STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505514	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Post Acute	1745 Pike Avenue Richland, WA 99354

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)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 00242 Based on interviews and record review, the facility failed to ensure hemodialysis (a machine that filters wastes, salts and fluids from the blood when the kidneys no longer were working properly) care and services were consistent with professional standards of practice for 1 of 2 residents (Resident 1) reviewed for dialysis care. The facility failed to remove the pressure dressing applied to the A/V fistula (arteriovenous fistula - surgically created connection between vein and artery to allow direct access to the bloodstream for dialysis) following dialysis treatment, failed to consistently monitor the resident's condition following dialysis and to ensure facility policies and procedures were implemented. This failed practice placed Resident 1 at risk for complications and adverse medical conditions. Findings included . Review of the facility policy titled, Hemodialysis Care, last revised on 11/2023, showed staff were to assess bruit (listen for blood flow through the fistula by placing stethoscope on the fistula, any changes in the pitch might indicate a clot or narrowing of the fistula) and thrill (vibration caused by blood flowing through the fistula - can be felt by placing fingers above the incision line) on a daily basis; evaluate fistula site for signs/symptoms of infection, swelling, redness, bleeding, bruising, hematoma (pool of mostly clotted blood) and distention (larger) veins near site; and follow instructions on when to remove dressings to the fistula site. Upon the resident's return from dialysis treatment the post dialysis assessment was to be completed. Residents who required hemodialysis were provided ongoing assessments and monitoring of the resident's condition before and after dialysis treatments including monitoring for complications and interventions as part of nursing standard of practice. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility with diagnoses which included end stage renal disease (condition in which the kidneys no longer were able to remove waste and balance fluids) and dementia. Review of a comprehensive assessment, dated 05/26/2024, showed Resident 1 had severe cognitive impairment. Review of Resident 1's plan of care, dated 05/23/2024, showed the resident required maximum assistance of one staff for turning in bed, totally dependent on one staff for dressing and toileting, extensive assistance with one staff for grooming and transfers and was unable to walk due to inability to bear weight on the left leg. In addition, Resident 1 received hemodialysis weekly on Tuesdays, Thursdays and Saturdays. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/18/2024 at 8:55 AM, Collateral Contact (CC) A (dialysis Registered Nurse - RN), stated for the past month Resident 1 would return to dialysis with their pressure dressing still in place over the fistula despite instructions provided to the facility to remove it after four hours. Collateral Contact A stated the facility had been notified three times weekly regarding that issue. On 07/18/2024 CC A stated they notified Staff C, Interim Director of Nursing, of the problem. Staff C stated they would have to address the issue with the LN responsible for the removal of the dressing. On 07/22/2024 at 1:53 PM, CC B (Manager at dialysis center), stated facility staff were not removing Resident 1's pressure dressing from their fistula site and the resident would then return to their next scheduled dialysis treatment with the pressure dressing still in place. Collateral Contact B stated that occurred on every dialysis treatment over the past month. On 07/13/2024 dialysis staff even wrote on the pressure dressing, please change me in four hours. Dialysis staff had called the facility five to six times over the past month to report the problem but nothing changed. Collateral Contact B stated one of the dialysis staff spoke to Staff C, Interim Director of Nursing, on 7/18/2024 regarding the pressure dressing not being removed and yet on 07/20/2024 (next scheduled dialysis treatment) Resident 1 arrived at dialysis with the same pressure dressing that had been placed by dialysis staff on 07/18/2024. On 07/23/2024 at 11:37 AM, Staff C, stated they had received a telephone call on 07/18/2024 from a staff member at the dialysis center who reported Resident 1 had arrived that day with the pressure dressing still over the fistula since 07/16/2024. Staff C stated they were working on an inservice with Staff D, evening shift Registered Nurse (RN), but did not follow through, thus no education was given. On 07/22/2024 at 12:45 PM, Staff D, stated they were not sure they removed the pressure dressing from Resident 1's fistula each time following dialysis. Staff D stated they did not really look at the fistula site. On 07/22/2024 at 12:50 PM, Staff E, day shift RN, stated Resident 1 left for dialysis at approximately 6:30 AM so they rarely even saw the fistula to do an assessment. Staff E stated the evening shift licensed nurses were to check the pressure dressing and remove it. On 07/22/2024 at 12:58 PM, Staff F, RN, stated facility staff would not be able to assess Resident 1's fistula with the pressure dressing on. Review of the facility Pre Dialysis Evaluations, dated 06/20/2024, 06/25/2024, 07/16/2024 and 07/18/2024, showed dialysis staff had hand written on the evaluation forms to remove the dressing to Resident 1's left upper arm within four hours. The evaluation forms were then sent with Resident 1 when they returned to the facility. Review of Resident 1's Pre dialysis evaluation form, dated 07/20/2024, showed CC B documented the dressing to the left upper arm was to be removed in four hours. If dressing is not removed w/in [within] 24 hours [Resident 1] runs the risk of [Resident 1's] access clotting and if this happens then [Resident 1] is unable to dialyze and [Resident 1] can die .This access is [Resident 1's] life line. Review of physician's orders, dated 05/24/2024, showed staff were to evaluate Resident 1's fistula for signs/symptoms of bleeding, bruising, hematoma and infection daily. In addition, review of physician's orders, dated 5/25/2024, showed staff were to complete the Post Dialysis Evaluations every Tuesday, Thursday and Saturday afternoons. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Despite physician's orders and facility policy to complete the Post Dialysis Evaluation forms following each dialysis visit, review of Resident 1's medical record showed they were only completed on 05/25/2024, 06/08/2024 and 07/06/2024. Reference (WAC) 388-97-1900(1)