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	01/15/2026

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

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a baseline care plan [(BCP) an initial, temporary plan of care, developed within 48 hours of admission to ensure immediate safety and continuity of care] that included the essential needs, physician orders, social services, and Preadmission Screening and Resident Review [(PASARR) - a federal requirement to help ensure that individuals were not inappropriately placed in nursing homes] recommendations for 3 of 3 residents (Resident 1, 2, and 3) reviewed for baseline care plan. This failure placed the residents at risk for immediate health and safety concerns.Findings included. Review of a policy titled, Baseline Care Plan, reviewed 08/29/2025, showed the facility must develop and implement a BCP for each resident that included instructions needed to provide effective, person-centered care that met professional standards of quality care. The BCP must be developed within 48 hours of admission and include the minimum healthcare information necessary to properly care for a resident, including initial goals based on admission orders, physician and dietary orders, therapy services, social services, and PASARR recommendations. Resident 1Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses including respiratory failure with hypoxia (a serious condition where body tissues don't get enough oxygen), hypoparathyroidism (a condition where the parathyroid glands do not make enough parathyroid hormone, resulting in too little calcium in the blood), anxiety, and insomnia (a sleep disorder that causes difficulty falling and staying asleep). The 01/05/2026 comprehensive assessment showed Resident 1 required set-up to partial assistance of one staff member for activities of daily living (ADLs) and supervision/touch assistance of one staff member for transfers. The assessment also showed the resident had an intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Record review of Resident 1's BCP dated 01/02/2026, provided by Staff B, Director of Nursing, showed no focus area, goals, or interventions related to Resident 1's use of quetiapine (an antipsychotic medication that works by altering brain chemicals to stabilize mood and thought processes), their use of acetazolamide (a medication used to decrease swelling caused by heart disease) for edema (swelling), Synthroid (a brand name medication used to treat low thyroid conditions), use of temazepam (a medication used short term to treat insomnia), use of hydroxyzine (a medication used to treat anxiety) or use of continuous oxygen. There were no focus areas, goals, or interventions related to Resident 1's preferences regarding medical treatments in emergent situations. The focus area for PASARR showed no information regarding Resident 1's Level II PASARR recommendations (a detailed assessments for individuals that have a potentially serious mental illness that determines if they need specialized services). Record review of Resident 1's Skilled Nursing Facility Transfer Orders, dated 01/02/2026, showed a medication order for levothyroxine 100 microgram (a unit of measure) tablet, take one tablet by mouth every morning (before breakfast) MUST BE BRAND NAME SYNTHROID. Resident 2Review of the medical record showed Resident 2 (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was admitted to the facility on [DATE] with diagnoses including care following hip replacement surgery, long term use of anticoagulants (a medication used to slow down the blood clotting process), anxiety, and depression. The 01/05/2026 comprehensive assessment showed Resident 2 required substantial assistance of one staff member for showers, lower body dressing, and transfers. The assessment also showed Resident 2 had a moderately impaired cognition. Record review of Resident 2's BCP dated 01/02/2026, provided by Staff B, showed no focus area, goals, or interventions related to Resident 2's anxiety disorder, PASARR or PASARR Level II recommendations. There were no focus areas, goals, or interventions related to Resident 2's preferences regarding medical treatments in emergent situations. Resident 3Review of the medical record showed Resident 3 was admitted to the facility on [DATE] with diagnoses including broken hip, post-traumatic stress disorder [PTSD) a mental health condition that develops after experiencing or witnessing a traumatic event], and anxiety. The 12/29/2025 comprehensive assessment showed Resident 3 required substantial/maximal assistance of one to two staff members for ADLs. The assessment also showed Resident 3 had an intact cognition. Record review of Resident 3's BCP dated 12/29/2025, provided by Staff B, showed no focus area, goals, or interventions related to Resident 3's PTSD diagnoses, or PASARR Level II recommendations. During an interview on 01/15/2026 at 11:27 AM, Staff C, Licensed Practical Nurse/Unit Care Coordinator (LPN/UCC), stated the process for completing a BCP included opening the BCP User-Defined Assessment [UDA) a template tool in the electronic medical record] and completing the assessment. They stated it was important to complete the BCP to have established goals and interventions for the staff to follow and care for the resident. Staff C stated the residents code status (preferences for medical treatment in emergent situations) did not automatically populate on the BCP UDA, and they had to manually enter it. They stated the BCP should be completed the first day a resident was admitted . Staff C stated the need for Resident 1 to have a