

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

PRINTED: 11/03/2014
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 C 10/24/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------------------

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 Abbreviated Survey conducted at Richmond Beach Rehabilitation on 10/23/2014-10/24/2014. A sample of 18 residents was selected from a census of 130.</p> <p>The following complaint was investigated as part of this survey:</p> <p>#3046491</p> <p>The survey was conducted by:</p> <p>Cathy Prentice, MN, R.N.</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 2, Unit C Creekside Two 20425 72nd Avenue South, Suite 400 Kent, WA 98032-2388</p> <p>Telephone: (253) 234 6003 Fax: (253) 395 5071</p> <p><i>Debra Voley</i> Residential Care Services Date 11-3-2014</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 abbreviated survey conducted 10/23/2014 - 10/24/2014. 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. RECEIVED compliance will be achieved by 12/1/2014 11/21/2014 NOV 17 2014</p>	
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Admini Greuter	(X6) DATE 11/10/2014
--------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------	--------------------------------

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: 505488	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/24/2014
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 441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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 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>	F 441	<p>F 441</p> <p><u>How the nursing home will correct the deficiency:</u> The resident was discharged. Resident # 5, 15, 18 were discharged. Resident # 17 was not isolated.</p> <p>Residents #1, 2, 4 - 11, 14 - 17 rooms and bathrooms were cleaned and ADL supplies and adaptive equipment were stored according to standard infection control protocol.</p> <p><u>How the nursing home will act to protect similar residents in similar situations:</u> Nursing staff reviewed the storage practices for ADL supplies and/or adaptive equipment for residents and care planned their wishes and/or stored their ADL supplies and/or adaptive equipment according to standard infection control protocol.</p> <p>Licensed nurses completed in-service training related to wound care protocols and standards of practice.</p> <p>The LNs (staff A&B) noted in the statement of deficiency received training related to wound care techniques and standards of care.</p> <p>Facility staff received in-service training related to using housekeeping chemicals according to manufacturer's recommendations and handwashing policy and procedure.</p>		

RECEIVED
NOV 17 2014

80 11/10/14

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 C 10/24/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------------------

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 441	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain infection control practices to provide a sanitary environment for 18 of 18 residents sampled (residents #1 through #18). This failure placed residents at risk for infection.</p> <p>Findings include:</p> <p>FACILITY INFECTION CONTROL RATE</p> <p>Record review of the facility Infection Control Report on 10/23/2014 revealed, the nosocomial (infection aquired in the facility) rate for August 2014 was 28.7 percent.</p> <p>In an interview on 10/23/2014 at 11:30 a.m., Staff C, the facility infection control nurse, stated the facility did inservicing after the high infection rate for August 2014. The facility did not yet have the rate calculated after August 2014.</p> <p>UNCLEAN WOUND CARE TECHNIQUES</p> <p>During observation of wound care for Resident #3 on 10/23/2014 at 11:37 a.m., Staff A, a licensed nurse, was observed to cut the old dressing off Resident #3, and then laid the scissors on the clean surface next to the clean wound dressing supplies. In addition, Staff A then removed gloves</p>	F 441	<p><u>Measures the nursing home will take or the</u> <u>facility will take to ensure that the</u> <u>problem does not recur</u></p> <p>The facility will complete audits routinely of resident rooms and bathrooms to assure ADL supplies and adaptive equipment are stored according to infection control standards and/or resident preference.</p> <p>Infection control nurse will conduct rounds weekly to audit and observe and educate on handwashing and infection control protocols.</p> <p><u>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</u> Infection control report and nosocomial infection rate shall be monitored by the staff development coordinator monthly for changes and trends.</p> <p>Results of the audits above and the infection control reports will be discussed at facility Quality Assurance Committee Meetings monthly for six months and periodically thereafter.</p> <p><u>Date corrective action will be completed:</u> 11/21/2014</p> <p><u>Title of the person responsible to ensure correction:</u> DNS/Administrator</p>	<p>RECEIVED</p> <p>NOV 17 2014</p>
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------

80 11/10/14

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

PRINTED: 11/03/2014
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 C 10/24/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------------------

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 441	<p>Continued From page 3</p> <p>but did not wash his hands, donned new gloves and cleansed the wounds, did not wash hands, opened all clean wound supply packages and dressings with bare unwashed hands, then cut the medicated wound dressing with the same scissors that cut the old dressings off. The medicated dressings were then applied to the 2 open wounds on Resident #3.</p> <p>Failure to provide clean scissors to cut clean wound supplies, wash hands between dirty and clean wound care, and failure to provide a separation of clean and soiled wound care supplies placed Resident #3 at risk for infection.</p> <p>UNCLEAN ENVIRONMENTAL CONDITIONS:</p> <p>Observations of resident rooms and care areas for Residents #1 through #18 on 10/23/2014 revealed the following unclean conditions:</p> <p>11:00 a.m., Room 103: soiled brief on bathroom floor, soiled brief in trashcan in bathroom with no bag, 4 clean washcloths on back of toilet, 4 clean briefs on back of toilet.</p> <p>11:10 a.m., oom 105: used washcloth on sink, used cup on sink, 5 to 6 clean washcloths on the sink.</p> <p>11:13 a.m., Room 106: toothbrush on sink, package of briefs on bathroom sink, graduate container used to empty urinary foley catheter on</p>	F 441	<p>RECEIVED</p> <p>NOV 17 2014</p> <p>CS</p>	
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	----------------------------------------------	--

