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	12/03/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an incident involving a missing resident to the administrator, local law enforcement, and the State Agency (SA) for 1 of 2 residents (Resident 1) reviewed for missing residents. This failure disallowed the administrator to conduct a thorough investigation, local law enforcement to assist in the search for Resident 1, and lack of oversight from the SA.Findings included. A review of the Nursing Home Guidelines or The Purple Book, dated October 2015, showed that facilities were required to report a missing resident to Law Enforcement and the State Agency Hotline. Resident 1Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including aftercare for hip replacement surgery, bipolar disorder (a lifelong mental health condition causing extreme mood swings, from manic highs [euphoria, high energy, impulsivity] to depressive lows [sadness, fatigue, hopelessness], significantly affecting energy, mood, and daily functioning), and anxiety. The 11/01/2025 comprehensive assessment showed Resident 1 required partial/moderate assistance of one staff member for transfers, bed mobility, lower extremity dressing, and toileting hygiene. The assessment also showed Resident 1 had a moderately impaired cognition. Review of a nursing progress note (PN) dated 11/03/2025 at 5:09 PM, showed Resident 1 left the facility at 9:30 AM with a friend to pay their rent and would return in a couple hours. The PN showed Resident 1 had not yet returned to the facility. There was no documentation that the Administrator or law enforcement had been notified. Review of a NP note dated 11/04/2025 at 3:00 AM, showed Resident 1 had still not returned to the facility. There was no documentation that the Administrator or law enforcement had been notified. During an interview on 12/03/2025 at 2:20 PM, Staff B, Director of Nursing, stated at the time, they had not considered Resident 1 as missing. During an interview on 12/03/2025 at 3:06 PM, Staff A, Administrator, stated they were unaware that Resident 1 was missing. They stated the facility would have followed the process for reporting and investigation if they had known. Refer to F689 for further information. Reference: WAC 388-97-1620(7)(b)

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement an effective discharge plan that included education for care and maintenance of an indwelling urinary catheter ([IUC] a flexible tube inserted into the bladder to drain the urine) and ensuring home health services were provided for 1 of 3 residents (Resident 3) reviewed for discharge planning. This failure placed the resident at risk of serious injury, rehospitalization, and lack of necessary care and services after discharge.Findings included. Review of the policy titled, Discharge Planning Process, reviewed 08/29/2025, showed the process included caregiver support and referrals to local contact agencies. The process focused on the residents' discharge goals and preparation for the residents to effectively transition them to post-discharge care. Document any referrals to local agencies/appropriate entities based on the residents' choices. Resident 3Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including diabetes (a group of diseases that result in too much sugar in the blood), heart failure, and urinary retention (inability to fully empty the bladder). The 10/21/2025 comprehensive assessment showed Resident 3 required moderate/maximum assistance of one staff member for activities of daily living. The assessment showed Resident 3 had an IUC and a moderately impaired cognition. Record review of physician discharge orders dated 10/20/2025, showed Resident 3 required PT (physical therapy) and OT (occupational therapy) eval(uation) and treat for physical debility. Skilled nursing for medication management and post discharge assessment. Record review of a Discharge summary dated [DATE], showed Resident 3 was discharging to home with an IUC in place and would be set up with home health services. There was no documentation that Resident 3 or the Resident Representative (RR) had received education regarding necessary care and maintenance of the IUC. During an interview on 12/02/2025 at 3:42 PM, the RR stated they were the caregiver for Resident 3 after they discharged from the facility on 10/21/2025. They stated they were not provided with any education on the care of the IUC and were not familiar with how to maintain it. They stated they did not receive home health services and Resident 3 had to return to the hospital due to a decline in their health. During an interview on 12/03/2025 at 1:30 PM, Staff G, Licensed Practical Nurse/Unit Care Coordinator, stated the process for discharging a resident included providing education for individualized specialty needs such as diabetic care. Staff G stated they did not recall providing any education/training to Resident 3 or the RR regarding care of the IUC. During an interview on 12/03/2025 at 11:59 AM, Collateral Contact (CC), Home Health Representative, stated they were unable to locate a referral for Resident 3. They stated their process for documentation of referrals included keeping the originals on file. They stated if they did not accept the referral, there would be documentation/notes in their system reflecting that. The CC stated they had nothing on file for Resident 3. During an interview