| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505488 | A. Building<br>B. Wing | 11/29/2024 |

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

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|---|---|
| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>48899<br><br>Based on interview and record review, the facility failed to properly notify the Office of the State Long Term Care (LTC) Ombudsman (an advocacy group for residents) in writing, describing the reason for transfer for 1 of 1 resident (Resident 36), reviewed for hospitalization . This failure placed the resident at risk for not having the access to an advocate who informed residents about options and resident rights.<br><br>Findings included .<br><br>Review of the facility's policy titled, Transfer or Discharge Notice, revised in March 2021, showed, A copy of the notice is sent to the Office of the State LTC Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.<br><br>Review of the progress note dated 09/30/2024, showed Resident 36 was transferred to the hospital for further evaluation.<br><br>Review of Resident 36's nursing progress note date 09/30/2024 to 11/25/2024 showed no documentation to show that the notice of transfer was sent to the State LTC Ombudsman office.<br><br>In an interview on 11/27/2024 at 2:32 PM, Staff I, Social Services Assistant, stated that their responsibility included completing the transfer notice form and faxing it to the State LTC Ombudsman office. Staff I stated that there was no documentation confirming the completed transfer notice had been sent to the State LTC Ombudsman office or a fax receipt that showed the transfer notice was sent. Staff I stated that they did not document their communication with the State LTC Ombudsman office about Resident 36's hospital transfer.<br><br>In an interview on 11/29/2024 at 10:41 AM, Staff A, Administrator stated that they expected the State LTC Ombudsman office to be notified in writing that Resident 36 was sent to the hospital. Staff A further stated that the communications between Staff I and the State LTC Ombudsman office should have been documented.<br><br>Reference: (WAC) 388-97-0120 (5)(b)(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.

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

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146<br><br>Based on interview and record review, the facility failed to accurately assess 1 of 19 residents (Residents 68), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments regarding capturing occurrences during the look-back period for oxygen placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life.<br><br>Findings included .<br><br>According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.19.1, dated October 2024, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.<br><br>The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). Most MDS items themselves require an observation period, such as seven or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during the look-back period will be captured. In other words, if it did not occur during the look-back period, it is not coded on the MDS.<br><br>The RAI manual's Oxygen coding instruction directed to code oxygen under Section O (Special Treatments, Procedures, and Programs) if during the 14-day look-back period the resident had received oxygen.<br><br>Resident 68 admitted to the facility on [DATE] with diagnoses that included asthma (a disease in which the airways in the lungs become narrowed and swollen, making it difficult to breathe) and respiratory failure (serious condition that makes it difficult to breathe).<br><br>Review of the admission MDS dated [DATE], showed Resident 68's oxygen use was not coded on the MDS assessment.<br><br>Review of the October 2024 Treatment Administration Record (TAR) showed that Resident 68 had received oxygen during the admission MDS's look-back period.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview and joint record review on 11/28/2024 at 10:39 AM, Staff H, Case Manager, stated that the MDS would be completed based on review of the resident's medical record, medication administration record, and TAR. A joint record review of Resident 68's October TAR showed the resident had received oxygen during the MDS look-back period. Joint record review of the admission MDS dated [DATE], showed oxygen was not coded on Resident 68's MDS. Staff H stated oxygen should have been coded on the MDS and they would correct the MDS.<br><br>On 11/29/2024 at 8:13 AM, Staff B, Director of Nursing Services, stated that their expectation was for the staff to follow the RAI Manual and complete MDS assessments accurately.<br><br>Reference: (WAC) 388-97-1000 (1)(b) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619<br><br>Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR- an assessment used to identify people referred to nursing facilities with Serious Mental Illness (SMI), Intellectual Disabilities (ID); or related conditions are not inappropriately placed in nursing homes for long term care) form was accurate and sent out for a Level II PASARR referral for 5 of 6 residents (Residents 41, 67, 36, 46 & 20), reviewed for PASARR Screening. This failure placed the residents at risk for not receiving the care and services appropriate for their needs.<br><br>Findings included .<br><br>Review of the facility's policy titled, PASRR, revised on 03/22/2024, showed that the social services department would review residents for any indicators that would need a level II screening, such as SMI or ID, and contact the community mental health program to request a Level II screening.<br><br>Review of the Department of Social and Health Services, Dear Nursing Home Administrator Letter, guidance titled, Clarification to the Pre-Admission Screening and Resident Review (PASARR or PASRR) Level I Screening Process, dated 07/06/2024 and amended on 08/23/2024, showed a positive Level I PASARR screen (that would then require a referral for a Level II PASARR) was if Any of the questions in Section IA (1, 2, and/or 3) are marked Yes.