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	12/30/2024

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to develop and implement an effective discharge planning process that addressed the resident's goals and needs, that involved the resident and the interdisciplinary team [(IDT) a group of healthcare professionals from different disciplines to help residents receive the care they need] for 2 of 4 residents (Resident 1 and 2) reviewed for discharge planning process. The failure to develop and implement a discharge plan consistent with the resident's needs and expressed discharge goals, placed the resident at risk for decreased self-worth and dissatisfaction with their living situation. Findings included . <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses including respiratory failure with hypoxia (a condition in which the body doesn't have enough oxygen in the tissues), heart disease, and kidney disease. The 10/28/2024 comprehensive assessment showed Resident 1 required substantial/maximum assistance of one staff member for activities of daily living (ADLs) and had a severely impaired cognition. The assessment also showed Resident 1's overall goal for discharge was to return to the community. Resident 1 discharged to home from the facility against medical advice on 11/20/2024. Review of Resident 1's comprehensive care plan dated 11/21/2024, showed no documentation that a comprehensive, person-centered discharge plan had been initiated for the resident. The care plan did not include information that identified the resident's discharge goals, needs, barriers to discharge, or the potential discharge location. During an interview on 12/23/2024 at 3:44 PM, Resident 1's Representative (RR) stated they had caregivers in place at home to care for Resident 1. The RR stated, all they (Resident1) wanted was to be at home. <Resident 2> (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record showed Resident 2 was admitted to the facility on [DATE] with diagnoses including heart failure, pneumonia (an infection of the lungs that causes inflammation of the air sacs), and kidney failure. The 12/11/2024 comprehensive assessment showed Resident 2 required supervision/partial assistance of one staff member for ADLs. The assessment also showed Resident 2 had an intact cognition and wanted to discharge to the community. Resident 2 discharged from the facility to the hospital on 12/20/2024. Record review of Resident 2's care plan dated 12/05/2024, showed no documentation that a comprehensive, person-centered discharge plan had been initiated for the resident. The care plan did not include information that identified the resident's discharge goals, needs, barriers to discharge, or the potential discharge location. During an interview on 12/30/2024 at 1:21 PM, Staff B, Social Services Director, stated the process for discharge planning started during their initial meet and greet meeting when the resident first arrived at the facility. They stated they set up an initial care conference, completed a social services assessment, and determined the resident's/representative's goals for discharge. Staff B stated after gathering the information, they added the discharge plan to the resident's care plan. Staff B stated they had a conversation with Resident 1's Representative on the same day Resident 1 had admitted to the facility. They stated the RR wanted to take Resident 1 home right away and had told Staff B that they did not think the facility was the right place for Resident 1. Staff B stated Resident 1 had caregivers at home through Veterans Administration (VA) services, along with a provider that made house calls, and therapy services from the VA. Staff B stated the RR would stop by their office almost daily, stating they wanted to take Resident 1 home. Staff B stated Resident 2 wanted to discharge to home and had services in place. Staff B stated it was their responsibility to ensure residents had a discharge plan entered on their care plan. During an interview on 12/31/2024 at 3:38 PM, Staff A, Administrator, stated discharge goals were identified at the initial care conference. They stated a discharge plan should have been included on the resident's comprehensive care plan. Reference: WAC 388-97-0080(3)(a)(5)(7)(a-c)