STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505070	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Richland	44 Goethals Drive Richland, WA 99352

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on interviews and record review, the facility failed to report an incident of neglect regarding a fall with significant injury to the State agency as required, involving 1 of 3 residents (Resident 1), reviewed for falls. This failed practice placed residents at risk for harm and diminished protection and oversight from the State agency. Findings included . Review of the facility policy titled, Abuse - Reporting and Response - No Crime Suspected, reviewed on 06/17/2024, showed the facility would ensure that all alleged violations involving neglect were reported immediately to the State Survey Agency if the events that caused the allegation involved abuse or resulted in serious bodily injury. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses which included heart problems. Review of the resident's comprehensive assessment, dated 09/10/2024, showed they had moderately impaired cognition. Review of the resident's plan of care, dated 09/04/2024, showed they required two staff to turn and reposition in bed, toileting and transfers; and one staff to assist with dressing and personal hygiene. Review of a facility investigation form, dated 09/13/2024 at 9:45 PM, documented by Staff A, Registered Nurse (RN), three days later on 09/16/2024 at 6:02 PM, showed they found found Resident 1 out of bed with their back leaning on the bed. Staff A assisted them to the floor. Staff B, Nursing Assistant (NA), assisted Staff A to lift the resident back to bed. There were no identified injuries, range of motion was within normal limits and the resident denied pain. Review of a written statement by Staff B showed that sometime after dinner on 09/13/2024 Staff A came to find them to report Resident 1 was on the floor and had slid out of bed. Staff A requested assistance to place the resident back in bed. An hour later Staff A stated they did not want to call the family or document the fall and to keep it a secret. Staff B stated they were not comfortable in not reporting the fall so they informed Staff C, RN. Review of Resident 1's medical record showed Staff A did not document the resident's fall on 09/13/2024 at 9:45 PM until 09/16/2024 at 6:02 PM (three days later). (continued on next page)

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Staff G, NA on 09/30/2024 at 9:48 AM and Staff H, NA on 09/30/2024 at 12:19 PM, showed Resident 1 was unable to move their right leg and complained of pain to the right leg when caring for the resident on their shift which started at 10:00 PM on 09/13/2024 and ended at 6:00 AM on 09/14/2024. Staff G and H reported their concerns regarding the resident's pain to Staff C at approximately 11:30 PM on 09/13/2024. Despite Staff C being informed by Staff B of Resident 1's fall the evening of 09/13/2024 and Staff G and H informing them of the resident's pain to their right leg, the only documented assessment by Staff C was on 09/13/2024 at 11:15 PM (Staff C worked until 6:00 AM on 09/14/2024) The assessment showed ongoing follow up for the fall showed no signs or symptoms of a latent injury. There was no assessment of the resident's right leg, no pain medication administered and no attempt to seek medical intervention. Review of Progress Notes, dated 09/14/2024 at 7:00 AM, documented by Staff E, Licensed Practical Nurse, showed the resident complained of pain to their right thigh and was unable to move their right leg due to the pain. The physician was notified and orders received to transport the resident to the emergency room . Review of hospital records, dated 09/14/2024, showed Resident 1 had a fractured right hip and surgery was planned for 09/15/2024. During an interview on 09/26/2024 at 3:20 PM, Staff E, stated when they received shift report from Staff C the morning of 09/14/2024 they reported Resident 1 did not sleep well, but there was no report of the resident having a fall the evening of 09/13/2024 or report of the resident having pain issues. During an interviw on 10/11/2024 at 2:15 PM Staff I, Administrator, stated they did not report the fall incident involving Resident 1 to the State agency as the investigation was more focused on Staff A, who did not report or document the fall. The investigation did not focus on the lack of timely assessments and delay in obtainng medical services for the resident. Refer to F684, Quality of Care (WAC) 388-97-0640(6)(c) This is a repeat deficiency from the Statement of Deficiencies dated 07/17/2024 and 04/16/2024.