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	08/12/2025

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. (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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(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	Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent elopement (a resident leaving the facility unsupervised and undetected) for 1 of 2 residents (Resident 1) reviewed for avoidable accidents. This failure placed the residents at risk for exposure to extreme weather temperatures, serious injury, and/or death. Findings included . Review of a policy titled, Incident and Reportable Event Management, revised 08/15/2023, showed an avoidable accident was an accident that occurred when the facility failed to implement interventions, including adequate supervision consistent with the resident's needs, goals, care plan, and current professional standards of practice to eliminate and/or reduce the risk of an accident. <Resident 1>Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including broken pelvic bones, Alzheimer's disease (a progressive brain disorder that gradually impairs memory, thinking, and the ability to carry out simple tasks), and difficulty walking with a history of falls. The 06/04/2025 comprehensive assessment showed Resident 1 required partial/moderate assistance of one staff member for transfers and walking and used a walker and/or wheelchair for mobility. The assessment also showed Resident 1 had a severely impaired cognition. An observation on 08/11/2025 at 2:30 PM showed Resident 1's room, the day of the elopement, was located across from the nurse's station, next to the exit door. The exit led to the parking lot of the facility with access to the neighboring parking lots and main road. Record review of a nursing evaluation titled, Elopement Risk Evaluation, dated 06/03/2025, showed Resident 1 had been identified as an elopement risk due to their cognitive impairment, ability to walk independently, and wandering behaviors. Record review of Resident 1's care plan dated 06/03/2025, revised on 07/14/2025, showed a focus area identifying Resident 1's risk for elopement and interventions that included adding their information to the elopement binder (a book located at the nurses stations that contained a photo and identifying information for resident's identified at risk for elopement), monitoring and documenting wandering behaviors, participation in activities to divert exit seeking behaviors, hourly safety checks, and providing structured activities such as toileting, walking inside/outside, and reorientation strategies that included signage, pictures, and memory boxes. Record review of a facility investigation dated 08/07/2025, showed on 08/02/2025 at 3:05 PM, Resident 1 was returned to the facility by Staff C, Activities Assistant. Resident 1 had been found walking on the sidewalk in the opposite direction of the facility, 0.8 miles away. The investigation showed a newly employed licensed nurse had opened the door for Resident 1 when they approached the door and stated, I'm just going out for my walk. Resident 1 had been let out of the facility at 2:15 PM and returned at 3:05 PM. The investigation showed the new employee was not aware that Resident 1 was an elopement risk. During an interview on 08/11/2025 at 2:15 PM, Staff D, Licensed Practical Nurse, stated they were new to the facility and had been working there for about two weeks. Staff D stated on their first day working with residents, Resident 1 had approached them at the exit door near the resident's room. They stated Resident 1 wanted to go outside for a walk. Staff D stated they put the code in to disarm the alarm and opened the door for Resident 1. They stated Resident 1 had no identification such as a wrist band that indicated they were a resident. Staff D stated they were unfamiliar with the residents since it was their first day working with them. Staff D stated they received elopement training during their orientation on the two days prior to Resident 1's elopement. Staff D stated, this was all on me, I let Resident 1 out, I didn't know my residents. During an interview on 08/12/2025 at 1:03 PM, Staff E, Registered Nurse, stated they were training Staff D the day Resident 1 eloped. They stated when Resident 1 was returned to the facility by a staff member and observed them being sweaty. Staff E stated Resident 1 had been identified as exit seeking and staff were aware of those behaviors. Staff E stated Staff D was a new employee and had stated they did not know Resident 1 was a resident and had let them out the door. Staff E was unaware that Resident 1 had left the facility until they had been returned by Staff C. During an interview on 08/11/2025 at 2:27 PM, Staff C stated they were driving home after leaving work at 3:00 PM on 08/02/2025 and saw Resident 1 walking on the sidewalk. They stated Resident 1 was hot, breathing heavy, and sweating. Staff C stated they opened their car door and Resident 1 got in and asked, are we going to Seattle? Staff C returned Resident 1 to the facility, took them to their room, and provided cool water. They stated they informed Staff E, Registered Nurse, who was unaware that Resident 1 had left the facility. During an interview on 08/12/2025 at 1:17 PM, Staff B, Director of Nursing, stated Resident 1 had been assessed and identified as an elopement risk on admission. There were care plan interventions in place to prevent elopement. They stated Staff D, who was a new employee, had seen Resident 1 at the exit door