROS

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505488	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/06/2013
NAME OF PROVIDER OR SUPPLIER  RICHMOND BEACH REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 13 drugs.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the drug regimen for two of the five residents (#91 & 255) selected for medication review were free of unnecessary drugs. Failure to ensure a gradual dose reduction of a psychoactive medication was attempted and ensure staff monitored the behavior a psychotropic medication was intended to treat placed the residents at risk for unnecessary medications.  Findings include:  RESIDENT #91  Resident #91 was admitted to the facility on [REDACTED] 13 with multiple diagnoses including [REDACTED]  Review of the resident's last annual Minimum Data Set (MDS: an assessment tool) assessment indicated the resident needed extensive assistance with the activities of daily living and was able to self-propel a wheelchair for locomotion throughout the facility. The behavioral section of the assessment noted the resident displayed wandering behavior.  Review of the Resident's current medications found the resident was administered [REDACTED] mg of [REDACTED] (an antidepressant), administered for	F 329	medicines to assure Gradual Dose Recommendations received the necessary attention from the resident's physician.  The licensed nursing staff were educated related to the sleep monitor and how to document on it and how to assure that it appears on the Medication Administration Record in the electronic health record.  <u>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</u> The Interdisciplinary team, including the Medical Director, social services personnel, Activities Director and Resident Care Managers meet routinely to discuss Gradual Dose Recommendations and sleep monitor documentation is audited and corrected prior to the meeting. Psychotropic Medicines are audited and discussed at least quarterly, at times more frequently depending on resident behaviors and the class of psychotropic medicine.		

12/30/13  
RECEIVED

JAN 03 2014

DSHS ADVISORS

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 14</p> <p>a diagnosis of insomnia. The resident received a routine dose of the medication each night. The treatment record indicated the Licensed Nurses monitored the hours of sleep each shift.</p> <p>The clinical record had a pharmacy consult dated 09/02/13 that recommended a gradual dose reduction of [REDACTED]. The physician checked a box on the form indicating Resident #91 had previously failed a gradual dose reduction. A notation written across the bottom of the form stated "because RN (Registered Nurse) states needed."</p> <p>On 12/05/13 at 11:45 a.m. Staff J, the resident care manager, was asked about the attempted dose reduction of the medication the physician had noted. However, she was not able to find any documentation indicating any dose reduction had occurred.</p> <p>The clinical record also noted the psychotropic medication was increased to [REDACTED] mg on 6/13/13.</p> <p>Although the resident care manager reported the resident slept better when dosage was increased, review of the sleep monitor for documenting hours of sleep during May revealed the resident routinely slept 7 hours during the night and one to two hours during the day. The record revealed the same sleep pattern was documented during October of 2013, even though the dosage was double it appeared to have no effect on the hours of sleep.</p> <p>Staff J was not able to find any documentation to verify a dose reduction of the medication occurred. The only mention of a dose reduction was documented by the Social Services staff in a</p>	F 329	<p><u>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</u></p> <p>The results of the above audits shall be discussed in Quality Assurance Committee. Appropriate action shall then occur to assure compliance.</p> <p><u>Date corrective action will be completed:</u></p> <p>01/13/2014</p> <p><u>Title of the person responsible to ensure correction:</u></p> <p>Resident Care Managers</p>		