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on interviews and record review, the facility failed to thoroughly investigate an incident of neglect, due to a fracture from a fall, for 1 of 4 residents (Resident 1), reviewed for investigations. Despite the significant changes in Resident 1's condition resulting in a hip fracture, and lack of staff assessments and timely medical care, the investigation did not include any statements by Staff C, G, and H. There was no investigation regarding the lack of timely assessments regarding significant changes in the resident's condition, pain medication and lack of obtaining the necessary medical evaluation and treatment. This failed practice placed residents at risk for unrecognized neglect, lack of monitoring, corrective action, and/or a diminished quality of life. Findings included . Review of the facility policy titled, Abuse - Conducting an Investigation, reviewed on 06/17/2024, showed that allegations of neglect were promptly and thoroughly investigated. The facility would prevent further neglect from occurring while the nvestigation was in progress, and take appropriate, corrective action, as a result of the investigation findings. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses which included heart problems. Review of the resident's comprehensive assessment, dated 09/10/2024, showed they had moderately impaired cognition. Review of the resident's plan of care, dated 09/04/2024, showed they required two staff to turn and reposition in bed, toileting and transfers; and one staff to assist with dressing and personal hygiene. Review of a facility investigation form, dated 09/13/2024 at 9:45 PM, documented by Staff A, Registered Nurse (RN) three days later on 09/16/2024 at 6:02 PM, showed Staff A found the resident with both feet on the floor trying to walk. The resident's back was leaning on the bed so Staff A assisted them to sit on the floor. Staff B, Nursing Assistant (NA), assisted Staff A to lift the resident back to bed. There were no identified injuries, range of motion was within normal limits and the resident denied pain. Review of a written statement by Staff B showed that sometime after dinner on 09/13/2024 Staff A came to find them to report Resident 1 was on the floor and had slid out of bed. Staff A requested assistance to place the resident back in bed. An hour later Staff A stated they did not want to call the family or document the fall and to keep it a secret. Staff B stated they were not comfortable in not reporting the fall so they informed Staff C, RN. Despite Staff C being informed by Staff B of Resident 1's fall the evening of 09/13/2024 the only documented assessment by Staff C was on 09/13/2024 at 11:15 PM. The assessment showed ongoing follow up for the fall revealed no signs or symptoms of a latent injury. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Progress Notes, dated 09/14/2024 at 7:00 AM, documented by Staff E, Licensed Practical Nurse, showed they received shift report from Staff C that Resident 1 did not sleep at all that night. Upon assessment the resident complained of pain to their right thigh at times and stated they were unable to move their right leg as it was too painful. The physician was notified and orders received to transport the resident to the emergency room . Review of hospital records, dated 09/14/2024, showed Resident 1 had a fractured right hip and surgery was planned for 09/15/2024. During an interview on 09/26/2024 at 3:40 PM, Staff C, stated they were aware of the resident's fall on 09/11/2024, but did not know they had fallen the evening of 09/13/2024 until the next day. Staff C stated they took over the care of the resident from Staff A at 10:00 PM on 09/13/2024 until 6:00 AM on 09/14/2024. Staff C stated they offered the resident Tylenol but they refused it. During an interview on 09/26/2024 at 4:05 PM, Staff B stated they reported Resident 1's fall to Staff C the evening of 09/13/2024. Staff C stated the resident was already on the fall list (due to a fall on 09/11/2024) so there wasn't much they could do. Staff B stated upon observation of the resident following their fall they could definitely tell the resident was in pain as their face was really red and they were grimacing in pain. During interviews with Staff G, NA on 09/30/2024 at 9:48 AM and Staff H, NA on 09/30/2024 at 12:19 PM showed Resident 1 was unable to move their right leg and complained of pain to the right leg when caring for the resident on their shift which started at 10:00 PN on 09/13/2024 and ended at 6:00 AM on 09/14/2024. Staff G and H reported their concerns regarding the resident's pain to Staff C at approximately 11:30 PM on 09/13/2024. Review of the resident's Medication Administration Record for September 2024, showed Tylenol was administered by Staff A at bedtime on 09/13/2024. There was no further pain medication administered by staff, and no documentation of the resident refusing Tylenol. Refer to F684, Quality of Care Reference (WAC) 388-97-0640(6)(a)(b) This is a repeat deficiency from the Statement of Deficiencies dated 07/17/2024.