

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 08/12/2024
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 44922 Based on observation, interview, and record review, the facility failed to ensure protection of residents from their Alleged Perpetrator (AP), after allegations of abuse/neglect were reported to the facility for 1 of 6 residents (Resident 51) reviewed for abuse/neglect. This failure placed all residents at an increased risk for unidentified abuse and/or further abuse, and unmet psychosocial care needs. Findings included . <Resident 51> Review of the resident's medical record showed the resident admitted to the facility with diagnoses of a coccyx (the bone at the end of the spinal column) fracture and heart failure. The 06/26/2024 comprehensive assessment showed the resident was cognitively intact and experienced frequent pain. During an interview on 08/05/2024 at 10:59 AM, Resident 51 made an allegation against a male staff member that worked at night. Resident 51 described the staff member as light skin colored, slightly balding head, taller than average, with a mustache/beard. Later identified as Staff F, Licensed Practical Nurse. Resident 51 stated they were afraid when Staff F worked, they would not get adequate pain management because they felt like Staff F was singling them out and judging them as if they were a junkie [a slang term for a drug addict or a fan of something] for asking for pain medication. Resident 51 stated they felt they needed to lie about their pain level to get their pain medication from Staff F which made it look as if their pain was always bad. Resident 51 stated Staff F made them stick their tongue out after they received their pain medication to ensure Resident 51 swallowed the pills and then would return five to ten minutes later to ask if the pain medication was effective. Staff 51 further stated they no longer wanted Staff F providing them care. During an interview on 08/06/2024 at 4:00 PM, Staff A, Administrator, was reported Resident 51's allegation and the identified staff member. Staff A stated they would immediately start an investigation. Additionally, at 5:30 PM, Staff A stated that Staff F had been moved to another hall. Review of an undated document provided by Staff A, on 08/09/2024 at 11:36 AM, showed a partially completed investigation summary into Resident 51's allegation. The document showed a post incident action that Staff F would be removed from Resident 51's care. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and concurrent interview on 08/09/2024 at 2:40 PM, Staff F was observed sitting on the edge of Resident 51's bed, leaning in towards the resident to talk to the resident about their pain medications and how Resident 51 must have misunderstood Staff F's assessment of their pain medications. Staff F told Resident 51 that they needed to tell them their real pain level and then would be back to reassess their pain, because that's what they are supposed to do as a nurse. Staff S, LPN, was also present in the room with Staff F but not sitting on the bed. Both Staff F and Staff S exited the room. Then, Staff F was asked about the discussion with Resident 51, Staff F while shaking? their head to the left and right, stated Resident 51 thought Staff F had been trivializing (minimizing) their pain .and was singling [Resident 51] out. Staff F stated they sat on the resident's bed to get down on their level and tell [Resident 51] face to face. When Staff F was asked about the investigation into the allegation made against them by Resident 51, Staff F stated they could not remember what was told to them by Staff A, other than Resident 51 thought Staff F singled them out. Staff F stated in a surprised voice oh s**t, I forgot all about [Staff A] telling me that I was supposed to change rooms with somebody so there weren't any further concerns and I forgot to do that. A concurrent observation and interview on 08/09/2024 at 2:44 PM, showed Resident 51 lying in their bed, and stated [Staff F] freaked me out and sat on the edge of my bed. Resident 51 in an angry voice stated, you assured me [Staff F] wasn't coming back in here, and here [Staff F] was! Resident 51 stated Staff F began to apologize to the resident and explain to them what their job was as a nurse and that Resident 51 needed to make sure they told them the honest truth about their pain level when they brought in their pain medications. During a follow-up interview on 08/12/2024 at 11:04 AM, Resident 51 stated they felt afraid when Staff F came into their room because they did not know what to expect when they sat on their bed. Resident 51 did not understand why Staff F could not have just stood and talked to them. During an interview on 08/09/2024 at 3:18 PM, Staff B, Interim Director of Nursing Services, stated Staff A did not communicate to them that Staff F was no longer allowed to provide care to Resident 51. Staff B stated they had checked with the scheduling coordinator, and they were not aware either. Staff B stated they had removed Staff F from Resident 51's care and going forward would no longer be providing care to Resident 51. During an interview on 08/09/2024 at 4:38 PM, Staff A stated they educated Staff F on the allegation outcome earlier in the week and informed Staff F they were no longer allowed in that room. Staff A stated Staff F should not have gone in that room. Reference: WAC 388-97-0640 (6)(a)		

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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** 43280 Based on observation, interview, and record review, the facility failed to report allegations of abuse and/or neglect to the State Agency for 2 of 6 residents (Residents 27 and 52) reviewed for abuse/neglect. This failure placed the residents at risk for unidentified and ongoing abuse/neglect. Findings included . Review of the Code of Federal Regulations 483.12 (c)(1), F609, Reporting of Alleged Violations showed, facility's must Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment .are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and the other officials (including to the State Survey Agency . Review of the facility's policy titled, Abuse-Screening, Training, Identification, Investigation, Reporting, and Protection, dated January 2023, showed the facility was to report all allegations of abuse to the appropriate state agency. <Resident 27> Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnoses including heart complications and a bladder infection. The comprehensive assessment dated [DATE], showed the resident had a moderately intact cognition, was able to understand others, and make their needs known. During an interview on 08/06/2024 at 9:15 AM, Resident 27 stated their former roommate tried to stab me with scissors. Resident 27 stated the former roommate (Resident 30) had moved out of their room the same day the incident had taken place, and they were unsure of what staff member they informed but had told facility staff about the incident. Review of the facility incident reporting log for July and August 2024, showed no allegation of abuse had been reported regarding Resident 27 being threatened with scissors by Resident 30. During an interview on 08/07/2024 at 1:03 PM, Staff C, Registered Nurse (RN)/Resident Care Manager (RCM) stated Resident 27 had informed them that Resident 30 had been yelling at Resident 27 to turn down the volume on the TV and then threatened Resident 27 with a pair of scissors. Staff C stated they had started to fill out a grievance form on 08/02/2024 but had not completed it. Review of an uncompleted grievance form dated 08/02/2024, showed Resident 27 reported to Staff C that during the night of 08/01/2024 to 08/02/2024, (Resident 27) has been telling various staff members that (Resident 27's) roommate threatened (Resident 27) with scissors during the night. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/08/2024 at 10:47 AM, Staff A, Administrator, stated they were unaware of Resident 27 being threatened by Resident 30 with scissors. Staff A stated that was an allegation of abuse from Resident 27, which should have been reported. <Resident 52> Review of Resident 52's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include heart complications, vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain), and anxiety (a feeling of worry, nervousness, or unease). The comprehensive assessment dated [DATE] showed that Resident 52's cognition was impaired and unable to make sound decisions. An observation on 08/07/2024 at 9:30 AM, showed Resident 52 wandering and exiting another resident's room (Rm 308). Resident 52 came out of room [ROOM NUMBER], walked down the 300-hall and wandered into room [ROOM NUMBER] and sat on the side a bed next to the window. In an interview on 08/07/2024 at 9:46 AM, Staff O, Nursing Assistant (NA), stated Resident 52 gets turned around (to become lost, to lose one's way) and wandered around the facility, in and out of other resident rooms. An observation on 08/07/2024 at 9:49 AM, Resident 52 was fully dressed, wander guard (bracelets that residents wear, sensors that monitor doors and that sends safety alerts in real time) to their left wrist and ambulating with a family member down the 100-hall. Resident 52 opened the exit door of the 100-hall (which had a keypad alarm) that did not alarm when the resident walked out the door. In an interview on 08/08/2024 at 10:36 AM, Staff Q, RN, stated that Resident 52 wandered through out the facility and sometimes when they tried to redirect the resident, they would get combative. Review of Resident 52's elopement (a resident who is incapable of adequately protecting themselves, and who departs the health care facility unsupervised and undetected) risk assessment dated [DATE], showed the resident was a low elopement risk. The resident had not been reassessed for an elopement risk until after the second elopement incident on 08/06/2024. Review of the incident reporting log for July and August 2024, showed the resident had elopement incidents logged but were not reported to the State Agency. In an interview on 08/08/2024 at 3:15 PM, Staff B, Interim Director of Nursing Services, acknowledged that Resident 52 had an elopement on 08/06/2024 and stated they had started their investigation. In an interview on 08/12/2024 at 10:56 AM, Staff A stated they were aware of Resident 52's elopement incidents and were correlating the incidents to the resident's visits from friends and family. Additionally, Staff A stated they did not report it to the State Agency. Reference: WAC 388-97-0640 (6)(c) 45642		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on observation, interview, and record review, the facility failed to conduct a thorough investigation into an allegation of abuse and/or neglect and prevent an elopement for 2 of 5 residents (Resident 27 and 52) reviewed for abuse/neglect. This failure placed the residents at risk for unidentified and/or continued abuse, recurrent elopements, and unmet care needs. Findings included . Review of the facility's policy titled, Abuse-Screening, Training, Identification, Investigation, Reporting, and Protection, dated January 2023, showed that all allegation of abuse were to be thoroughly investigated. <Resident 27> Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnoses including heart complications and a bladder infection. The comprehensive assessment dated [DATE], showed the resident had a moderately intact cognition, was able to understand others and make their needs known. During an interview on 08/06/2024 at 9:15 AM, Resident 27 stated their roommate (Resident 30) attempted to stab them with scissors during the night. Resident 27 stated they informed a facility staff member about the incident and then remembered Resident 30 being moved out of their room the same day the incident had taken place. During an interview on 08/07/2024 at 1:03 PM, Staff C, Registered Nurse/Resident Care Manager (RN/RCM), stated Resident 27 had informed them that Resident 30 had threatened them with scissors during the nighttime after yelling at them to turn down the television volume. Staff C stated Resident 27 did not have any behaviors and had never made any allegations towards other residents before but did not think that Resident 30 could have got up on their own to threaten Resident 30. Staff C had started filling out a grievance form but was waiting for Resident 27's Representative to get back to them about the possibility that they had picked up the scissors, so Staff C had not completed it yet. Review of an uncompleted grievance form dated 08/02/2024, showed Resident 27 reported to Staff C that during the night of 08/01/2024 to 08/02/2024, Resident 27 informed various staff that Resident 30 had threatened them with scissors during the night. This should also be reworded. Same exact statement in F609. During an interview on 08/08/2024 at 10:47 AM, Staff A, Administrator, stated they were unaware of Resident 27 being threatened by Resident 30 with scissors and it