12/30/13  
RECEIVED  
JAN 03 2014  
DORIS... 13

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505488	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/06/2013
NAME OF PROVIDER OR SUPPLIER  RICHMOND BEACH REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 15 progress note dated 08/28/13. The staff read "Attempted to decrease [REDACTED] to [REDACTED] mg several months ago, but patient presented with increased insomnia."  Additional review of the clinical record found the resident had experienced falls during waking hours over the past several months. The medication administration record listed side effects of the medication including changes in blood pressure, drowsiness, and blurred vision. Review of the last three fall incident reports found no evidence side effects of the anti depressant medication were ruled out as a contributing factor. This placed the resident at risk for negative outcome related to the use of psychotropic medications, such as falls and injury.  RESIDENT #255  This resident was originally admitted to the facility [REDACTED]/13. Resident #255 was receiving [REDACTED] (a sedative medication that aids with sleep).  Review of the physician's orders for the [REDACTED] directed staff to monitor the hours of the sleep for this resident. Review of the November and December 2013 MAR (Medication Administration Record) did not include any sleep monitoring.  On 12/06/13 at 10:05 a.m., Staff J was unable to find evidence that staff were documenting hours of sleep for Resident #255. Staff J went on to state staff should have been monitoring hours of sleep, but it wasn't cued for them to do so on the MAR.	F 329			
F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR,	F 364			

12/30/13  
[REDACTED]  
JAN 03 2014  
DSHS/ADL/1103

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 364 SS=E	Continued From page 16 <b>PALATABLE/PREFER TEMP</b>  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that food served were palatable and at the proper temperature. Failure to ensure foods were palatable and served at the proper temperature placed the 10 of the residents (# 249 ,257 ,252 ,17 ,142 ,256 ,255 ,47, 149 and 250.) at risk for weight loss and could negatively impact the residents quality of life.  Findings include:  During Stage I interviews 10 of 21 resident interviewed complained about food quality and/or the temperatures of the hot food. The resident complaints included comments about lack of flavor, the food is " institutional " and another commented the vegetables are " overcook. " Six of the residents stated the hot foods were cold.  Review of the resident council meeting revealed the resident did at times record concerns expressed by residents. The November notes indicated one of the residents who normally ate in the dining room, expressed concerns about the temperatures of food when a meal tray was delivered to her room. The resident also expressed her concern for residents who always had meals delivered to their rooms. Another	F 364	F 364  <u>How the nursing home will correct the deficiency as it relates to the resident:</u> Residents 249, 257, 255, were discharged. Residents 252, 17, 142, 256, 47, 149, and 250 were re-interviewed by the dietary manager and food preferences and concerns were heard. In some cases, the resident plans of care were updated when warranted.  <u>How the nursing home will act to protect similar residents in similar situations:</u>  An audit occurred for a sample of 80 residents (both active and discharged) in order to identify similar issues. Residents who expressed concern with food satisfaction were heard. In some cases, the resident plans of care were updated when warranted.  Staff were in-serviced and informed that when residents raise concerns about food temperature or flavor, the opportunity for improvement form should be completed for resolution of the resident concerns.		

**12/30/13**  
RECEIVED

JAN 03 2014

0043-100011.02

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	<p>Continued From page 17</p> <p>resident, who attended the meeting expressed dissatisfaction with the weekly menu. In October several complaints were documented, one included a complaint about soggy toast, and dissatisfaction with items received on their trays.</p> <p>During Stage II, four residents' who complained about the food quality were selected for additional review.</p> <p><b>RESIDENT # 252</b></p> <p>Resident #252, was admitted to the facility after the [REDACTED] repair of a [REDACTED]. The resident was admitted to the facility on [REDACTED] and on [REDACTED]/13, it was discovered the resident had lost [REDACTED]% of her body weight since admission.</p> <p>The resident was interviewed during the survey on multiple occasions. On 12/02/13 at 11:00 am the resident stated she did not like the food, she reported " everything tastes the same. " Although the resident was actively losing weight the facility staff had not identified or assessed the resident ' s weight loss. After the significant weight loss was discussed with the Dietitian on 12/05/13, the facility sought out more information about the resident food preferences. (See F 272 for lack of assessment of the resident's weight loss.)</p> <p>On 12/06/13 during the noon meal, the resident received an alternate meal for lunch. Resident #252 reported the facility staff had discussed the weight loss she experienced and obtained additional information about preferences.</p> <p><b>RESIDENT #257</b></p>	F 364	<p><u>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</u></p> <p>Residents will continue to be asked questions related to food satisfaction including food flavor and temperature at least quarterly, and concerns will be identified and brought to the attention of the Dietary Manager for resolution. Data and statistics from the above questionnaires shall be gathered, aggregated and trended by the dietary manager.</p> <p><u>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</u></p> <p>The results of the above data shall be discussed monthly in Quality Assurance Committee. Appropriate action shall then occur to assure compliance.</p> <p><u>Date corrective action will be completed:</u></p> <p>01/13/2014</p> <p><u>Title of the person responsible to ensure correction:</u></p> <p>Dietary Manager</p>	