<br><br>RESIDENT 41<br><br>Review of the face sheet printed on 11/27/2024 showed Resident 41 admitted to the facility on [DATE] with medical diagnoses that included major depressive disorder (mood disorder that causes a persistent feeling of sadness) and anxiety disorder (a condition that causes excessive feelings of fear or worry that can interfere with daily life).<br><br>Review of Resident 41's current Level I PASARR completed by Staff I, Social Services Assistant, dated 09/05/2024 showed Section I was marked for a SMI indicator for Mood Disorders (Depression), but not for Resident 41's anxiety disorder.<br><br>Joint record review and interview on 11/29/2024 at 8:28 AM with Staff I, showed Resident 41's Level I PASARR, revealed an evaluation referral for a Level II PASARR was not completed. Staff I stated that anyone who had anything marked for Section IA would require a Level II referral. Staff I stated that there was no referral sent for Resident 41 and that there should have been one. Staff I further stated that Resident 41's anxiety disorder should have also been marked as a SMI indicator.<br><br>On 11/29/2024 at 8:53 AM, Staff G, Social Services Director, stated that if the PASARR form was incorrect, they would expect it to be corrected. Staff G stated that they were aware of the regulation requiring a Level II PASARR referral for any SMI indicators per Section IA. Staff G further stated, did not understand it, until now.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 11/29/2024 at 10:10 AM, Staff A, Administrator, stated it was their expectation to review PASARR forms to ensure accuracy in accordance with residents' diagnoses. Staff A further stated that if any SMI were marked for Section IA, they would expect a referral for a Level II assessment.<br><br>45146<br><br>RESIDENT 67<br><br>Resident 67 admitted to the facility on [DATE] with diagnoses that included anxiety and major depressive disorder.<br><br>Review of the admission Minimum Data Set (an assessment tool) dated 10/16/2024, showed Resident 67 had an active diagnoses of anxiety disorder and depression.<br><br>Review of Resident 67's Level I PASARR dated 10/11/2024, showed under Section IA was marked Yes to include the diagnosis of anxiety disorder. Further review of the PASARR showed mood disorder - depressive was not marked on the PASARR and Section IV showed, No Level II evaluation indicated.<br><br>Review of the physician's progress note dated 10/15/2024 showed Resident 67 had an active diagnosis of anxiety and depressive disorder.<br><br>Review of the Electronic Health Record (EHR) showed no documentation that Resident 67's PASARR Level I was corrected or a Level II PASARR referral was sent for review.<br><br>In an interview and joint record review on 11/28/2024 at 10:03 AM, Staff G stated that when residents were admitted from the hospital, they would review their PASARR and check for accuracy. A joint record review of Resident 67's Level I PASARR dated 10/11/2024, showed Section IA was marked yes for diagnosis of anxiety disorder but not for depressive disorder. Staff G stated that Resident 67's PASARR Level I should have been corrected and referral for Level II should have been sent.<br><br>On 11/29/2024 at 11:09 AM, Staff A stated that they expected that PASARR should be reviewed on admission for accuracy and Level II referral sent for any indicators of SMI.<br><br>48899<br><br>RESIDENT 36<br><br>Review of the face sheet showed that Resident 36 initially admitted to the facility on [DATE] with multiple diagnoses that included bipolar disorder (a mental health condition characterized by extreme mood swings, which include emotional highs), anxiety disorder, and delusional disorder (a mental health condition that makes it hard for a person to distinguish reality from fantasy).<br><br>Review of Resident 36's Level I PASARR form dated 02/21/2024, showed that mood and anxiety disorders were marked in section IA for SMI. Further review of the document showed that the SMI Indicators section was marked yes [has SMI].<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Joint record review of the face sheet and interview on 11/29/2024 at 8:14 AM with Staff I, showed Resident 36 had diagnosis that included mood, anxiety and delusional disorders. Joint record review of Resident 36's Level I PASARR showed that mood and anxiety disorders were marked. The review of Resident 36's Level I PASARR also showed that delusional disorder was not marked. Further review of the record showed that SMI Indicators section was marked yes. Staff I stated that Resident 36's Level I PASARR should have been consistent with their medical diagnosis. After reviewing the new regulation, Staff I stated that they should have sent a Level II PASARR referral to evaluator for Resident 36.<br><br>In an interview on 11/29/2024 at 10:06 AM, Staff G stated that they expected Resident 36's Level I PASARR should have been consistent with their medical diagnosis.<br><br>In an interview on 11/29/2024 at 10:41 AM, Staff A stated that they expected Resident 36's medical diagnosis to align with their Level I PASARR evaluation. Staff A stated Level II PASARR referral should be sent for any indicators of SMI.<br><br>51090<br><br>RESIDENT 46<br><br>Resident 46 admitted to the facility on [DATE] with diagnoses that included post-traumatic stress disorder (PTSD - a mental health condition that can develop after a person experiences a traumatic event), anxiety, and major depressive disorder.<br><br>Review of Resident 46's physician's order, dated 07/31/2024, showed Resident 46 received an antidepressant medication for diagnosis of major depressive disorder.<br><br>Review of Resident 46's Level I PASARR completed on 02/29/2024, showed IA was marked Yes to include the diagnosis of PTSD and anxiety disorder. Further review of the PASARR showed major depressive disorder was not marked in section IA and Section IV showed No level II evaluation indicated.<br><br>Review of Resident 46's EHR showed no documentation that a Level II PASARR referral was completed.