STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505488	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents (#1) sampled for restraints was free of physical restraints. This failure placed the resident at risk for injury due to the inability to move in the wheelchair, and the limited access he had to his body due to the restraints. Findings included . Review of facility medical records showed, Resident #1 resided in the facility for long term care. According to the facility Minimum Data assessment dated [DATE], Resident #1 was dependent on staff assistance for all activities of daily living, and had no limitation in range of motion of upper or lower extremities. Resident #1 used a wheelchair. Review of the facility care plan dated 12/18/19 showed, Resident #1 had risks for falls due to dementia and [MEDICAL CONDITION]. The facility interventions included a tilted wheelchair. There were no other restraint devices noted for Resident #1 on the care plan. There was no physician order for [REDACTED].#1 dated 12/17/19 noted Resident #1 removes socks. Review of the facility incident report and investigation dated 02/25/20 showed, Resident #1 was found in the hallway in the wheelchair in the early morning with sheets tied around his torso and lower legs/footrests. The facility substantiated the use of physical restraints for Resident #1 by Staff D, a nurse aide. The nurse aide (Staff D) who applied the sheet restraints was suspended and educated. Review of the facility investigation written statement by Staff D, the nurse aide who applied the sheet restraints to Resident #1 showed, Staff D stated her purpose was to cover Resident #1 because he kept taking the sheet off of him and she wanted to keep him covered. Review of the progress notes for February 2020 showed, Resident #1 had confusion, restlessness and dementia. The facility progress note dated 02/25/20 showed, Resident #1 was found in the hallway in his wheelchair in the early morning by staff, with sheets tied around feet and torso and tied to the wheelchair. The resident was untied from wheelchair and made safe. Subsequent progress notes dated 0[DATE], 0[DATE], [DATE] showed, Resident #1 had no distress or injury from being restrained in wheelchair. Review of the facility policy for the use of restraints dated 2014 showed, the definition of a restraint is based on the functional status of the resident .if the resident cannot remove the device in the same manner in which the staff applied it, the device is considered a restraint and restraints shall only be used for safety and to treat the resident's medical symptoms. In an interview on 03/05/20 at 10:45 a.m., Staff A, a nurse aide, stated Resident #1 tries to take his clothes off while sitting in the wheelchair. The written witness statement in the facility investigation by Staff E, the nurse aide who found Resident #1 restrained with sheets in the wheelchair on the morning of 02/25/20 showed, Staff E stated she found Resident #1 restrained by his feet and chest to his chair and she removed the sheets right away. In an interview on 03/05/20 at 11:00 a.m., Staff B, a licensed nurse, stated Resident #1 normally has a lot of body movement when he is in his wheelchair. In an interview on 03/06/20 at 10:40 a.m., Staff C, a nurse aide, stated Resident #1 normally grabs his clothes and everything on him and around him, and sometimes grips and will not let go. Staff C also stated Resident #1 grabs blankets off of himself and throws them on the floor, as well as kicking them off his feet. During observation on 03/05/20 at 10:45 a.m., Resident #1 was in his wheelchair and was pulling on his shorts. During another observation on 03/06/20 at 10:40 a.m., Resident #1 was in his wheelchair moving his arms and legs up and down. In an interview on 03/06/20 at 2:00 p.m., Staff E, the nurse aide who found Resident #1 with the sheets over him tied to the wheelchair in the early morning hours on 02/25/20, stated the sheets were flat bed sheets and Resident #1 was tugging on a sheet that was covering him (not tied). When Staff E checked under the sheet covering Resident #1, she stated she found a sheet tied over his legs and feet on top of his footrests and tied to the footrests. Staff E stated Resident #1 could not lift his feet at all, although he usually moves his legs all the time. In addition, Staff E stated there was another flat sheet tied across Resident #1's chest/torso and tied to the handles in the back of the wheelchair, and Resident #1 could not sit up or lift his upper body as he usually did. Staff E stated she immediately unrestrained Resident #1. In an interview on 03/09/20 at 8:30 a.m., Staff D, a nurse aide who applied the tied sheets to the wheelchair on Resident #1 stated, during the early morning of 02/25/20 she transferred Resident #1 into the wheelchair. Resident #1 was fully dressed with shirt, pants, socks and shoes and placed in the hallway where staff could visualize him for safety. Staff D stated she covered resident #1 with a sheet because he tends to take his clothes off. Staff D further stated that morning Resident #1 kept kicking the sheet off she had placed over him so she tied the sheets to the wheelchair so Resident #1 could not remove the sheet and become uncovered. Staff D also stated it is usual for Resident #1 to have very busy hands and to move his feet up and down. Resident #1 usually takes his clothes and shoes and socks off and removes his incontinent brief. Staff D stated she tied the sheets across him in the wheelchair so he couldn't throw it off and tied a sheet on the footrest so Resident #1 could not kick the sheet off. Reference (WAC) 388-97-0620(1)

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

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.