

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Warm Beach Health Care Center on 10/15/12, 10/16/12, 10/17/12, 10/18/12, 10/19/12, 10/22/12, 10/23/12, and 10/24/12. A sample of 39 residents was selected from a census of 58. The sample included 31 current residents and the records of eight former and/or discharged residents.</p> <p>The survey was conducted by: Robin Windhausen, RD, MS Ann E. Lee, MSW Teresa Diane Kirse, RN, BSN</p> <p>The survey team is from: Department of Social &amp; Health Services Aging &amp; Disability Services Administration Residential Care Services, District 2, Unit B 3906 172nd Street NE, Suite 100 Arlington, Washington 98223-4740</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>[Signature]</i> Residential Care Services                      Date</p>	F 000	<p>RECEIVED DEC 19 2012 ADSARCS Smokey Point</p> <p>IDR AMENDED</p>	
-------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Executive Dir. NHA</i>	(X6) DATE <i>12/19/12</i>
---	------------------------------------	------------------------------

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.

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 241 SS=D	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents were provided care and services in manner which enhanced their dignity and in a manner which recognized each resident's individuality. This effected four residents (Resident #62, #105, #2 and #113) of 31 current residents reviewed during Stage II of the survey.</p> <p>Findings include:</p> <p><b>RESIDENT #113</b> On 10/18/12 at 12:10 p.m., an observation was conducted of the delivery of lunch trays to residents on C-Wing who had chosen to eat in their rooms. Resident #113 was observed to be the first resident to receive her tray. At approximately the same time as her tray was delivered, Staff I, the Bath Aide and a Nursing Assistant (NA), entered Resident #113's room stating "It's time for your bed bath." The resident's door was then closed. Over the next 35 minutes, additional NAs and a licensed nurse (LN) were observed going in and out of the room.</p> <p>At 12:45 p.m., a NA exited the room leaving the door to the room open. The NA had a plastic sack of dirty linen/clothes which had a strong</p>	F 241	<p><b>F-241 POC Correction</b> <b>Date December 10, 2012</b> We have corrected the deficiency as it relates to the survey by;</p> <p>Res #113 is to have all personal care completed prior to delivery of room tray. Res # 62 had an odor control gel dispenser placed in her room on the 22<sup>nd</sup> of October when the complaint was brought to the attention of the DNS. She was also treated for current [REDACTED] Res #2 has flowered clothing protectors which have been purchased by her Guardian. She wears these daily over her blouse, per her request, and did have one in place on date in question. Staff will be in serviced to cue resident to use utensils, however residents' choice/preference to self-feed with fingers and in location of choice will be honored. Hygiene assistance will be provided after meals. Res #105 will be encouraged to keep his shirt pulled down over top button of pants to</p>

**IDR AMENDED**

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 241	<p>Continued From page 2</p> <p>odor of fecal material. There was also a fecal odor in Resident #113's room. (It appeared Resident #113's roommate had received incontinence care at the same time as Resident #113 was receiving her bed bath.)</p> <p>At 12:52 p.m., Staff I was heard to say to Resident #113 "Enjoy your lunch Dearie" and left the room. Resident #113 had waited 42 minutes from the time her tray was delivered until she had the opportunity to begin her meal. No staff were overheard to offer to heat up the resident's tray or do anything about the lingering smell of feces. Resident #113 was approached by the surveyor and was asked how her food was. She replied "I just started eating it." When asked if the food was warm enough, she said again "I just started eating it."</p> <p>Providing care to Resident #113 after her tray had been received, failure to offer to warm up the resident's food and failure to ensure a pleasant environment for eating did not respect Resident #113's dignity or enhance her sense of individuality.</p> <p><b>RESIDENT #62</b></p> <p>On 10/15/12 at 12:18 p.m. during initial rounds of the building, a strong smell of urine was detected in the room occupied by Resident #62. At the time of the observation, the resident was observed lying in bed and the resident spouse was seated at the bedside.</p> <p>On 10/17/12 at 1:21 p.m. during an interview, the resident complained about the malodorous room; the room was noted to be odorous. During the interview, the resident complained about the odors and said when she asked the staff if an air</p>	F 241	<p>honor his preference to unbutton pants after meals while maintaining dignity.</p> <p>We will take the following actions to prevent further issues regarding Dignity and Respect</p> <ol style="list-style-type: none"> <li>1. Nursing Assistants have been in serviced on delivery of meal trays, including atmosphere and environment of room, the need for personal care to be completed and resident is ready to eat prior to delivery of tray. If resident is unable to accept tray when delivered, tray will be discarded and another tray obtained to maintain appropriate temperature of tray.</li> <li>2. Nursing Assistants, Nurses and Housekeeping staff have been informed of availability of odor absorbing gel dispensers for rooms with pervasive odors.</li> <li>3. Nursing Assistants to make sure Residents are</li> </ol>	