<br><br>In a joint record review and interview on 11/29/2024 at 8:43 AM with Staff I, showed Resident 46's Level I PASARR dated 02/29/2024 did not show the diagnosis of major depressive disorder was marked in Section IA and that Section IV was marked no level II evaluation indicated. Staff I stated, Depression should be checked, and it wasn't captured, so I missed that. Staff I further stated that they were aware of the new law and that I don't think I put in a level II [PASARR evaluation] for [them].<br><br>RESIDENT 20<br><br>Resident admitted to the facility on [DATE] with diagnoses that included delusional disorders and major depressive disorder.<br><br>Review of Resident 20's Level I PASARR completed on 08/20/2021, did now show the diagnosis for major depressive disorder was marked in Section IA and that Section IV was marked No level II evaluation indicated.<br><br>Review of Resident 20's EHR showed no documentation that a Level II PASARR referral was completed.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Joint record review and interview on 11/29/2024 at 8:43 AM with Staff I, showed Resident 20's Level I PASARR dated 08/20/2021 revealed the diagnosis of major depressive disorder was not marked in Section IA and that Section IV was marked No level II evaluation indicated. Staff I stated, It came from the hospital this way and I can't believe I didn't correct it. Staff I further stated Resident 20 should have had a level II PASARR referral completed.<br><br>In an interview on 11/29/2024 at 8:53 AM, Staff G stated social services were responsible for reviewing PASARR documents received from the hospitals and that they expected them to be accurate. Staff G stated that they expected PASARR Level I form to have been accurate and that Level II PASARR evaluation referrals should have been completed for Resident 46 and Resident 20.<br><br>In an interview on 11/29/2024 at 12:09 PM, Staff A stated they were aware of the clarification on the PASARR Level I since July 2024. Staff A further stated that they expected PASARR forms to be accurate and that Level II referrals would be completed as needed.<br><br>Reference: (WAC) 388-97-1915 (2)(a)(b) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146<br><br>Based on interview and record review, the facility failed to develop baseline care plans and/or provide a written summary of the baseline care plan to the residents and/or their representatives for 2 of 2 residents (Residents 40 & 151), reviewed for baseline care plan. This failure placed the residents at risk for unmet care needs and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, Care Plans - Baseline, revised in March 2022, showed, The resident and/or representative are provided a written summary of the baseline care plan (in language that the resident/representative can understand) that includes, but limited to the following:<br><br>a. The stated goals and objects of the resident<br><br>b. A summary of the resident's medication and dietary instructions.<br><br>c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and<br><br>d. Any updated information based on the details of the comprehensive care plan, as necessary.<br><br>RESIDENT 40<br><br>Resident 40 admitted to the facility on [DATE].<br><br>A review of Resident 40's Electronic Health Record (EHR) showed no documentation that a written summary of the baseline care plan was provided to the resident or their representative.<br><br>RESIDENT 151<br><br>Resident 151 admitted to the facility on [DATE]. Review of the admission Minimum Data Set (an assessment tool) dated 11/17/2024 showed Resident 151 had intact cognition.<br><br>A review of Resident 151's EHR showed no documentation that a written summary of the baseline care plan was provided to the resident or their representative.<br><br>On 11/27/2024 at 8:51 AM, Resident 151 stated that they have not received a written summary of their baseline care plan.<br><br>On 11/28/2024 at 9:13 AM, Staff E, Resident Care Manager, stated that the baseline care plan would be developed upon residents' admission and the written summary would be provided to resident or their representative by social service personnel.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview and joint record review on 11/28/2024 at 12:19 PM, Staff G, Social Services Director, stated that the facility has had a process of providing a written summary of baseline care plan in the past. Joint record review of Resident 40 and Resident 151's EHR showed no record that a written summary of the baseline care plan was provided to them or their representatives. Staff G stated that there was no documentation that showed the summary of baseline care plan was given or offered to these residents.<br><br>On 11/29/2024 at 8:17 AM, Staff B, Director of Nursing Services, stated that they expected a baseline care plan would be developed within 48 hours of admission and that a written summary of the baseline care plan would be provided to the residents.<br><br>Reference: (WAC) 388-97-1020(3) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090<br><br>Based on observation, interview, and record review, the facility failed to ensure oxygen tubing were appropriately stored for 2 of 3 residents (Residents 17 & 46), reviewed for respiratory care. This failure placed the residents at risk for unmet care needs and potential negative outcomes.<br><br>Findings included .<br><br>Review of the facility's policy titled, Departmental (Respiratory Therapy) - Prevention of Infection, revised on November 2011, showed, Infection control considerations related to oxygen administration .keep the oxygen cannulae [NC -lightweight tube that splits into two prongs at one end and is inserted in the nostrils to deliver oxygen] and tubing used PRN [as needed] in a plastic bag when not in use.<br><br>RESIDENT 17<br><br>Resident 17 admitted to the facility on [DATE] with diagnoses that included congestive heart failure (a condition where the heart does not pump blood effectively, causing a backup of fluid in the body) and asthma (a chronic lung disease).<br><br>Review of Resident 17's physician's order, dated 10/13/2024, showed oxygen at one to four liters (a unit of measurement) per minute (flow rate of oxygen being delivered to a resident) via NC PRN for shortness of breath.