| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505080 | A. Building<br>B. Wing | 01/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Kennewick | 1508 West Seventh Avenue<br>Kennewick, WA 99336 |

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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>00242<br><br>Based on observations, interviews and record review, the facility failed to ensure staff followed acceptable standards of practice regarding medication administration for 1 of 3 residents (Resident 1), reviewed for narcotic pain medication. Resident 1's narcotic pain medication was not available to administer to the resident as it was not ordered timely by staff when the supply became low. In addition, scheduled agency staff and newly hired staff did not have authorization codes to use the Omnicell (emergency dispensing machine for medications). Administrative staff made no attempt to call the pharmacy to determine an action plan based on scheduled staff not having access to the Omnicell, nor did any LNs come to the facility to obtain the narcotic medication for the resident. As a result, the same narcotic pain medication belonging to different residents, was administered twice to Resident 1 and the resident was transferred to the emergency room (ER) for pain management. This placed the resident at risk for increased pain due to a delay in the administration of their narcotic pain medication.<br><br>Findings included:<br><br>Review of the facility policy titled, Medication Shortages/Unavailable Medications, revised on 01/01/2022, showed:<br><br>1) Upon discovery of an inadequate supply of a medication or medication shortage is discovered at the time of medication administration, staff should immediately take action to notify the pharmacy.<br><br>2) If the medication has not been ordered staff should place the order or reorder for the next scheduled delivery.<br><br>3) If the next available delivery causes delay staff should obtain the medication from the Omnicell.<br><br>4) If the medication is not available in the Omnicell staff should call the pharmacy emergency answering services to arrange for an emergency delivery, if medically necessary.<br><br><Resident 1><br><br>(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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the medical record showed Resident 1 had diagnoses of heart and lung problems and diabetes. Review of Resident 1's comprehensive assessment, dated 12/10/2024, showed the resident had no cognitive impairments. Review of the resident's plan of care, dated 02/08/2022, showed they required one staff to assist with turning in bed, dressing, toileting and transfers. Review of the resident's plan of care, dated 01/26/2024, showed they were on narcotic pain medication for pain to their right foot.<br><br>Review of physician's orders, dated 11/29/2024, showed Oxycodone (narcotic pain medication) 10 milligrams (mgs) was ordered to be given every four hours as needed for pain.<br><br>Review of the facility Narcotic Log showed the last dose of Oxycodone, ordered for Resident 1, was administered to them on 12/25/2024 at 7:21 PM by Staff A, Agency Licensed Practical Nurse. The next supply of Oxycodone for Resident 1 did not arrive to the facility from the pharmacy until the late evening hours of 12/27/2024 (over two days later).<br><br>Review of Resident 1's December 2024 Medication Administration Record (MAR) showed Staff A administered Oxycodone 10 mgs on 12/26/2024 at 2:08 AM and 12/27/2024 at 12:46 AM despite no Oxycodone being available in Resident 1's medication supply.<br><br>Review of Progress Notes, dated 12/28/2024 at 2:56 AM, documented by Staff C, Registered Nurse (RN), showed Resident 1 was taken to the ER by ambulance at 11:00 PM on 12/27/2024 per their request due to complaints of excruciating pain in various body parts and their Oxycodone supply not being in the facility as the pharmacy had not made their delivery yet.<br><br>Observation of Resident 1 on 01/13/2025 at 1:05 PM, showed they were having respiratory distress and were not responding to questions. An oxygen mask was applied by staff due to low oxygen readings using a nasal cannula. Staff were unable to get the resident out of bed due to their change of condition.<br><br>On 01/13/2025 at 5:30 PM, Staff A, stated they had called Staff B, Director of Nursing, on 12/26/2024 during the night shift as there was no Oxycodone to administer to Resident 1 and they did not have an authorization code to use the Omnicell as they were agency staff. Staff B instructed Staff A to determine if there were any other residents in the facility with a supply of Oxycodone 10 mgs. Staff A could then borrow that medication and administer it to Resident 1. Staff A stated they were not comfortable with those instructions but did borrow from another resident. During the night shift on 12/27/2024 Staff A stated they again borrowed Oxycodone from another resident to administer to Resident 1. Staff A stated they reordered Oxycodone from the pharmacy on the night shift of 12/27/2024.<br><br>On 01/13/2025 at 9:00 AM, Staff B, stated Staff A had called them during the early morning hours of 12/26/2024 asking what to do regarding Resident 1's Oxycodone as there was no supply. Staff B stated they authorized Staff A to borrow Oxycodone from other residents and they would ensure it was replaced. Staff B verified Resident 1 was transferred to theER on the evening shift of 12/27/2024 as the pharmacy had not yet delivered the Oxycodone supply for the resident. Resident 1 wanted to go to the ER rather than wait for the Oxycodone to be delivered to the facility. Staff A did not have an authorization code for the Omnicell and Staff C also did not have a code as they were new to the facility (date of hire was 11/20/2024).<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 01/16/2025 at 1:50 PM, Staff C, stated Resident 1's pain level was 10 out of 10 (pain scale with 0 being no pain and 10 being excruciating pain) and they were crying at the time they were transferred to the ER the evening of 12/27/2024. The resident requested to be transferred to the ER rather than wait for the Oxycodone supply to be delivered by the pharmacy. Staff C stated at the time of Resident 1's transfer to the ER they had not received an authorization code to utilize the facility Omnicell. Twenty minutes after the resident was transferred to the ER their supply of Oxycodone was delivered to the facility.<br><br>On 01/13/2025 at 11:56 AM, the supervisor at the consulting pharmacy, stated due to the holiday schedule the pharmacy was closed on 12/25/2024 and no medication deliveries were made. They stated when staff did not have an authorization code to utilize the Omnicell Staff B could have called the pharmacy and they would have provided a temporary code for agency licensed nurses (LNs). Also Staff B or another LN with authorization codes could have come to the facility and obtained the narcotic from the Omnicell rather than borrowing from another resident or transferring them to the ER. In addition, management staff, in reviewing staff schedules, should have realized they had agency staff working during the holidays so they could have called the pharmacy and obtained a three day temporary code to enable them to access the Omnicell.<br><br>On 01/13/2025 at 12:50 PM, a consulting pharmacy staff member, stated staff could call and reorder narcotic medications when seventy-five percent of the medication quantity had been used. Pharmacy holiday notices were sent out to facilities regarding their schedule prior to the Thanksgiving day holiday and then weekly thereafter in the delivery packets, and daily during the week of Christmas.<br><br>Reference (WAC) 388-97-1620(2)(b)(ii) |