

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/08/2014
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF RICHLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 44 GOETHALS DRIVE RICHLAND, WA 99352
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Life Care Center of Richland on September 11, 2014, September 18, 2014, and October 8, 2014. A sample of 8 residents was selected from a census of 69 residents. The sample included 3 current residents and the records of 5 discharged and/or former residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#3038079 #3032887</p> <p>The survey was conducted by: Patti Zimmer, R.N.</p> <p>The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, Washington 98902</p> <p>Telephone (509) 225-2800 Fax: (509) 574-5597</p> <p><i>Kathleen Zimmer 10/27/14</i></p>	F 000	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</p>	
F 157 SS=D	<p>Residential Care Services Date</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an</p>	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Colleen Moon</i>	TITLE Executive Director	(X6) DATE 11/5/14
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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.

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F 157	Continued From page 1 accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to notify the legal representative of a significant change in condition for 1 of 3 sampled residents (#6) reviewed. Failure to inform the legal representative put the resident at risk for not receiving the most optimal care which could delay his recovery. Findings include: Resident #6: Review of a physician assessment	F 157	F157 Resident #6 is no longer in facility. Residents experiencing a change in condition will have their legal representative notified. Education to License Nurses and Social Services provided about notification of POA, Guardian, and Responsible Party when there is a change of condition. DON or designee will perform audits weekly for 4 weeks then monthly for 3 months on telephone orders, 24 hour report, and during grand rounds to verify responsible party notified of change of condition. Audits will be reviewed at the monthly Performance Improvement committee. DON will ensure compliance.	11-10-14	

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F 157	Continued From page 2 of the resident on 8/13/14 noted he was evaluating the resident secondary to abnormal lab results dated 8/12/14 noting a significant decline in kidney function. In reviewing the lab tests with the resident the physician recommended he be transferred to the hospital, however the resident "declined." The physician documented he suspected dehydration and/or congestive heart failure. Despite the significant change in the resident's condition there was no documentation the legal representative was notified of the above changes and physician's recommendation of hospitalization. A telephone interview at 12:20 p.m. on 8/16/14 with the resident's legal representative revealed she was not notified by staff and did not become aware of his decline until she visited the facility at approximately 4:30 p.m. on 8/14/15 (day resident was transferred to the ER at 5:15 p.m.).	F 157		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to provide care to promote the dignity of five of 15 sampled residents (#s 1,2,3,4, and 5) being cared for by Staff A (Nursing Assistant) on the night shift from 8/10-11/14. This	F 241	F241 Residents # 1, 2,3,4,5 have been assessed and Care Plans updated. Other Residents on the affected hallway were assessed and had no ASE from the care that staff A provided. Staff A is no longer employed in facility. DOH was notified. LN Supervisor on that shift had education with disciplinary action. Nursing staff had education on care and supervision.	11-10-14

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F 241	<p>Continued From page 3</p> <p>placed residents at risk for experiencing a diminished quality of life. Findings were:</p> <p>Resident #1: Admitted to the facility on [REDACTED] 14 with diagnoses which included a neurological disorder and dementia. Review of the resident's plan of care revealed she had impaired cognition but able to make her needs known, required one staff member to assist with toileting, and was able to utilize her call light when assistance was needed.</p> <p>Review of a facility investigation report revealed on 8/11/14 Staff B (Nursing Assistant) answered the resident's call light at the beginning of the day shift. The resident was "soaked" with urine from "head to toe" and had feces on her brief. The resident was notably upset and stated she had waited so long and "this shouldn't have happened." She stated she was making a complaint and did not want Staff A caring for her any longer.</p> <p>An interview on 9/18/14 at 1:00 p.m. with Staff B revealed the resident was found in a "mess" the morning of 8/11/14.</p> <p>Resident #2: Admitted to the facility on [REDACTED] 14 with diagnoses which included muscle weakness and lung problems. Review of the resident's plan of care revealed she had the possibility of bladder incontinence due to her need for staff assistance with toileting.</p> <p>Review of Progress Notes dated 8/11/14 noted the resident was alert with confusion, able to make her needs known, required one staff member to assist with toileting and transfers, and was on continuous oxygen. In addition, the</p>	F 241	<p>Social Service or designee will perform random resident interviews on personal care compliance and supervision.</p> <p>Audits will be completed weekly for 4 weeks then monthly for 3 months and forwarded to the monthly performance improvement committee.</p> <p>DON will ensure compliance</p>		