<br><br>Observation on 11/23/2024 at 1:27 PM, showed Resident 17's wheelchair had a portable oxygen tank with an oxygen tubing and cannula attached. Further observation did not show that Resident 17's oxygen tubing and cannula was stored properly while not in use.<br><br>Observation on 11/26/2024 at 8:40 AM showed Resident 17's wheelchair had a portable oxygen tank and that the attached oxygen tubing and cannula was not stored properly while not in use. Further observation showed that the oxygen tubing was hanging on the wheelchair's left wheel lock and that the cannula nasal prongs touched the floor.<br><br>In a joint observation and interview on 11/26/2024 at 10:00 AM with Staff K, Licensed Practical Nurse (LPN), showed Resident 17's oxygen tubing and cannula was hanging on their wheelchair's left wheel lock and that the nasal prongs touched the floor. Staff K stated that Resident 17's oxygen tubing and cannula should be stored in a bag when not in use.<br><br>RESIDENT 46<br><br>Resident 46 admitted to the facility on [DATE] with diagnoses that included congestive heart failure, asthma and chronic respiratory failure with hypoxia (a condition that affects the lungs leading to a consistently low level of oxygen in their body).<br><br>Review of Resident 46's physician's order, dated 10/28/2024, showed supplemental oxygen dependent due to respiratory failure, may use oxygen at two to three liters per minute via NC.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 11/29/2024 at 8:27 AM showed Resident 46's oxygen tubing and cannula was not properly stored while not in use and was on the floor beside their bed.<br><br>In a joint observation and interview on 11/29/2024 at 8:37 AM with Staff N, LPN, showed Resident 46's oxygen tubing and cannula was not properly stored while not in use and was on the floor beside their bed. Staff N stated that Resident 46's oxygen tubing and cannula found on the floor was their daytime tubing and that it was normally bagged when not in use. Staff N further stated, It should be trashed.<br><br>In an interview on 11/29/2024 at 9:26 AM, Staff F, Resident Care Manager, stated they expected residents' oxygen therapy supplies should be stored in a bag when not in use.<br><br>In an interview on 11/29/2024 at 11:42 AM, Staff B, Director of Nursing Services, stated they expected oxygen therapy supplies stored in a bag when not in use to prevent cross contamination (germs transfer from one surface to another).<br><br>Reference: (WAC) 388-97-1060 (3)(j)(vi) |

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| | 505488 | A. Building<br>B. Wing | 11/29/2024 |

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

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899<br><br>Based on interview and record review, the facility failed to ensure dialysis (the kidneys no longer function and require a process to remove waste and excess fluids from the blood stream) care was consistently evaluated after treatments according to professional standards for 1 of 1 resident (Residents 70), reviewed for dialysis. This failure placed resident at risk for unmet care needs, and deterioration of chronic condition.<br><br>Findings included .<br><br>The facility's policy titled, Hemodialysis (a medical procedure used to treat kidney failure, where the kidneys are no longer able to filter waste products and excess fluids from the blood effectively.) Access Care, revised in October 2010, stated that to prevent infection and/or clotting (a process by which blood transforms from a liquid to a semi-solid state), the access site must be always kept clean, and signs of infection (warmth, redness, tenderness or edema) should be checked at the access site when performing routine care and at regular intervals.<br><br>Review of the face sheet showed Resident 70 admitted to the facility on [DATE].<br><br>Review of the November 2024 physician order showed Resident 70 received dialysis three times a week at an offsite dialysis center.<br><br>Review of quarterly Minimum Data Set (an assessment tool) dated 10/17/2024 showed Resident 70 was cognitively intact and had been receiving dialysis therapy.<br><br>Review of Resident 70's dialysis care plan directed staff to monitor, document, and report any signs and symptoms of infection at the access site.<br><br>In an interview on 11/24/2024 at 1:51 PM, Resident 70 stated they went to dialysis on Mondays, Wednesdays, and Fridays.<br><br>Review of Resident 70's Electronic Health Record (EHR) showed that there was no record that the resident was consistently evaluated after their dialysis treatments.<br><br>In an interview on 11/27/2024 at 2:20 PM, Staff K, Licensed Practical Nurse, stated that they would check the resident after dialysis only if there was anything abnormal. When asked about the Resident 70's location of the dialysis access site, Staff K replied, I don't really know.<br><br>In an interview and joint record review on 11/27/2024 at 2:25 PM, Staff F, Resident Care Manager, stated that Resident 70's dialysis access site was on their left arm and that it was checked by staff each time they returned from dialysis. Staff F stated that Resident 70 had order for their access site to be checked after every dialysis visit. Joint record review of Resident 70's EHR showed that there was no documentation indicating that Resident 70 had an active order to check the access site or consistently evaluated after dialysis treatments.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In a follow up interview on 11/28/2024 at 12:20 PM, Staff F stated that the order to check the dialysis access site was not reinstated when the resident was readmitted to the facility in July 2024. Staff F stated that the order should have been reinstated and the staff should have been checking the dialysis access site after each dialysis visit. Staff F further stated that there should have been a clear order in place, and the staff should have been following it accordingly.<br><br>In an interview on 11/28/2024 at 8:42 AM, Resident 70 stated that the facility never checked the dialysis access site or consistently evaluated after dialysis treatments.