on 12/03/2025 at 2:30 PM, Staff H, Social Services Director, stated they were responsible for sending the referral for home health services. The process included sending the referral by fax or email and receiving confirmation of receipt. Staff H stated they had no documentation that the referral had been completed. During an interview on 12/03/2025 at 2:03 PM, Staff B, Director of Nursing, stated anytime there was a resident discharging with equipment needs, diabetes, oxygen use, etcetera, education should be completed on discharge with return demonstration by the resident and/or their representative. Staff should have reviewed IUC care and emptying of the bag with Resident 3 and their RR. Staff B stated they were unable to locate any documentation that the education/training had been completed. During an interview on 12/03/2025 at 3:06 PM, Staff A, Administrator, stated Social Services was responsible for completing the home health referrals upon discharge. Staff A stated they needed to look into why the referral was not completed. Reference: WAC 388-97-0120(3)(a)

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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)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide adequate supervision and notification to administrative staff and local law enforcement for 1 of 3 residents (Resident 1) reviewed for elopement. This failed practice placed the residents at risk for serious injury and/or exposure to the elements.Findings included. Review of a policy titled, Missing Residents/Actual Elopement Event, reviewed 04/03/2024, showed elopement occurred when a resident left the facility without authorization (an order for discharge or leave of absence) and/or necessary supervision. A resident with decision making capability's, who chose to leave the facility intentionally would not be considered an elopement unless the facility is unaware of the resident's departure and/or whereabouts. If staff were unable to account for the whereabouts of a resident during the course of the day, the sign out log should be reviewed to determine if the resident/representative had signed out of the facility. The Executive Director or representative and department heads would be notified that the resident cannot be located. A search of the facility and facility grounds would be conducted, and law enforcement would be notified. Resident 1Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including aftercare for hip replacement surgery, bipolar disorder (a lifelong mental health condition causing extreme mood swings, from manic highs [euphoria, high energy, impulsivity] to depressive lows [sadness, fatigue, hopelessness], significantly affecting energy, mood, and daily functioning), and anxiety. The 11/01/2025 comprehensive assessment showed Resident 1 required partial/moderate assistance of one staff member for transfers, bed mobility, lower extremity dressing, and toileting hygiene. The assessment also showed Resident 1 had a moderately impaired cognition. Review of the facility's Resident Sign In/Out Log showed Resident 1 had signed out of the facility on 11/03/2025 at 9:00 AM to pay rent. There was no documented time in, showing when Resident 1 returned to the facility. Review of Staff D's, Registered Nurse, nursing progress (NP) note dated 11/03/2025 at 5:09 PM, showed Resident 1 stated they would be going home and would not be coming back. The PN showed after receiving education, Resident 1 agreed to wait for a provider and therapy to clear them for discharge. Resident 1 stated a friend was going to pick them up, they were going to go pay their rent and would be back in a couple hours. Resident 1 left at 9:30 AM and had not returned to the facility. Review of Staff E's, Licensed Practical Nurse (LPN), NP note dated 11/04/2025 at 3:00 AM, showed Resident 1 was out of facility. Review of a NP note dated 11/04/2025 at 8:10 AM, showed Staff C, LPN/Unit Care Coordinator, received a call at the nurse's station from Resident 1, who stated they were at home. Resident 1 reported they had signed out of the facility the previous day to visit home with a friend but currently had no transportation back to the facility. Resident 1 further stated they were unable to ambulate or transfer from the bed to the wheelchair independently. Staff C contacted 911 to arrange transportation to the emergency room for further evaluation due to a decline in Resident 1's activities of daily living functioning. During an interview on 12/03/2025 at 11:03 AM, Staff D stated on 11/03/2025, Resident 1 told them they were going to the bank to pay their rent. Staff D stated Resident 1 had not returned by 5:30 PM. They stated they did not try to call Resident 1 to see where they were. Staff D stated they told the night shift nurse that Resident 1had not returned from their outing. During an interview on 12/03/2025 at 12:46 PM, Staff E stated Resident 1 had left the facility prior to the start of their shift. They stated they were waiting for Resident 1 to return. Staff E stated they did not try to call Resident 1. They stated they did not know if anyone knew where Resident 1 was. During an interview on 12/03/2025 at 1:17 PM, Staff C stated they had received a call from Resident 1. They stated Resident 1 was at their apartment and unable to move from the bed to their wheelchair. Staff C stated they had called 911 to enter Resident 1's apartment and transport