had not been reported to them. Staff A stated that Resident 27's statement was an allegation of abuse and should have been investigated. <Resident 52> (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 52's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include Vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain), anxiety (a feeling of worry, nervousness, or unease). The comprehensive assessment dated [DATE], showed Resident 52's cognition was impaired and they were unable to make sound decisions. An observation on 08/07/2024 at 9:30 AM, showed Resident 52 wandering and exiting another resident's room (Rm 308). Resident 52 came out of room [ROOM NUMBER] looking down at the floor with a frown on their face, shaking their head. The resident then walked down the 300-hall wandered into room [ROOM NUMBER] where they sat on the side of another resident's bed next to the window. An observation on 08/07/2024 at 9:49 AM, Resident 52 was fully dressed, wearing a wander guard (bracelets that residents wear, sensors that monitor doors and that sends safety alerts in real time) to their left wrist and ambulating with a family member down the 100-hall. Resident 52 opened the exit door of the 100-hall (which had a keypad alarm) which did not alarm when the resident walked out the doorway. Review of the facility's incident reporting log for July and August 2024 showed that the resident had elopement incidents logged. Review of Resident 52's elopement risk assessment dated [DATE], showed the resident was a low elopement risk. The resident had not been reassessed for an elopement risk until after the second incident on 08/06/2024. In an interview on 08/08/2024 at 3:15 PM, Staff B, Interim Director of Nursing Services, acknowledged that Resident 52 had an elopement on 08/06/2024 and they had begun their investigation. In an interview on 08/12/2024 at 10:56 AM, Staff A stated that they were aware of Resident 52's elopement incidents and were correlating the incidents to the resident's visits from friends and family. Staff A stated they did not report the elopements to the State Agency, that they acknowledged that the risk of elopement was not on the resident's care plan timely, until after the 2nd elopement on 08/06/2024. Reference: WAC 388-97-0640 (6)(a)(b)(c) 45642		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on observation, interview, and record review the facility failed to ensure residents Preadmission Screening and Resident Reviews ([PASARR], an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities are not inappropriately placed in nursing homes for long term care) were correct on admission and had required level II referral if residents had a positive level I PASARR, for 4 of 5 residents (Residents 43, 5, 23, and 34) reviewed for PASARR. This failure placed the residents at risk of not receiving the mental health care and services appropriate for their needs. Findings included . Review of the Department of Social and Health Services, Dear Nursing Home Administrator Letter, guidance titled, Clarification to the Pre-Admission Screening and Resident Review (PASARR or PASRR) Level 1 Screening Process, dated 07/06/2024, showed a positive level I PASARR screen (that would then require a referral for a level II PASARR) was Any of the questions in Section 1A (1, 2, and/or 3) are marked Yes: or Sufficient evidence of SMI is not available, but there is a credible suspicion that a SMI may exist; and the requirements for exempted hospital discharge do not apply . Additionally, nursing facilities will ensure residents with a positive level I PASARR screen have been evaluated by the designated state-authority through the level II PASARR process and approved for admission prior to admitting to the nursing home. <Resident 43> Review of the resident medical records showed they were admitted to the facility on [DATE] with diagnoses including multiple heart complications, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (a feeling of worry, nervousness, or unease) and Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves, causing shaking movements). The comprehensive assessment dated [DATE] showed the resident had a moderately intact cognition, was able to understand others and make their needs known. Review of Resident 43's PASARR, dated 07/09/2024 showed SMI indicators, in section 1A, were checked marked for Resident 43's diagnosis of depression and anxiety (a positive level I PASARR). No level II referral was completed and showed .No Level II evaluation indicated . During an interview on 08/08/2024 at 12:54 PM, Staff M, Social Service Director (SSD), stated their process was to have hospitals complete the level II evaluation prior to the resident being admitted , but that it had not been happening. Staff M stated that Resident 43 should have had a level II PASARR evaluation completed upon admission, due to the resident having a positive level I PASARR. <Resident 5> Review of Resident 5's medical record showed the resident admitted to the facility on [DATE] with a diagnosis of anxiety. Review of the comprehensive assessment dated [DATE], showed the resident's cognition was intact. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 5's physician orders showed that the resident had been prescribed Cymbalta (a brand of medication given for depression and anxiety). Review of Resident 5's July and August 2024 Medication Administration Record (MAR), showed that the resident had been receiving Cymbalta daily as ordered. Review of Resident 5's PASARR, dated 06/25/2024 showed the SMI indicators, in section 1A, had not been checked for the residents diagnoses of anxiety. During an interview on 08/08/2024 at 11:01 AM, Staff E, Licensed Practical Nurse/Resident Care Manager, stated that the admissions director worked with the hospital to ensure that residents had their PASARR completed accurately. Staff E stated that they received the information once the resident was admitted , and that medical records scanned the information into the resident's medical record. In an interview on 08/08/2024 at 11:05 AM, Staff T, Admissions Director, stated they assisted with the PASARR when residents were being admitted to the facility. Staff T stated they contacted the hospital and worked with them to ensure an admitting resident had a PASARR. Staff T stated that they were aware of the change to PASARR process, and they had seen more level II PASARR's. Staff T stated that once a resident admitted to the facility the social services department took over the process. <Resident 23> Review of the resident's medical record showed the resident admitted to the facility 05/23/2024 with diagnoses to include depression, anxiety, and insomnia (a sleep disorder that makes it hard to fall asleep or stay asleep). The 05/26/2024 comprehensive assessment, showed the resident's cognition was severely impaired. Review of Resident 23's August 2024 MAR, showed the resident received psychotropic (any drug that affects behavior, mood, thoughts, or perception) medications as follows; Sertraline (a brand of anti-depressant medication) daily, Trazodone (a brand of anti-depressant medication also used for Insomnia) daily at bedtime, and Alprazolam (a brand of anti-anxiety medication) twice daily. Review of Resident 23's PASARR, dated 05/23/2024, showed no diagnoses for anxiety or insomnia even though the resident received medications for those SMI disorders. <Resident 34> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with a diagnosis of anxiety. Review of the 07/10/2024 comprehensive assessment, showed the resident's cognition was intact. Review of Resident 34's July 2024, and 08/01/2024 to 08/06/2024 MAR, showed the resident had an order for ativan (a brand of anti-anxiety medication) every six hours as needed for anxiety. Review of Resident 34's PASARR, dated 07/03/2024, showed no diagnosis for the SMI disorder. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/08/2024 at 10:00 AM, Staff M stated they, along with the admissions nurse reviewed PASARRs on admission for accuracy, required level IIs if needed to be submitted for an assessment. Staff M stated if PASARRs were not accurate they would ensure they were accurate prior to admission or if after admission, they would correct them. Reference: WAC 388-97-1915 (1)(2) 45642 44922		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on interview and record review the facility failed to develop a baseline care plan (BCP) within 48 hours of admission that included resident specific initial goals and treatment plans, nor provide a summary of the required information from the BCP to the resident for 3 of 6 residents (Residents 7, 58, and 52) reviewed for baseline care plans. This failure placed the residents at risk for a lack of knowledge regarding the initial plan for delivery of care/services and unmet care needs. Findings included . <Resident 7> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including a recent fall with a head laceration (a deep cut or tear in skin) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of the resident's comprehensive assessment dated [DATE], showed Resident 7 required extensive assistance of one caregiver for activities of daily living (ADL's) and was cognitively intact. During an interview on 08/08/2024 at 10:08 AM, Resident 7 stated they were not provided a BCP within 48 hours of admission that discussed their specific goals or treatment plan while in the facility. Resident 7 stated, I wish they would have so I would have known what the plan was for getting better and being able to go home. 43280 44922 <Resident 58> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include multiple fractures from a motor vehicle accident and Chronic Obstructive Pulmonary Disease (a chronic lung disease that makes breathing difficult and causes cough, mucus and wheezing). The 07/16/2024 comprehensive assessment, showed the resident's cognition was intact. The record further showed no baseline care plan had been developed. During an interview on 08/05/2024 at 3:01 PM, Resident 58 stated they had not received a BCP summary of their initial goals, medications, dietary instructions, services/treatment that were to be administered by the facility nor the details of their BCP. During an interview on 08/08/2024 at 9:43 AM, Staff M, Social Services Director, stated they would complete their first assessment, I would assume that is our portion of the baseline care plan on the History/Discharge document for social services within day one to day seven of admission. Staff M further stated they did not give a copy of that to the resident or the Resident Representative (RR). (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 07/16/2024 history/discharge document showed the document had not been started until seven days after admission and not developed within the 48 hours after admission. During an interview on 08/08/2024 at 10:23 AM, Staff D, Licensed Practical Nurse (LPN)/Resident Care Manager, (RCM) stated they used the Kardex as the baseline care plan and would go over that with the resident or RR on admission. Staff D stated if the resident or RR had questions regarding their medications then they would print off their physician orders and go over the medications with them. Staff D stated they did not give the resident or RR a copy of the documents unless they asked for one. Review of Resident 58's 08/12/2024 Kardex, showed a box that was labeled Requirements of Participation: that showed no information for diet, what type of wounds and where, a summary of orders, or treatments, and a signature line for the resident or the RR to sign and acknowledge that they were offered a copy of their plan of care. Surveyor: [NAME], [NAME] P. 45642 <Resident 52> Review of the medical record showed that the resident was admitted to the facility on [DATE] with diagnosis to include heart complications, vascular dementia (Problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain), and anxiety . The comprehensive assessment dated [DATE] showed that Resident 52's cognition was impaired and unable to make sound decisions. In an interview on 08/06/2024 at 9:46 AM, Resident 52's RR, stated they had not reviewed the BCP with staff 48 hours after admission to the facility. In an interview on 08/09/2024 at 11:13 AM, Staff E, LPN/RCM, stated that they review the residents' plan of care during the care conferences. Additionally, that they did not discuss the BCP with the residents or provide them a copy of the care plan. Reference: WAC 388-97-1060 (3)		

