

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 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000 INITIAL COMMENTS

F 000

This ammended report is the result of an unannounced Quality Indicator Survey conducted at Richland Rehabilitation Center on 10/21/14, 10/22/14, 10/23/14, 10/24/14, 10/27/14, 10/28/14, 10/29/14 and 10/30/14. A sample of 26 residents was selected from a census of 68. The sample included 18 current residents and the records of 8 former and/or discharged residents.

The following was a complaint investigated as part of this survey:

#3041608

The survey was conducted by:

Liisa Johnson, RN
Lucy Fromherz, RN
Refugia Botello, RN
Hermelinda Thompson, RN

The survey team is from:

Department of Social & Health Services
Aging & Long Term Support Administration
Residential Care Services, District 1, Unit D
3611 River Road, Suite 200
Yakima, Washington 98908

Telephone: (509) 225-2800
Fax: (509) 574-5597

Received
Yakima RCS

DEC 04 2014

[Handwritten Signature] 11/24/14 (amended)

Residential Care Services Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Handwritten Signature]</i>	TITLE <i>Administrative</i>	(X6) DATE <i>12/1/14</i>
---	--------------------------------	-----------------------------

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.

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 10/30/2014
NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329 SS=E	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to quantitatively and qualitatively monitor target behavioral symptoms of depression and/or psychosis for 4 of 5 residents (#5, 152, 125, 237). Further, 1 of 1 resident (#5) receiving an antipsychotic medication had no attempted gradual dose reduction to ensure appropriate use of the antipsychotic medication. This placed the</p>	F 329	<p>F000 Initial Comments</p> <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Richland Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F 329</p> <p>It is the policy of this facility for each resident's drug regimen to be free from unnecessary drugs.</p> <ol style="list-style-type: none"> Resident's # 5 and # 125 medication regimen to be reviewed by pharmacist. <p>Resident's # 152 & #237 have been discharged from the facility.</p> <ol style="list-style-type: none"> Current residents receiving psychotropic 	

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 10/30/2014
NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 2</p> <p>residents at risk for lack of efficacy, proper medication selection and adverse consequences. Findings include:</p> <p>1. Resident #5. Admitted [REDACTED] diagnoses included dementia with behaviors, generalized anxiety and depression.</p> <p>On 10/27/2014 at approximately 1:45 p.m., Staff Member E, the Social Service Director (SSD) stated he is not able to say if the resident's behaviors are better or worse from month to month "because the nurses do not document the frequency of the behaviors." He added he too had not identified the resident's target behaviors or documented the behavior frequency on his monthly psychoactive drug reviews.</p> <p>On 10/24/2014 at approximately 1:45 p.m., Staff Member C, a Licensed Nurse (LN), stated the resident does have a tendency to cry and be sad. She added she is aware of the behavior flow sheets but does not use them. She uses the resident progress notes to document the resident's crying behaviors.</p> <p>The resident was observed on 10/23, 24, 27/14 in her room and each time she initially would smile and say she was fine, than she would start to cry and say "I am afraid to go to the grave. I do not want to die. They are coming (she was unable to identify who "they" were)."</p> <p>On 10/28/2014 at approximately 11:23 a.m., the resident was weepy and stated "I am afraid of the grave. I just know I am going there and I do not want to be underground. I just know I am going there today."</p>	F 329	<p>medications will be reviewed by the Interdisciplinary team (IDT) and review of behavior flow sheets and interventions for individualization to address specific behaviors and needs.</p> <p>3. Nursing staff has been re-educated on the need for appropriate documentation on behavior monitoring sheets by the DNS/designee. Social Services Director and Resident Care Managers have been re-educated regarding policies and procedures for behavior monitoring and psychotropic medication use by DNS/designee.</p> <p>4. The DNS or designee will complete random weekly audits over the next 3 months to ensure quantitative documentation of behaviors on behavior</p>		

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 10/30/2014
NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 3</p> <p>On 10/27/14 at approximately 1:30 p.m., Staff Member A, the Director of Nursing Services (DNS), stated the resident "has a history of certain beliefs she believes she was raped by 2 men." She added this allegation had been reported and investigated by the "State" and had not been proven to be true.</p> <p>On 10/28/14 at approximately 10:45 a.m., Staff Member D, the Administrator, stated the reason the staff are not documenting the resident's fear of death and being taken to the grave yard "could be that the staff think it is just a part of her behavior."</p> <p>On 10/27/2014 at approximately 10:50 a.m., both Staff Member A, the DNS and Staff Member E, the SSD, acknowledged the facility had a system problem with the licensed nurses (LN) not documenting the target behaviors on the behavior flow sheets. Staff member E, the SSD, added "We have a communication issue."</p> <p>The behavior flow sheets (March, June, August, September, and October 2014) provided were reviewed and revealed generic target behaviors. Lacking on the behavior flow sheets were the resident's beliefs, including her daughter being killed, the resident's fear of death and being taken to the grave yard.</p> <p>Review of the most current physician orders revealed an order for [REDACTED] (an anti-psychotic) a dose of 50 milligrams (mg) to be administered at bedtime with a start date of 01/04/14. The pharmacy March 2014 review provided the primary provider a note about the black box warning related to the use of [REDACTED] on nursing home residents. Staff Member F, the Advanced</p>	F 329	<p>flow sheets for residents receiving mood or behavior altering medications.</p> <ol style="list-style-type: none"> 5. Issues will be brought to the monthly Quality Assurance and Process Improvement Committee meeting monthly x3 months to identify opportunities for performance improvement. 6. The DNS will ensure compliance. 7. 8. Date of Compliance – December 4, 2014 		

