

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Regency Canyon Lakes Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 S Ely St Kennewick, WA 99337	

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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242</p> <p>Based on observation, interview and record review, the facility failed to provide timely care and services and perform assessments for 1 of 3 residents (Resident 1) reviewed with indwelling urinary retention catheters. Resident 1 experienced harm when they had prolonged bladder pain due to urinary retention with a delay in treatment. The facility corrected the deficient practice prior to the initiation of the abbreviated survey on 09/04/2024. This failure was past non-compliance (the facility was not in compliance at the time the situation occurred; however, there was sufficient evidence that the facility corrected the non-compliance after it was identified) and was corrected by the facility on 08/29/2024 and is no longer outstanding. The facility removed the noncompliance by:</p> <ul style="list-style-type: none"> - Resident 1 was immediately assessed by a LN and action was taken to address their medical needs. The physician was notified, and orders received to continue to monitor resident. - Staff A and Staff B, involved in the care and assessment of Resident 1, were suspended and then terminated for failure to assess a change of condition in accordance with professional standards. There were no other residents affected by that practice. - All LNs had received education regarding change of condition related to catheter care, maintenance and output monitoring on 08/23/2024. - Audits would be conducted weekly through the clinical meeting process to ensure residents with catheters were voiding without difficulty. Results of the audits would be reviewed through the facility Quality Assurance Performance Improvement Committee process monthly for three months to ensure compliance with plan of correction and further develop a plan if needed. First audit was completed and reviewed. <p>Findings included .</p> <p><Resident 1></p> <p>Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease (chronic, progressive brain disorder that affected the nervous system and caused motor and non-motor symptoms) and urinary retention (a condition that occurred when someone was unable to empty their bladder completely). The resident was transferred to the hospital on 08/07/2024 for heart and kidney problems. They were readmitted to the facility on [DATE] with an indwelling urinary retention catheter due to urinary retention.</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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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>Review of Resident 1's comprehensive assessment, dated 08/16/2024, showed they had moderately impaired cognition. Review of their plan of care, dated 08/12/2024, showed they required moderate assistance by one staff for grooming/personal hygiene; moderate assistance by one staff for transfers using a Steady lift (manual sit-to-stand transfer aid that enabled one caregiver to transfer residents); maximum assistance by one staff for toilet use, dressing and turning in bed; and one staff to set up for meals.</p> <p>Review of physician's orders, dated 08/12/2024, showed staff were to irrigate the catheter as needed if plugged or leaking.</p> <p>Review of the facility investigation, dated 08/22/2024, showed Resident 1 voiced they had a hard time getting assistance during the early morning hours of 08/22/2024, despite asking for help on several occasions. The investigation determined the resident's urinary output was not adequate during the evening shift (2:00 PM to 10:00 PM) of 08/21/2024 and during the night shift (10:00 PM on 08/21/2024 until 6:00 AM on 08/22/2024). The indwelling urinary retention catheter had become plugged and limited the resident's output. Staff A, Registered Nurse (RN) on the evening shift of 08/21/2024, failed to recognize the decreasing urinary output and document their assessment in the resident's medical record. In addition, Staff A failed to utilize tools such as the bladder scanner (portable ultrasound device used to measure the volume of urine within the bladder) or irrigate the resident's catheter to ensure their assessment was thorough and accurate. Staff B, Licensed Practical Nurse, on the night shift ending at 6:00 AM on 08/22/2024, failed to perform any assessment, or provide the necessary care and services to the resident.</p> <p>Review of Resident 1's August 2024 Medication Administration Record showed no pain medication was administered to the resident on the evening shift of 08/21/2024 through the night shift ending at 6:00 AM on 08/22/2024.</p> <p>On 09/04/2024 at 10:40 AM, Staff C, Nursing Assistant (NA), stated they had worked with Resident 1 from 6:00 AM to 10:00 PM on 08/21/2024. At 4:00 PM on 08/21/2024 the resident began complaining of pain in their urethra, (tube which allowed urine to pass outside the body). When Staff C checked the resident's catheter between 6:30 PM to 7:00 PM they observed a build-up of pink-red sediment from the insertion site down five inches of the catheter. The catheter collection bag was emptied at 8:30 PM on 08/21/2024 for a total of 75 milliliters (ml's) of dark brown, foul smelling urine. Staff C stated they notified Staff A at that time as usually Resident 1 had large amounts of urinary output. Between 8:30 PM to 10:00 PM the resident had no additional urinary output. Staff C stated when she cared for the resident earlier that day between 6:00 AM to 2:00 PM there was a total of 1800 ml's of urine as the resident usually drank large amounts of water. Staff C stated she had discussed Resident 1's complaints of pain and changes in their urinary output at least twice with Staff A during the evening shift. Staff A had responded to Staff C stating the only thing they could do for Resident 1 was to order a urinalysis (UA) to be done.