them to the emergency room for an evaluation because they were unable to transfer themselves and that was a change in condition from the previous day. Staff C stated the process for residents leaving the facility included making sure the resident was alert and orientated, checking with therapy to ensure they were safe with transport, and signing out of the facility with an expected return time. If the resident did not return at their expected time, the facility would follow up with a phone call to see where they were. They stated if they were unable to reach the resident, the facility would initiate their missing person's protocol and contact the resident's emergency contact. Staff C stated Resident 1 was not safe at home alone. During an interview on 12/03/2025 at 1:56 PM, Staff B, Director of Nursing, stated the process for a resident that had left the facility and not returned would include calling them by the end of the business day to locate them. They stated they assumed Resident 1 had left against medical advice. Staff B stated they would have expected the nursing staff to call Resident 1 as they were clearly not safe at home by

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who had an indwelling urinary catheter (IUC, a tube placed in the bladder which drains urine out into a collection bag) received care and services to prevent urinary tract infections (UTI, a condition were bacteria enter through the urinary meatus [a passage or opening leading to the interior of the body] and infect the kidneys or bladder) for 1 of 2 residents (Resident 2), reviewed for urinary catheter care. This failure placed the residents at risk of developing serious medical complications, secondary to an infection in the bladder.Findings included. Review of a Centers for Disease Control and Prevention document titled, Indwelling Urinary Catheter Culture Stewardship: Overview, dated 03/14/2024, showed if the IUC had been in place for longer than 14 days, the IUC should be replaced prior to specimen collection. Further review showed never collect a urine culture from the collection bag. Review of a policy titled, Indwelling Urinary Catheter (Foley [a type of IUC]) Management, reviewed 09/04/2025, showed IUC and drainage bags should be changed based on clinical indications such as infection, obstruction, or when the closed system was compromised. Resident 2Review of the medical record showed Resident 2 was admitted to the facility on [DATE], with diagnoses including chronic kidney disease (moderate to severe kidney damage), neuromuscular dysfunction of the bladder (caused when an injury or disease interrupts the electrical signals between the nervous system and bladder function), and retention of urine. The 11/18/2025 comprehensive assessment showed Resident 2 required maximum assistance of one staff member for toileting/personal hygiene and bed mobility and was dependent on one to two staff members for transferring. The assessment also showed Resident 2 had no memory issues and was able to make independent decisions regarding their daily life. Record review of a nursing progress note (PN) dated 09/02/2025, showed Resident 2 had an IUC in place upon admission. Record review of a nursing PN dated 09/16/2025, showed Resident 2 was not feeling well, with episodes of confusion. The resident's provider was notified on 09/16/2025, and a new order was received to obtain a urine specimen, with culture and sensitivity (a medical test that identifies germs and effective treatments). The record showed the specimen was collected on 09/16/2025 and the resident was started on antibiotics on 09/19/2025. Record review of a nursing PN dated 09/25/2025, showed Resident 2 had continued altered mental status and a recent UTI. The resident had completed antibiotic therapy for their previous UTI on 09/24/2025 but was still symptomatic. Orders were received for a urinalysis with culture and sensitivity. The record showed the specimen was collected and the resident was started on antibiotics. Record review of the September 2025 Medication Administration Record (MAR) showed an order to change the IUC for infection, obstruction, or when the closed system was compromised. A second order showed change catheter bag as needed for infection, obstruction, or when the closed system is compromised. There was no documentation that the IUC or catheter bag was changed. Record review of a nursing PN dated 10/21/2025, showed Resident 2 was symptomatic for a UTI and a verbal order was received from the provider to collect urine for urinalysis and culture if indicated. The urine was collected, and antibiotics were initiated for Resident 2. Record review of the October 2025 MAR showed no documentation that the IUC or catheter bag had been changed. During an interview on 12/03/2025 at 1:45 PM, Staff F, Registered Nurse/Unit Care Coordinator, stated the frequency for changing IUCs included changing them as needed and with signs/symptoms of a UTI. Staff F stated there was no documentation in the medical record that the IUC was changed at the time of the UTIs. During an interview on 12/03/2025 at 2:09 PM, Staff B, Director of Nursing, stated the process for changing IUCs included changing them when the resident was started on an antibiotic. They stated the facility had a standing order for changing the IUC for obstruction and/or infection. Staff B stated the process was not followed. Reference: WAC 388-97-1060(3)(c)