**IDR AMENDED**

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 241	<p>Continued From page 3</p> <p>freshener spray could be used, she was told it was not allowed. She complained about the strong odor of urine and stated it was due to the medications.</p> <p>On 10/22/12 at 8:25 a.m., an interview was conducted with Resident #62's spouse. The resident's spouse verified they had asked the staff about keeping an air freshener in the room and were told it was not allowed. The spouse explained that the resident's medical conditions contributed to the odors and stated while in their apartment, an air freshner was readily available to use if visitor's stopped by.</p> <p>An interview was conducted on 10/23/12 at 1:09 p.m. with LN Staff C. When asked if she was aware the resident had complained about the urine odor she stated no. The LN did acknowledge the resident's urine was concentrated. She explained air fresheners were available to use in resident's rooms if needed.</p> <p>The facility's failure to ensure the residents environment was free of odors could contribute to feelings of embarrassment and diminish Resident # 62's quality of life.</p> <p><b>RESIDENT #2</b> Resident #2 was a long time resident of the facility having been admitted to the facility in [REDACTED] Diagnoses included [REDACTED]</p> <p>Her most recent quarterly Minimum Data Set (MDS) assessment dated [REDACTED] indicated she required the extensive physical assistance of one person to perform dressing tasks.</p>	F 241	<p>appropriately dressed and groomed after meals. This will include washing of hands/face and clothing appropriately cleaned.</p> <p>Nurse Managers, Staff Development and Director of Nursing Services will oversee the above tasks. The Quality Assurance committee will monitor for ongoing compliance.</p>	
-------	--	-------	--	--

IDR AMENDED

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 241	<p>Continued From page 4</p> <p>On 10/15/12 during lunch observations, Resident #2 was observed in a television common area eating her lunch. At least four other residents were observed at all times in the room including one resident receiving a tube feeding. Resident #2 was observed to be eating a cupcake/muffin with frosting on the food item. Using her left hand, the resident was attempting to eat the food item resulting in frosting all over her face, frosting and crumbs on her left hand and food particles all over her shirt. She was not wearing any type of clothing protector to cover her shirt.</p> <p>At 12:17 p.m., a LN inquired if Resident #2 was enjoying her lunch to which the resident replied positively. The LN placed a towel on the resident's lap but did not attempt to clean the resident's appearance. At 12:36 p.m., another observation of Resident #2 was made which revealed the resident still having food particles down the front of her shirt.</p> <p>On 10/16/12 at 12:10 p.m. the resident was seated at the table in the gazebo room. The staff did place a clothing protector on the resident prior to serving the meal. At 12:50 p.m., the resident was again checked during the meal. The resident had food stuff smeared on her face and clothing protector. The resident was observed using a bare hand to scoop coleslaw from a dish which had been set beside the plate. After observing the resident for several minutes, three staff members entered the area to assist with washing the resident's hands and face. One of the staff cued the resident with her utensils, but the resident stated she was done and the tray was removed.</p>	F 241		
-------	--	-------	--	--

