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| 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 10/03/2024 |
| 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) |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>45117</p> <p>Based on interview and record review, the facility failed to report a fall with significant injury to the State Agency as required, experienced by 1 of 3 residents (Resident 1), reviewed for falls. This failed practice placed the residents at risk for harm and diminished protection and oversight from the State Agency.</p> <p>Findings included .</p> <p>Review of a policy titled, Abuse - Reporting and Response - No Crime Suspected, reviewed 06/17/2024, showed the facility would report alleged violations to the State Agency, if the incident that caused the allegation resulted in serious bodily injury. Additionally, the report should be made immediately but not later than two hours after the allegation was made.</p> <p><Resident 1></p> <p>Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including a stroke with left arm paralysis (loss of muscle function), muscle weakness, and heart failure. The 07/24/2024 comprehensive assessment showed Resident 1 was dependent on two staff members for bed mobility (the ability to move in bed) and transfers between surfaces. The assessment also showed Resident 1 had an intact cognition.</p> <p>Review of a facility investigation report dated 09/19/2024 at 7:04 AM, showed Resident 1 had fallen out of a sling while being transferred on a mechanical lift. The investigation showed staff did not appropriately secure the sling to the mechanical lift prior to lifting the resident. The investigation showed Resident 1 had injuries to their face that included a hematoma (a collection of blood that forms outside of blood vessels, usually caused by an injury or trauma) to their left forehead, extending to their eye and lower face. The left eye was almost swollen shut. The investigation showed Staff B, Nursing Assistant (NA), was sent home until proper training could be completed on Hoyer (mechanical lift) transfers.</p> <p>During an interview on 10/03/2024 at 10:28 AM, Staff A, Director of Nursing Services, stated they did not report the incident because there was no significant injury, no fractures, and no head trauma, despite the investigation showing Resident 1 had injuries to their forehead, face, and neck. Staff A stated they did eventually report the incident on 10/01/2024 due to the resident's family having concerns about not reporting the incident.</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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| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: Facility ID: 505080 | If continuation sheet Page 1 of 6 |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Reference: WAC 388-97-0640(6)(a)(c)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - 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** 45117</p> <p>Based on observation, interview, and record review, the facility failed to identify avoidable accident hazards during a mechanical lift transfer for 1 of 3 residents (Resident 1) reviewed for falls. Resident 1 experienced harm when they fell to the floor from the mechanical lift and sustained a hematoma (a collection of blood that forms outside of blood vessels, usually caused by an injury or trauma) and an abrasion to the forehead, requiring a transfer to the emergency room .</p> <p>Findings included .</p> <p>Review of a policy titled, Limited Lift Program (Safe Patient Handling), revised 09/19/2024, showed the facility would provide education upon hire and annually to staff on proper use of mechanical lifts in accordance with the manufacturer's guidelines. The education would also include the need to have two staff members present during the transfer. Additionally, manufacturer guidelines would be used to determine the type and size of sling that should be utilized when a lifting device was required.</p> <p>Review of the facility provided manufacturer's instructions for use for a Vive Healthcare Patient Lift Sling (the sling used with Resident 1 on 09/19/2024), received by the facility via email on 09/20/2024 at 2:06 PM, showed the sling was compatible with most floor lift models.</p> <p>Review of the Joerns Hoyer Lift (Hoyer HPL700 - used with Resident 1 on 09/19/2024) manufacturer's user instruction manual, dated 2024, showed the Hoyer HPL700 lift .is designed to be used in conjunction with the Hoyer range of slings. Additionally, there were several warnings regarding sling use, including: Hoyer recommends the use of genuine Hoyer parts. Hoyer slings and lifts are not designed to be interchangeable with other manufacturer's products. Using other manufacturer's products on Hoyer products is potentially unsafe and could result in serious injury to patient and/or caregiver.