12/20/13  
RECEIVED

JAN 03 2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 364	<p>Continued From page 18</p> <p>Resident #257, approached the nursing station at 9:30 a.m., the resident complained to the staff at the nursing station about a housekeeper entering her room spraying cleaning chemicals in the area when her breakfast arrived. About 15 minutes later the resident approached the Dietitian, Staff D and handed her the meal ticket with her name on it.</p> <p>During a follow up interview on 12/04/13, Resident # 257 stated the facility had put her on a diabetic diet. She explained that some things menu items would be substituted, and reported she had discussed the diet with the Dietitian, and she agreed to change it. She expressed frustration that the change had taken so long.</p> <p>On 12/04/13, during a follow up interview the Dietitian, explained the resident was put on a restrictive diet at the time of admission. She stated the issue was discussed with the resident and agreed the diet could be liberalized. She stated there was a delay in implementing the change. The Dietitian reported a diet change slip was initiated " three days ago " but the change was not processed right away.</p> <p>RESIDENT # 142</p> <p>Resident #142, was alert and oriented and able to make his needs known. The resident complained about the food quality. He stated the food is usually cold when it is received. The resident was observed during the survey to be independent with most activities of daily living, including walking.</p> <p>On 12/04/13 at 8:35 the resident was seen returning to his room after breakfast. When</p>	F 364			

RECEIVED 12/30/13  
JAN 03 2014  
DORIS...

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 364	Continued From page 19 asked how the breakfast meal was that day, the resident stated " they just don ' t know how to cook a medium egg " he then stated " but I ate it anyway. "  On 12/05/13, at 11:00 a.m. Staff C, the Food Service Manager, was asked if he was familiar with the Resident. He stated he did know the resident, but denied he was aware of the residents request for a med cooked egg.  During a follow up interview on 12/09/13, Resident # 142, he stated on 12/06/13, Staff C prepared his egg for breakfast. He stated he received a " perfect egg ", but it only occurred on the one occasion. The Dietitian, who was present during the conversation, assured the resident she would talk to the dietary staff again to ensure his preference for a medium cooked egg was honored.	F 364			
F 371 SS=D	RESIDENT #255 On 12/02/13 at 11:11 a.m., Resident #255 stated the vegetables were often overcooked and that generally foods intended to be hot were too cool. On 12/04/13 at 1:59 a.m., Resident #255 reported he did not get the potatoes with his breakfast that were intended per the menu. On 12/06/13 at 9:42 a.m., he stated his toast for breakfast was "soaking wet."  483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371	F 371  <u>How the nursing home will correct the deficiency as it relates to the resident:</u> The items referenced by the state surveyor were sanitized. These		

