

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Kennewick		STREET ADDRESS, CITY, STATE, ZIP CODE 1508 West Seventh Avenue Kennewick, WA 99336	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision and ensure appropriate interventions were thoroughly implemented to prevent avoidable accidents for 1 of 3 residents (Resident 1) reviewed for accidents. Resident 1 experienced leg wounds while using their motorized wheelchair (w/c). This failure placed Resident 1 at risk for medical complications from the repeated leg wounds.</p> <p>Findings included .</p> <p><Resident 1></p> <p>Review of Resident 1's medical record showed they were admitted to the facility on [DATE] with diagnoses of cervical disc displacement (an injury to a disc [cushion] between the spinal bones, that resulted in pain, loss of sensation in arms and hands, and stiffness of the neck), rheumatoid arthritis (a chronic disorder that could cause pain, swelling, stiffness and loss of function in the joints of the body), anxiety, and muscle weakness. The 04/05/2024 comprehensive assessment showed the resident was independent using their motorized w/c and had an intact cognition.</p> <p>Review of Resident 1's medical record showed they experienced accidents on 02/04/2024, 04/24/2024, and 05/20/2024 while using their motorized w/c that caused injury to their legs.</p> <p>Review of the facility progress notes (PN) dated 02/04/2024, showed Resident 1 caught their arm on the motorized w/c, drove into their bed and caught their right lower leg which caused bleeding. The PN also showed Resident 1 was sent to the hospital.</p> <p>Review of a wound PN dated 02/06/2024, showed Resident 1 had a skin tear that measured 9.0 centimeters (cm - a unit of measure) by 4.5 cm and bruising on their right lower leg.</p> <p>Review of Resident 1's PN dated 04/24/2024, showed the resident was in their motorized w/c and bumped their left leg on their bed frame. Resident 1 experienced a 10.0 cm skin tear on their left lower leg and a bump on their right lower leg and they were sent to the emergency room .</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>Review of Resident 1's PN dated 05/20/2024, showed Resident 1 had slit their leg open on their bed again, while they used their motorized w/c. A significant amount of bleeding was present, and the laceration (a deep cut or tear to skin) was unable to be measured due to the bleeding of the injury. The PN showed the resident was transferred to the hospital ER for evaluation. Further review of the PN showed Resident 1 required 19 sutures to the right lower leg laceration.</p> <p>During an interview and review of Resident 1's care plan on 05/23/2024 at 10:12 AM, Staff A, Director of Nursing, stated the change to the care plan was the bed rails were padded. The 02/07/2024 care plan showed the resident had actual impairment to skin integrity of their right lower extremity related to a motorized w/c incident. The care plan intervention dated 05/21/2024, showed pad bed rails, or any other source of potential injury if possible.</p> <p>During an interview and observation on 05/21/2024 at 4:34 PM, Resident 1 stated they experienced a right lower leg injury from hitting their leg on their bed frame, that required them to receive 19 sutures. Resident 1 stated they were using their motorized w/c when they pushed the joystick (controller) forward and drove into their bed frame. Resident 1 stated this happened before when they used their motorized w/c and caused leg injuries. Resident 1 exposed their right leg to show their recent injury. Their lower right leg showed a white dressing with a reddish-brown fluid that seeped through the dressing. The white gauze that was to have been wrapped around the wound was loosely down on their ankle area. Resident 1's bed frame, that faced the entrance to their room, showed there was pink padding that was secured with clear tape on a 12-inch section and a second 10-inch section covered with black tape. There was eight inches of bed frame with two bolt heads exposed without padding. On the opposite side of Resident 1's bed frame that faced their room window, showed the same padding. Resident 1's motorized w/c had been removed from their room and stated they had remained in their bed during the day and were not planning to get out of bed.</p> <p>An observation on 05/23/2024 at 1:04 PM, showed the previous exposed eight inches of Resident 1's bed frame with exposed bolt heads was covered with padding.</p> <p>During an interview on 05/21/2024 at 4:36 PM, Resident 2, Resident 1's roommate, stated they had witnessed Resident 1 injure their legs before when they used their motorized w/c and drove into their bed. Resident 2 stated the facility put some padding on only a small part of Resident 1's bed frame on one side after the first accident. Resident 2 stated after the April 2024 accident the facility put additional padding on the opposite side of the bed frame near the window and another small section on the previous padded section, however they left part of the bed frame still uncovered that exposed bolt heads where Resident 1 cut their leg.</p> <p>During an interview on 05/23/2024 at 11:07 AM, Staff B, Occupational Therapist, stated Resident 1 had experienced other accidents when they drove their motorized w/c into their bed. Staff B stated Resident 1 had been assessed prior to using the motorized w/c and was approved to use it. Staff B stated after the accident on 02/04/2024, they reassessed Resident 1, and they passed their assessment to utilize the motorized w/c. Staff B stated after the next accident in April (04/24/2024), they performed a visual screening on how the resident used their motorized w/c in the puzzle room, not in their own room, because Resident 1 had signed a document they were to request assistance from staff and not use their motorized w/c in their room.</p> <p>(continued on next page)</p>		