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on interviews and record review, the facility failed to identify and take timely action when a change of condition after a fall occurred for 1 of 3 residents (Resident 1) reviewed for changes in condition. Resident 1 experienced harm due to right hip pain and a delay in medical treatment for a fractured right hip. Findings included . <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses which included heart problems. Review of the resident's comprehensive assessment, dated 09/10/2024, showed they had moderately impaired cognition. Review of the resident's plan of care, dated 09/04/2024, showed they required two staff to turn and reposition in bed, toileting and transfers; and one staff to assist with dressing and personal hygiene. Review of a facility investigation form, dated 09/11/2024 at 9:30 PM, showed Resident 1 was found by staff lying on the floor. Resident 1 stated they were trying to go to the bathroom and lost their balance upon standing. The resident was transferred by three staff using a mechanical lift from the floor to their bed. No injuries were observed and the resident denied pain. Review of a facility investigation form, dated 09/13/2024 at 9:45 PM, documented by Staff A, Registered Nurse (RN), three days later on 09/16/2024 at 6:02 PM, showed Staff A heard Resident 1 yelling out. Staff A found the resident with both feet on the floor trying to walk. The resident's back was leaning on the bed so Staff A assisted them to sit on the floor. Staff B, Nursing Assistant (NA), assisted Staff A to lift the resident back to bed. There were no identified injuries, range of motion was within normal limits and the resident denied pain. Resident 1 stated they were trying to walk. Review of a written statement by Staff B showed that sometime after dinner on 09/13/2024 Staff A came to find them to report Resident 1 was on the floor and had slid out of bed. Staff A requested assistance to place the resident back in bed. An hour later, Staff B wrote that Staff A told them not to tell anyone as the other nurses and aides would give Staff A a hard time if they knew Resident 1 was on the floor. Staff A stated they did not want to call the family or document the fall and to keep it a secret. Staff B stated they were not comfortable in not reporting the fall so they informed Staff C, RN. Review of a written statement by Staff D, NA, showed the incident occurred after dinner on 09/13/2024. Staff D passed by Resident 1's room and observed Staff A and B in the room. Staff B told Resident 1 that they could not be transferring on their own and needed to use the call light. Staff A asked Resident 1 if anything hurt and they needed to stay in bed. Staff D stated Staff B informed them on 09/13/2024 that the resident fell . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's Progress Notes (PNs), dated 09/13/2024 at 3:06 PM, showed swelling and pain were observed to the left hip area (documented following the resident's fall on 09/11/2024 at 9:30 PM). The physician was notified and orders received for an x-ray of the resident's left hip. The order was placed with the portable x-ray company, who stated they would be at the facility on 09/14/2024 to take the x-ray. Review of Resident 1's PNs, dated 09/13/2024 at 10:00 PM, but not documented by Staff A until 09/16/2024 at 6:02 PM (approximately three days following the fall), showed Resident 1 sustained no injuries following the fall on 09/13/2024. Staff A documented Resident 1 already had an order for an x-ray to be obtained due to swelling from a previous fall on 09/11/2024. Review of PNs, dated 09/13/2024 at 11:15 PM, documented by Staff C, RN, showed ongoing follow up for fall showed no signs or symptoms of a latent injury. Resident 1 continued with impulsive behaviors and was a significant fall risk. There were no further assessments documented by Staff C of the resident. Review of PNs, dated 09/14/2024 at 7:00 AM, documented by Staff E, Licensed Practical Nurse, showed they received report from Staff C that Resident 1 did not sleep at all that night. The resident was alert and oriented to self only. Swelling was observed to the right and left thighs with skin tight and hard to the right thigh. The resident complained of pain to their right thigh at times and stated they were unable to move their right leg as it was too painful. The physician was notified and orders received to transport the resident to the emergency room for possible blood clots. Review of the resident's Medication Administration Record for September 2024, showed Tylenol was administered by Staff A at bedtime on 09/13/2024. There was no further pain medication administered to the resident, and no documentation of the resident refusing Tylenol. Review of hospital records, dated 09/14/2024, showed Resident 1 had a fractured right hip and surgery was planned for 09/15/2024. The resident was readmitted to the facility on [DATE]. During an interview on 09/26/2024 at 3:20 PM, Staff E, stated when they