12/30/13  
RECEIVED

JAN 03 2014

DSHS/ALLENROS

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 20 under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that foods were stored prepared and distributed under sanitary conditions. Failure to ensure temperatures were maintained below the danger zone, ensure that equipment was clean and sanitary condition and ensure that items were dated and labeled when thawed placed resident at risk for food borne illness.</p> <p>Findings include: Failure to maintain temperatures</p> <p>On 12/01/13 at 1:30 p.m., during the initial tour in the dietary department, a reach in refrigerator located near the tray line was found without a thermometer. The contents of the refrigerator included milk items. The food service manager then located a thermometer and placed in the interior of the unit.</p> <p>On 12/05/13 the refrigerator was checked again, this time the cooling unit was empty. The Food Service Manager, Staff C, stated on 12/01/13 after the thermometer was placed in the refrigerator, it was found to be above 41 Degrees Fahrenheit (DF). Staff C reported all the contents were discarded because the temperature was in the danger zone. He then explained the unit had been intermittently serviced because of the unit</p>	F 371	<p>items were placed on a cleaning and sanitizing schedule.</p> <p>The reach in refrigerator was replaced.</p> <p><u>How the nursing home will act to protect similar residents in similar situations:</u> The RD inspected the remaining kitchen equipment for cleanliness. Items she identified were sanitized accordingly and placed on a cleaning schedule.</p> <p>The RD inspected the remaining kitchen temperature logs to assure Richmond Beach had no similar issues with cold holding equipment.</p> <p>Kitchen staff were educated related to safe cold holding equipment temperatures, how to take temperatures in cold holding equipment, and how to report equipment failure issues for resolution, and how to assure food was maintained at safe temperatures.</p> <p><u>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</u></p>		

12/18/13  
RECEIVED  
JAN 03 2014  
DSHS/ALUM

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 21</p> <p>lack of maintaining an appropriate temperature and provided the service records dated 05/13 and 07/13.</p> <p>Review of the service records noted the repair technician found the system low on refrigerant. The technician noted a leak in the coolant system but was not able to find it. Review of the November temperature log found during the month the temperature was record above 41 during the afternoon hours for 11 of the 30 days recorded. The a.m. temperatures recorded noted the temperature was above 41 only on two occasions, the afternoon the temperatures showed temperatures were in the danger zone sometimes for several consecutive days.</p> <p>Soiled equipment</p> <p>On 12/01/13 during the initial tour in the kitchen at 1:30 p.m., one of the three buckets of sanitizer did not have a sufficient concentration of the chemical sanitizer. The head of the juice dispenser was soiled, the microwave had food spills in side, the mixer had dried food splash on the base and underside of the rotary blade. The cutting board on the sandwich station was stained orange and black in some areas. The surface of the cutting board had deep scores and cuts on the surface, making it difficult to sanitize.</p> <p>On 12/6/13, at 6:30 a.m., during a follow up inspection the mixer, can opener and microwave were found soiled. Staff C, was asked to remove the head on the juice gun and a ring of black mildew was visible on the white colored head.</p> <p>Failure to ensure food were properly labeled</p>	F 371	<p>The Dietary Manager will inspect the kitchen bi-weekly to assure cleaning schedules are followed.</p> <p>The Dietary Manager will inspect cold holding equipment temperature logs to assure compliance with temperature taking and equipment safety.</p> <p>The RD will inspect the kitchen monthly to assure kitchen hygiene and sanitation is occurring according to Health Department Standards.</p> <p>The RD will inspect kitchen temperature logs routinely to assure equipment is consistently holding food at safe temperatures.</p> <p><u>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</u></p> <p>The results of the above inspections/ audits shall be discussed in Quality Assurance Committee. Appropriate action shall then occur to assure compliance.</p> <p><u>Date corrective action will be completed:</u></p> <p>01/13/2014</p>		

12/30/13  
RECEIVED  
JAN 03 2014  
OSHS

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 22 While in the walk in, 6 -8 health shakes were found, but there was no label to identify when the items had been thawed. (The item was received by the facility frozen and then thawed before use, however the cartons did not have an expiration date.) Not ensuring the product was labeled when thawed, left the facility staff without the information needed to monitor shelf life and expiration dates.	F 371	<u>Title of the person responsible to ensure correction:</u>  Dietary Manager, Registered Dietician	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	F 441  <u>How the nursing home will correct the deficiency as it relates to the resident:</u> Residents 100, 107, 171, 141 continue to reside at Richmond Beach. There is no evidence of a nosocomial infection related to the activity referenced by the state surveyor.  <u>How the nursing home will act to protect similar residents in similar situations:</u> Staff were in-serviced related to the use of hand sanitizer, infection control procedures, hand washing and hand hygiene in the kitchen, care areas, during med pass, and in dining rooms.	