<br><br>In an interview on 11/29/2024 at 10:09 AM, Staff B, Director of Nursing Services, stated that when Resident 70 readmitted to the facility their order to check dialysis access site was not placed back. Staff B further stated they expected the staff to check Resident 70's dialysis access site, consistently evaluate the resident after each dialysis treatment, every shift and document it.<br><br>Reference: WAC 388-97-1900 (6) (a-c) |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Post nurse staffing information every day.<br><br>48899<br><br>Based on observation, interview, and record review, the facility failed to ensure the daily nurse staffing form was accurately completed with actual hours worked for each shift for 6 of 7 days (11/23/2024, 11/24/2024, 11/25/2024,11/26/2024,11/27/2024 & 11/28/2024), reviewed for sufficient and competent staffing. This failure placed the residents and residents' representatives at risk of not being fully informed of the current staffing levels.<br><br>Findings included .<br><br>Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, revised in August 2022, showed that shift staffing information must be recorded on a form for each shift. The policy further showed the form should include the actual hours worked during that shift for each category and type of nursing staff [Registered Nurse, Certified Nursing Assistant and Licensed Practical Nurse].<br><br>Observations on 11/23/2024 at 1:36 PM, on 11/24/2024 at 2:26 PM, on 11/25/2024 at 2:21 PM, on 11/26/2024 at 1:23 PM, on 11/27/2024 at 1:43 PM and on 11/28/2024 at 2:03 PM, showed that the facility's daily nursing staffing form posted did not show the actual hours worked for each shift for all nursing staff.<br><br>In an interview on 11/29/2024 at 8:38 AM, Staff B, Director of Nursing Services stated that they were responsible for completing the nurse staffing postings. Staff B stated that they had not been filling out the actual total hours because that was how their previous staffing coordinator trained them.<br><br>In an interview on 01/20/2024 at 10:05 AM, Staff A, Administrator, stated, Daily nurse staff postings need to be visible and available, with the actual hours filled out.<br><br>No associated WAC |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090<br><br>Based on observation, interview, and record review, the facility failed to ensure drugs and/or biologicals were properly labeled, stored, and/or expired supplies were removed/discarded in accordance with current accepted professional standards for 2 of 4 medication carts (Cascade and Olympic Medication Cart) and for 2 of 2 medication room refrigerators (Cascade and [NAME] Medication Room Refrigerators), reviewed for medication storage and labeling. These failures placed the residents at risk for receiving compromised and ineffective medications and medical supplies.<br><br>Findings included .<br><br>Review of the undated facility's dispensing pharmacy reference guide titled, Did you know? showed that Unless otherwise stated by manufacturer or stricter facility policy, open meds generally expire on the printed expiration date or one year since open date (whichever is sooner) .record an 'open date' on all opened meds (liquids, topicals, insulin [hormone that lowers blood sugar level] vials, insulin pens, eye drops, etc.) . Expiration dates: Insulins should be dated once opened and stored in [medication] cart .Storage: no unlabeled meds (e.g., from e-kit [emergency medication supply]).<br><br>Review of the facility's undated policy titled Medication Labeling and Storage, showed that Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices .The medication label includes, at a minimum: medication name, prescribed dose; strength; expiration date, when applicable; resident's name; route of administration; and appropriate instructions and precautions .If medication containers have missing, incomplete or incorrect labels, [facility staff] contact the dispensing pharmacy for instructions regarding returning or destroying these items .only the dispensing pharmacy may label or alter the label on a medication container or package.<br><br>CASCADE MEDICATION CART<br><br>Joint observation and interview on [DATE] at 8:57 AM, showed Staff P, Licensed Practical Nurse (LPN), primed (removing air from the insulin pen to ensure the correct dose of insulin was delivered) two newly opened insulin pens. Further observation showed Staff P did not date the two insulin pens before storing the insulin pens in the medication cart. When asked if insulin pens should be dated with an open date, Staff P stated they should have dated the insulin pens with the open date.<br><br>OLYMPIC MEDICATION CART<br><br>Joint observation and interview on [DATE] at 10:03 AM with Staff K, LPN, showed a prescription bronchodilator (used to prevent and treat difficulty breathing) inhaler (medical device that delivers medication directly to the lungs through a mist or spray that the user breaths in) that had a pink label sticker. Written on the sticker was Resident 301's last name and an incomplete date, ,d+[DATE]. Further observation showed Resident 301's inhaler did not have a prescription or pharmacy label. Staff K stated, The label should come from the pharmacy; this is not the right label. Staff K further stated the pink label attached to Resident 301's inhaler did not contain a complete name or date.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Joint record review and interview on [DATE] at 11:55 AM with Staff B, Director of Nursing Services, showed the facility's pharmacy reference guide was the guidance followed and implemented by the facility. Staff B stated they expected OTC medications and prescribed inhalers to be properly labeled with the resident and prescription information when they were stored in the medication cart.<br><br>45146<br><br>CASCADE MEDICATION ROOM REFRIGERATOR<br><br>According to the Centers for Disease Control and Prevention (CDC) website titled, Vaccine Storage and Handling, dated [DATE], showed, To ensure the safety of vaccines, the storage unit minimum and maximum temperatures should be checked and recorded at the start of each workday. If using a TMD [Temperature Monitoring Devices] that does not display minimum and maximum temperatures, then the current temperature should be checked and recorded a minimum of two times (at the start and end of the workday).