**IDR AMENDED**

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 241	<p>Continued From page 5</p> <p>Not ensuring the resident recieved assistance with set up and/or cuing during meals could negatively impact the residents quality of life.</p> <p><b>RESIDENT #105</b> Resident #105 was admitted to the facility on [REDACTED] with multiple medical diagnosis including [REDACTED]. His admission MDS dated [REDACTED] indicated he required the extensive physical assistance one person to perform dressing tasks and noted the resident was rarely understood when communicating verbally.</p> <p>On 10/17/12 at 8:38 p.m. Resident #105 was observed wheeling a wheelchair out of his room and down the hall way . His pants were observed to be unbuttoned partially exposing his under garments. On 10/18/12 at 10:00 a.m. the resident was again seated in a common area and the waist band on the pants, a different pair, was undone.</p> <p>A similar observation was made on 10/19/12 at 10:10 a.m. Resident #105 was observed in a common area close to the nursing station. After Staff B, the Director of Nursing Services, was alerted the resident needed assistance with adjusting the clothing, she assisted the resident to his room. She returned the resident to the common area. At the time she reported the resident position in the chair caused the pants to be unsecured.</p> <p>For the next several days during the survey, 10/22, 10/23, and 10/24, the resident was observed on multiple occassions during each observation the waist band was not visible. Not</p>	F 241		

IDR AMENDED

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 241  F 364 SS=E	<p>Continued From page 6 ensuring Resident #105 was properly dressed in common areas of the facility could diminish feelings of self worth and dignity.</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure meals were palatable, attractive and served at the proper temperature. Failure to meet these requirements resulted in eight of the 19 residents interviewed during Stage I of the survey expressing dissatisfaction with the temperature and palatability of the foods served.</p> <p>Findings include: Eight of the 19 residents who participated in quality of life interviews during Stage I complained about the food quality and temperatures of the meals served. Comments from the residents included; "The food is the facilities weak point"; the food "Just doesn't taste good and I don't like it"; and another commented the "Taste varies" and sometimes "It is not what is expected." Other residents reported the food was cold.</p> <p>On 10/22/2012 at 9:50 a.m., the Food Service</p>	F 241  F 364	<p><b>F-364 POC Correction Date December 10, 2012</b></p> <ul style="list-style-type: none"> <li>• We have corrected the deficiency as it relates to the survey by:</li> <li>• New 5 week cycle menu is being implemented with review and input from Resident Council</li> <li>• Quarterly review of menu with Resident Council to change and add options</li> <li>• Cold food will be kept at/or below 41 degrees</li> <li>• Hot food will be kept at/or above 140 degrees</li> <li>• Temperatures will be continued to monitor through temperature logs</li> </ul>	

IDR AMENDED

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 7</p> <p>Manager, Staff F was interviewed. Staff F stated he had written a four week menu cycle which was implemented approximately 11 months ago. He reported the facility was given a corporate menu but he had review and changed the food items at the residents requests.</p> <p>Staff F clarified questions concerning the menu the following day, 10/23/12. He reported the regular diet offered 2300 to 2800 calories a day and provided copies of the menu signed by a registered dietitian acknowledged and approved the changes.</p> <p>Review of the current weekly menu, for the week of 10/21/12 through 10/27/12, found similar food items were served for consecutive meals. For instance, the noon meal on 10/21/12 (Monday) was "Balsamic Chicken Breast" was the main entrée for the noon meal and "BBQ Chicken Drumsticks" was the main entrée served for dinner. During observation of the noon meal the entrée was a chicken breast smothered with a ketchup and vinegar based sauce which looked, smelled and tasted similar to barbeque sauce. Other similar entrees on the menu were "Braised Beef Sicilian" served with egg noodles and later in the week the "Beef Stroganoff" with egg noodles was served.</p> <p>Other repetitive menu items included deserts served the residents who needed sugar free desserts. The menu stated they received sugar free vanilla pudding and/or mouse three of the four meals a dessert was planned during the first two days of the preplanned menu.</p> <p>On 3/23/12 at 2:20 p.m., Staff F was interviewed</p>	F 364	<p>To be monitored by Chef and Dietary manager. Ongoing monitoring will be done by RD and Quality Assurance committee through review of Resident Council minutes.</p>	