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 10/30/2014
NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 4</p> <p>Registered Nurse Practitioner (ARNP), documented on 03/12/14 the patient had a long term use of the medication and was tolerating the medication well, "predict decompensation if the dose was decreased or discontinued."</p> <p>On 10/24/14 at approximately 1:52 p.m., Staff Member F, the ARNP, stated she is responsible for the resident's medication management and she had not considered a gradual dose reduction for [REDACTED] for this resident.</p> <p>2. Resident #237. Admitted on [REDACTED] and, following a hospitalization, readmitted on [REDACTED]. Diagnoses included chronic pain, anemia, renal failure, and depression.</p> <p>Physician orders included [REDACTED] (a hypnotic/sleeping pill) and two antidepressants, [REDACTED] and [REDACTED].</p> <p>On 10/27/14 at 1:00 p.m., Staff Member E, SSD, stated the resident received [REDACTED] and the monitoring was documented in the MAR. She was receiving two antidepressants also, and her episodes of depression were monitored in the nursing progress notes. He stated there was a monitoring system in place.</p> <p>The resident's care plan for altered mood state contained 'target behaviors' of refusing food, crying frequently, withdrawing from social contact, complaints of unhappiness, excessive sleeping and negative statements. The goal was to decrease sad episodes related to depression.</p> <p>On 10/27/14 at 3:00 p.m., Staff Member G, a LN, stated there had been a monitoring sheet in place in the MAR for depression, but when she</p>	F 329		

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 10/30/2014
NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 5</p> <p>reviewed the MAR, she could not find the sheet. She stated the resident was "so much better" since admit; not so teary and more positive about things. However, she could not find where it was documented. She stated she did document in the progress notes about the resident's behaviors. Further, she looked but did not find the sheet to document the resident's hours of sleep for the [REDACTED]</p> <p>On 10/28/14 at 11:30 a.m., Staff Member M, a LN, stated she was not sure what symptoms of the resident's depression had changed, but she was overall in a better mood and working with therapy to go home. Staff Member M stated the resident's medical complications would cause most people to become depressed. When the MAR was reviewed, she stated there were no sheets to document signs of depression; only the side effects of the two antidepressants. While reviewing the MAR, she found a sheet to document the hours of sleep which was added the night before (10/27/14 - after the surveyor had discussed the issue with Staff Member E). No other documentation was available.</p> <p>Review of the resident's progress notes did not find consistent documentation of the identified and documented target behaviors listed in the care plan.</p> <p>3. Resident #125. The admission comprehensive assessment dated [REDACTED] identified the need for care plan development of psychotropic medication and psychosocial well-being. The assessments for psychological well-being noted the resident had little interest in doing things in the facility and was feeling "down" due to the nursing home admit.</p>	F 329			

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

PRINTED: 11/21/2014
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 10/30/2014
NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 6</p> <p>The comprehensive assessment dated 10/18/14 revealed he was cognitively intact with mild depression.</p> <p>The 10/07/14 care plan contained the issue of 'Mood State' with target behaviors of crying, withdrawn, complaints of unhappiness, excessive sleeping and negative statements documented. The goal was to decrease these episodes. The approaches included medications as ordered, a behavior monitoring plan, monitoring side effects of the medications and referral to a mental health professional as needed.</p> <p>Physician orders and the Medication Administration Record (MAR) revealed an anti-depressant, [REDACTED] 10 mg, was administered to the resident daily. Documentation for symptoms of side effects of the [REDACTED] were listed but that did not include target behavioral symptoms.</p> <p>The 09/17/14 psychotropic medication review documented [REDACTED] for depression was reviewed and a gradual dose reduction was to be discussed with the medical professional.</p> <p>A documented assessment/history progress note by Staff Member E, SSD, dated 06/29/14, noted the resident "is taking antidepressant medication and care plan and B/F (Behavioral Flowsheet) in place..."</p> <p>However, review of the target behaviors, which the care plan identified to be monitored on the behavior monitoring plan, revealed July, August, and September, 2014, had not been documented as to if behaviors were present or not.</p>	F 329		