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NAME OF PROVIDER OR SUPPLIER Richland Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1745 Pike Avenue Richland, WA 99354	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to develop and/or implement comprehensive resident centered care plans for 2 of 6 residents (Residents 34 and 51) reviewed for unnecessary medications and skin conditions. This failed practice put residents at risk for unmet care needs. Findings included . <Resident 34> Review of the resident's medical record showed the resident admitted with diagnoses to include metastatic (cancer spreads beyond the place where it started to other areas of your body) breast and bone cancer (a disease resulting from uncontrolled growth and division of abnormal cells), anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), and elevated blood pressure (the blood pressure in the arteries is persistently elevated.) The 07/10/2024 comprehensive assessment, showed the resident's cognition was intact. A concurrent observation and interview on 08/05/2024 at 3:27 PM, Resident 34 was observed to have redness to their right eye and the lower portion below the eye was swollen. The resident stated they had issues with their right eye since before admission to the facility and believed it to be an issue derived from their cancer. Resident 34 further stated they were currently being treated for cancer of their bones and breasts and was at the facility for therapy to get stronger so they could go home. The resident stated they were to continue with their cancer treatment as soon as they were strong enough. Resident 34 stated they did not know when that would be, and they had not been updated by anyone. During review of Resident 34's August 2024 physician orders, showed the resident was currently being treated with medications for elevated blood pressure, anxiety, peripheral edema (swelling of the lower legs or hands), hypothyroidism (the thyroid gland does not produce enough hormones to keep the body running normally) and showed no treatment for the diagnoses of cancer. During review of Resident 34's 07/23/2024 care plan, it showed no care plan had been developed for the resident's diagnoses of elevated blood pressure, hypothyroidism, peripheral edema, or anxiety. The care plan further showed no focus for the resident's cancer diagnoses. <Resident 51> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include fracture of the tailbone, heart failure, and dermatitis (a general term for skin inflammation caused by various factors). The 06/26/2024 comprehensive assessment, showed the resident's cognition was intact. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/06/2024 at 10:54 AM, Resident 51 stated they had a rash underneath both breast creases. Resident 51 stated they had used medicated powder but that had not worked to clear it up and the rash bothered them with burning and itching, and they had used pain medications for a fracture to their tailbone. Resident 51 further stated they did not have a clue what was happening with their care plan, or their discharge. Additionally, they had a care conference shortly after their admission to the facility but nothing since then. During review of the 06/21/2024 care plan, showed no care plan had been developed for Resident 51's rash under their breasts or was the care plan resident centered. The care plan showed pain issues but did not reflect where the pain was located or resident specific interventions to manage the pain other than with medications. The skins integrity care plan showed the resident had a potential/actual impairment to the skin . related to and then it was blank with no further information. There also was no skin at-risk assessment score or category of risk (an assessment completed on admission that showed what the resident's risk of skin breakdown score and category were assessed to be). During an interview on 08/08/2024 at 10:46 AM, Staff D, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated when resident 34 admitted to the facility, their understanding of the care plan was to treat the resident in a palliative manner (relieving symptoms without dealing with the cause of the condition) per the Resident's Representative, but then when Staff D talked to the resident, they decided that was not what they wanted. Staff D further stated they must not have updated the care plan to reflect either of the resident's wishes and needed to schedule a care conference to discuss what the care plan should be. Staff D stated they were not aware that Resident 51 continued with the rash underneath their breasts and that had not been communicated to them, nor do they recall not personalizing the care plan to be specific to the resident's care needs. Staff D stated they did not update the resident or resident's care plan if there were changes to their care plan each week after their Interdisciplinary team (IDT, different members of the care team to discuss the goals and treatments of the residents) meetings. During an interview on 08/08/2024 at 9:43 AM, Staff M, Social Services Director, stated they had the initial care conference within five to seven days after admission to the facility. Staff M further stated the facility held meetings weekly to discuss the resident's progress with therapy or medical treatments, but if there were changes, they did not relay those updates with the residents regarding their care in the facility. Staff M further stated they did not recall communicating to the residents on admission that if they wanted updates more frequently than every quarter (90 days) or closer to discharge (usually 100 days), they could ask for them at any time. Reference: WAC 388-97-1020 (1),(2)(a)(b)		

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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. 44922 Based on observation, interview, and record review the facility failed to provide care and services for 1 of 2 residents (Residents 51), reviewed for skin care when they did not obtain a skin treatment order for an on-going rash for Resident 51. This failure placed the residents at risk for further skin irritation, discomfort, and pain. Findings included . <Resident 51> Review of the resident's medical record showed the resident admitted to the facility with a fracture to their tailbone and dermatitis (a term for conditions that cause inflammation of the skin). The 06/26/2024 comprehensive assessment, showed Resident 51's cognition was intact. A concurrent observation and interview on 08/06/2024 at 10:54 AM, Resident 51 was lying in bed, just had a shower, and complained of irritation under their breasts. The resident had bright red, shiny appearing skin underneath the creases of both breasts. Resident 51 stated the staff had been applying powder to their rash under their breasts but had not in a few days and thought they would since they just had a shower. A concurrent observation and interview on 08/07/2024 at 8:41 AM and again on 08/08/2024 at 9:03 AM, Resident 51stated they still had not had any powder put on the rash under their breasts. Resident 51 stated they had two bottles of powder on the back of the toilet in their restroom, but no one had used it. An observation in Resident 51's bathroom, showed two bottles on the back of the tank of the toilet, labeled cornstarch powder and they had no labels on them to identify if they belonged to Resident 51 or their roommate. Review of the resident's June 2024 Medication Administration Record (MAR) showed: A 06/22/2024 order for Nystatin (a brand of medicated powder used to stop the growth of yeast) powder to be used for 14 days (ended on 07/05/2024) under the breasts daily every shift, A 06/25/2024 order to monitor the rash under the breasts weekly on Tuesdays until rash resolved, and to document a plus sign if the rash had improvement and a negative sign if the rash had resolved or worsened A 07/02/2024 order for weekly skin checks every Tuesday. The staff were to document a plus (+) sign if there were new skin issues identified, and a minus (-) sign if no new skin issues were identified. Review of the August 2024 MAR showed on 08/06/2024 a skin assessment had been completed by Staff (AA), Licensed Practical Nurse, and documented the weekly skin assessment and the weekly rash assessment both with a minus sign. The MAR showed no new orders that new treatment had been obtained for the rash. (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 08/09/2024 at 1:03 PM, Staff AA stated their process for weekly skin checks would be to complete a head-to-toe visual check of the Resident's body and then to document findings, if any, on a weekly skin assessment sheet. Staff (AA) stated they assessed Resident 51's skin and it looked great and when asked about the redness under Resident 51's breasts, Staff AA stated they had an order for Nystatin powder they could put on the rash and if they did not, they would get one. During a follow-up interview on 08/12/2024 at 11:08 AM (three days later after informing the nurse of the redness), Staff AA stated they had not talked with the provider regarding new orders for Resident 51's rash and that the provider was in the facility that day and would discuss it with them. During an interview on 08/12/2024 at 11:29 AM, Staff B, Interim Director of Nursing Services, stated their expectation for skin assessments would be to assess from head-to-toe thoroughly and document their findings on the weekly skin check document. Staff B stated they would then expect the nurse to compare the previous weeks skin check to the current one to see if there was anything new. Staff B stated if there were new skin issues identified or worsening skin issues, they would expect the nurse to complete an incident report and call the provider to obtain new treatment orders. Reference: WAC 388-97-1060 (1)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to ensure the prevention, development, and worsening of a facility-acquired pressure injury (PI) for 1 of 4 residents (Resident 23) reviewed for PIs. The facility did not consistently provide ordered wound treatments, perform/document skin assessments, or obtain/implement Durable Medical Equipment (DME, medically necessary equipment used by people with a medical condition, disability, or injury) as ordered. Resident 23 experienced harm when they developed an avoidable PI that was not present upon admission. This failure placed Resident 23 at risk for further wound complication and unmet care needs. Findings included . Review of the National PI Advisory Panel's (NPIAP, the leading expert in PIs/wounds) guidelines and definitions, dated September 2016, defined PI stages as follows: Stage 1 PI has intact skin with a localized area of non-blanchable erythema (redness). Stage 2 PI is a partial thickness skin loss with exposed dermis (the top inner layers of skin). Stage 3 PI is a full thickness loss of skin, in which adipose (fat) tissue is visible in the ulcer. Slough (dead tissue) and or eschar (dried blood and tissue) may be visible, granulation tissue and epibole (rolled or curled under edges) may include with undermining (a pocket of dead space under the visible wound edges) and tunneling (a passageway under the wounds surface which may be shallow or deep and impairs wound closure). Stage 4 PI is a full thickness loss of skin and tissue with exposed or directly palpable fascia (a layer of connective tissue), muscle, tendon, ligament, cartilage, or bone in the ulcer. Epibole undermining and tunneling often occur. Unstageable PI is a full thickness skin and tissue loss to which the extent of the tissue damage cannot be seen. <Resident 23> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include an in-operable left fibula (lower, outer leg bone) fracture, diabetes (a condition that happens when the sugar [glucose] in your blood is too high), and end stage kidney disease. The 05/26/2024 comprehensive assessment, showed the resident's cognition was severely impaired and required the assistance of one to two staff for all activities of daily living. The assessment further showed the resident admitted without pressure injuries. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation on 08/05/2024 at 2:05 PM, Resident 23 was lying in their bed, had a Podus boot (PB, an off-loading device that floats [suspending in the air] the heel, eliminating pressure or friction, and enhances blood circulation for healing) over a soft, white splint (a device that supports and protects a broken bone or injured tissue) to their left lower extremity (LLE). The splint was placed underneath the back part of the leg and extended from their toes to their upper thigh, and their leg was internally rotated (the leg was turned towards the center of the body), with the inner part of the LLE lying flat on the bed. The boot had an attached phalange (an arm that keeps the leg from rotating and acts like a kickstand) that was to be used to maintain proper positioning of the LLE, but the phalange had not been used to maintain the LLE in an upward/correct position (toes to the ceiling). During an observation on 08/07/2024 at 9:18 AM, Resident 23 was lying in bed, they had a gauze wound dressing to their LLE below the knee, with 08/04/2024 handwritten in black marker, that was saturated with areas of red and brown drainage. Staff J, Nursing Assistant (NA) and Staff K, NA, repositioned Resident 23 while providing care, the LLE lied flat and internally rotated on the bed and did not move or turn when moving the resident from side to side. Neither Staff J or K positioned the phalange on the PB, nor did they provide any positioning of the LLE so that Resident 23's leg was in the correct position. Additionally, the top of the white soft splint had brownish stains, which Staff J and Staff K identified as dried bowel movement. A concurrent observation and interview on 08/07/2024 at 11:52 AM, Staff I, Registered Nurse (RN), and Staff D, Licensed Practical Nurse/Resident Care Manager, provided wound care to Resident 23. Staff I removed the PB from the LLE, then the soft white splint, followed by a dressing to the top of the left foot and another to the heel. Under the dressing to the top of the foot was a dime-sized wound, reddened, top layer of skin missing, and on the heel was an opened wound the size of a golf ball that had blackened areas, white areas, and areas of red flesh, the wound dressing was moist with brown and red wound drainage. The wound was identified by Staff D as pressure injuries obtained from the soft white splint. Neither Staff I nor Staff D positioned the phalange on the PB to the appropriate position when the wound care was completed. At the top of the LLE, towards the outer part of the knee area showed 08/07/2024 handwritten in black marker and Staff I stated they had replaced that prior to this wound care because it was saturated with wound drainage. An observation on 08/08/2024 at 2:41 PM, showed Resident 23 was sitting in their wheelchair (w/c) with their LLE resting, internally rotated, on the elevated footrest of the w/c. The PB phalange was not positioned to keep the LLE positioned correctly and there were no positioning devices in place to assist with maintaining the LLE in the correct position. Review of the Orthopedic Surgeon's (specialist who focuses on injuries and diseases affecting the musculoskeletal system) orders on 05/31/2024 showed orders for decubitus [wounds that occur from prolonged pressure on your skin] precautions and a PB with a side phalange to prevent rotation of the LLE. Further review, showed an order on 06/26/2024 for a Hip-Knee-Ankle-Foot Orthosis (HKAFO, used for rotation control of the lower extremity) that was to be supplied by a named DME clinic (No follow-up, notes, or orthosis had been obtained regarding the order). Review of Resident 23's 05/23/2024 care plan (CP) showed no directive for positioning of the LLE, no directives for the PB with the phalange, and no updates for current skin integrity status since 06/03/2024. The care plan showed decubitus precautions with no further directives. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 23's June 2024 Treatment Administration Record (TAR), showed a treatment order on 06/18/2024 to an unstageable PI on the left outer knee that was discontinued on 06/19/2024, an order on 06/19/2024 to an unstageable PI on the left heel to be completed twice daily and as needed (PRN)(eight of 23 treatment opportunities were not completed) and on 06/20/2024 an order for a blister on the left outer knee to be completed daily and PRN (six of 11 treatment opportunities were not completed). Review of the July 2024 TAR showed the left heel had 10 out of 36 treatment opportunities not completed, and for the left outer knee, 12 out of 30 treatment opportunities were not completed. During an interview on 08/08/2024 at 2:53 PM, Staff D stated they had attempted to refer Resident 23 to an outside wound provider, but Resident 23 was denied services by the provider due to their current medical coverage. Staff D stated they were informed it would be double dipping [obtaining money from two mutual sources at the same time] because the facility already contracted with another wound provider. Staff D stated the resident could not receive services from the facilities contracted wound care provider because they received dialysis treatments (a treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to) at an outside dialysis facility on Tuesdays, Thursdays, and Saturdays for approximately eight hours and would leave the facility at 7:00 AM. Staff D stated the contracted wound care provider could only see residents in the facility on Tuesdays and was unable to see Resident 23 due to their conflicting schedules. Staff D stated neither the contracted wound care provider nor the dialysis facility was willing to adjust their schedules to meet the needs of the resident. Staff D stated the Resident's Representative (RR) allowed Resident 23 to miss a dialysis treatment on 07/30/2024 to accommodate the contracted wound care provider's schedule, so the resident could be seen. An observation on 08/09/2024 at 12:45 PM, showed Resident 23 lying in bed, their LLE placed on the top of a pillow, the PB was on but the Velcro that held the boot closed was not attached, causing the white soft portion of the splint to slide off the hardened portion of the splint, leaving the LLE with no support. The LLE was internally rotated, resting on the bed. During an interview on 08/09/2024 at 12:48 PM, Staff J stated they were normally assigned to Resident 23 and when provided care to the resident, required two staff because their LLE always had to be kept straight. Staff J stated they were told to float Resident 23's legs on a pillow and were not provided training on the PB phalange placement. Staff J stated they were allowed to remove the boot for cares but not the soft splint . Review of the May 2024 through July 2024 Licensed Nurse (LN) Tasks document showed an order on 05/29/2024 for weekly skin checks to be completed every Wednesday on evening shift. On 05/23/2024 an order to monitor the circulation, motion, sensation (CMS) and skin breakdown to the LLE soft cast every shift and document assessment daily. The LNs were to document a plus (+) and minus (-) signs as additional documentation, but the record showed no documentation from 05/23/2024 to 06/17/2024. During an interview on 08/09/2024 at 1:22 PM, Staff L, RN, stated the splint was originally placed on the outer portion of the left foot/leg to support the fracture of the outer bone and when Resident 23 developed pressure injuries from the splint, the splint was moved to the underside of the left foot/leg. Staff L stated they checked the skin under the brace every shift and documented their findings in their daily progress notes. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation on 08/12/2024 at 11:00 AM, Resident 23 was lying in bed, PB phalange was not positioned, and no positioning devices were used to keep the LLE in the correct position. The LLE was internally rotated. During an interview on 08/12/2024 at 11:10 AM, Staff K stated they had not been provided specific training on the positioning of the LLE or the placement of the PB phalange. Staff K stated they positioned Resident 23 so that their LLE was floated on a pillow. Review of Nursing Progress notes on 06/07/2024 at 1:31 PM, showed the first documentation on the status of the left lower extremity CMS intact to left lower extremity (LLE) but nothing about the skin underneath the brace (15 days after admission). Notes on 06/10/2024 at 2:17 PM, 06/11/2024 at 6:00 PM, on 06/17/2024 at 12:55 PM, and on 06/18/2024 at 5:27 PM, showed the CMS was intact to the LLE and no documentation about removing the brace or the status of the skin. A note on 06/19/2024 at 9:51 AM, showed the care staff reported skin concerns to the resident's LLE. Two nurses then went in to assess Resident 23's skin. Review of the 06/19/2024 Skin Evaluation assessment, showed the left knee (outer) had a four centimeter (cm, a unit of measure) by 2.2 cm circular intact blister. The left heel showed a 3.9 cm by 3.2 cm circular unstageable PI, the left shin had a 0.2 cm by 0.2 cm circular abrasion, and the left inner thigh had a five cm by 0.3 cm irregular shaped abrasion with a pink wound bed. The 07/17/2024 skin assessment showed the left outer knee blister had deteriorated and changed to an unstageable PI which measured at 3.9 cm by 4.7 cm by 0.1 cm depth with an irregular shape, dead tissue, and moderate red clear drainage. The left heel measured at 4.2 cm by 6.3 cm by 0.1 cm depth with dead tissue. Review of the contracted wound provider notes on 07/30/2024 (41 days after wounds developed), showed Resident 23 had splint on lower extremity and when splint was removed/loosened in order to change, areas of breakdown were noted. Resident 23's wounds were assessed as; 1) left heel, stage 3 PI, measured 3.3 cm by 5.4 cm by 0.2 cm depth with dead tissue, 2) left outer knee, stage 3, measured 3.0 cm by 1.3 cm by 0.7 cm depth, with yellow fibrin (dead tissue within a wound), and undermining at 11 o'clock of 0.8 cm with moderate drainage. The note showed the left heel and outer knee PIs needed to be surgically debrided (a procedure to remove debris or infected/dead tissue from a wound for the wounds to heal). Measurements after debridement showed the left heel was 3.4 cm by 5.5 cm by 0.3 cm depth and the left outer knee was 3.1 cm by 1.4 cm by 0.8 cm depth and both PIs were full thickness PIs. During an interview on 08/12/2024 at 11:30 AM, Staff B, Interim Director of Nursing Services, stated the NA's had not been trained on the PB with the phalange, or the proper positioning of the residents LLE to keep the leg from internally rotating and did not find any directives on the Kardex (nursing directives for a resident's plan of care). Staff B further stated the nurses were to document their skin checks underneath braces if the Orthopedic Surgeon did not have orders to not remove the brace. Staff B further stated Resident 23 had a referral to an outside wound provider but in Resident 23's case, they were unable to see them. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/13/2024 at 7:58 AM, Collateral Contact (CC) stated they received a wound referral for Resident 23 on 07/10/2024 and had to send it back to the prescribing provider to update with additional information that was needed. The CC stated they did not deny Resident 23 wound care services and when they received the updated information they needed from the provider, they reached out to the RR of the resident to schedule an appointment on 07/29/2024. The CC stated the time lapse of 19 days between receiving the referral, returning it to the prescriber, and receiving it back would have depended on how quick the provider sent them the updated referral information they requested. The time lapse was not on the part of the CC. During an interview on 08/15/2024 at 1:33 PM, Staff D stated Resident 23 was seen by their Orthopedic Surgeon after they obtained the PIs, and the surgeon did not order any additional treatment interventions for treating the PIs. Staff D stated the RR wanted them to obtain a second opinion after the 06/26/2024 visit because they did not agree with the surgeon not having a better treatment plan. Staff D stated Resident 23's RRs had attended that appointment with the resident but did not provide notes pertaining to the outcome of the visit and the facility did not call the surgeon's office to request the appointment notes so were not aware the Orthopedic Surgeon had ordered the HKAFO orthosis (Staff D was informed of the orthosis during a telehealth meeting with the family on 08/13/2024). Staff D stated following that meeting, they had given the order for the orthosis to Staff A and Staff B for their review since the orthosis was costly. Reference: WAC 388-97-1060 (3)(b)		

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NAME OF PROVIDER OR SUPPLIER Richland Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1745 Pike Avenue Richland, WA 99354	