IDR AMENDED

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 8</p> <p>about resident input into the menu. He stated the resident feedback about the menu changes had been obtained through the Resident Council.</p> <p>Review of the meeting minutes documented new menus were implemented in November of 2011. The meeting minutes did not indicate the changes had been discussed with the group, however, they did reveal at times, residents complained about the changes which had been made in the menu. On 12/13/11, after the new menu was introduced, residents requested "more simple names of dishes " and documented residents complained they were "unfamiliar" with the menu items.</p> <p>The Council Meeting Minutes, dated 01/10/12, documented the group requested "eggs to order on the weekly menu again." The group continued to bring up this request during the council meeting on 02/12, 03/12, 04/12, 05/12, 06/12, 07/12 and again on 10/09/12. Although the residents repeatedly requested the menu item be served weekly, the menus in use between 10/14/12 - 10/28/12, the "eggs to order" requested were not included on the menu.</p> <p>Other complaints noted in the minutes of the Resident Council, included complaints about the variety of snacks, portion serving sizes of items provided at the residents request, use of spices in the foods prepared. There was no evidence the resident had input into the development of the menus and when menu suggestions were provided there was no evidence any menu changes occurred.</p> <p><b>COLD FOOD TEMPERATURES</b></p>	F 364		

IDR AMENDED

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 9  On 10/23/12 the temperatures' a test tray to obtain temperatures of the point of service, the staff prepared a test tray. Two tray carts were prepared, the first left the kitchen at approximately 12:05 p.m. and the second cart which held 5 trays left the kitchen at approximately 12:10 p.m. The last tray from the first cart was not delivered until 12:35 p.m.  Although the temperatures of the hot food were tested after the last tray was served at 12:35 p.m. Although the temperatures of the food in the kitchen were tested and found to be above 140 Degrees Fahrenheit (DF), the temperatures test found the entrée was 111 DF and the vegetable was 112 DF. The last resident served Resident # 51, commented when she was first admitted the trays were cold and stated "this one is warm." The last tray served was on the first cart which left the kitchen and it remained on the cart parked in the hallway for 30 minutes before it was served to the resident.  Not ensuring meals were palatable and served at the proper temperature could negatively impact the resident appetite and contribute to poor food intake.	F 364	
F 371 SS=E	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 under sanitary conditions	F 371	

IDR AMENDED

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure food were stored, prepared and distributed under sanitary conditions. Failure to meet these requirements increased the risk of a food borne illness.</p> <p>Findings include:</p> <p>On 10/23/12 between 11:30 and 12:10 p.m., the dietary staff were serving the noon meal to the main dining room and preparing trays for room service. During the observation an open tray cart containing dessert dishes filled with custard was stationed next to the steam table.</p> <p>After the room trays were prepared, a temperature check was completed of both hot and cold food items. When the temperature of the dessert dishes was tested, the custard was found to be 50 Degrees Fahrenheit (DF). The cold food item was not being held below 41 degrees, which is temperature recommended to prevent growth of bacteria and prevent food borne illness.</p> <p>During the initial tour of the kitchen completed on 10/15/12 at 9:00 a.m., the following food preparation equipment was found soiled:</p> <ul style="list-style-type: none"> <li>- Three mixers were found which had food spills and splash dried to the underside of the rotary blade were food in the preparation area;</li> <li>- The large mixer had a splash guard which</li> </ul>	F 371	<p><b>F-371 POC Correction Date December 10, 2012</b></p> <ul style="list-style-type: none"> <li>• We have corrected the deficiency as it relates to the survey by:</li> <li>• All equipment has been cleaned and sanitized</li> <li>• All equipment will be on assigned cleaning lists and kept clean and sanitized</li> <li>• All food items will be individually labeled and dated</li> <li>• Sanitizer dispenser has been removed</li> <li>• Sanitation liquid will be replaced every 2 hours to maintain correct strength</li> </ul> <p>To be monitored by Chef and Dietary Manager through proper sanitation logs. Ongoing monitoring will be done by Dietary Manager and Quality Assurance committee</p>	
-------	---	-------	---	--