<br><br>Review of the Cascade medication room refrigerator temperature log for [DATE], [DATE] and [DATE] showed that the refrigerator's temperature was checked once a day during night shift. Further review of the log showed a written direction that stated, CDC recommends twice daily temps if vaccines present.<br><br>In a joint observation and interview on [DATE] at 8:29 AM with Staff E, Resident Care Manager (RCM), showed there was a vaccine for Respiratory Syncytial Virus (RSV - a common respiratory virus usually causes mild, cold-like symptoms, serious lung infections) stored in the Cascade medication room refrigerator. Staff E stated that the vaccine stored in the refrigerator was for RSV.<br><br>In an interview and joint record review on [DATE] at 10:55 AM, Staff E stated that the facility followed CDC's guideline for vaccines storage. Joint record review of the Cascade medication room temperature log for [DATE], [DATE] and [DATE] showed that the refrigerator's temperature was checked once a day. Staff E stated the refrigerator temperature should have been checked twice a day.<br><br>BAKER MEDICATION ROOM REFRIGERATOR<br><br>During a joint observation and an interview on [DATE] at 11:10 AM with Staff D, RCM, showed there was a box containing intravenous starter needle (IV - a small plastic tube, inserted into a vein to administer medications or fluid) with an expiration date of [DATE]. Staff D stated the IV needles were expired and should have been discarded.<br><br>During a joint record review and an interview on [DATE] at 11:22 AM with Staff D, showed the [NAME] medication room refrigerator temperature log revealed no records of temperature on [DATE], [DATE] and [DATE]. Further review of the temperature log showed the temperature were checked once a day on [DATE], [DATE], [DATE], [DATE] and [DATE]. Staff D stated the refrigerator's temperature should have been consistently checked twice daily.<br><br>In a joint observation and an interview on [DATE] at 8:42 AM with Staff D, showed there was an RSV vaccine stored in the medication room's refrigerator. Staff D stated that the vaccine stored in the refrigerator was for RSV and the refrigerator's temperature should have been checked twice daily.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On [DATE] at 10:59 AM Staff C, Infection Preventionist, stated the medication rooms refrigerators' temperature should have been checked twice daily.<br><br>On [DATE] at 8:22 AM, Staff B stated that the facility followed CDC's guideline for storage of vaccines and the medication rooms refrigerators temperature should have been checked twice daily. Staff B further stated expired IV starter needles should have been discarded.<br><br>Reference: (WAC) [DATE] (2) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090<br><br>Based on observation, interview, and record review, the facility failed to ensure insulin (hormone that lowers blood sugar level) pens were properly disinfected and hand hygiene practices were followed during medication administration for Resident 155, and failed to properly store personal care items for room [ROOM NUMBER] and Personal Protective Equipment (PPE) for 5 of 7 isolation carts in (Rooms 200, 215, 205, 118 & 325), reviewed for infection control. In addition, the facility failed to provide hand hygiene supplies for 2 of 2 medication rooms (Cascade & Baker), and failed to ensure disinfection of shared transfer lift equipment was conducted between resident use for 2 of 2 residents (Residents 82 & 301). These failures placed the residents and staff at an increased risk for infection and related complications.<br><br>Findings included .<br><br>Review of the facility's policy titled, Infection Prevention and Control Program, revised in October 2018, showed, The program is based on accepted national infection prevention and control standards .The infection prevention and control program . a facility-wide effort involving all disciplines and individuals . Policies and procedures reflect the current infection prevention and control standards of practice.<br><br>Review of the website titled, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated April 12, 2024, showed that the following core practice categories were listed:<br><br>5c. Injection and Medication Safety<br><br>1. Prepare medications in a designated clean medication preparation area that is separated from potential sources of contamination, including sinks or other water sources.<br><br>5f. Reprocessing of reusable medical equipment<br><br>1. Clean and reprocess (disinfect or sterilize) reusable medical equipment .prior to use on another patient or when soiled .<br><br>2. Maintain separation between clean and soiled equipment to prevent cross contamination.<br><br>RESIDENT 155<br><br>INSULIN PEN DISINFECTION & HAND HYGIENE<br><br>Review of the facility's policy titled, Handwashing/Hand Hygiene, revised in August 2019, showed that hand hygiene is the final step after removing and disposing of PPE, including after removing gloves.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation and interview on 11/26/2024 at 8:57 AM, showed Staff P, Licensed Practical Nurse (LPN), donned a gown and gloves prior to administering two separate insulin doses for Resident 155. After administering the first dose of insulin to Resident 155, Staff P needed a second alcohol wipe (used to clean the skin prior to insulin administration). Staff P then placed Resident 155's two insulin pens and one new insulin pen needle directly on the sink counter in Resident 155's room and doffed their gloves. Staff P did not perform hand hygiene after doffing gloves. While wearing a gown, Staff P found an alcohol wipe in their uniform pocket. Staff P did not perform hand hygiene after touching their uniform and gown before donning a new pair of gloves to administer Resident 155's second insulin dose. Further observation showed Staff P stored the two insulin pens in the medication cart without cleaning them. Staff P stated, After using them [Resident 155's insulin pens], yes, we should be wiping [cleaned/disinfected] them, I did not. Staff P further stated they did not perform hand hygiene before and after glove use when they administered Resident 155's insulin doses and that they should have performed hand hygiene.