received shift report from Staff C the morning of 09/14/2024, they reported Resident 1 did not sleep well, but there was no report of the resident having a fall the evening of 09/13/2024. Staff E stated they did not find out the resident had fallen the evening of 09/13/2024 until 5:00 PM on 09/14/2024. Staff E stated they wondered why the resident was complaining of their right leg hurting. Staff E stated their assessment of the resident the morning of 09/14/2024 was that they could not turn as they were in so much pain. The resident yelled out they had not slept all night. It was very different from the day before as Staff E had assisted the resident off the toilet without difficulty. During an interview on 09/26/2024 at 12:50 PM, Staff F, Physical Therapist/Director of Rehab, stated during the day on 09/13/2024 Resident 1 had physical and occupational therapy. In addition to a group exercise program they walked 75 feet with one person assist and a walker. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/26/2024 at 3:40 PM, Staff C, stated they were aware of Resident 1's left hip problem on 09/11/2024 but did not know they had fallen the evening of 09/13/2024 (despite being informed of the fall by Staff B on 09/13/2024). Staff C stated they took over the care of Resident 1 at 10:00 PM on 09/13/2024 from Staff A and continued until 6:00 AM on 09/14/2024. The resident was restless and moving around in bed. Staff C stated they offered the resident Tylenol but they refused it. They did not find out Resident 1 fell on [DATE] until the next day. During an interview on 09/26/2024 at 4:05 PM, Staff B, stated that Staff A asked them for assistance in getting Resident 1 off the floor. In observing the resident they could definitely tell [Resident 1] was in pain and [Staff A] wasn't doing anything, heavy to get into bed, [Staff A] only grabbed [Resident 1's] feet. The resident's face was really red and they were grimacing in pain. An hour later, Staff B stated that Staff A told them not to tell anyone Resident 1 had fallen as they did not want to do the paperwork. Staff A stated they had witnessed the fall so they did not need to fill out paperwork. Staff B then reported to Staff C regarding Resident 1's fall and that Staff A did not want to tell anyone about it. Staff C responded the resident was already on the fall list so there wasn't much they could do. Staff B stated they wrote their statement regarding the resident's fall on 09/13/2024, three days later on 09/16/2024. During an interview on 09/30/2024 at 9:48 AM, Staff G, NA, stated they received shift report at 10:00 PM from Staff B that Resident 1 fell earlier that evening on 09/13/2024. Not too long after that, the resident told Staff G they were aware they had a fall and complained of pain in their right leg. The resident was not able to move their right leg. Staff G stated usually they could turn the resident without assistance but they had to get help that night due to the resident's pain and inability to move their right leg. Staff G obtained assistance from Staff H, NA, to change the resident as they were incontinent. After changing the resident Staff G reported to Staff C at approximately 11:30 PM on 09/13/2024 that the resident was in a lot of pain. Staff C stated they would give the resident something for pain. The resident was not sleeping much and stated they were in pain. Staff G turned the resident with assistance every two hours. Staff G stated they informed the day shift NA on 09/14/2024 that the resident fell the previous evening and was getting an x-ray that morning. During an interview on 09/30/2024 at 12:19 PM, Staff H, stated they and Staff G tried to change Resident 1's brief and noticed they were in a lot of pain in their right hip. Staff H stated they had informed Staff C the resident was having pain in their right hip. The resident was restless but different that night as they were not trying to get out of bed due to not being able to move their right leg. During an interview on 09/30/2024 at 12:26 PM, Staff D, stated they were walking by Resident 1's room after dinner and could hear Staff A and B in the room. Staff B was telling the resident to stay in bed and Staff A was asking the resident if anything hurt. The resident was in bed at the time of the observation. Later, Staff B came to the nursing station and stated the resident fell again. Either on on 09/14/2024 or 09/15/2024 Staff D stated they were asked to write a statement as nothing had been reported regarding the resident's fall. Staff D stated they did not report it to the night shift NAs as they thought it would be reported in shift report by the Licensed Nurses. Staff E did not know the resident fell until later in the day. Reference (WAC) 388-97-1060(1) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	This is a repeat deficiency from the Statement of Deficiencies dated 07/17/2024, 04/16/2024, 01/09/2024, and 09/13/2023.

