STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505488	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Beach Rehab	19235 - 15th Avenue Northwest Shoreline, WA 98177

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45146 Based on interview and record review, the facility failed to ensure the necessary treatment and services for pressure ulcer/pressure injury (PU/PI - an injury to skin and underlying tissue resulting from prolonged pressure on the skin) was provided consistent with professional standards of practice for 1 of 1 resident (Resident 1), reviewed for pressure ulcer care. This failure placed the resident at risk for deterioration of their pressure ulcer and a diminished quality of life. Findings included . Review of the facility's policy titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, revised in March 2014, showed, The physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement [the process of removing adherent dead or foreign material from wounds to minimize the risk of infection and promote healing] approaches, dressings (occlusive, absorptive, etc.), and application of topical agents if indicated for type of skin alteration. Review of Resident 1's admission Minimum Data Set (an assessment tool) dated 11/01/2024, showed Resident 1 had an intact cognition. The MDS further showed Resident 1 had one unstageable PU/PI related deep tissue injury (a purple or maroon area of discolored intact skin due to damage to the underlying soft tissue). In an interview on 12/26/2024 at 11:01 AM, Resident 1 stated that they had pressure ulcer to their buttock. When asked if they were receiving wound care, Resident 1 stated that they were not getting wound treatment according to their physician's order stating, My wound cleaning solution is missing. Review of the nursing progress note dated 12/03/2024, showed Resident 1 had an order to, Apply moistened gauze with Dakin's [a solution used to prevent and treat skin and tissue infections] solution 25 percent into wound bed. Review of a wound consultant note dated 12/12/2024, showed Resident 1 had a Stage 4 (a PU/PI with full thickness tissue loss with exposed bone, tendon or muscle) with a treatment recommendation to, Apply 1/4 [quarter] strength Dakin's soaked gauze. The nursing progress note dated 12/23/2024 showed that Resident 1 refused their wound treatment due to, Dakins solution not being available and being in a significant amount of pain. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing progress notes dated 12/26/2024, 12/28/2024, 12/29/2024, 12/31/2024, 01/02/2025, and 01/03/2025, showed that Dakin's solution was not available for Resident 1's wound treatment. Further review of the progress notes did not show that Resident 1's physician or their wound consultant were notified about the unavailability of the Dakin's solution. In an interview on 01/10/2025 at 10:33 AM, Staff D, Licensed Practical Nurse, stated that Resident 1's Dakin's wound treatment solution was not available in the past and, they were treating Resident 1's wound with wet-to-dry (a wet or moist gauze dressing applied on wound and allowed to dry) dressing. When asked if Resident 1's physician was notified or a new wound care order was received, Staff D stated that Resident 1's wound doctor was aware, but their physician was not notified, or a new wound treatment order was received. In an interview and joint record review on 01/10/2025 at 12:40 PM, Staff C, Resident Care Manager, stated that when a prescribed wound treatment solution was not available, the pharmacy and the resident's physician would be notified. Staff C stated that they were aware of Resident 1's Dakin's solution was not available on 12/23/2024 and they notified the Director of Nursing (DON), and the solution was ordered. Joint record review of Resident 1's progress notes from 12/23/2024 to 01/03/2025 showed no record to show that Resident 1's physician was notified. Staff C stated that licensed nurses should have notified Resident 1's physician when the solution was not available. On 01/10/2025 at 1:18 PM, Staff B, DON, stated that Resident 1's physician should have been notified and an alternative wound treatment order should have been obtained when Dakin's solution was not available. Reference: (WAC) 388-97-1060 (1)(3)(b)