**IDR AMENDED**

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 11</p> <p>had visible food particulate matter on it;</p> <ul style="list-style-type: none"> <li>- Oven gloves were visibly soiled with food matter were observed hanging above the vegetable preparation area;</li> <li>- The can opener was observed and the blade appeared to be soiled;</li> <li>- The two blenders in the food preparation area had visible food matter dried on the base; and,</li> <li>- Two large packages of raw meat were found in a tub on the shelf which were not dated or labeled.</li> </ul> <p>On 09/22/12 at 9:30 am the Robo Coup, a blender, was found seated on the base, with the lid turned upside down as if ready to use. After removing the lid, it was found to have food residue on the lid and interior. The can opener was visibly soiled. And three large packages of meats were found in a tub on the shelf in the walk in, only one had been labeled.</p> <p>One of two buckets holding sanitizer did not have a sufficient concentration of the chemical to sanitize surfaces or other items it was intended to clean. At 11:00 a.m., the sanitizer bucket in the waitress station in the main dining room was also found without a sufficient concentration of sanitizing solution.</p> <p>A dispenser containing hand sanitizer was located above the only hand washing sink in the kitchen. When asked about the dispenser, the Food Service Manager Staff F, said he was not certain if the staff used the device. (The use of hand sanitizer in food service areas instead of hand washing is not recommended.)</p>	F 371		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	F 387		

**IDR AMENDED**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 387	<p>Continued From page 12</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure physician visits occurred within the required time frame for four (Resident # 58, 46, 65, 32) of four sampled residents of one physician. Failure to ensure this physician visits occurred within the required time periods had the potential to compromise the resident's health, wellbeing and their overall quality of life and care.</p> <p>Findings include:</p> <p>On 10/24/2012 at 11:00 a.m. during an interview with Staff C, a registered nurse, she stated physician visits were not occurring as they should for residents under the care of a one particular physician. She stated it was very difficult to get in touch with him and he rarely came to see his patients.</p> <p>A review of the visit history for the four sampled residents revealed no evidence of a physician visit for the following time periods:</p> <p>Resident #58, who suffers from [REDACTED]</p>	F 387	<p><b>F-387 POC Correction Date December 10, 2012</b></p> <ul style="list-style-type: none"> <li>• We have corrected the deficiency as it relates to the survey by;</li> <li>•</li> <li>• The Medical Director has notified MD in writing of requirements for residents to be seen every 60 days.</li> <li>•</li> <li>• Medical Records will continue to monitor visits. DNS will notify Medical Director if visits are not done in a timely manner. Quality Assurance Committee will monitor.</li> </ul>

**IDR AMENDED**

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 387	<p>Continued From page 13</p> <p>██████████ was not seen for 127 days from 12/16/11 through 04/21/12;</p> <p>Resident #46, who suffers from ██████████ was not seen for 88 days between 06/04/12 through 08/31/12;</p> <p>Resident #65, who suffers from ██████████ was not seen for 85 days between 01/27/12 through 04/21/12 and for 132 days between 04/21/12 through 08/31/12; and,</p> <p>Resident #32 who suffers from ██████████ was not seen for 90 days between 01/27/12 through 05/21/12 and for 132 days from 04/21/12 through 08/31/12. In an interview with the resident on 10/16/12 at 12:30 p.m., he stated he got tired of waiting for the doctor to come to see him so he just made his own appointment and went to the doctor's office.</p> <p>During an interview on 10/24/2012 at 11:05 a.m. with Staff D, Medical Records, she stated she sends all physicians reminders of when their visits are due. Staff D provided written copies of the notices to this particular physician. She stated if the physicians did not comply after the notices were sent, the DNS (Director of Nursing) was notified.</p> <p>In an interview with Staff B, DNS on 10/24/2012 at 12:30 p.m., she stated she calls the physicians if they do not visit the residents as required. If the problem continues, she calls the medical director.</p> <p>There was no evidence the physician had been</p>	F 387		
-------	---	-------	--	--

IDR AMENDED

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 387	Continued From page 14 contacted by the DNS or the medical director related to the delays of one particular physician seeing these residents.	F 387		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS  The facility must assist residents in obtaining routine and 24-hour emergency dental care.  A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to assist, one of three residents (#32) reviewed for dental issues during Stage II of the survey, with obtaining dental services. Failure to meet this requirement increased the risk of health complications associated with dental problems (i.e. weight loss, malnutrition).  Findings include:  Resident #32 was admitted to the facility on [REDACTED] with multiple medical conditions [REDACTED] According to the two Minimum Data	F 411	<p><b>F-411</b> <b>POC Correction Date</b> <b>December 10, 2012</b></p> <ul style="list-style-type: none"> <li>• We have corrected the deficiency as it relates to the survey by;</li> <li>•</li> <li>• Resident has been seen by his dentist.</li> <li>•</li> <li>• We will continue to assess residents for dental needs on admission, Quarterly and PRN. We will arrange for dental visits as needed.</li> </ul> <p>Quality Assurance Committee will monitor</p>	