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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 - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on interview and record review, the facility failed to consistently assess, perform dressing changes as ordered, and implement wound provider recommendations timely for application of a wound treatment device for 1 of 3 residents (Resident 2), reviewed for pressure injuries (PIs - injury to the skin and underlying tissue due to prolonged pressure). The facility failed to timely monitor, assess, implement wound provider recommendations, and perform dressing changes as ordered. This failed practice resulted in harm to Resident 2, when they experienced worsening/deterioration of the PI to the sacrum (the triangular bone at the base of the spine that connects the lower back to the pelvis). Findings included . Review of the National PI Advisory Panel's (NPIAP, the leading expert in PIs/wounds) guidelines and definitions, dated September 2016, defined PI stages as follows: Stage 1 PI had intact skin with a localized area of non-blanchable erythema (redness). Stage 2 PI was a partial thickness skin loss with exposed dermis (the top inner layers of skin). Stage 3 PI was a full thickness loss of skin, in which adipose (fat) tissue was visible in the ulcer. Slough (dead tissue) and or eschar (dried blood and tissue) might be visible, granulation tissue and epibole (rolled or curled under edges) might include with undermining (a pocket of dead space under the visible wound edges) and tunneling (a passageway under the wounds surface which might be shallow or deep and impaired wound closure). Stage 4 PI was a full-thickness skin and tissue loss with exposed or directly palpable fascia (connective tissue), muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar might be visible. If slough or eschar hides the extent of tissue loss that was an unstageable PI. <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility on [DATE] with diagnoses which included PIs, cellulitis of right lower leg (infection that could cause pain, swelling, redness and tenderness), heart problems and Parkinsons (chronic, progressive and degenerative brain condition that affected the central nervous system). Review of the resident's comprehensive assessment, dated 08/15/2024, showed severely impaired cognitive function and was dependent on staff for activities of daily living. Review of the resident's plan of care, dated 08/27/2024, showed they had an unstageable PI to the right and left buttocks due to immobility. Interventions included weekly treatment documentation to include measurements of skin breakdown's width, length, depth, type of tissue and exudate (fluid that leaked out of blood vessels into nearby tissues). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 2's Wound Observation Tool, dated 08/15/2024 (day of admission), showed an unstageable PI to the sacrum which measured 5.0 by 8.0 centimeters (cm), eschar to areas, moisture-associated skin damage (MASD - inflammation caused by prolonged exposure to moisture such as urine, stool, wound drainage), and epithelial tissue (type of body tissue that covered the inside and outside of the body, including the skin) present with necrosis (death of body tissue). Review of Resident 2's Wound Observation Tool, dated 08/24/2024, showed an unstageable PI to the sacrum that had worsened with measurements of 4.5 by 6.0 with 0.7 cm of depth. There was a moderate amount of serosanguinous drainage (thin, watery fluid that leaked from the wound) present with necrotic tissue. The consulting wound provider (Nurse Practitioner - NP) performed debridement to the wound (procedure that removed unhealthy or dead tissue from a wound to help it heal). New treatments orders were obtained. Review of a wound assessment of Resident 2, dated 08/24/2024, by the consulting wound provider (NP), showed a Stage IV PI measuring 4.5 by 6.0 by 0.7 cm. The wound bed was covered in slough and eschar with minimal granulation tissue (new connective tissue that formed during the healing process) in the wound bed. Wound edges were rolled and there was a large amount of serous exudate (the drainage that seeps out of wounds). There was no redness or thickening/hardness of the skin surrounding the wound. Review of Resident 2's Wound Observation Tool, dated 08/30/2024, showed an unstageable PI to the sacrum that had not changed since the previous assessment dated [DATE]. Review of a wound assessment of Resident 2, dated 08/30/2024, by the consulting wound provider, Nurse Practitioner (NP), showed a Stage 4 PI to the sacrum measuring 4.5 by 6.0 by 0.7 cm. There was a large amount of foul smelling purulent drainage (pus that indicated an infection). There was no redness or thickening/hardness of the skin surrounding the wound. The area was debrided by the NP. A wound culture was recommended due to the increased drainage. The assessment stated the necrotic tissue was likely the source of the drainage rather than an infection. The NP recommended a wound vac (treatment that used suction to help wound healing) to be placed after the wound culture results were received and treated if needed. Review of physician's orders showed a wound vac was ordered for Resident 2 on 09/04/2024 with dressing change to be