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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** 45642 Based on observation, interview and record review, the facility failed to provide the adequate supervision and safety monitoring for 1 of 1 resident (Resident 52) reviewed for elopements (the potential danger when a resident, often deemed impaired to make sound decisions, leaves the facility premises or safe area unauthorized, posing immediate threats to their health or safety). This failure placed the resident at risk for serious injury related to an inaccurate risk assessment for elopement. Findings included . Review of the facilities policy dated 10/2022 titled, Elopement/Wandering, showed Residents are evaluated for potential for elopement during the admission/readmission process, and when a change of condition is noted, resulting in cognitive or behavioral changes placing them at risk for elopement. <Resident 52> Review of Resident 52's medical record showed that the resident was admitted to the facility on [DATE] with diagnosis to include vascular dementia (Problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain), anxiety (a feeling of worry, nervousness, or unease), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and seizures (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain). The comprehensive assessment dated [DATE] showed that Resident 52's cognition was impaired and unable to make sound decisions. Additional review of Resident 52's EHR showed an elopement risk assessment dated [DATE] that the resident had a low risk for elopement. Review of Interdisciplinary (a group of health care professionals with various areas of expertise who work together toward the goals of their residents/clients) weekly meeting notes dated 07/12/2024 through 08/01/2024, showed no concerns regarding mood or behavior. Further review of Resident 52's medical record progress notes showed the following: Progress notes on 07/12/2024 at 7:52 PM, Resident 52 had trouble sleeping and had combative behavior with their care. Progress notes on 07/16/2024 at 4:19 PM, showed Resident 52 had behaviors distressing others. Progress notes on 07/24/2024 at 9:04 PM, showed Resident 52 had wandering behavior. Progress notes on 07/25/2024 at 6:58 AM, showed Resident 52 had intrusive wandering behavior and observed exit seeking. Progress notes on 07/28/2024 at 4:00 PM, showed Resident 52 had occasional behavior demonstrated. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the July 1 thru July 31st, 2024, reporting log showed on 07/28/2024 Resident 52 had an elopement incident. Additional review of Resident 52's EHR showed no documentation of the elopement incident, re-assessment for elopement risk or care plan updates. During an interview on 08/06/2024 at 9:51 AM, Resident 52's collateral contact (CC), stated Resident 52 had got out the window of their room when they first were admitted to the facility a couple of weeks ago. The CC explained Resident 52 now was wearing a wander guard alarm on their wrist as a result of the incident. Review of the August 1 thru August 7th, 2024, reporting log showed Resident 52 had another elopement on 08/06/2024 at 2:30 AM and got outside into the courtyard. Staff were alerted to the resident's whereabouts when the door alarm went off as the resident was coming back inside the facility. An observation on 08/07/2024 at 9:30 AM, showed Resident 52 wandering and exiting another resident's room (Rm 308), Resident 52 came out looking very upset shaking their head. The resident then walked down the 300-hall wandered into room [ROOM NUMBER] where they sat on the side of another resident's bed next to the window. During the same observation at 9:33 AM, Staff O, Nursing assistant (NA), entered room [ROOM NUMBER], stated to Resident 52 Let's go back to your room this room belongs to these gentlemen. In an interview on 08/07/2024 at 9:46 AM, Staff O stated Resident 52 gets turned around and does wander around the facility in resident rooms. An observation on 08/07/2024 at 9:49 AM, showed Resident 52 was fully dressed, wander guard to their left wrist, and ambulating with a family member down the 100-hall. Resident 52 opened the exit door which did not alarm when the resident walked out the doorway. The exit door had a keypad lock and was to alarm when opened per Staff O. The family member redirected the resident back into the facility and to their room. In an interview on 08/08/2024 at 10:36 AM, Staff Q, Registered Nurse, stated that when Resident 52 wandered throughout the facility they sometimes attempted to redirect Resident 52, and they would get combative. An observation on 08/08/2024 at 2:06 PM, showed the back courtyard had cement walkways, the walkway guided to three entrances to the facility. The first door entered the assisted feeding dining room, the second door was a side door that entered to the employee snack hall, and the third entrance was at the end of the 200-hall. Further observation of the courtyard walkway guided to two gates that had unlocked latch locks that opened to the parking lot. An observation and interview on 08/08/2024 at 3:21 PM, Staff A, Administrator, provided a wander guard to Staff G, Maintenance Director, who attempted to use the wander guard out the main front door to check the functioning of the alarm system and the door did not alarm. Staff A took the wander guard to ensure Staff G obtained the wander guard that was working. Staff G stated the main door and the end door to 100-hall and end door of the 200-hall were keypad alarms only, and that the two sliding doors, the main entrance door, the double door in-between the activities room and main dining room were the only doors that were set up for the wander guard system. Staff G opened the door at the end of the 100-hall and the door did not alarm. Staff G stated the employees used the keypad alarms to exit and do not reset the alarms. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/08/2024 at 3:33 PM, Staff B, Interim Director of Nursing Services, stated after talking with the night shift nurses, they found that Resident 52 woke up at 2:00 AM, appeared agitated, and redirection attempts were not successful with Resident 52. In an interview on 08/09/2024 at 9:11 AM, Staff G stated they checked the wander guard system daily to ensure functionality and they did not keep copies or have a documented log of the wander guard checks. In an interview on 08/09/2024 at 11:38 AM, Staff D, Licensed Practical Nurse/Resident Care Manager, stated the process for an elopement would be that the care staff and nurses that were involved performed a huddle to address the residents needs and be pro-active for the prevention of the elopements. The resident care manager would also go into detail about the resident's needs at the Interdisciplinary meetings to ensure that they included everyone that needed to be involved. Staff D stated that the care plan updates usually take up to 48 to 72 hours after the incident and the interventions get done immediately. The resident was included in the elopement book located at the nurse's station that had their demographics. In an interview on 08/12/2024 at 10:56 AM, Staff A stated that the courtyard gates could be locked, but they do not lock them due to being the facility's fire egress requirement. Staff A stated they were aware of Resident 52's elopement and stated they did not report the elopement to the state agency. Additionally, Staff A stated they placed the risk of elopement on the care plan on 08/06/2024. Staff A acknowledged that the resident had an elopement prior to last week's elopement. and that they would have to educate Resident 52's Resident Care Manager on updating the care plan. Reference WAC: 388-97-1060(3)(g)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review the facility failed to ensure oxygen orders were obtained, the resident's respiratory status was monitored, or the maintaining of respiratory equipment was completed for 2 of 3 residents (Residents 58 and 5) reviewed for respiratory care. were provided such care, consistent with professional standards of practice. This failed practice placed these residents at risk for unmet respiratory needs and potential negative outcome. Findings included . Review of the policy titled Respiratory Treatment dated 06/22/2022, showed residents were to receive respiratory treatments and monitoring, per their physician orders and when oxygen tubing and nebulizer (a machine used to turn liquid medications into a fine mist) masks were not in use they would be stored in a bag. <Resident 58> Review of the resident's medical record showed the resident admitted to the facility with Chronic Obstructive Pulmonary Disease (COPD, a chronic lung disease that makes breathing difficult and causes cough, mucus, and wheezing). The 07/16/2024 comprehensive assessment showed the resident had intact cognition. During an observation on 08/05/2024 at 10:52 AM, Resident 58 had a nebulizer machine on the nightstand to the right of their bed, along with the nebulizer mask and tubing, connected, with a small amount of clear fluid in the bottom of the medicine chamber, without any covered protection to keep it clean. The resident had an oxygen concentrator (a medical device that is used as part of oxygen therapy) to the left side of the bed with attached oxygen tubing lying over the head of the bed not contained in a bag or a container to maintain cleanliness. A concurrent observation and interview on 08/05/2024 at 2:43 PM, Resident 58 was lying in their bed, oxygen tubing lying on the floor to the left side of the bed, the nebulizer mask and tubing were connected to the machine and lying on the nightstand without being in a bag or container to maintain cleanliness. Resident 58 stated they used the oxygen for comfort and stated they had not used oxygen in their home prior to admission to the facility. The resident stated they had COPD and used the nebulizer machine when they would feel short of breath. An observation made on 08/07/2024 at 8:52 AM, showed Resident 58 lying in bed with their oxygen tubing in place to their nose and their nebulizer mask with the tubing attached, lying on the nightstand, not contained in a bag or container. On 08/08/2024 at 9:12 AM, showed the oxygen tubing hanging over the top of the television and the nebulizer mask with the tubing attached in the same place as observed on 08/08/2024. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/09/2024 at 1:07 PM, Staff AA, Licensed Practical Nurse (LPN), stated their process for nebulizer masks after resident use was to wash them, hang them, and allow them to air dry, then place them in a bag and put them in the resident's drawer. The process for the oxygen tubing was to check the condition of the tubing daily and replace it if any cracks or soilage was observed, clean the machine, filters, and change the tubing once a week. Staff AA stated when the oxygen was not in use, the oxygen tubing t was placed in the plastic bag that was attached to the side of the oxygen concentrator machine. Review of Resident 58's August2024 Medication Administration Record showed no orders for the use of oxygen therapy, to replace the tubing weekly, or to maintain the cleanliness of the oxygen concentrator. The record further showed an order for albuterol solution (a brand of liquid medication used to open the airways of the lungs) to be used with a nebulizer machine as needed (PRN). The medication did not have a pre/post assessment for monitoring effectiveness, nor were there orders to maintain the cleanliness of the machine, mask, or tubing. During an interview on 08/12/2024 at 11:36 AM, Staff B, Interim Director of Nursing Services, stated their expectation for respiratory equipment (nebulizer mask, tubing, and oxygen tubing) would be to contain them in a bag when not in use to maintain cleanliness and the nebulizer masks should be cleaned, hung, and dried prior to containing in a bag. Staff B stated during the first few days of Resident 58's admission, the hospital sent them with oxygen, but no order for the oxygen use, and the nursing staff just continued that process. Staff B further stated the resident should have had an order to use the oxygen that showed the amount of oxygen that was to be used, frequency, and an assessment each shift of their oxygen saturation? status. Further, Staff B stated the resident should have had pre/post assessments that were to be completed when using the PRN nebulizer medications. <Resident 5> Review of Resident 5's medical record showed the resident was admitted to the facility on [DATE] with diagnoses including heart complications and anxiety(define). The comprehensive assessment dated [DATE], showed the resident required staff assistance with activities of daily living and was cognitively intact. An observation and concurrent interview on 08/06/2024 at 9:25 AM, showed a nebulizer mask fully assembled, condensation drops in the mask, and draped over the nebulizer machine with tubing connected to the machine. Resident 5 stated they received nebulizer treatments three times a day. Observations on 08/07/2024 at 9:26 AM of the fully assembled nebulizer mask, tubing connected to the machine and the mask, lying on the nightstand without a bag. The same day at 3:54 PM, the nebulizer mask fully assembled was connected to the nebulizer machine and lying on top of the machine. An observation and concurrent interview on 08/08/2024 at 9:33 AM, Resident 5 stated they received a nebulizer treatment in the morning and at night. Resident 5 stated they had just finished a treatment. The mask was fully assembled with condensation in the medicine chamber of the mask and was lying on the nightstand without a bag. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/09/2024 at 1:29 PM, Staff E, LPN/Resident Care Manager, stated the expectation was after each administration of a nebulizer treatment the nurses were to take the mask apart, rinse out the chamber and place the supplies on a barrier to dry. Additionally, after being dried, it was to be placed in a bag so that the supplies were ready for the next use. Reference: WAC 388-97-1060 (3)(j)(vi) 45642		