IDR AMENDED

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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 411	<p>Continued From page 15</p> <p>Set Assessments, dated 04/27/12 and 07/24/12, the facility had not identified any dental issues.</p> <p>During observations and interviews completed on 10/22, 10/23 and 10/24/12 the resident's upper dental plate was observed to move when speaking. On 10/24/12 at 10:15 a.m., the resident reported the dentures he was wearing did not fit.</p> <p>Review of the clinical record found the original nutrition assessment, dated 05/04/11, noted the resident had "ill-fitting or loose dentures." Review of the nursing progress notes found an entry by a licensed nurse (LN), dated 05/20/12, which indicated they had contacted the resident's spouse to discuss dental issues. The entry indicated the resident had trouble with them and "did not always place them snugly." The nurse's entry noted the LN would "talk to the NAC's" (nursing assistants) about "helping" the resident "snap them in all the way."</p> <p>Although the LN's entry indicated the resident needed assistance with placement of the dentures, the only directives on the care plan concerning the dentures, dated 05/10/12, stated "Assist with brushing dentures as needed." The care plan did not identify the need for any assistance with the placement of the denture to ensure they were seated correctly.</p> <p>On 10/25/12, the facility forwarded information to the survey agency indicating the facility had arranged for a future dental consult. Not ensuring this resident's dental issues were identified assessed and care planned may have contributed to a delay in the resident receiving dental services</p>	F 411		

IDR AMENDED

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

PRINTED: 12/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARM BEACH HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA 98292</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	

**IDR AMENDED**

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>505405</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE <b>10/24/2012</b>
NAME OF PROVIDER OR SUPPLIER <b>WARM BEACH HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA</b>	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 156</b>	<p><b>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</b></p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible</p>		

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

The above isolated deficiencies pose no actual harm to the residents

**IDR AMENDED**

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>505405</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>10/24/2012</b>
NAME OF PROVIDER OR SUPPLIER <b>WARM BEACH HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA</b>		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
<b>F 156</b>	<p>Continued From Page 1 for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: On 10/24/2012 at 09:30 a.m., three residents (#40, #110 and #60) were interviewed and stated they did not know where all the required posted information was located. During an interview with the wife of Resident #35, she was unable to state where any of this information could be located.</p> <p>During a tour of the facility on 10/24/12 at 9:00 a.m., the required postings of the state hotline and ombudsman program numbers were located across the hall from the social workers office. The postings were slightly above eye level for a standing person but not at the level of residents who were in wheelchairs. Medicare and Medicaid access information was not present.</p> <p>On 10/24/12 at 10:30 a.m., in a tour with Staff H (social services), she acknowledged the required postings were not at eye level for the residents using wheelchairs. She also acknowledged the required postings regarding how to access Medicare and Medicaid were not posted.</p>
<b>F 246</b>	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide reasonable accommodation of individual need and consistently placed call light within reach of the residents.</p> <p>Findings include:</p> <p>During observations throughout the survey at various times, resident were observed with call lights out of reach. Resident #65 was observed attempting to rise from the bed on 10/22/12 at 3:25 p.m. The call light cord was visible and was found under the resident bed pillows at the head of the bed. On 10/16/12 at 3:13 p.m., Resident #3 was heard calling for help to use the bathroom; the call light was not visible. The apparatus was found between the bed and the wall. After providing access to the resident, she used it to call for assistance. On 10/16/12 at 10:11 a.m., Resident #46's was seated in a wheelchair next to the bed. The call</p>

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>505405</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>10/24/2012</b>
NAME OF PROVIDER OR SUPPLIER <b>WARM BEACH HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>20420 MARINE DRIVE NORTHWEST STANWOOD, WA</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 246</b>	<p>Continued From Page 2</p> <p>light was clipped to the pillow on the bed and she was not able to reach the call light.</p> <p>Not ensuring the resident's call lights were consistently accessible placed residents at risk of not being able to alert the staff if an urgent need arose.</p>		