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	07/02/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify a change in condition for 1 of 3 residents (Resident 1) reviewed for assessments. The failure to perform an assessment disallowed an opportunity to adequately evaluate the resident's medical condition, which potentially caused a delay in treatment. Findings included . <Resident 1> Review of Resident 1's medical record showed they were admitted on [DATE] with diagnoses including an upper arm fracture, pancreatic cancer, and diabetes (a disease that results in too much sugar in the blood). Review of the admission summary note dated 06/21/2025 showed the resident was alert and oriented to self, was able to conversate about their health and was able to follow directions without difficulty. The admission summary notes also showed Resident 1 had a foley catheter (a flexible tube used to drain urine from the bladder into a collection bag). Review of Resident 1's vitals sign records showed on 06/25/2025 at 7:05 AM, there was one set of vital signs recorded as followed; blood pressure 113/94 ([BP]-systolic the force of blood pushing against the walls of the blood vessels and the diastolic resting pressure between heartbeats; Normal BP 120/80), heart rate 67 (HR-normal rate 60-100), oxygen saturation 92% (normal range 95-100%). There were no additional recorded vital signs for the day. During an interview on 06/27/2025 at 10:54 AM, Resident 1's Representative, (RR), stated they had arrived at the nursing home facility to accompany Resident 1 to an appointment on 06/25/2025. The RR stated they had to wait at the nurse's station for 45 minutes for their transportation to arrive. The RR stated during this time, Resident 1 was slumped over and leaning far to the right in a wheelchair and was hard to arouse. The RR stated when they voiced their concern to staff at the nurse's station, nobody checked on Resident 1. The RR stated the transport ride was 20 minutes and upon arrival at the medical appointment, clinic staff were very concerned about Resident 1's condition. The RR stated the clinic staff performed a quick assessment and called emergency services and transported Resident 1 to the emergency room. The RR further stated Resident 1 was admitted to the hospital and was placed on comfort care until they pass away. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/27/2025 at 11:22 AM, Staff A, Nursing Assistant, stated they noticed a change in Resident 1 during lunchtime on 06/25/2025. Staff A stated Resident 1 was not responding to them very well. Staff A stated they assisted a nurse with Resident 1's dressing change after lunch and noticed when Resident 1 was holding onto a grab bar during the dressing change in the restroom, they became weak and seemed like they wanted to drop. Staff A stated after the dressing change, they assisted Resident 1 to dress and then wheeled them to the nurse's station to wait for their transport to the medical appointment. Staff A noticed Resident 1 was heavily leaning to the right and not responding to voice or visual commands. Staff A stated other staff members came to adjust Resident 1 in the wheelchair by placing blankets on their right side to prop them up. Staff A stated they were not asked by a nurse to take any vital signs. During an interview on 06/27/2025 at 12:16 PM, Staff B, Registered Nurse, stated Resident 1 was sleepy as the resident had not taken a nap on 06/25/2025. Staff B stated Resident 1 was leaning to their right side and they propped them up to straighten them out in the wheelchair. Staff B stated they thought it was odd for Resident 1 to be sleepy. They did not chart any assessments for Resident 1 as they were only to document by exception (documentation for deviations from a resident's established norm or expected outcome). Staff B stated Resident 1's vital signs were normal earlier in the day and they did not have an indication to perform an assessment for their sleepiness. Additionally, Staff B did not obtain a current set of vital signs. Review of the 06/25/2025 ambulance report showed emergency medical services (EMS) was notified on 06/25/2025 at 2:39 PM to respond for Resident 1 with an altered level of consciousness (LOC) at a medical providers office appointment. The report showed Resident 1 had been weaker and had an altered LOC prior to the appointment. The EMS findings showed Resident 1 slumped over in a wheelchair, responsive to sternal rub (a vigorous rub to the breastbone), pupils were constricted, low BP and urine in the foley catheter bag was dark with visible debris. The report showed the following BPs obtained by EMS: 2:51 PM, BP 69/47; 2:55 PM, BP 50/30; 2:58 PM, BP 60/36; 3:03 PM, BP 61/43; 3:06 PM, BP 79/45. Review of the hospital emergency notes dated 06/25/2025, showed Resident 1 presented with shock (a serious life-threatening medical emergency that can cause extremely low blood pressure, confusion, unconsciousness and sleepiness) and treatment included high flow oxygen support and medication to increase blood pressure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/27/2025 at 10:19 AM, a medical clinic Collateral Contact I, (CCI), stated Resident 1 had a 3:00 PM medical appointment on 06/25/2025 and had arrived by a transport service and was not appropriate for the appointment in the condition they presented in. CCI stated Resident 1 was slumped over in a wheelchair and was unable to be aroused without a sternal rub when they arrived for a medical appointment. CCI stated the staff obtained vital signs which showed Resident 1's blood pressure measured 51/33. During an interview on 06/27/2025 at 12:55 PM, Staff C, Director of Nursing, stated when a resident seemed different the staff should perform an immediate assessment and obtain vital signs and then notify the provider and await further instructions. Staff B stated Resident 1 should have had an assessment and vital signs obtained and based on the findings laid down in bed and decided if the resident needed to be transported to the emergency room. During an interview on 06/27/2025 at 4:01 PM, Collateral Contact II, (CCII), stated upon arrival at the nursing facility on 06/25/2025 at 2:12 PM, Resident 1 was slumped over in a wheelchair and their face was almost to their knees. CCII asked a staff member which resident they would be transporting and a staff member pointed at Resident 1 and stated, Ya that's what we are dealing with today. CCII stated they placed Resident 1 into the transport vehicle and had to lift Resident 1's upper body to place the seatbelt on. CCII stated during the transport Resident 1 was unarousable and they were extremely concerned about their well-being. Reference WAC: 388-97-1060(1)