<br><br>room [ROOM NUMBER]<br><br>STORAGE OF PERSONAL CARE ITEMS<br><br>Observation on 11/23/2024 at 8:18 AM, showed unbagged personal care items that included a portable toilet seat extender (a device that attaches to a toilet seat to increase its height), a female bed pan (portable container used for toileting) and two plastic basins stacked and placed directly on the bathroom floor in room [ROOM NUMBER]'s bathroom.<br><br>Joint observation and interview on 11/24/2024 at 9:57 AM with Staff D, Resident Care Manager, showed unbagged items that included a portable toilet seat extender, a female bed pan, and two plastic basins stacked and placed directly on the bathroom floor in room [ROOM NUMBER]. Staff D stated that the personal items stacked on the floor were used and that It should be removed. Staff D stated personal hygiene items should be bagged whenever they were clean and stored in the resident's bathroom and that once they are used, they need to be taken to the dirty utility [room] to be washed.<br><br>PPE AND ISOLATION CARTS<br><br>Review of the CDC website tiled, Implementation of Personal Protective Equipment Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs-germ that is resistant to medications that treat infections), dated April 2, 2024, showed, Make PPE, including gowns and gloves, available immediately outside of the resident room.<br><br>room [ROOM NUMBER]<br><br>Observation on 11/24/2024 at 9:01 AM, showed the isolation PPE cart for Enhanced Barrier Precautions (EBP- gown and glove use to protect residents from MDRO in front of room [ROOM NUMBER] had one bag of Lays (a brand) chips stored in the first drawer, two plastic drink cups stored with a box of gloves in the second drawer, and an empty third drawer. Further observation did not show gowns were stored in the isolation cart.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Joint observation and interview on 11/24/2024 at 9:05 AM, showed Staff H, Case Manager, took out the two plastic cups and the bag of chips from room [ROOM NUMBER]'s isolation cart. Staff H stated the two cups and bag of chips should not have been stored with PPE and that face shields, gowns and gloves should be stored in the isolation cart for EBP. Staff H further stated that room [ROOM NUMBER]'s isolation cart did not have gowns stored.<br><br>In an interview on 11/24/2024 at 9:21 AM, Staff C, Infection Preventionist, stated the bag of chips and two cups should not have been stored in the isolation cart for room [ROOM NUMBER].<br><br>room [ROOM NUMBER]<br><br>Observation on 11/24/2024 at 9:09 AM, showed the isolation cart for EBP in front of room [ROOM NUMBER] had linen stored in the third drawer. Further observation did not show gowns were stored in the isolation cart.<br><br>In an interview and joint observation on 11/24/2024 at 9:11 AM, Staff Q, LPN, stated they did not know what PPE should be stored in the isolation cart for EBP. Joint observation showed that room [ROOM NUMBER]'s EBP signage directed staff to wear gloves and a gown for high contact resident care activities. Further joint observation showed that room [ROOM NUMBER]'s isolation cart did not have gowns stored. Staff Q stated there should not have been a bedsheet stored in the third drawer and that gowns should be stored in the isolation cart.<br><br>In a joint observation and interview on 11/24/2024 at 9:18 AM with Staff C, showed room [ROOM NUMBER]'s isolation cart had a draw sheet in the third drawer. Staff C took out the draw sheet and stated it should not have been stored with the PPE. Staff C further stated that room [ROOM NUMBER]'s isolation cart should have had gowns readily available for staff.<br><br>room [ROOM NUMBER]<br><br>Observation on 11/24/2024 at 9:08 AM, showed the isolation cart for EBP in front of room [ROOM NUMBER] had incontinent briefs stored in the first drawer with a box of gloves.<br><br>In an interview and joint observation on 11/24/2024 at 9:13 AM, Staff Q stated, I have no idea why [room [ROOM NUMBER]] would be on precautions. Joint observation showed room [ROOM NUMBER] had an EBP signage posted at their door and that incontinent briefs were stored in the first drawer of the isolation cart. Staff Q stated they did not think incontinent briefs should be stored with PPE. When Staff Q was asked what PPE should be stored in the isolation cart, Staff Q stated, I think you should ask management.<br><br>Joint observation and interview on 11/24/2024 at 9:17 AM with Staff C, showed room [ROOM NUMBER]'s isolation cart had incontinent briefs stored with PPE. Staff C stated the incontinent briefs should not have been stored with PPE. Staff C further stated that they expected staff know the facility's process for EBP.<br><br>room [ROOM NUMBER]<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Joint observation and interview on 11/24/2024 at 9:24 AM with Staff H, did not show the isolation cart in front of room [ROOM NUMBER] had gowns stored. Staff H stated No, it's not properly stocked; we are getting those supplies now.<br><br>room [ROOM NUMBER]<br><br>Observation on 11/24/2024 at 9:37 AM, showed the isolation cart for EBP in front of room [ROOM NUMBER] had oxygen tubing and normal saline stored with PPE.<br><br>Joint observation and interview on 11/24/2024 at 9:40 AM with Staff B, Director of Nursing, showed the oxygen tubing and normal saline were stored in room [ROOM NUMBER]'s isolation cart. Staff B stated medical supplies should be stored in the medication room and should not have been stored in the isolation cart.