12/18/13  
JAN 03 2014  
JHS/AD

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 23</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure staff used proper hand washing to prevent the development and /or transmission of disease and infection. The failure placed Residents (#100, 107, 171, 41) receiving medications and dining at risk for infection.</p> <p>Findings include:</p> <p><b>MEDICATION PASS</b></p> <p>On 12/04/13, around 12:35 p.m., during an observation of a noon medication pass, Staff L, a Licensed Nurse (LN) began dispensing medications into a medication container for Resident #107. The medication container handed by the resident was also handled by the LN. Hand-washing was not observed prior to the activity or on completion of the activity. On completion of dispensing of the medications, Staff L dispensed and took medication to Resident #100's room. The resident handed the medication along with a cup of water container then gave them back to the LN after taking the medications. Staff L took the cup and medication container and</p>	F 441	<p><u>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</u></p> <p>The Infection Control Coordinator will complete an observation/written audit of medication pass routinely to assure compliance with handwashing during medication pass.</p> <p>The Dietician will complete an observation /written audit of the kitchen procedures frequently to assure hand washing is completed when warranted.</p> <p>The Infection Control Coordinator will complete a frequently dining room observation audit to assure compliance with handwashing during meal time activities.</p> <p><u>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</u> Data from the audits above will be aggregated and discussed in quality assurance committee to assure action is taken when trends occur.</p> <p><u>Date corrective action will be completed:</u>  01/13/2014</p>		

12/30/13  
RECEIVED  
JAN 03 2014  
JHS/AL...

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 24</p> <p>threw them in the garbage. He then, picked up a meal tray (which had been eaten from and had food on it) left the room, then placed the meal tray on the hall cart.</p> <p>Without performing hand-washing or using a hand sanitizer, Staff L began to dispense medications for Resident #171. He took the medications into the room and gave them to the resident. After the resident had taken the medications, Staff L threw the empty medication and water containers into the garbage. Again, Staff L removed a half-eaten tray from the resident's room and without performing hand-washing or using a hand sanitizer.</p> <p>Staff L dispensed medications to a fourth (Resident #41). He completed the medication task again, without performing hand-washing or using a hand sanitizer for either task. When asked, Staff L agreed hand-washing should have been done but offered no reason why he did not wash or sanitize his hands.</p> <p>The facility's infection control policy included; staff were to perform hand-washing between resident contact and after handling dirty items to prevent the spread of infection.</p> <p>LACK OF HANDWASHING DURING DINING.</p> <p>On 12/05/13 during observation of meal service at 8:15 a.m. and 8:45 a.m., in the dining rooms, Staff J was observed assisting residents and passing trays. Staff J was wearing a winter coat, as if she had just entered the building from outside. After entering the dining room, the staff did not wash hands, Staff J passed trays and</p>	F 441	<p><u>Title of the person responsible to ensure correction:</u></p> <p>Dietary Manager, Infection Control Coordinator.</p>		

12/30/13  
RECEIVED

JAN 03 2014

OSH...

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505488</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHMOND BEACH REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 25 assisted residents. The staff did pick up the utensils from several different plates and then place them in the residents hands. Staff J did not wash hands after handling the utensils and/ or before assisting another resident.  LACK OF HANDWASHING IN THE DIETARY DEPARTMENT  On 12/05/13 at 11:00 a.m., a Dietary Aide, Staff P was observed scraping food residue from pans in a three compartment sink in the dish room. The staff then went to a counter on the clean side of the dishwasher wiped down the clean counter area, without washing hands.	F 441			

12/30/13  
JAN 03 2014  
SHS/D