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 10/30/2014
NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 7</p> <p>Review of the progress notes since admit did not contain monitoring of the target behaviors for which the resident required the antidepressant medication. A 09/19/14 entry at 10:30 p.m. documented "No behavioral changes noted this shift." A 09/05/14 entry at 10:18 p.m. revealed the resident had no aggressive behavior this shift. The 06/25/14 and 06/26/14 entries for evening shift documented there were no signs and symptoms of depression this shift.</p> <p>On 10/28/14 at 4:00 p.m., Staff Member I, a LN, stated that there was an approach in the MAR to monitor side effects of the antidepressant but that was all she knew was required for documentation. She stated that she did document in the progress notes if she observed any signs of mood issues, like depression symptoms.</p> <p>On 10/29/14 at 11:00 a.m., Staff Member E, SSD, stated that there was no documented monitoring of the symptoms of depression in the resident's record that he could locate. However, he had found two forms - one was dated 09/17/14 for a psychoactive drug review committee which noted the [REDACTED] 10 mg started on 06/21/14 and there were no behaviors (identified under 'target behaviors') and no frequency of behaviors.</p> <p>On 10/29/14 at 1:15 p.m., Staff Member H, a Resident Care Manager, stated the resident was admitted in [REDACTED] discharged to the hospital on [REDACTED] with worsening of his respiratory disease, and then readmitted on [REDACTED]. She stated she had looked for documentation of the behavioral plan target symptoms and found three sheets but "they were not filled out" by the nurses.</p>	F 329			

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

PRINTED: 11/21/2014
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 10/30/2014
NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 8</p> <p>Two of the sheets she located were dated 2014 with no month indicated and one sheet was dated 08/2014.</p> <p>4. Resident #152. Admitted on [REDACTED] with diagnoses that included anxiety and depression. The comprehensive assessment dated 10/20/14 revealed the resident was cognitively intact. An anti-depressant medication was ordered for daily administration on 10/18/14. The resident also had current orders for two different anti-anxiety medications. The comprehensive care plan identified the resident with target behaviors of worried thoughts, negative statements, panic attacks, shortness of breath, lack of sleep and extreme fears.</p> <p>On 10/27/14 at approximately 9:00 a.m., Staff Member J, a nursing assistant (NA), stated Resident #152 would get tearful often and had anxiety at times, and "they give her something for that." The NA stated that when she noticed the resident had signs of tearfulness and/or anxiety, she would verbally report it to the LN assigned to the resident.</p> <p>On 10/27/14 at approximately 9:15 a.m., Staff Member L, a LN, identified that Resident #152 had "mood swings and crying spells." He stated that he does not document behaviors in the behavior monitor sheets that were placed in front of the MARs to document the types and frequency of the behaviors.</p> <p>On 10/27/14 at approximately 10:00 a.m, the facility's licensed psychologist explained that he had seen Resident #152 one time the prior week because "she had to be centered." He explained that she was crying and emotional and had asked</p>	F 329		

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 10/30/2014
NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 9</p> <p>to visit with him. He stated the resident's thinking was "muddled and confused" due to her feeling overwhelmed. The psychologist stated he gave the resident some suggestions about how to deal with her depression until the following week when he would visit her again.</p> <p>On 10/27/14 at 2:05 p.m., the resident was observed working with therapy in her room. The resident became tearful twice in a 15 minute time span. When interviewed at 2:25 p.m., the resident became tearful and stated, "I am so depressed...I just feel very, very empty."</p> <p>The behavior monitor sheets for Resident #152 revealed one episode of tearfulness, one episode of sad facial expressions, and one episode of anxious statements since admission.</p> <p>The facility failed to monitor specific symptoms of depression, anxiety and/or delusions/fixed beliefs for Residents #5, 152, 125 and 237, who were receiving psycho-active medication for these symptoms. The lack of quantitative and qualitative data did not allow staff to analyze the residents' medications to ensure they were the most effective type of medication and that they were provided in appropriate dosages to improve well-being. The facility also failed to attempt a gradual dose reduction for a antipsychotic medication.</p>	F 329			
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;</p>	F 514			