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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. 44922 Based on observation, interview, and record review, the facility failed to ensure dialysis (a process that removes your blood from your body, filters out toxins in a machine, and then sends your filtered blood back into your body) care and services were consistent with professional standards of practice for 1 of 1 resident (Resident 23) reviewed for dialysis care. The facility failed to administer morning medications consistently, to include insulin (a medication that helps regulate blood sugar levels) and monitoring blood sugar levels (a procedure that required a stick to the fingertip with a lancet, and a drop of blood placed on the tip of a test strip that is inserted into a machine to determine what the blood sugar level is) to the resident prior to leaving for dialysis. This failed practice placed Resident 23 at risk for complications and adverse side effects from inconsistent medication administration. Findings included . <Resident 23> Review of resident 23's medical record showed the resident admitted to the facility with end stage kidney disease and required dialysis treatments and diabetes (condition that affects your blood sugar levels and can cause serious complications). The 05/26/2024 comprehensive assessment showed the resident's cognition was severely impaired. Review of Resident 23's 08/01/2024 thorough 08/08/2024 Medication Administration Record (MAR) showed an order on 05/25/2024 for dialysis treatments completed every Tuesday, Thursday, and Saturday. The record further showed medications ordered to be given daily in the morning for; aspirin (used for heart failure), docusate (used to soften stools), iron (used for anemia), multivitamin (used as a supplement), alprazolam (used for a mood disorder), sertraline (used for a mood disorder), memantine (used for a cognitive disorder), metoprolol (used for elevated blood pressure), omeprazole (used for a gastric stomach disorder), prostat (a liquid supplement used for wound healing), and lanthanum (used to lower levels of phosphorus [keeps the body from absorbing calcium] in the blood. The MAR showed as follows: aspirin, docusate, iron, multivitamin, sertraline, memantine, metoprolol, omeprazole, and prostat had not been given on two out of eight days, the lanthum, which was scheduled to be given at 8:00 AM and 12:00 PM, had not been given on four out of 16 shifts. Review of the July 2024 MAR showed morning medications had not been given as follows: aspirin, docusate, iron, multivitamin, sertraline, memantine, metoprolol, omeprazole, prostat, and lanthum were not given on 12 out of 31 shifts alprazolam and an order for heparin (a brand of a medication used to thin the blood to prevent blood clots from forming, from 05/24/2024 to be given for two months) injections had not been given for ten out of 31 days. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the June 2024 MAR showed as follows: all morning medications had not been given on 13 out of 30 days. All medications were not given on Resident 23's dialysis days (there was no notification to the provider or the dialysis facility). Review of Resident 23's 08/01/2024 through 08/08/2024 Diabetic Administration Record (DAR) showed an order on 07/05/2024 for novolog (a brand of insulin) to be injected before each meal and at bedtime. Prior to administering the insulin, the blood sugar levels needed to be monitored. The record further showed an order on 05/24/2024 for basaglar (a brand of insulin) to be given once daily. The DAR showed as follows: the basaglar insulin had not been given on two out of nine shifts, the novolog insulin had not been given nor were the blood sugar levels monitored on six out of 18 shifts. Review of the July 2024 DAR showed as follows: the basaglar insulin had not been given on 12 out of 31 shifts, the novolog insulin had not been given and blood sugar monitoring was not obtained on 23 out of 52 shifts. Review of the June 2024 DAR showed as follows: the basaglar insulin had not been given on 13 out of 30 shifts, the novolog insulin had not been given and blood sugar monitoring had not been obtained on 25 out of 60 shifts. All days the medication and and monitoring of the blood sugar were not completed, were Rsident 23's dialysis days. During an interview on 08/09/2024 at 1:17 PM, Staff L, Registered Nurse, stated when they worked, they did not give Resident 23 their medications, insulin, or monitor their blood sugar levels prior to them leaving for dialysis because Resident 23 left the facility too early. Staff L stated Resident 23 left the facility at 7:00 AM and did not return until approximately 2:00 PM -2:30 PM, nearly the end of their shift. Staff L stated they completed a form prior to the resident leaving for dialysis with their vital signs and any other information the dialysis facility needed to know. Staff L stated they did not communicate on the form to the dialysis facility that the resident did not have medications, insulin, or their blood sugar levels monitored prior to leaving the facility. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/09/2024 at 1:32 PM, Staff D, Licensed Practical Nurse/Resident Care Manager, stated they were not aware Resident 23 was not being given their morning medications, insulin, or having their blood sugar levels monitored consistently prior to leaving for dialysis. Staff D stated the medications were scheduled to be given prior to the resident leaving for dialysis and they believed the physician was most likely unaware Resident 23 was missing their medications. During an interview on 08/12/2024 at 11:34 AM, Staff B, Interim Director of Nursing Services, stated Resident 23 should have been given their medications, including insulin and the monitoring of blood sugar levels, as ordered, prior to the resident leaving the facility for dialysis. Reference: WAC 388-97-1900 (1)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on observation, interview, and record review, the facility failed to ensure that residents who were trauma survivors received trauma-informed care in accordance with professional standards of practice by not assessing or monitoring past experiences of Post Traumatic Stress Disorder [(PTSD) an anxiety disorder that develops in some people who have experienced a shocking, scary, or dangerous event] for 1 of 2 residents (Resident 13) reviewed for mood and behavior. This failure placed residents at risk for unidentified triggers and re-traumatization. Findings included . <Resident 13> Review of the medical record showed Resident 13 was admitted to the facility on [DATE] with a diagnosis of PTSD. Resident 13's comprehensive assessment dated [DATE] showed they required minimal assistance of one staff member for activities of daily living (ADLs, daily actions like dressing, transferring and toileting) and had an intact cognition. During an interview on 08/06/2024 at 1:55 PM, Resident 13 stated they had a very frightening event happen a few nights before. Resident 13 stated at 10:00 PM, a male resident entered their room and was staring at them lying in bed. Resident 13 stated they yelled and screamed loudly because it scared them, and it took several of the nurses to calm them down. Resident 13 stated a nurse had to stay with them before trying to go back to their room and sleep. Resident 13 stated the nurses explained the male resident had dementia (an impairment of brain function, which causes memory loss, forgetfulness and impaired thinking abilities) and wandered into other rooms sometimes because they did not know where they were and meant no harm. Resident 13 stated this explanation did not relieve their fear because they had a history of PTSD from being repeatedly raped in the middle of the night. During the same interview on 08/06/2024 at 1:55 PM Resident 13 stated after they reported the event to the nurses that night, they felt like no one cared or followed up with them to assure them that there were things that could be put into place to prevent that male or any other from entering their room again. Resident 13 stated they had laid awake at night worrying about it ever since it happened and at times had been terrified to go to sleep. Review of a document titled SNF (Skilled Nursing Facility) Trauma Screen dated 07/23/2024, showed Staff R, Social Services Assistant, had completed the assessment for Resident 13 which showed the resident did not want to discuss any past trauma at that time. During an interview on 08/08/2024 at 11:30 AM, Staff R stated if PTSD was on a resident's diagnosis list when they were admitted they would complete a trauma screen, but if the resident said they did not want to talk about any trauma or PTSD, they did not continue asking any questions about it. Staff R stated when they heard a resident was having problems or showed signs of PTSD later in their stay, they would follow up with the resident again at that time. Staff R stated they had not been informed Resident 13 had experienced any recent trauma. (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 13's care plan from 07/22/2024 to 08/09/2024, showed there were no focus areas or interventions associated with the resident's diagnosis of PTSD for the staff to monitor. During an interview on 08/09/2024 at 10:46 AM, Resident 13 stated they had been told the male resident that entered Resident 13's room had gone home a few days earlier, and no one had come to speak with them about the event, their PTSD, or plans to prevent the event from happening again. Resident 13 stated they were glad they were discharging home the following day, so they did not have to worry about it any further. Reference: WAC 388-97-1060(3)(e)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 44922 Based on interview and record review, the facility failed to ensure recommendations from the Pharmacist's monthly medication review (MMR) were reviewed and appropriately completed by the medical provider for 1 of 5 residents (Resident 23) reviewed for unnecessary medications. This failed practice put the resident at risk for receiving duplicate therapy (more than one, same class of medication used for the same indication) of depression (a persistent feeling of sadness and loss of interest) medications that were unnecessary and a negative medical reaction. Findings included . Review of a policy titled Drug Regimen Review dated 04/2019, showed the pharmacist would review medications, to include drugs used in duplication [duplicate therapy] monthly and make recommendations as needed. Then the facility would notify the physician of the recommendations and the physician would follow-up in a timely fashion. <Resident 23> Review of the resident's medical record showed the resident admitted to the facility with diagnoses of dementia (a group of symptoms affecting memory, thinking and social abilities), anxiety (a feeling of worry, nervousness, or unease about an imminent event or something with an uncertain outcome), and depression. The 05/26/2024 comprehensive assessment showed the resident's cognition was severely impaired. Review of Resident 23's August 2024 Medication Administration Record showed an order on 05/24/2024 for sertraline (a brand of anti-depressant medication) 50 milligrams (mg, a unit of measure) daily for depression and on 05/23/2024 an order for trazodone (a brand of anti-depressant medication) 100 mg daily at bedtime for depression and insomnia (inability to sleep). Review of the Pharmacist's monthly medication reviews for May, June, and July 2024 showed a recommendation had been sent to the provider to review the use of two anti-depressant medications being used in conjunction together for the treatment of depression. Review of the May 2024 and July 2024 recommendations showed the provider had not responded to the Pharmacist's recommendations. The June 2024 recommendation showed the provider declined the Pharmacist's recommendation on 06/11/2024 but did not provide a written rationale for the reasons why the recommendation was declined per the regulation requirement. During an interview on 08/09/2024 at 9:48 AM, Staff B, Interim Director of Nursing Services, stated the expectation would be for the Pharmacist's recommendations to be reviewed by the provider and completed in a timely manner and would expect them to be reviewed no later than within one week. Staff B stated they were not aware the provider did not complete the documentation required on the June 2024 recommendation. Reference: WAC 388-97-1300 (4)(c)(d)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview and record review, the facility failed to ensure residents were free of unnecessary psychotropic medications (medications capable of affecting the mind, emotions, and behavior) for 3 of 5 residents (23, 34 and 35) reviewed for unnecessary medications. The facility failed to ensure residents had an appropriate diagnosis for use of psychotropic medications, had person-centered behaviors being monitored to reflect adequate need for the medications or implement non-pharmacological interventions to attempt prior to administering psychotropic medications. Additionally, the facility failed to complete an Abnormal Involuntary Movement Scale (AIMS, to assess for the presence