performed three times weekly and as needed. Review of the facility delivery receipt showed the wound vac for Resident 2 was delivered on 09/05/2024. Review of Resident 2's Progress Notes, dated 09/09/2024 at 5:54 PM, showed the wound vac was applied to the sacral area (five days after it was ordered). Resident 2's plan of care, dated 08/24/2024, showed treatment assessments were to be performed weekly. Review of assessments, for the time period between 08/30/2024 through 09/18/2024 showed there was no documentation of an assessment of the sacrum by nursing or providers until 09/18/2024 (19 days later). Review of the 09/18/2024 assessment, performed by the consulting wound physician, showed the Stage 4 PI to the sacrum had worsened as shown by measurements of 4.9 by 3.5 by 2.5 cm (extended depth). The wound bed was covered with brown/gray, necrotic smelling and slough. The wound edges were rolled. The fascia was exposed across the base and the wound physician was able to probe to the bone, although it was not visualized. The physician recommended immediate evaluation and treatment at the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505070	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Richland	44 Goethals Drive Richland, WA 99352

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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of hospital records, dated 09/18/2024, showed imaging would be performed on Resident 2 to evaluate for an underlying abscess (painful, pus-filled lump that developed in the body and usually caused by an infection) and possible osteomyelitis (serious bone infection). Intravenous (via the vein) antibiotic therapy was initiated and a surgical consult was obtained. Review of Resident 2's Treatment Administration Record (TAR) for August 2024, showed daily wound care to the sacrum was not documented on 08/27/2024, 08/28/2024, and 08/29/2024. Review of Resident 2's TAR for September 2024, showed daily wound care to the sacrum was not documented on 09/03/2024 and 09/12/2024. During an interview on 09/26/2024 at 3:42 PM, Staff K, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), stated they remembered measuring Resident 2's wound when the wound vac was applied on 09/09/2024. The measurements were written on a paper towel and Staff K did not recall where that was located as it was never documented in the resident's medical record. Staff K stated the wound vac was ordered but it was not placed on the wound for an entire week. Resident 2's family was very upset due to the wound vac sitting in the resident's room that long. The resident's sacrum had 100% necrotic tissue, thus it had to be surgically debrided at the hospital. During an interview on 09/27/2024 at 9:00 AM, the consulting wound provider (NP), stated they had planned to see Resident 2 following their visit on 08/30/2024, however Staff I, Administrator, told them they could no longer see residents in the facility as they did not have all the credentialing information on them that they needed. Resident 2 had granulation tissue and eschar to the sacral wound so they were a candidate for the wound vac. On their visit on 08/30/2024 the resident did not need any surgical debridement. The wound was bad, but they did not need to go to the hospital at that time. During an interview on 09/30/2024 at 9:00 AM, the consulting physician, stated they assumed the NP was covering for them while they were on vacation. On 09/18/2024 observation of Resident 2's sacral wound showed it stunk, and it was soft and boggy (sign of a deep tissue injury which was damage to the soft tissue caused by pressure). In probing the sacral wound with a Q-tip it went right to the bottom (indicative of increased wound depth). The consulting wound provider stated it was unacceptable for the PI to get to that point as the smell alone was so bad. They stated that Staff J, Director of Nursing, was present during the observation and stated they had no idea. There was necrosis all over the wound and that was why the resident needed to be hospitalized . During an interview on 09/30/2024 at 10:29 AM, Resident 2's representative, stated instead of the resident's wound to the bottom getting better it got worse. Dressing changes were not done as ordered. The wound vac should have been applied to the wound on 09/05/2024, but it was not done until 09/09/2024. It took a long time for the consulting wound physician to see the resident. When the wound physician did see the resident they stated there was nothing they could do at the facility thus the resident was sent to the hospital so fast. During an interview on 10/11/2024 at 2:30 PM, Staff K, stated they had taken over performing wound assessments on all residents when the consulting wound physician made their weekly visits at 6:00 AM. The second week of September 2024, they informed Staff J that one nurse could not do all the wound assessments and it was not working. Additional help was obtained for one week from administrative nursing staff, but it still was not working. (continued on next page)

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	505070	A. Building B. Wing	10/11/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Reference (WAC) 388-97-1060(3)(b) This is a repeat deficiency from the Statement of Deficiencies dated 07/17/2024.