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F 241	<p>Continued From page 4 resident was at risk for falls.</p> <p>Review of a facility investigation report revealed on the morning of 8/11/14 the resident stated to Staff B that Staff A was supposed to take her to the bathroom. Staff A took off the resident's oxygen and wheeled her to the bathroom, then walked out leaving her there without assisting her to the toilet and putting her oxygen back on. She stated she did not want Staff A assisting her with care any longer.</p> <p>An interview on 9/18/14 at 2:20 p.m. with the resident regarding the above incident revealed she had to use the bathroom "real bad" and had her call light on for quite a while. When Staff A finally came through the door she looked "mad." She stated Staff A took her to the bathroom in her wheelchair. The resident was in the process of getting out of her wheelchair onto the toilet when Staff A turned and left the room.</p> <p>Resident #3: Admitted to the facility from the hospital on [REDACTED] 14 with diagnoses of muscle weakness and glaucoma. Review of the resident's plan of care revealed he required two staff members to assist with toileting and transfers with a mechanical lift. He was at risk for falls due to weakness and impaired balance.</p> <p>Review of a facility investigation report revealed on the morning of 8/11/14 the resident was found by Staff B with dried feces on his buttocks and sheets. The resident stated to Staff B that the "lady" on night shift had put him to bed like that and walked out..."she didn't finish her job."</p> <p>An interview on 9/18/14 at 1:00 p.m. with Staff B revealed that when she entered the resident's</p>	F 241		

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F 241	<p>Continued From page 5</p> <p>room the morning of 8/11/14 the resident was halfway out of bed and his feet were hanging off the floor. The resident had stated to her, "she (Staff A) was supposed to come back." The resident then called his family member and stated he did not want Staff A caring for him any longer.</p> <p>Resident #4: Admitted to the facility on [REDACTED] 14 with an intestinal infection and expired on [REDACTED] 14. Review of the resident's plan of care revealed she had impaired cognition, incontinent of bowel and bladder, and was to receive "prompt" perineal care after an incontinency episode.</p> <p>Review of a facility investigation report revealed on 8/11/14 the resident was found in the early morning by Staff B with urine and feces up to her back area.</p> <p>Resident #5: Admitted to the facility on [REDACTED] 14 following a fracture. Review of the resident's plan of care revealed she had impaired cognition, and required staff assistance with care.</p> <p>Review of a facility investigation report revealed on 8/11/14 Staff B went to toilet the resident in the early morning and found her completely saturated in urine to her shoulders with wet bed linens.</p>	F 241		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 281		

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F 281	Continued From page 6 by: Based on record review the facility failed to ensure services provided met professional standards of care for 1 of 3 sampled residents (#6) reviewed for physician's orders. The failure to follow physician's orders regarding a urinalysis could potentially result in a lack of prompt medical treatment and further complications for the resident. Findings include: According to Lippincott Manual of Nursing Practice, ninth edition, (Lippincott, Williams, and Wilkins), page 17, states "Departure from Standards of Care" includes failure to implement a physician's order properly or in a timely fashion. Resident #6: Admitted to the facility on [REDACTED] 14 from the hospital following management of acute respiratory failure after cardiac surgery. The resident was admitted with a urinary retention catheter. Review of Progress Notes on 7/16/14 noted the resident's retention catheter was draining clear, yellow urine. Seven days later on 7/23/14 documentation stated at two different times that day the resident's urine was dark in color. The physician was notified and orders received to obtain a urine specimen for analysis, culture and sensitivity. There was no documentation the urine specimen was ever obtained by staff. Upon further investigation by the Administrator on 10/8/14 it was noted the urine specimen was never obtained by staff, thus physician's orders were not followed.	F 281	F281 Resident # 6 no longer in facility Audits were complete for ordered urinalysis and follow up was completed as required. License staff educated about protocol on processing orders for urinalysis. DON or designee will perform weekly audits for 4 weeks then monthly for 3 months on physician orders and urinalysis results. Results of the audits will be discussed at the monthly performance improvement committee. DON will ensure compliance	11-10-14	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309			

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F 309	Continued From page 7 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to comprehensively assess, recognize and competently address causes of the resident's decline in physical and mental condition for 1 of 3 sampled residents (#6) reviewed for changes in condition. This deficient practice resulted in actual harm to Resident #6, who was transferred to the Emergency Room (ER) and diagnosed with acute kidney failure, obstructive uropathy (condition in which the flow of urine is blocked which causes urine to back up and injure the kidneys), and urosepsis (bacteria in the blood resulting from a urinary tract infection). Findings include: Resident #6: Admitted to the facility on [REDACTED] 14 from the hospital following acute respiratory failure after heart surgery. Other diagnoses included chronic kidney disease and dementia. The resident was admitted with a urinary retention catheter. Review of the initial nursing assessment dated 7/16/14 noted the resident was alert and oriented, required staff assistance with ambulation, and was on continuous oxygen per nasal cannula at two liters per minute.	F 309	F309 Resident # 6 no longer in facility Residents with weight gain and recent discontinuation of Foley catheter were reviewed to ensure correct assessment is completed. License Nurses educated on recognizing, comprehensively assessing, and addressing changes of condition especially in relation to monitoring of output after discontinuation of catheter, weight gain and edema. DON or designee will audit/review telephone orders, 24 hour report, changes in condition, and grand rounds for completion of nursing assessment and communication to physician. Audits will be forwarded to the monthly Performance Improvement committee meeting. DON will ensure compliance.	11-10-14	

