

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/05/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Richland		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 00242</p> <p>Based on observations, interviews and record review, the facility failed to supervise to ensure the physician's diet order for 1 of 3 residents (Resident 1) was followed as ordered. This failed practice placed Resident 1 at risk for medical complications due to a choking incident.</p> <p>Findings included .</p> <p>&lt;Resident 1&gt;</p> <p>Review of the medical record showed Resident 1 had diagnoses which included difficulty swallowing following a stroke with left sided weakness. Review of Resident 1's comprehensive assessment, dated 09/25/2024, showed they had moderate impairment with cognition. Review of the resident's plan of care, dated 10/09/2024, showed they required assistance with one staff for toileting, turning in bed, dressing and eating to cut up the food items; and two staff for transfers utilizing a sit to stand mechanical device (designed to help those with limited mobility transfer from a seated position to an upright posture, and vice-versa).</p> <p>Review of Resident 1's prescribed diet order, dated 04/25/2023, showed regular diet with easy to chew texture (given to residents that might have difficulty chewing hard, tough, stringy or crunchy foods), and no side breads.</p> <p>Review of the Quarterly Nutrition Data Collection form, dated 10/28/2024, completed by the Registered Dietician, showed no side breads were to be given to Resident 1 due to their history of choking, chewing/swallowing and aspiration (breathing in a foreign object into the lungs, could occur during choking incidents and lead to complications such as pneumonia).</p> <p>Review of Resident 1's Progress Notes (PNs) showed the following:</p> <p>12/12/2021 at 2:35 PM - It was reported a Nursing Assistant (NA) did the Heimlich (first-aid method for choking, known as abdominal thrusts because the method involved thrusting into the abdominal area) when Resident 1 was choking in the dining room. A small bolus of bread was coughed up from the resident's throat or lungs after two abdominal thrusts and a large bolus of bread after an additional four thrusts.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12/22/2022 at 9:37 PM - A Licensed Nurse performed the Heimlich on Resident 1 after they had choked on a piece of pizza. Several abdominal thrusts and oral suctioning were performed prior to the resident being able to dislodge the pizza. Resident 1 was transported to the hospital on 12/22/2022 and was readmitted to the facility on [DATE] following a diagnosis of aspiration pneumonia.</p> <p>11/23/2024 at 4:29 PM - Resident 1 was served the wrong diet texture and they choked. Staff performed the Heimlich successfully. Chest x-rays were performed with normal findings.</p> <p>Review of the facility investigation report, dated 11/23/2024 at 12:30 PM, showed Resident 1 stated they had swallowed wrong and choked on a dinner roll on their food tray. The resident's diet order was not followed by staff as they were not to have any side breads.</p> <p>Observation of Resident 1 on 12/04/2024 at 12:30 PM, showed them seated in a wheelchair in the main dining room. Their diet card was next to the meal tray and showed they were not to receive any side breads. There were no bread items on the meal tray.</p> <p>On 12/04/2024 at 11:32 AM, Staff F, NA, stated at the time of the incident on 11/23/2024, Resident 1 had a soft roll on their meal tray which was not cut up. Staff F had not checked the resident's tray card prior to serving them the meal.</p> <p>On 12/04/2024 at 11:37 AM, Staff G, Food Service Manager, stated they were aware of Resident 1's history of choking. They stated a former Speech Therapist did not want the resident to have bread items as they would put the entire piece into their mouth.</p> <p>On 12/04/2024 at 12:05 PM, Staff H, Cook, stated they had recently been hired to work in the kitchen. They became flustered due to several staff coming into the kitchen during meal time with different requests. Staff H stated they just did not see the no side breads on the resident's dietary card, thus the roll was placed on the food tray.</p> <p>Reference (WAC) 388-97-1060(3)(g)</p> <p>This is a repeat deficiency from the Statement of Deficiencies dated 09/27/2023.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>00242</p> <p>Based on interviews and record review the facility failed to ensure annual Nurse Aide Certified (NAC) performance reviews were completed for 4 of 4 NACs (Staff A, B, C, D) reviewed who had been employed longer than one year. This failed practice had the potential to negatively affect the competency of those NACs and the quality of care provided to residents.</p> <p>Findings included .</p> <p>&lt;Staff A&gt;</p> <p>Review of Staff A's personnel file showed they were hired by the facility on 10/12/1993. The last performance review was on 10/30/2019 (over five years ago).</p> <p>&lt;Staff B&gt;</p> <p>Review of Staff B's personnel file showed they were hired by the facility on 06/14/2022. There had been no performance reviews completed on Staff B (over two years).</p> <p>&lt;Staff C&gt;</p> <p>Review of Staff C's personnel file showed they were hired by the facility on 12/27/2021. The last performance review was on 03/24/2023 (over one year).</p> <p>&lt;Staff D&gt;</p> <p>Review of Staff D's personnel file showed they were hired by the facility on 02/22/2023. There had been no performance reviews completed on Staff D (over one year).</p> <p>On 12/05/2024 at 11:30 AM, Staff E, Administrator, stated the former Director of Nursing had not been doing the performance reviews as required. A performance improvement plan was in place to get them done.</p> <p>(WAC) 388-97-1680(2)(b)(i)</p>