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/04/2024 at 12:15 PM, Staff A, stated they had worked between 6:00 PM to 10:00 PM on 08/21/2024. They were doing a medication administration pass at 8:00 PM when Staff C came to them stating Resident 1 was complaining of burning with urination. Staff A saw Resident 1 at 8:30 PM that evening and they stated it was burning but denied pain. Staff A stated they palpated the resident's abdomen and had no concerns and no complaints of pain by the resident. The catheter was draining amber colored urine. Staff A stated they informed Resident 1 they would get a physician's order in the morning for a UA to be done to rule out a urinary tract infection. Staff A put a note in the provider book regarding the need for a UA to be done and informed Staff B during shift report at 10:00 PM on 08/21/2024. The provider would get the note the following day. Staff A stated they had been informed by Staff C of the resident's low urinary output. Staff A stated they had not contacted the provider, nor had they documented their assessment in the resident's medical record. Despite Resident 1's complaints of burning with urination Staff A stated they had not administered pain medication to the resident as they had not complained of pain.</p> <p>On 09/04/2024 at 11:37 AM, Staff D, NA, stated they cared for Resident 1 from 10:00 PM on 08/21/2024 to 6:00 AM on 08/22/2024. Staff D stated at 11:00 PM on 08/21/2024 there was only 10 to 20 ml's of urine in Resident 1's catheter bag. At 2:00 AM on 08/22/2024 the resident complained of abdominal pain. The resident's abdomen was hard at that time and there was no additional urinary output. Staff D stated Resident 1 agreed to take Tylenol. Staff D informed Staff B of the resident's hard abdomen, minimal urine output and the need for pain medication. Staff D also stated to Staff B that something was not right, with Resident 1. Staff B was to give Resident 1 Tylenol and stated maybe a bladder scan should be done. When Staff D returned to the resident's room between 3:30 AM to 4:00 AM Resident 1 was in so much pain, had tears in their eyes and felt helpless. Staff D stated everything they told Staff B was being disregarded. Resident 1 had no further urine output. Resident 1 stated the Licensed Nurse (LN) never came to their room despite them putting their call light on between 3:00 to 4:00 AM. At 4:00 AM the resident stated, I'm going to die here. A total bed change was done at 4:00 AM as the resident had urinated around the catheter soiling the bed sheets. The resident had used their call light two to three times and asked if the LN was going to do anything about their concerns. Staff D again reported to Staff B that something was not right with the resident. Staff D stated they were not aware of Staff B ever being in the resident's room during the shift, nor was pain medication administered to the resident.</p> <p>On 09/04/2024 at 12:04 PM, Staff B, stated the only thing that was reported by Staff A in shift report at 10:00 PM on 08/21/2024 was Resident 1 was having burning with urination and a UA was to be done. At 3:45 AM on 08/22/2024 Staff D informed them the resident only had 100 ml's of urine output, to which Staff B responded they would perform a bladder scan on the resident. At that time another resident had fallen to which Staff B had responded. Staff B stated they then administered medications to residents at approximately 4:30 AM, forgetting about the need to perform a bladder scan on Resident 1. At 5:20 AM on 08/22/2024 Staff E, RN, arrived to work and performed a bladder scan on the resident which showed 600 ml's to 700 ml's in the resident's bladder. Staff E also put a new catheter in the resident. Staff B stated they were aware of the resident's low urinary output but stated they had not complained of any pain. Staff B stated they had gotten side tracked, when a resident had fallen. Staff B stated they had not administered any pain medication to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/04/2024 at 10:30 AM, Staff E, stated at 5:30 AM on 08/22/2024 they were told by Staff B Resident 1 had bladder pain and painful urination and a UA needed to be obtained. Staff B stated they received that information in shift report at 10:00 PM on 08/21/2024 from Staff A. Staff E stated they were approached by Staff D at 6:15 AM on 08/22/2024 that they had informed Staff B three to four times during their shift that Resident 1 was having bladder pain and no urinary output on the evening and night shifts. Staff D also reported they had touched the resident's abdomen and it was rock hard. Staff E stated they immediately went to assess Resident 1 and observed their abdomen was very distended and rock hard. The resident appeared miserable, had tears in their eyes and was in a lot of pain. Staff E performed a bladder scan on the resident with the first reading of 1066 ml's and the second reading showed 977 ml's of urine. Staff E observed a dark brown sediment in six inches of the catheter tubing from the insertion site. The catheter appeared to be plugged thus a new catheter was inserted with a total of 1700 ml's of urine obtained (normal bladder capacity ranges between 400 and 600 ml's). The resident was immediately relieved of pain with the new catheter. The resident informed Staff E they had put their call light on several times on the previous evening and night shifts with no one addressing their concerns.</p> <p>On 09/04/2024 at 2:45 PM Resident 1 stated to questions regarding their catheter, they remembered the pain through the night, were concerned about their stomach becoming distended and hard, remembering it felt like they were going to die and no one seemed to pay any attention to them. Despite their pain they did not recall receiving any pain medication. Resident 1 was observed lying in bed at the time of the interview. Their indwelling urinary retention catheter was draining clear, yellow urine.</p> <p>Reference: WAC 388-97-1060(1)</p>		