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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>During a concurrent interview on 05/23/2024 at 1:04 PM, Resident 1 stated they did not remember if staff told them not to use their motorized w/c in their room. Resident 1 stated their hand would get stuck on the joystick for the motorized w/c and caused them to drive into their bed frame and panic. Resident 2 stated staff did not assist Resident 1 with their motorized w/c in their room and Resident 1 would use their motorized w/c by themselves.</p> <p>During an interview on 05/23/2024 at 1:13 PM, Staff C, Nursing Assistant (NA), stated Resident 1 was able to move around the facility in their motorized w/c and they typically went to the puzzle room and main dining room for activities. Staff C stated they were not aware Resident 1 was not to use their motorized w/c in their room or out of their room without assistance from staff. Staff C stated they had not received any education or instruction regarding Resident 1's w/c use.</p> <p>During an interview on 05/23/2024 at 1:18 PM, Staff D, NA, stated Resident 1 would use their motorized w/c in and out of their room and they were independent. Staff D stated staff had not been driving or controlling the w/c. Staff D further stated they had not been provided any education or any new instruction for Resident 1's use of their motorized w/c.</p> <p>During an interview on 05/23/2024 at 1:22 PM, Staff E, NA, stated they were the primary NA for Resident 1 and were aware they had accidents when they used their motorized w/c that caused them injuries. Staff E stated they would stand by as the resident drove their motorized w/c from their room to the hallway and back into their room if they were aware the resident was returning. Staff E stated they did not operate the motorized w/c. Staff E stated there were many times Resident 1 returned to their room by themselves. Staff E further stated they were not provided any education about Resident 1 not able to utilize their motorized w/c in their room alone and was not instructed to assist them in/out of their room.</p> <p>During an interview on 05/23/2024 at 1:28 PM, Staff F, Maintenance Director, stated they placed some padding on Resident 1's bed frame after the first accident in February (02/04/2024) and they placed a second piece of padding after the next accident about a month ago (second accident, 04/24/2024). Staff F stated they placed the padding where the injuries they believed occurred on the bed frame. They did not place padding on all the exposed bed frame. Staff F stated they placed a smaller piece of padding on the bed frame that was still exposed after the 05/20/2024 accident, on 05/22/2024.</p> <p>During an interview on 05/23/2024 at 1:38 PM, Staff G, NA, stated they were aware that Resident 1 had accidents when they used their motorized w/c. Staff G stated Resident 1 told them they sometimes lost control of the joystick because their hand would slip. Staff G stated they would occasionally watch Resident 1 use their motorized w/c in the hall or puzzle room. Staff G stated they were not provided any education or instruction about Resident 1 not able to use their motorized w/c in their room without assistance. Staff G continued to state they would not be able to watch Resident 1 all day because they had other residents to care for.</p> <p>During an interview on 05/23/2024 at 1:50 PM, Staff A, stated after Resident 1's first accident in February, they padded the entire bottom of the bed frame that faced the resident's door. Staff A stated after the second accident in April, Resident 1 was instructed not to use their motorized w/c in their room without assistance and they were to request assistance from their doorway to their bed. Staff A stated staff were to be next to the resident when they were in their room and only provide cueing. Staff A stated they expected Resident 1 to be compliant with the use of their motorized w/c.</p> <p>(continued on next page)</p>		

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