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 10/30/2014
NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 10</p> <p>accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to document skin status for 1 of 3 residents (#162) reviewed for pressure ulcers and failed to ensure the medication administration record accurately reflected the physician orders for 1 of 1 resident (#183) reviewed who required numbing of the skin prior to drawing blood. This placed these residents at risk of not receiving skin care and/or receiving a medication that was not ordered. Findings include:</p> <p>1. Resident #162. Admitted on [REDACTED] with diagnoses of dementia, right hip fracture, and pressure ulcer on right and left heel.</p> <p>Record review revealed a skin assessment dated 04/10/14 documented multiple bruises on his arms and back; a scab on outside lateral side of his right knee, next to the right elbow, and a 1.5 centimeter (cm, or approximately 1/2 inch) by 1.0 cm (approximately 1/3 inch) on left heel. A 2.0 cm by 2.0 cm (approximately 3/4 inch by 3/4 inch) black bruise on his right heel. Additional the Braden Assessment dated 04/10/14, for risk of skin breakdown had been scored as 14 moderate</p>	F 514	<p>F 514</p> <p>It is the policy of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>1. Resident # 162 Treatment Administration Record (TAR) was reviewed updated at the time of survey to ensure documented skin monitoring and appropriate skin treatments are in place.</p> <p>Resident #183 Medication has been reviewed. The medication in question was ordered and written as directed on the Medication Administration Record (MAR).</p> <p>2. Current residents admitted with pressure ulcers have been reviewed to ensure skin treatments were initiated expeditiously and</p>		

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 10/30/2014
NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 11 risk for skin breakdown.</p> <p>The April 2014 treatment flow sheet revealed the following; weekly skin checks, heels to be floated when the resident was in bed, betadine to heels bilaterally and to the scab on the right ankle. From April 10th through April 21st the treatment licensed nurses had not initialed the flow sheet to indicate the skin treatments had been implemented.</p> <p>On 10/24/14 at approximately 8:32 a.m., Staff Member B, a Resident Care Manager (RCM) stated "he came in with pressure ulcers on his heels from the hospital."</p> <p>On 10/24/14 at approximately 8:45 a.m., Staff Member N, a Nursing Assistant (NA) stated the nursing assistants were responsible for making sure the resident's heels were floated when he was in bed. She added the resident has an alternating low air mattress.</p> <p>On 10/24/14 at approximately 8:49 a.m., Staff Member O, a Bath Aide stated she bathed the resident twice a week. "I have been told to check his feet. Sometime in April I wiped one of his heels with a wash cloth and noticed some blood on the wash cloth and told the nurse. I bathed him yesterday and his heel looked dry and scaly. It is not open anymore."</p> <p>On 10/24/14 at approximately 9:53 a.m., Staff Member C, a LN, completed a dressing change to the resident's right heel. The skin on the heel was dry, intact, with no evidence of drainage or odor. The surrounding skin was scaly, dry, and intact.</p>	F 514	<p>skin monitoring documented. No other residents were affected by this practice.</p> <p>Current MARs of re-admitted residents have been reviewed to ensure medications have been reconciled with current physician orders in place. No other residents were affected by this practice.</p> <p>3. Licensed Nurses (LNs) were re-educated regarding completeness and accuracy of admission/re-admission physician orders, documentation of skin assessments and treatments in order to ensure records are complete and accurate by the DNS/designee.</p> <p>4. To ensure ongoing compliance, the Director of Nursing (DNS)/designee will complete random weekly audits of residents</p>	

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 10/30/2014	
NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 12</p> <p>On 10/27/2014 at approximately at 10:50 a.m., Staff Member A, the Director of Nursing, stated "the nurse who documented the resident's pressure ulcer on admit no longer works in the facility." She acknowledged the lack of documented skin monitoring during the first 11 days of his stay. She added "I now have put in a new system regarding admission skin assessment to avoid delayed documentation of skin treatments."</p> <p>2. Resident #183. Admitted on [REDACTED]</p> <p>On 10/30/14 at approximately 9:45 a.m., Resident #183's family member stated the resident had a blood draw, attempted by a staff member, through a port that was placed under her skin. The family member stated that the resident was supposed to have lidocaine cream applied to the area prior to the draw for comfort.</p> <p>On 10/30/14 at approximately 2:00 p.m., Staff Member D, the administrator, stated Resident #183 was discharged on [REDACTED] to a local hospital, then readmitted to the facility on [REDACTED]. She explained that once a resident is discharged, all the medications and treatments are to be reordered just like a new admission. She further explained that there was not a current lidocaine order since the new admission.</p> <p>The resident's record contained a physician order dated 10/10/14 for the lidocaine cream to be applied on the skin one hour prior to the blood draw.</p> <p>Although there was no physician order for the Lidocaine cream after the readmission on [REDACTED] the October 2014 MAR, read, "Use</p>	F 514	<p>admitted with pressure ulcers to ensure treatments and skin checks have been completed and documented appropriately. DNS/designee will also audit re-admit MARs to ensure accuracy and current physician orders in place.</p> <p>5. Issues will be brought to the monthly Quality Assurance and Process Improvement Committee meeting monthly x3 months to identify opportunities for performance improvement.</p> <p>6. The DNS will ensure compliance.</p> <p>7. Date of Compliance – December 4, 2014</p>	

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

PRINTED: 11/21/2014
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 10/30/2014
NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 13 lidocaine one hour before," the weekly blood draw that was ordered by the physician.	F 514		