<br><br>In an interview on 11/29/2024 at 10:57 AM, Staff C stated the facility followed CDC's guidelines for infection prevention and control. Staff C stated that they expected PPE would be available at the point of use, stored in isolation carts. Staff C stated that they expected staff would perform hand hygiene before and after glove use. Staff C further stated that infection prevention practices would be followed when handling insulin pens to include disinfection after each use and before they were stored in the medication cart.<br><br>In an interview on 11/29/2024 at 11:42 AM, Staff B stated they expected PPE supplies to be readily available in isolation carts and that they expected staff to know what PPE should be stored in the isolation carts and the indications for EBP. Staff B stated, that If [staff] forget, they can always read the [EBP] sign. Staff B stated the facility followed the process of cleaning insulin pens before and after each use and that insulin pens should not be placed on a surface near a sink. Staff B stated they expected staff to perform hand hygiene with glove use and always before and after having contact with the resident or their environment. Staff B further stated they expected personal hygiene supplies stored in residents' bathrooms to be bagged and should not have been placed directly on the floor.<br><br>45146<br><br>HAND HYGIENE SUPPLIES-CASCADE AND BAKER MEDICATION ROOMS<br><br>Review of the facility's policy titled, Handwashing/Hand Hygiene, revised in August 2019, showed, Hand hygiene products and supplies (sink, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies.<br><br>Observation of the Cascade medication room on 11/26/2024 at 10:43 AM, showed that the medication room had a hand washing station but there was no paper towel or trashcan available in the room. Further observation showed the medication room's hand sanitizer dispenser was empty.<br><br>During a joint observation and an interview on 11/26/2024 at 11:03 AM with Staff D, showed the [NAME] medication room did not have a working hand washing station or hand sanitizer available in the room for use. Further joint observation of the room's sink showed a notice, Do not use, faucet pipe under construction. Staff D stated, We should have hand sanitizer in here.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505488 | A. Building<br>B. Wing | 11/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Richmond Beach Rehab | 19235 - 15th Avenue Northwest<br>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.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview and joint observation on 11/26/2024 at 12:57 PM, Staff C stated, Hand washing supplies and hand sanitizer should be available in the medication rooms. Joint observation showed there was no trashcan available for use in the Baker's medication room. Joint observation of the Cascade medication room at 12:59 PM showed there was no hand sanitizer, paper towel or trashcan available for use in the medication room. Staff D stated hand hygiene supplies should have been available for use in the medication rooms.<br><br>On 11/29/2024 at 8:22 AM, Staff B stated that hand hygiene supplies should have been available in the medication rooms.<br><br>48899<br><br>TRANSFER LIFT EQUIPMENT<br><br>Review of facility's policy titled, Cleaning and Disinfection of Resident Care Items and Equipment, revised in September 2022, showed Resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard [a regulation designed to protect workers from the health hazards of exposure to bloodborne pathogens].<br><br>According to the OSHA Bloodborne Pathogens Standard website, standard number 1910.1030, titled Bloodborne pathogens, section 1910.1030(d)(4)(ii) showed All equipment and environmental and working surfaces shall be cleaned and decontaminated after contact with blood or other potentially infectious materials.<br><br>Observation on 11/23/2024 at 11:51 AM, showed that Staff L, Certified Nursing Assistant (CNA) and Staff M, CNA, transferred Resident 82 from their bed to a wheelchair using a Hoyer lift (or transfer lift-a mechanical device designed to assist with transferring residents who have limited mobility). After completing the transfer, Staff L did not disinfect the Hoyer lift before leaving it in the hallway. Further observation showed an EBP was indicated for Resident 82.<br><br>Observation on 11/23/2024 at 12:16 PM, showed Staff K, LPN, and Staff M transferred Resident 301 from a wheelchair to their bed using the same Hoyer lift that had been previously used for Resident 82.<br><br>In an interview on 11/23/2024 at 12:38 PM, Staff K stated that they, along with Staff M, transferred Resident 301 from a wheelchair to a bed using Hoyer lift. Staff K stated that they did not disinfect the Hoyer lift because the resident did not touch it. Staff K stated, they would clean Hoyer lift if the resident had an active infection.<br><br>In an interview on 11/23/2024 at 12:45 PM, Staff L stated that they assisted Staff M in transferring Resident 82 from their bed to a wheelchair using a Hoyer lift. Staff L stated after the transfer, they left the Hoyer lift in the hallway without disinfecting. Staff L stated, I was supposed to sanitize it but forgot.<br><br>In an interview on 11/23/2024 at 12:52 PM, Staff M stated that they transferred both Resident 82 and Resident 301 using the same Hoyer lift. Staff M stated that they did not clean or sanitize the Hoyer lift before and after transferring Residents 82 or 301.<br><br>(continued on next page) |

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|---|---|---|---|
| | 505488 | A. Building<br>B. Wing | 11/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Richmond Beach Rehab | 19235 - 15th Avenue Northwest<br>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.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 11/27/2024 at 1:30 PM, Staff C stated that their expectation was for the Hoyer lift to be cleaned after each use. Staff C stated that Staff K, Staff L, and Staff M should have cleaned the Hoyer lift after each use.<br><br>In an interview on 11/29/2024 at 10:09 AM, Staff B stated that they expected staff to clean the Hoyer lift after each use. Staff B stated that Staff K, Staff L, and Staff M should have cleaned the Hoyer lift after using it.<br><br>Reference: (WAC) 388-97-1320 (1)(a)(c)(5)(a)(c) |