</p> <p><Resident 1></p> <p>Review of the medical record showed Resident 1 was admitted to the facility with diagnoses of a stroke with left arm paralysis (loss of muscle function), muscle weakness, and heart failure. The 07/24/2024 comprehensive assessment showed Resident 1 was dependent on two staff members for bed mobility (the ability to move in bed) and transfers between surfaces. The assessment also showed Resident 1 had an intact cognition.</p> <p>Review of Resident 1's care plan, dated 07/31/2024, showed the resident required two-person assistance for transfers with a Hoyer Lift (a mechanical lift used to transfer a resident between two surfaces) and bed mobility.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Review of a facility investigation report showed on 09/19/2024 at 7:04 AM, Resident 1 was transferred from their bed to their wheelchair using the Hoyer Lift. The investigation showed the interdisciplinary team (a group healthcare professionals from different disciplines to help people receive the care they need) had established the mechanical lift sling had not been hooked appropriately to the Hoyer Lift which caused the strap to slide off, causing Resident 1 to fall out of the sling onto the floor. Resident 1's head hit the floor, and their right shin hit the edge of the Hoyer Lift. Resident 1 was moved from a face down position to a seated position on the floor. The resident was noted to have a hematoma to the head and complained of leg pain.</p> <p>Review of hospital records, dated 09/19/2024, showed Resident 1 had arrived at the emergency room for evaluation of injuries after falling out of a Hoyer Lift and hitting their head on the floor. Resident 1 was noted to have a large forehead contusion (a type of hematoma of tissue, damaged by trauma, causing localized bleeding that spreads into surrounding tissues) and was taking a blood thinner.</p> <p>Review of a written statement by Staff B, Nursing Assistant (NA), dated 09/19/2024 at 7:15 AM, showed Staff B hooked up (attached the sling loops to the Hoyer Lift hooks) Resident 1 to the Hoyer Lift and was in control of the Hoyer Lift. Staff C, NA, guided the resident to position them into their wheelchair. Staff B proceeded to lower Resident 1 into the wheelchair; next thing we knew, client (Resident 1) is on the floor.</p> <p>Review of a written statement by Staff C, dated 09/19/2024, showed Staff C had answered a call on their radio requesting assistance with a transfer. When Staff C entered Resident 1's room, the resident was already hooked up to the Hoyer Lift. Staff B and Staff C lifted the resident with the Hoyer Lift, while Staff C guided the resident's feet, Staff B opened the legs to the Hoyer Lift. Staff C placed Resident 1's wheelchair in place, and just as doing so, one of the sling straps slipped and the resident fell out of the sling onto their face.</p> <p>Review of a written statement by Staff D, NA, dated 09/19/2024, showed Staff D had responded to a call on the radio that there was a fall in Resident 1's room. They ran to the room and saw Resident 1 face down on the Hoyer Lift legs and floor. One strap of the sling was hanging on the lift, not connected.</p> <p>A concurrent observation and interview on 10/01/2024 at 3:47 PM, showed Resident 1 sitting in their room in their wheelchair. They had a large hematoma measuring 5.2 centimeters [(cm) a unit of measurement] by 6.1 cm on their forehead with a pea sized scab in the center of the hematoma. Resident 1 had significant faded purple/yellow facial bruising surrounding each eye, along the left cheek bone, and deep purple bruising measuring 5.1 cm by 11.0 cm on their neck. When asked if they felt they had a significant injury due to the fall, Resident 1 stated yes, I face planted out of the lift and had a CT scan [computed tomography (CT) - an imaging technique used to obtain detailed internal images of the body]. Resident 1 stated they were unable to remember if the sling had been attached to the lift correctly.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 10/01/2024 at 4:26 PM, Staff C stated Resident 1 was already hooked up to the Hoyer Lift when they went into their room to assist with the transfer. Staff C stated just as they went to grab onto Resident 1 to position them in their wheelchair, one of the sling straps (the leg strap) had slipped off the Hoyer Lift and Resident 1 fell off the sling. Staff C stated Staff B had strapped the resident to the Hoyer Lift before they entered the room; they were just assisting with the transfer. Staff C stated they had received safe Hoyer Lift training upon hire and right after the fall. Staff C stated they were instructed on how to hook up the sling and safely transfer a resident. They stated they were also trained to make sure the sling they were using matched the mechanical, but I don't know exactly which lift goes with which sling. During a follow-up interview on 10/03/2024 at 1:02 PM, Staff C stated they did not double check the straps on the sling prior to lifting Resident 1. Staff C stated they had not used the flat sling prior to using it to transfer Resident 1 and had not received any training on the use of that sling. Staff C stated they were hurrying that morning and did not double check the hooks for safety and I should have.