

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 12/26/2024
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 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242</p> <p>Based on interviews and record review, the facility failed to ensure 1 of 3 residents (Resident 1), reviewed for medication administration, was free from a significant medication error. Resident 1 experienced harm when Staff A (Registered Nurse) did not follow standard practices for medication administration when they administered multiple medications, belonging to another resident, to Resident 1. This resulted in Resident 1 becoming unresponsive with low blood pressure (BP) and low blood glucose (BG) levels, necessitating an emergency transfer to the emergency room and admission to the hospital. The facility corrected the deficient practice prior to the initiation of the abbreviated survey on 12/26/2024. 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) was corrected by the facility on 12/18/2024 and is no longer outstanding. The facility removed the immediacy by:</p> <ul style="list-style-type: none"> - Resident 1 was immediately assessed by the Nurse Practitioner (NP) and action was taken to address their medical needs. The NP remained in the facility and was present at the time Resident 1 was sent to the emergency room . Staff was monitoring the resident closely for changes in their condition. There were no other residents affected. - Staff A and all Licensed Nurses received education on 12/17/2024 regarding the rights of medication administration, and verifying the resident by name and picture or name and date of birth. - A performance review was conducted on Staff A on 12/17/2024. - Residents were interviewed regarding their medications for any concerns, timeliness of administration, and receiving all the medications that were ordered by the physician. - A Skills Checklist was performed on Staff A on 12/18/2024. - Random medication pass audits will be completed weekly for 8 weeks. The results of the audits would be reviewed through the facility Quality Assurance Performance Improvement Committee process at the end of January 2025 with the final results being discussed in April 2025. <p>Findings included .</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 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, General Dose Preparation and Medication Administration, revised on 11/15/2024, showed prior to the administration of medication, facility staff should take all measures required by facility policy and applicable law, including but not limited to the following:</p> <ol style="list-style-type: none"> 1) Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct time, for the correct resident. 2) Confirm that the Medication Administration Record reflects the most recent medication order. <p>During medication administration, facility staff should perform the following:</p> <ol style="list-style-type: none"> 1) Verify resident identification using resident's picture in the computer and at the entrance to their room. 2) Provide the resident with any necessary instructions, including the medication use and possible side effects. <p><Resident 1></p> <p>Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses which included arthritis and chronic respiratory disease. Review of Resident 1's comprehensive assessment, dated 11/19/2024, showed they had moderate impaired cognition. Review of a Progress Note, dated 12/16/2024, showed Resident 1 required moderate assistance with one staff for walking, turning in bed and transfers; maximum assistance with one staff for dressing and toilet use; and set up assistance for eating. The resident was able to make their needs known.</p> <p>Review of an assessment by the NP, dated 12/17/2024, showed Resident 1 had a significant medication error involving 12 medications; which included three medications to reduce BP, three medications used in the treatment of diabetes to lower BG, one medication to prevent blood clotting, one medication to reduce swelling, one medication to treat depression and anxiety, one medication to treat a condition where the thyroid gland does not produce enough thyroid hormone, one medication to treat irritable bowel syndrome, and one potassium medication to help nerves and muscles work properly. The resident did well throughout the morning without any acute changes. At lunch time the resident became unresponsive. Their eyes were open, lips were blue (caused by low oxygen levels in the blood), and was unable to answer questions and follow instructions. The resident's BG level was found to be in the 60's (normal BG levels would be 125 or lower), thus a medication to treat low BG was given. Their systolic BP (measures the pressure of the blood pushing against the artery wall - normal reading was less than 120) was in the 60's. Emergency Medical Services (EMS) was called to transport Resident 1 to the emergency room .</p> <p>Review of hospital records, dated 12/17/2024, showed intravenous (via a vein) fluid was given to Resident 1 for treatment of their low BG and low BP. Due to the resident's persistent low BG and slightly low BP they were admitted to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/26/24 at 11:44 AM, Staff A, stated they only worked one to two days a month at the facility, and had not met Resident 1 until the day of the medication error (12/17/2024). Staff A stated they had looked at the picture of Resident 1 on the computer, which looked similar to the resident whose medications were given to Resident 1. They stated they had not properly identified the resident, nor had they identified the medications to Resident 1, in a rush. Upon Staff A's return to the medication cart after the administration of medications to Resident 1, they immediately became aware of the medication error as Resident 1's room number was different. Staff A stated they immediately notified their supervisor of the medication error.</p> <p>On 12/27/2024 at 10:07 AM, Resident 1 stated that during the medication administration on 12/17/2024 they had told Staff A the 11-12 medications looked strange to them. Staff A had responded, they change them occasionally. Resident 1 stated the medications were hard to recognize in the small medication cup so they took all the medications. They stated they did not know anything about the medications and Staff A did not describe any of them. Resident 1 then went to lunch and ate 25-50% of their meal. They stated that during lunch they began having vision problems and did not feel good. Following lunch they were taken by staff to the end of the hall. Resident 1 did not recall anything further until they were hospitalized . Resident 1 was discharged from the hospital three days later on 12/20/2024.</p> <p>Reference (WAC) 388-97-1060(3)(k)(iii)</p>		