

1452

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 C 02/03/2014
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NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352
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<p>F 000</p> <p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Richland Rehabilitation Center on February 3, 2014. A sample of 3 residents was selected from a census of 56 residents. The sample included the records of 2 current residents and the records of 1 former and/or discharged resident.</p> <p>The following was a complaint investigated as part of this survey:</p> <p>#2950181</p> <p>The survey was conducted by: ██████████, 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>[Signature]</i> 2/11/14 Residential Care Services Date</p> <p>F 309 SS=D</p> <p>HIGHEST WELL BEING</p> <p>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.</p>	<p>Received Yakima RCS MAR 10 2014</p>	<p>F 000</p> <p>F 309</p>	<p>F000 Initial Comments "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>F309</p> <ol style="list-style-type: none"> 1. Resident #1 has been discharged from the facility. 2. Current residents are being assessed for change of condition; physician's notified of the change in condition and timely treatment initiated per physician orders. 	<p>(X5) COMPLETION DATE</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ██████████	TITLE <i>Administrator</i>	(X6) DATE 3-4-14
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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 per 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 309	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to perform necessary assessments and facilitate timely care and treatment in response to changes in the condition of 1 of 3 sampled residents (#1). This failed practice potentially resulted in delay in medical treatment of the resident. Findings include: Resident #1: Admitted to the facility on [REDACTED]/13 from the hospital with diagnoses which included [REDACTED] problems including a [REDACTED], [REDACTED] ([REDACTED]), chronic [REDACTED] and [REDACTED] disease, [REDACTED], and [REDACTED]. Review of hospital records noted physician documentation on 12/18/13 which stated the resident was at high risk for [REDACTED] decompensation secondary to multiple medication issues and advanced age with underlying [REDACTED]. Review of physician's orders revealed a medication to lower blood pressure was ordered twice daily, routine breathing treatments, and oxygen therapy at 2-3 liters per minute via nasal cannula to keep the resident's oxygen saturation levels above 90%. On [REDACTED]/14 at 9:45 p.m. the resident was transferred to the Emergency Room (ER) after a Nursing Assistant reported he had increased lethargy when she was trying to help him to bed. When the Licensed Nurse (LN) attempted to talk with the resident there was no response. His B/P was low at [REDACTED] with oxygen saturation levels at [REDACTED]%. The resident returned to the facility from	F 309	3. Staff have been re-educated by the Director of Nursing (DON) / designee, on reporting any change in condition to the Licensed Nurse (LN). LN's have been re-educated on assessment of resident's with a change in condition, physician notification and follow through of any new orders in the Plan of Care (POC) by the DON / designee. Resident Care Managers will review resident progress notes on a daily basis via Managing Acute Condition Change (MACC) process, to ensure all care concerns were appropriately assessed and notifications and follow up completed. Negative findings will be forwarded to the DON for review and to ensure appropriate follow up is completed.		

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F 309	<p>Continued From page 2</p> <p>the ER at 1:15 a.m. on [REDACTED]/14 following intravenous fluids due to [REDACTED].</p> <p>On [REDACTED]/14 at 9:37 a.m. (approximately 9.25 hours following the resident's return from the ER) the resident's B/P was recorded on the vital sign form as [REDACTED]. Despite the significantly low B/P at that time there was no nursing assessment until 3:47 p.m. which did not reflect the resident's mentation, fluid intake (recent diagnosis of [REDACTED]), and respiratory status (with the exception of a recorded oxygen saturation level of 92%). In addition, there was no further B/Ps taken until 3:19 p.m. that afternoon.</p> <p>Review of documentation on 1/11/14 by the Physical Therapist (PT) revealed during the morning session the resident's oxygen saturation level was low at 70% on 2 liters of oxygen, thus he was returned to the nursing station. The PT informed the LN of the resident's low oxygen saturation level. The LN then increased the oxygen flow from 2 liters to 3 liters, however the oxygen saturation level decreased further to 68%. The therapy session was placed on hold until later that day at which time the LN reported to the PT she had administered medications and breathing treatments to the resident which resulted in his oxygen saturation being 89%. With minimal activity during the afternoon therapy session the resident's oxygen saturation level decreased to 80% on 3 liters of oxygen, thus the PT ended the session and again informed the LN regarding the resident's condition.</p> <p>Despite the above decline in the resident's oxygen saturation levels during the PT session review of documentation in the Progress Notes by the above LN stated his oxygen saturation level</p>	F 309	<ol style="list-style-type: none"> 4. The DON or designee will complete random weekly audits over the next 3 months to ensure care issues with subsequent assessment and physician notification have been completed and documented in resident medical record. The DON will track and trend the audit results and report findings to the QAPI Committee monthly x 3 months to identify opportunities for performance improvement. 5. The DON will ensure compliance. 6. Date of Compliance – 3/17/2014. 	

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F 309	<p>Continued From page 3</p> <p>was at 87% and did not reference his decline in respiratory status during the two therapy sessions.</p> <p>Review of Progress Notes dated [REDACTED]/14 at 2:06 p.m. stated the resident was lethargic that morning and "appeared to be breathing rapidly." The resident was put to bed at approximately 11:00 a.m. The resident's family came to visit and requested to see the LN who returned from her lunch break at 11:05 a.m. Upon assessment of the resident the LN noted he had shallow respirations with an oxygen saturation level of 82% and a B/P of 70/40 with pulse rate of 124 beats per minute. The family requested the resident be sent to the ER. After 10 minutes of administering breathing treatments to the resident his oxygen saturation level decreased further to 77%. The physician was then notified and orders received to transport to the ER.</p> <p>Review of hospital records dated [REDACTED]/14 noted the resident had respiratory distress with low blood pressure when initially assessed in the ER. After intravenous fluids his B/P increased, however he continued to have difficulty breathing with low oxygen saturation levels. A chest-ray and CT scan showed significant/severe [REDACTED] disease. Due to his frequent hospitalizations and worsening condition the resident was placed on palliative care and comfort measures.</p> <p>An interview on 2/3/14 at 1:50 p.m. with Staff Member A (Nursing Assistant) revealed the resident was having trouble "catching his breath" when he was eating breakfast on 1/12/14. When Staff Member B returned the resident to his room following the meal he continued to have trouble breathing, which she reported to a LN. The</p>	F 309		

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F 309	Continued From page 4 resident also acknowledged to her he was having trouble breathing. The resident's family member stated on 2/3/14 at 12:15 p.m. via a telephone interview that when they visited the resident the morning of 1/12/14 he had rapid respirations, was "really struggling for air...looked somewhat nonresponsive." They immediately tried to locate a LN to assess the resident due to their concerns. Despite documentation on 1/12/14 stating the resident was lethargic and was breathing rapidly that morning there was no documented respiratory rate, or oxygen saturation level at that time. In addition, despite the resident's change of condition there was no further assessment of the resident until the LN returned from her lunch break at 11:05 a.m.	F 309		