</p> <p>During an interview on 10/01/2024 at 4:45 PM, Staff E, Licensed Practical Nurse, stated they had performed an assessment on Resident 1 after the fall on 09/19/2024. They stated when they entered the room, the sling was still hanging from the mechanical lift with three points of contact, not four points of contact. Staff E stated it looked like the sling had not been hooked up properly. They stated the sling they used was different than the normal slings. Staff E stated they had questioned the use of the sling but was told it was ok to use. Staff E stated they did not know where that particular sling came from and were unsure why staff had chosen to use that sling.</p> <p>During a concurrent observation and interview on 10/01/2024 at 5:20 PM, Staff A obtained a mechanical lift sling from a locked closet and stated that was the sling that was in use when Resident 1 fell on [DATE]. Observation of the sling showed a flat sling with four straps; each strap had four loops for attaching to the mechanical lift. There was no manufacturer identification on the sling. Staff A stated the sling had been donated by a family and going forward, the facility would use the sling for smaller residents because the sling was too small for the resident it was used on. Staff A provided the package insert/documentation that was in the bag with the sling.</p> <p>During an interview on 10/03/2024 at 12:11 PM, Staff B stated their normal process for using the Hoyer Lift was to call for a second person to help with the transfer. They stated they normally wait for the second person before hooking up the sling to the Hoyer Lift. Staff B stated the morning of 09/19/2024, they asked for assistance with the transfer over the radio. Staff B stated they made a mistake by hooking up Resident 1 prior to the second staff member coming into the room. Staff B stated Resident 1 asked if they were secure on the Hoyer Lift prior to lifting them, and both Staff B and Staff C assured Resident 1 they were secure. Staff B stated they remembered attaching all four straps to the Hoyer Lift and checking them to make sure they were on correctly. Staff B stated they proceeded to lift Resident 1 with the Hoyer Lift, and the strap came off the hook. Resident 1 had fallen on their front side and had a little cut on their forehead. Staff B stated they were very confused as they remember checking the straps before lifting the resident. They stated the sling they used that morning to transfer Resident 1 was the sling that had been assigned to the resident on the day they were admitted. Staff B stated they had not seen or used that sling prior to using it with Resident 1. They stated the sling was a full body, flat sling that did not have the cross straps for the legs. Staff B stated they had not been trained on the use of that type of sling. Staff B stated after the incident, they were pulled from the floor and sent home pending an investigation and had to demonstrate proper use of the sling prior to returning to work. Staff B stated after the fall, Resident 1 complained of a headache and was sent to the emergency room.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 10/03/2024 at 10:28 AM, Staff A, Director of Nursing Services, stated they had read the manufacturer's guidelines for use of the sling prior to putting it into service. During a follow-up interview that same day at 1:39 PM, Staff A stated the nursing assistants received mechanical lift training during their orientation and annual competency's. They stated Staff B needed more training, a refresher, because they only worked as needed and Staff B was just moving too fast that morning. Staff A stated the process for transferring a resident with a Hoyer Lift included two staff members, and they should always check the straps prior to lifting the resident. Staff A stated they did not provide training on that particular sling before putting it into use. They stated they felt staff would know how to use the sling and would not require additional training on the proper use of the flat sling. Staff A stated during the transfer of Resident 1 on 09/19/2024, one strap of the sling fell off during the resident's transfer and they were not sure why it fell off. Staff A further stated they checked the manufacturer's guidelines for the sling but did not check the manufacturer's guidelines for the Hoyer Lift to ensure they were safe to use together.</p> <p>Reference (WAC) 388-97-1060(3)(g)</p> | | |