Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505070	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Richland	44 Goethals Drive Richland, WA 99352

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 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. 45117 Based on observation, interview, and record review, the facility failed to identify, accurately assess, and provide sufficient supervision to prevent elopement (a resident leaving the facility unsupervised and undetected) for 2 of 3 residents (Resident 1 and 2) reviewed for elopement. This failure placed the residents at risk for exposure to the elements, serious harm, and/or death. Findings included . Review of a policy titled, Unsafe Wandering and Elopement Prevention, dated 12/13/2018 and revised 03/04/2025, showed the facility would ensure residents were assessed to determine the risk of elopement and implement interventions to mitigate the identified risks. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including dementia (a group of conditions that cause a decline in memory, thinking, language, and problem solving that interferes with daily life), delirium (a serious, sudden change in mental abilities characterized by confused thinking, disorientation, and a decreased awareness of surroundings), attention-deficit hyperactivity disorder (persistent patterns of inattention, hyperactivity, and/or impulsivity that interfere with daily functioning), and anxiety. The 02/28/2025 comprehensive assessment showed Resident 1 required supervision/moderate assistance of one staff member for activities of daily living (ADLs) and substantial/maximal assistance of one staff member for transfers and ambulation. The assessment also showed Resident 1 had a moderately impaired cognition. (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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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a nursing evaluation titled, Elopement Risk, dated 01/14/2025 showed Section A, Elopement Risk Evaluation contained seven questions related to identifying risks for elopement. Question two, Is the resident cognitively impaired with poor decision-making skills (i.e., intermittent confusion, cognitive deficits, or disoriented), or have a diagnosis of Dementia, OBS[(organic brain syndrome) a mental disorder that causes impairment of intellectual functioning, behavior, mood, or judgement], Alzheimer's (a progressive disease that destroys memory and other important mental functions), Delusions, Hallucinations (seeing, hearing, or feeling things that don't exist), Anxiety Disorder, Manic Depression, Schizophrenia (a mental disorder that disrupts thought processes, perceptions, emotional responses, and social interactions)? was answered Yes. Section B of the form showed Summary of Findings, and question one showed Resident is at risk for elopement at this time? (any yes answer would indicate that this resident is a potential for elopement). Although Resident 1 had qualifying diagnoses related to elopement, Section B, question one was answered No. Record review of a second nursing Elopement Risk evaluation, dated 02/26/2025, was completed when Resident 1 had returned from a hospital stay. The evaluation showed Resident 1 had no qualifying diagnoses and was not at risk for elopement. Record review of a facility investigation dated 03/02/2025 at 2:44 PM, showed facility staff responded to a door alarming on 03/02/2025 at 7:15 AM. A missing resident code was called when there was no one seen at the exit and a wheelchair was found without a resident. Staff located the eloped resident within about three minutes and Resident 1 was returned to the facility. Record review of Resident 1's care plan, last reviewed on 01/29/2025, showed there were no focus areas, goals, or interventions for prevention of elopement until a revision was completed on 03/02/2025, after Resident 1 had eloped from the facility. During an interview on 03/11/2025 at 4:03 PM, Staff B, Licensed Practical Nurse, stated Resident 1 wandered all over the place since their admission to the facility. They stated Resident 1 was disorientated, had no safety awareness, and would get up at night and wander the halls. During an interview on 03/12/2025 at 1:38 PM, Staff C, Nursing Assistant, stated after Resident 1 came back from the hospital stay (02/26/2025), they were always exit seeking. They stated, about every other day Resident 1 would try to leave the facility. During an interview on 03/12/2025 at 8:50 AM, Staff D, Registered Nurse, stated Resident 1 would impulsively walk independently throughout the facility. They stated the resident was not cognitively intact but could make their needs known. Staff D stated prior to Resident 1's hospital stay, there were times they would become anxious and would exit seek. Staff D stated when Resident 1 returned from the hospital, their impulsiveness drastically increased and staff were unable to redirect the resident. Staff D stated Resident 1 had wandering behaviors in the hallways prior to their hospitalization , but afterwards, they were wandering into other resident rooms and other hallways in the facility. Staff D stated there were times they were afraid Resident 1 was going to leave the facility. <Resident 2> (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 medical record showed Resident 2 was admitted to the facility with diagnoses including anxiety and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). The 12/12/2024 comprehensive assessment showed Resident 2 required substantial/was dependent on one to two staff members for ADLs. The assessment also showed Resident 2 had a severely impaired cognition, was easily distracted, and had difficulty focusing their attention. Record review of Resident 2's Elopement Risk form dated 12/10/2024, showed they had qualifying diagnoses indicative of an elopement risk. The summary of findings showed No the resident was not at risk for elopement. Record review of a second Elopement Risk form dated 03/02/2025, showed Resident 2 had qualifying diagnoses, was able to independently ambulate, and had wandering behaviors. The summary of findings showed Resident 2 was an elopement risk and the 12/29/2024 care plan had been updated with a focus area, goals, and interventions to prevent elopement. During an interview on 03/11/2025 at 4:12 PM, Staff A, Director of Nursing, stated the process for identifying elopement risks included completing the elopement risk evaluation during the admission process. They stated they updated the elopement risk evaluation as needed, especially with a change in condition. Staff A stated the care plan would be updated with that change, the resident would be put on alert charting, and behavior monitoring. They stated the resident's photo would be put into the elopement binder along with their demographic sheet and care plan. Staff A stated there was a book located at each nursing station and the front desk. Staff A stated Resident 1 and Resident 2 had not been identified as elopement risks during the admission process. They stated Resident 1 was identified as an elopement risk after they had eloped. Staff A stated the process for identifying a change in resident behaviors included the nursing staff reporting their concerns to Staff A. They stated prior to Resident 1's elopement, they discussed their increased behaviors in their morning team meeting and had told the unit manager to update Resident 1's care plan to reflect the increased risk for elopement. Staff A stated the care plan had not been updated until they completed it, after Resident 1 eloped. During a follow up interview on 03/12/2025 at 3:18 PM, Staff A stated Resident 2 was not identified as an elopement risk until they had completed an audit of all residents, after Resident 2 had eloped. Reference: WAC 388-97-1060(3)(g) This is a repeat deficiency from the Statement of Deficiencies dated 12/05/2024.