

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505514	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Richland Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on interviews and record review, the facility failed to report an incident of neglect regarding a fall to the State agency as required, involving 1 of 3 residents (Resident 1), reviewed for falls. This failed practice placed residents at risk for harm and diminished protection and oversight from the State agency. Findings included . Review of the facility policy titled, Abuse - Screening, Training, Identification, Investigation, Reporting, and Protection, revised on 01/2023, showed if the allegation involves neglect, that does not involve abuse or serious injury, the incident is reported within 24 hours to the state survey agency, as required. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors). Review of a comprehensive assessment, dated 12/07/2024, showed Resident 1 had severe cognitive loss. Review of Resident 1's plan of care, dated 12/17/2024, showed Resident 1 required two staff to assist with transfers and toileting. Review of a facility investigation report, dated 12/26/2024 at 4:02 PM, showed Resident 1 had a witnessed assisted fall to the floor when being transferred from their bed to the wheelchair by Staff A, Nursing Assistant. Despite the resident's plan of care showing they required two staff for transfers, Staff A transferred the resident alone and was not strong enough to hold the resident. Resident 1 did not sustain any injuries from the fall. On 01/15/2025 at 3:08 PM, Staff D, Administrator, stated the incident involving Resident 1 was not reported to the state agency as they did not see it as an incident of neglect. Refer to F689 for additional information. Reference (WAC) 388-97-0640(6)(c) This is a repeat deficiency from the Statement of Deficiencies dated 08/12/2024.		

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on interviews and record review, the facility failed to supervise to ensure staff provided care according to the resident's plan of care and facility policy to prevent falls for 1 of 3 residents (Resident 1), reviewed for falls. This failed practice resulted in potential injuries to Resident 1 when they fell to the floor. Failure to follow residents' plans of care placed residents at risk for injury, falls, and a diminished quality of life. Findings included . Review of the facility policy titled, Gait Belt Policy and Procedure, not dated, showed it was the policy of the facility to use a gait belt with any resident that was not independent. If the resident was unsteady with their gait or unable to transfer independently, a gait belt should be used. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors). Review of a comprehensive assessment, dated 12/07/2024, showed Resident 1 had severe cognitive loss. Review of Resident 1's plan of care, dated 12/17/2024, showed Resident 1 required 2 staff to assist with transfers and toileting. Review of a fall assessment, dated 12/04/2024, showed Resident 1 was at high risk for falls. Review of Progress Notes, dated 12/26/2024 at 8:37 PM, showed Resident 1 was being transferred from bed to wheelchair by one staff. The resident's knees buckled and the Nursing Assistant (NA) guided the resident to the floor on their knees. The resident did not sustain any injuries. The resident was unable to assist with the transfer at all due to their inability to bear any weight. Review of the facility investigation report, dated 12/26/2024 at 4:02 PM, showed at approximately 4:00 PM Resident 1 was being assisted from their bed to the wheelchair by Staff A, NA. The resident was unable to assist with any part of the transfer. Review of a post-fall assessment for Resident 1's fall on 12/26/2024, dated 12/30/2024, showed the resident was unable to independently come to a standing position, exhibited a loss of balance with standing, required hands-on assistance to move from place to place, and they had a decrease in muscle coordination. Staff A was transferring the resident alone and they were not strong enough to hold the resident when the resident did not assist with the transfer. On 01/15/2025 at 9:25 AM, Staff B, Physical Therapist, stated Resident 1 had poor body control with weakness and fatigue. The resident's head and shoulder would lean to the left side and they required significant assistance to stand. The resident needed two staff to assist with mobility. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/2025 at 2:32 PM, Staff A, stated they had transferred Resident 1 by themselves at the time of the fall on 12/26/2024. Staff A stated they had received report from the day shift NA who stated the resident required one staff for transfers with a gait belt. Staff A stated the resident's spouse was in the room at the time of the fall and had stated prior to the fall that often the resident was tired after meals. Staff A stated they transferred the resident and they buckled and fell on the floor on their knees. The resident's spouse informed Staff A the resident required two staff to assist with transfers and the care directives showing that were on the inside of the resident's closet door. Staff A stated it did not appear they used a gait belt during the transfer of Resident 1. On 01/15/2025 at 11:38 AM, Staff C, NA, stated the resident's spouse was in the resident's room at the time of the fall on 12/26/2024. Staff A was not using a gait belt at the time of the fall, as Staff C had to ask for one to transfer Resident 1 back into bed following the fall. On 01/09/2025 at 11:50 AM, Resident 1's spouse, stated a NA came into the resident's room on 12/26/2024 and was going to transfer the resident by themselves. The spouse informed Staff A the resident required two staff per their plan of care and the instructions on the inside of their closet door. Staff A grabbed the back of the resident's sweat pants and proceeded to stand the resident up, which resulted in them falling to the floor. The spouse stated Staff A did not utilize a gait belt during the transfer. The resident was six feet tall and weighed 230 pounds (review of the resident's medical record showed the resident's weight on 12/22/2024 was 220.5 pounds). Reference (WAC) 388-97-1060(3)(g) This is a repeat deficiency from the Statement of Deficiencies dated 08/12/2024.		