80 11/10/14

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

PRINTED: 11/03/2014
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 C 10/24/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------------------

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 441	<p>Continued From page 4 back of toilet.</p> <p>11:17 a.m., Room 108: clean briefs on floor by nightstand, 4 ounce containers of body lotion and baby powder on the bathroom sink.</p> <p>11:30 a.m., Room 314: urinary leg bag hanging on handrail by bathroom sink and hanging inside trash can, urinal hanging beside it on handrail, toilet plunger uncovered on floor.</p> <p>11:33 a.m., Room 315: used washcloth in sink, 4 ounce container baby powder on sink, 6 clean washcloths on sink, 7.5 ounce Perifresh perineal cleanser on sink.</p> <p>12:33 p.m., Room 310: wash basin full of water on floor by bed about 6 to 8 feet from open door with isolation sign. (Interview of Staff B at 12:33 p.m., revealed the basin of water was used by Staff B at 9:30 a.m., 3 hours before the observation, to soak the foot of Resident #1 who had an infection requiring isolation precautions).</p> <p>12:35 p.m., Room 308: 3 clean briefs on back of toilet, used washcloth on sink.</p> <p>12:40 p.m., Room 302: Periwash perineal cleanser bottle on sink.</p> <p>4:10 p.m., Shower Room, Cascade Hall Two: 3 used towels on shower chair in shower stall on</p>	F 441	<p>RECEIVED NOV 17 2014 CNS/ADSA/RCS</p>	
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--------------------------------------------------	--

11/10/14
EP

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

PRINTED: 11/03/2014
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 C 10/24/2014
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 441	<p>Continued From page 5</p> <p>right, appeared unclean. Observed with Staff C, who confirmed in an interview at 12:05 p.m. om 10/24/2014, that the shower aide had finished at 2:00 p.m. and did not clean and disinfect the shower room observed.)</p> <p>10/24/2014 at 10:50 a.m., Room 314: toilet plunger with no cover in bathroom on floor, urinary leg bag hanging on handrail in bathroom and hanging in garbage can, urinal hanging by sink no cover.</p> <p>10:55 a.m., Room 315: 4 ounce container baby powder on back of toilet, used washcloth on sink, bedpan and urinary measure graduate container on floor next to toilet and plunger uncovered.</p> <p>The above noted observations for environments for Residents #1 through #18, had assessments and care plans in the facility medical records that noted Residents #1 through #18 were dependent on staff for hygiene and wound care, and Residents #2 through #18 were dependent on staff for toileting.</p> <p>Failure of the facility to maintain a clean environment placed residents at risk for infection.</p> <p>DISINFECTING</p> <p>In an interview on 10/23/2014 at 10:45 a.m., Staff F, a housekeeping supervisor, stated all facility staff used Virex 2 to disinfect resident areas,</p>	F 441		

RECEIVED
NOV 17 2014
LTC SERVICES

EP 11/10/14

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

PRINTED: 11/03/2014
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 C 10/24/2014
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 441	<p>Continued From page 6 surfaces, and equipment.</p> <p>Record review of the Virex 2 Reference Sheet provided by the facility revealed, the directions for use indicated, "for disinfection, all surfaces must remain wet [with the disinfectant] for 10 minutes".</p> <p>In an interview on 10/23/2014 at 4:22 p.m., Staff D, a shower aide, stated she leaves the Virex 2 Disinfectant on the shower chair and room surfaces for 10 to 15 seconds before wiping off.</p> <p>In an interview on 10/23/2014 at 11:30 a.m., Staff C, the facility infection control nurse, did not know how long the disinfectant used by facility staff had to remain on the surface before being wiped off.</p> <p>Failure of the facility staff to know and use disinfectant correctly, placed residents at risk for infection.</p> <p>HANDWASHING</p> <p>In an interview on 10/23/2014 at 12:12 p.m., Staff E, a housekeeping employee stated she washed her hands for 10 seconds.</p> <p>Record review of the Center for Disease Control (CDC) handwashing Guidelines dated, revealed the CDC recommends washing "all surfaces of your hands for 15 to 20 seconds".</p>	F 441			

RECEIVED

NOV 17 2014

S

SP
11/10/14