and severity of abnormal movements of the face, limbs, and body) prior to beginning the psychotropic medications. These failures placed the residents at an increased risk for receiving medications they no longer needed and/or increased behaviors due to inadequate dosing of medication. Findings included . <Resident 23> Review of the resident's medical record showed they admitted to the facility on [DATE] with diagnoses to include depression (a persistent feeling of sadness and loss of interest), anxiety (a feeling of worry, nervousness, or unease about an imminent event or something with an uncertain outcome), and insomnia (the inability to sleep). The 05/26/2024 comprehensive assessment showed the resident's cognition was severely impaired. A concurrent observation and interview on 08/09/2024 at 9:05 AM, showed Resident 23 lying in bed, hair uncombed, eating their breakfast. The resident is alert, smiling, pleasant to talk with, and answered questions as appropriate as they were able to. Review of Resident 23's August 2024 Medication Administration Record (MAR), showed an order on 08/01/2024 for alprazolam (a brand of anti-anxiety medication) 0.25 milligrams (mg, a unit of measure) by mouth two times daily for anxiety, an order on 05/23/2024 for trazodone (a brand of anti-depressant medication) 100 mg by mouth daily at bedtime for depression and insomnia, and an order on 05/24/2024 for sertraline (a brand of anti-depressant medication) 50 mg by mouth daily for depression. Further review of Resident 23's medical record showed no AIMS assessment had been completed since admission, there were no person-centered behaviors specific to Resident 23 being monitored, and the resident's sleep pattern had not been monitored to ensure effectiveness of the medications. <Resident 34> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include anxiety. Review of the 07/10/2024 comprehensive assessment, showed Resident 23's cognition was intact and received anti-anxiety medication. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/05/2024 at 3:46 PM, Resident 34 was sitting up in their wheelchair, talkative, alert and answered questions appropriately. Resident 34 stated they were receiving a medication for their anxiousness, but the prescription ran out and they no longer received it. Resident 34 stated the cancer would cause them anxiety and would get in my head. Review of the July 2024 MAR, showed on 07/03/2024 an order for ativan (a brand of anti-anxiety medication) 0.5 mg every six hours as needed for 14 days for their anxiety and agitation (ended on 07/17/2024). Resident 34 received the medication three times during that period. Further review of the medical record showed there was no person-centered behavior monitoring specific to Resident 34 nor were there person-centered non-pharmacological interventions attempted prior to administering the ativan. Additionally, no AIMS assessment had been completed prior to the start of a psychotropic medication. During an interview on 08/08/2024 at 10:10 AM, Staff M, Social Services Director, stated nursing and Social Services were to implement behavior monitoring and non-pharmacological interventions for residents on psychotropic medications. That the interventions were placed on the care plan and the Kardex so the nursing assistants could document on them. Staff M stated they used standard behaviors and interventions to monitor until they get familiar with the resident. Staff M further stated that if a resident had been receiving an as needed medication or had been in the facility since 05/2024 then they would have experienced some type of behavior, and their care plan should have been updated to reflect the behavior. Staff M stated they were not responsible for completing the AIMS assessments. 35676 <Resident 35> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including a right hip fracture, dementia (the loss of thinking, remembering, and reasoning- to the extent that in interferes with ADL's), severe with other behavioral disturbances, disorientation, and insomnia (a sleep disorder that makes it hard to fall asleep, stay asleep, or get quality sleep). Resident 35's comprehensive assessment dated [DATE], showed they required substantial assistance of 1 to 2 caregivers for activities of daily living (ADLs), cognition was severely impaired. An observation on 08/05/2024 at 11:24 AM, showed Resident 35 in a wheelchair in the hallway. Resident 35 acknowledged staff by speaking to them, smiling and nodding their head. An observation on 08/07/2024 at 12:34 PM, showed Resident 35 had wheeled themselves into the dining room. Resident 35 was smiling and stated hello when spoken to. During an observation and concurrent interview on 08/08/2024 at 10:10 AM, showed Resident 35 being laid down in bed by Staff V, Nursing Assistant (NA). Resident 35 was smiling and compliant with care during the transfer from the wheelchair to the bed and while being provided personal care. Staff stated they had cared for Resident 35 since their admission, and they had always been compliant with all care and had never shown any agitated or aggressive behaviors. Staff V stated Resident 35 was kind and did not speak often. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/12/2024 at 11:46 AM, Staff W, Registered Nurse (RN), stated they had taken care of Resident 35 since their admission and had never seen them agitated or difficult to care for. Staff W stated Resident 13 was slow to respond to questions however they would answer when given time and was always very kind and easy to care for. During an interview on 08/12/2024 11:36 AM, Staff C, Registered Nurse, Resident Care Manager (RN/RCM), stated Resident 35 had not shown any type of agitated or combative behavior before. Staff C stated Resident 35 could be impulsive and attempt self-transfers but had always been a gentle, nice person who would communicate with staff appropriately when provided enough time to respond in conversations. Review of Resident 35's physician orders showed the medication Olanzapine [an antipsychotic (A type of drug used to treat symptoms of psychosis) medication used for mental disorders including Schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves) and bipolar disorder (a brain disorder that causes changes in a person's mood, energy, or ability to function)] was ordered to be administered every evening beginning on 06/25/2024. Review of Resident 35's MAR for June, July and August 2024 showed, Olanzapine 5 mg tablet was administered every evening. Review of Resident 35's care plan dated 08/02/2024, showed a problem for behavior monitoring related to the use of Olanzapine. Care plan interventions were to monitor for pinching/scratching/spitting/wandering/threatening behavior/rejection of care/kicking/hitting/grabbing/biting/abuse language and sexually inappropriate behaviors. The care plan further showed if behaviors were exhibited staff were to refer to the system listed interventions and assist Resident 35 to a quiet area, offer snacks, allow them to express concerns, music in room, redirect, and toileting assistance. Review of Resident 35's June, July and August 2024 MARs showed there was no monitoring for the behaviors that were listed on the care plan related to the use of Olanzapine. Review of a provider visit note dated 07/05/2024, showed Resident 35 had diagnoses of unspecified dementia severe, unspecified dementia type, unspecified whether behavioral, psychotic, or mood disturbance or anxiety. Review of a Resident 35's pharmacy review dated July 2024, showed, Resident is receiving Olanzapine an antipsychotic, but behavioral monitoring is not present. Specific behaviors need to be added to the Physician orders. Reference WAC : 388-97-1060(3)(k)(i)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on observation, interview, and record review, the facility failed to ensure 1) the labeling of several small containers of syrup on three trays located in dry 1 of 1 dry storage rooms in the kitchen, and 2) the resident's nutritional refrigerator was kept in a sanitary manner and undated /expired foods were discarded for 1 of 1 nutritional refrigerators in the facility. These failures placed residents at risk for consuming contaminated, expired foods, and food-borne illness. Findings included . <Dry storage> A concurrent observation and interview on [DATE] at 9:45 AM, showed in the dry storage room, on the third shelf, had three trays of syrup poured into small condiment containers with no dates on containers to show expiration date. Staff Y, Dietary Director, acknowledged there were no dates on the condiment containers and stated, they need to have a date. <Nutritional Refrigerator> An observation on [DATE] at 11:01 AM, of the nutritional refrigerator located in the dining room showed in the freezer there were large ice cream containers brought in with only a resident's name and no open or best by date observed. There were multiple (more than 10) multi-use ice packs within the freezer, a grocery bag with popsicles labeled with a resident's room number on the bag with no date. Within the refrigerator were three plastic see through storage food containers with fresh fruit inside, labeled with a resident's name, no best by date observed, and an unidentified food tray (with an unknown type of sandwich, a container of milk and a cup of juice) . The bottom of the refrigerator had a dark brown substance, and the inside walls had old food (dark brown hard particles) stuck to them. In an interview on [DATE] at 2:38 PM, Staff Y stated that the evening shift cook had the responsibility of checking the dates on the foods, and cleaning the refrigerator out daily. Staff Y stated they were unsure where the ice packs came from and that the nutritional refrigerator was a communal (shared, or used in common by members of a group or community) refrigerator. Additionally, Staff Y stated that resident families, staff, and the residents used the nutritional refrigerator. An observation on [DATE] at 8:53 AM, showed the nutritional refrigerator continued to have the three plastic food containers of fruit with a resident's name and no best by date observed. Further observation showed the bottom drawer contained an opened bag of beef sticks and a half drank bottled tea without best by dates observed. The bottom of the refrigerator underneath the drawer was a dark brown substance and the inside refrigerator walls had old food (dark brown hard particles) stuck to the side. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a concurrent observation and interview on [DATE] at 1:20 PM with Staff Y, showed the nutritional refrigerator with a dark brown substance underneath the bottom drawers. Staff Y acknowledged that the nutritional refrigerator had not been kept in a sanitary manner, took a picture, and stated they had work to do. Reference WAC: [DATE] (3)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on observation, interview, and record review, the facility failed to implement components of their infection prevention and control precautions for, 1) hand hygiene and glove change for 2 of 6 residents (Resident 3 and 23) reviewed during daily resident cares and wound care treatment, and 2) Legionella (a bacteria that can cause a severe respiratory disease) testing protocols and procedures when control measures (actions or steps taken) were not met to reduce the risk of growth/spread of pathogens (bacteria, virus or other microorganisms that can cause diseases) in water for 1 of 1 water management program (WMP) reviewed for infection control. These failures placed residents at an increased risk for exposure to cross contamination (harmful spread of diseases) and transmission of infectious diseases. Findings included . Review of Centers for Disease Control and Prevention (CDC) recommendations titled, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 02/27/2024 showed that hand hygiene was to be implemented to reduce the harmful spread of infections in the healthcare setting. When conducting hand washing .rub hand together vigorously for at least 15 seconds .scrubbing hands and fingers with soap . Review of the facility's policy titled, Hand Hygiene, revised 12/15/2021, showed, .hand hygiene is the primary means of preventing the transmission of infection . and hand hygiene was required when hands were visibly soiled, before and after direct contact with resident, before and after assisting a resident with personal care, before and after changing a resident wound dressing and after removing gloves and/or before applying new gloves. Review of the Department of Social and Health Services, Dear Nursing Home Administrator Letter, guidance titled, Clarifying Requirements to Reduce Legionella Risk in Healthcare Facility Water Systems, dated 09/18/2018, showed the facility's WMP must, at a minimum: Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system. Develops and implements a WMP that considers the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) industry standard and the Center for Disease Control (CDC) toolkit. Specifies testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained. Maintains compliance with other applicable Federal, State and local requirements. Review of the CDC toolkit titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, dated 06/24/2021, showed that a process should be in place for when control measures are not being met (outside of acceptable ranges) and that a facility would need to take corrective action? to get control measures back within acceptable ranges. Control measures with acceptable ranges should be established for each control point along with what actions would be taken. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Water Management Plan, revised April 2019, showed the facility's areas of risk for the spread of Legionella, included Shower(s), Hot water heaters, Water storage tanks, Sinks, Whirlpool tubs, Drinking fountains, Unused sinks/showers. The facility's control measures included: Flushing water heaters monthly, Disinfecting sinks and showers regularly, Flushing unused sinks/showers to reduce stagnation of water, Visually inspecting appliances for signs of biofilm growth (an encased group of microorganisms that can grow on surfaces and protect themselves from the disinfection process), Ensuring that expected water temperatures at fixtures (a fixed or attach structures like a sink and/or shower that delivers water). Additionally, the policy stated the facility would .establish procedures to execute if control measures are not met . <Hand Hygiene/Glove Change> <Resident 3> Review of the medical records showed they were admitted to the facility on [DATE] with diagnoses including Stage pressure injury (a wound from prolonged pressure to an area of the skin that extends below the skin layers into muscle, tendon or bone) to the sacrum (bottom or lower backside of the body), infection of an indwelling urinary catheter (a flexible tube that is inserted into the bladder to drain urine and is a high risk for infection), and dementia (an impairment of brain function, which causes memory loss, forgetfulness and impaired thinking abilities). The comprehensive assessment, dated 05/21/2024, showed Resident 3 had severe cognitive impairment, frequently incontinent of bowels (no voluntary control over bowel movements), dependent (staff preforms all the effort) on staff for perineal hygiene (care for toileting, cleaning and wiping of private areas of the body) and movement in bed. Review of Resident 3's care plan dated 05/22/2024 showed the resident had contractures (a permanent tightening of muscles and tendons that cause joint of the body to shorten and stiffen) in bilateral (both sides of the body) lower extremities. An observation on 08/05/2024 at 1:31 PM showed Staff K, Nursing Assistant (NA), and Staff Z, NA, in Resident 3's room assisting the resident with incontinent care for a bowel movement (BM). Resident 3 was noted to have a contraction (a shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become stiff, often leading to a deformity) of bilateral lower extremities with abduction (moving inward towards the body) of the legs together, with their urinary catheter squeezed in-between the resident's legs. Resident 3 had a bordered foam (type of wound bandage) dressing on their sacrum and residents BM had soiled the bordered foam dressing along with moving up the resident legs towards their urinary catheter. Staff K and Staff Z did not perform catheter care nor call for a nurse to change Resident 3's solid bordered foam wound dressing. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued observation on 08/05/2024 at 1:31 PM, showed Staff Z not changing gloves nor hand hygiene after cleaning the resident's BM. Staff Z then proceeded to assist in turning the resident, applied a clean brief, adjusted the resident's legs, shirt, socks and bed linen while wearing their soiled gloves. Staff Z then took off their gloves and performed hand washing for four seconds after applying soap. Staff K assisted with Resident 3's BM cleaning and clean brief change with the same soiled gloves. Staff K then proceeded to adjust Resident 3's urinary catheter tubing and drained the resident's catheter bag without changing their soiled gloves or performing hand hygiene. During an interview on 08/12/2024 at 9:27 AM, Staff Z stated the process with Resident 3's brief change was to perform catheter care due to the resident frequent bowel incontinence and if the resident's BM soiled the sacrum wound dressing, they would get the nurse to change it. Staff Z stated the wound dressing was soiled and they should have got a nurse to put on a clean wound dressing. Staff Z stated they forgot to complete catheter care on Resident 3 and their process for hand hygiene was to scrub with soap for 20 seconds. During an interview on 08/12/2024 at 9:56 AM, Staff K stated they should have changed their gloves and completed hand hygiene after they performed a brief change on Resident 3. Further, that they should have changed their gloves, performed their hand hygiene after they touched the resident's urinary catheter/bag and when moving from a soiled task to a clean task. Staff K stated that urinary catheter care and changing of the resident's sacrum wound dressing should have been completed. During an interview on 08/12/2024 at 10:48 AM, Staff B, Interim Director of Nursing Services/Infection Preventionist (IDNS/IP) stated that Staff Z and Staff K did not follow the correct infection control process and should have performed urinary catheter care and have Resident 3's nurse change out the soiled sacrum wound dressing. Staff B stated they would expect all staff to have performed a glove change/hand hygiene when moving from a soiled task, to a clean task and hand washing for 20 seconds. <Resident 23> Review of the resident's medical record showed they were admitted to the facility with diagnoses to include a fracture to their outer lower left leg and dementia. The 05/26/2024 comprehensive assessment showed Resident 23's cognition was severely impaired. A concurrent observation and interview on 08/07/2024 at 9:18 AM, showed Staff K and Staff J, NA, provided incontinent care to Resident 23 who had a BM. Staff J and Staff K applied gloves, and Staff J cleansed the BM off of the left hip and leg and Staff K cleansed the BM off of the left buttock and crease with wet wipes. Resident 23 had a soft white splint to the left lower leg and the top edges of the splint had dried brown/black soiled areas on it and newly fresh brown/black soiled areas. Staff K identified the soiled areas as BM and stated the splint was not cleanable to that area because it was a cloth-like material. Staff J and K, with the same soiled gloves, continued cleaning the resident, applying their clean brief, adjusting their pillows, blankets, and bed, without changing gloves, or performing hand hygiene. Staff J removed gloves and performed hand hygiene by applying soap, and then immediately rinsing their hands with water and rinsed for 20 seconds. Staff K did not perform hand hygiene prior to exiting Resident 23's room. Staff J stated their process was to wash hands prior to applying gloves, provide the care, remove the gloves, and wash hands again. Staff K stated they should have changed their gloves and performed hand hygiene in-between dirty and clean tasks and should have lathered their hands with soap for at least 20 seconds prior to rinsing with water. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent observation and interview on 08/07/2024 at 11:52 AM, showed Staff I, Registered Nurse, and Staff D, Licensed Practical Nurse/Resident Care Manager, providing wound care to Resident 23. Staff I and Staff D donned (to put on) gloves, and Staff I proceeded to removing a dressing from the top of the resident's left foot wound, cleansed the area, applied a wound gel (a substance that creates a moist environment to promote wound healing), and then applied a new dressing over the wound. Then Staff I removed a dressing from the left heel that was saturated with red, and brown drainage, cleansed the wound, applied a wound gel, then covered with a new dressing without removing the gloves or performing hand hygiene in-between the clean and dirty tasks for either of the residents wound dressing changes. Staff I stated they did not feel they needed to perform hand hygiene because they did not touch the inner portion of the dressing that was soiled but recognized they had cleansed the wound with gauze (a thin fabric used for wound care treatments) and cleanser after removing the dressing to both areas. Staff I stated they would normally have completed hand hygiene in-between dirty and clean tasks but did not. <Water Management Plan> Record review of facility water management plan program/procedure book, reviewed February 2024 by Staff A, Administrator, Staff B, and Staff G maintenance Director, showed they did not have specific testing protocols in place nor did they identify what procedure would be taken if acceptable ranges for the facility's control measures were not met. During an interview on 08/06/2024 at 4:41 PM, Staff A, stated they did not conduct any testing related to legionella/water management plan and that testing was not a requirement. When asked how the facility monitored to make sure control measures were met, Staff A stated they were unsure. During an interview on 08/08/2024 at 4:04 PM, Staff G, stated they had not been testing their water sources and was unsure if testing had been completed before they had started working as the Maintenance Director at the beginning of 2024. Staff G stated they did not know what the facility's testing protocols were or what the procedure would be if their control measures were not within acceptable ranges. Staff G was unsure if monitoring of all control measures was completed and unable to provide documentation of the facility unused sinks/showers and flushing of them nor the inspection of the facility's appliance for signs of biofilm growth. During an interview on 08/09/2024 at 9:39 AM, when requested documentation regarding the facility testing protocol and procedures they executed when control measures were not within acceptable ranges, Staff A was unaware and stated they would reach out to their corporate office and local health jurisdiction contact on what the facility testing procedures would be required. Staff A was unable to present documentation towards testing protocol/procedures that would be executed if the facility's control measures were not met. Record review of the facility's water management plans control measure logbook documentation report, showed no testing protocols if control measures were not within acceptable ranges. The records showed the flushing of water heaters were not completed monthly (last done 05/10/2024), no documentation of flushing of facility's unused sinks/showers (except for one eye wash station) or inspection of appliance for signs of biofilm growth (except for one ice machine). (continued on next page)		

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

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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 08/12/2024
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 08/12/2024 at 11:30 AM Staff A had no further information on the facility's water management plan testing protocols for legionella or the corrective actions that would be taken if the facility's control limits were not maintained. Reference: WAC 388-97-1320 (1)(a,c) 44922		

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 08/12/2024
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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44922 Based on observation and interview the facility failed to provide a functional, comfortable and sanitary environment for 1 of 1 laundry rooms (LR1) reviewed for environmental conditions. This failure placed staff and residents at an increased risk for infections related to unsanitary surfaces. Findings included . During a concurrent observation and interview on 08/07/2024 at 3:54 PM, with Staff H, Housekeeping/Laundry Director, showed a washing machine with rolled up towels on the laminate (a type of flooring) floor surrounding the base of the washing machine. The towels were soaked with water that had been leaking from the washing machine. Staff H stated that the washing machine had been leaking for a couple of months. When surveyor walked over by the washing machine, the laminate floor squished down, and a grayish sludge (a thick, soft, wet mixture of liquid) oozed out from in-between the laminate flooring. During an interview on 08/08/2024 at 4:05 PM, in the laundry room, Staff G, Maintenance Director, and Staff H, stated the washing machine had been leaking on/off for months. Staff G stated that Staff H had informed them of the sludge that had come up from the laminate flooring, which was not sanitary, and they would be working to fix the floor and washing machine. Reference: WAC 388-97-3220 (1)		