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F 309	<p>Continued From page 8</p> <p>Review of Progress Notes revealed the resident's urinary retention catheter was discontinued per physician's orders on 8/8/14. Review of the resident's Intake & Output form between August 8-14 revealed no actual measurements of the resident's urine output. Without that information staff was unable to accurately determine the hydration status of the resident. Staff documented the following:</p> <p>8/8/14 - resident voided twice on the dayshift 8/9/14 - resident voided once on the dayshift and three times on the evening shift 8/10/14 - resident voided once on the dayshift 8/11/14 - no documentation of any voidings 8/12/14 - resident voided once on the dayshift 8/13/14 - no documentation of any voidings 8/14/14 - no documentation of any voidings</p> <p>Review of the resident's weights noted his/her weight increased from [redacted] pounds on admission [redacted] 14) to [redacted] pounds on 8/13/14, for a weight gain of 18 pounds over [redacted] days. Review of documentation by the therapy department revealed on 8/11/14 the foot of the resident's bed was raised for "managing fluids accumulated in LE's (lower extremities)." On 8/12/14 the therapist documented the resident's lower extremities were "extremely swollen" and was unable to bend his/her knees to place his/her feet on the standard leg rests, thus he/she was provided with elevating leg rests.</p> <p>Despite the increase in the resident's weights and above noted assessments by therapy staff there was no assessment or recognition by nursing of the resident's edema and need for monitoring.</p>	F 309		

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F 309	<p>Continued From page 9</p> <p>Review of Physical Therapy (PT) notes revealed on 8/12/14 the resident was able to ambulate 27 feet with his/her walker and minimal staff assistance. On 8/13/14 documentation by PT noted a "significant decline" as he/she only tolerated standing for one minute due his/her complaint of shortness of breath and fatigue. The PT discussed the resident's decline, unstable heart rate, and drop in oxygen saturation levels with nursing.</p> <p>On 8/13/14 review of the physician's assessment revealed abnormal lab results (decline in kidney function tests) were reviewed with the resident. The physician documented the abnormal labs were consistent with dehydration or congestive heart failure (accumulation of fluid in the resident's lungs). The physician had recommended the resident be transferred to the ER at that time, but the resident declined. The resident was to be encouraged to increase his/her oral intake.</p> <p>On 8/14/14 documentation by Staff C (PT Assistant) noted the resident reported feeling "very sleepy." His/her oxygen saturations were low at 72-85% on three liters of oxygen. The PT Assistant then increased the oxygen to four liters which increased the saturation level to 98%. The resident was unable to sit up unsupported and remained very sleepy. The oxygen level had decreased to 90-92% after lying the resident down in bed and his/her heart rate fluctuated between 37-128 beats per minute. Nursing staff was informed by the PT Assistant of the resident's lethargic condition and unstable vitals.</p> <p>An interview on 10/8/14 at 3:00 p.m. with Staff C revealed the above therapy session on 8/14/14</p>	F 309		
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F 309	<p>Continued From page 10 began at approximately 10:00 a.m.</p> <p>Despite the resident's significant change of condition (as noted by the physician and therapy staff) and need for close monitoring there was no evidence of a nursing assessment on 8/13/14. The next nursing assessment was documented at 10:49 p.m. on 8/14/14 stating the resident was transferred to the Emergency Room (ER) due to lethargy. His/her oxygen saturation levels had decreased to 86% on three liters of oxygen. A nebulizer breathing treatment had been given with very slight increase to 87%. The resident was having difficulty in breathing and his/her abdomen was distended. The physician saw the resident at that time and ordered the transfer to the ER, which was done at 5:15 p.m.</p> <p>Review of hospital ER records revealed the resident was diagnosed with urosepsis, obstructive uropathy acute kidney failure, and irregular heart rate. A urinary retention catheter was inserted after two unsuccessful attempts, and over one liter of urine was obtained following the catheter insertion. The resident expired at the hospital on [REDACTED] 14.</p> <p>Despite the resident's recent history of kidney failure and heart disease, significant weight increase and noted edema, removal of the urinary retention catheter on 8/8/14, above noted abnormal lab results, and noted decline by therapy staff; nursing staff failed to recognize the need to monitor the resident's clinical condition closely, and alert the physician to changes in his condition in a timely manner.</p>	F 309			