brand name medication should have been on the BCP. During an interview on 01/15/2026 at 11:21 AM, Staff D, Social Services Director, stated they were responsible for completing the PASARR and social services area of the BCP. They stated it should include PASARR information, the residents' cognitive status, and discharge planning. Staff D stated PASARR information included the information related to the Level II PASARR, the date it had been sent out for review and any recommendations if it was received. Staff D stated for Resident 1, the Level II PASARR had been sent out by the hospital staff and that date should have been on the BCP. Staff D stated a Level II evaluation was required for Resident's 1, 2, and 3 and that information should have been on the BCP. During an interview on 01/15/2026 at 12:18 PM, Staff B stated the process for completing a BCP included filling out the BCP UDA when the resident arrives to the facility. They stated the purpose of the BCP was to establish the care and services a resident needed when they were admitted to the facility and communicate those needs to the staff. Staff B stated the resident's code status should have been on the BCP. During an interview on 01/15/2026 at 1:18 PM, Staff A, Administrator, stated the facility needed to follow the regulatory requirement to have a complete BCP for all new admits within a short amount of time after admission that included at least the basics for necessary care and services.Reference: WAC 388-97-1020(3)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure professional standards of practice were followed when nursing staff failed to accurately transcribe and follow physician orders for 1 of 3 residents (Resident 1) reviewed for medication administration. This failure placed the residents at risk for a delay in receiving medications, medication errors, and adverse outcomes. Findings included. Review of the Lippincott Manual of Nursing Practice, 11th edition, copyright 2019, Chapter 2, showed professional nursing had standards of practice that set minimum levels of acceptable performance for which practitioners were accountable. Departure of standards of care included failure to implement a provider's order properly or in a timely fashion, failure to make prompt, accurate entries in a medical record, and failure to adhere to facility policy or procedural guidelines. Review of a policy titled, Medication Reconciliation Across the Continuum of Care, revised 09/09/2025, showed upon admission or readmission to the facility, the licensed nurse would reconcile the resident's medications. The home medication list would be completed in the electronic medical record with input from the resident/representative, even if the resident was admitted from a hospital or other setting. The home medication list, the physician admitting order, and the hospital admitting form received by the licensed nurse would be reconciled, phone the provider as needed for clarification, obtain the provider orders, and update the electronic medical record. The licensed nurse would complete a medication reconciliation from in the electronic medical record. Resident 1Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses including respiratory failure with hypoxia (a serious condition where body tissues don't get enough oxygen), hypoparathyroidism (a condition where the parathyroid glands do not make enough parathyroid hormone, resulting in too little calcium in the blood), anxiety, and insomnia (a sleep disorder that causes difficulty falling and staying asleep). The 01/05/2026 comprehensive assessment showed Resident 1 required set-up to partial assistance of one staff member for activities of daily living (ADLs) and supervision/touch assistance of one staff member for transfers. The assessment also showed the resident had an intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Record review of the Skilled Nursing Facility Transfer Orders dated 01/02/2026, showed a provider order for levothyroxine (a synthetic thyroid hormone used to replace missing thyroid hormone in the body) 100 mcg (microgram - a unit of measure) tablet, take one tablet by mouth every morning (before breakfast) MUST BE BRAND NAME SYNTHROID. A second provider order showed oxycodone-acetaminophen (a powerful narcotic prescription pain medication that is used to treat moderate to severe pain) 10-325 mg (milligram - a unit of measure), take one table by mouth every four hours as needed (pain). A concurrent observation and interview on 01/08/2026 at 10:57 AM, showed Resident 1 lying in bed on their left side with their bedside table next to them. The drawers to the bedside were open; the top drawer held a clear bag that contained a prescription bottle and an inhaler (a small, handheld medical device that delivers medication directly into the lungs). There were three additional unopened boxes of prescription inhalers in the drawer. The prescription bottle was labeled Synthroid (a brand name synthetic thyroid hormone) 100 mcg. Resident 1 stated they kept their own home Synthroid medication in their drawer because the generic (levothyroxine) did not work for them. They stated they had informed the nursing staff multiple times that they needed the brand name, but they did not listen. Resident 1 stated when the staff brought the levothyroxine in to administer it, they would either throw it on the floor or in the trash can, and they would administer their own Synthroid. Resident 1 stated the nursing staff would leave the medication in the room and did not watch them take their (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications. Resident 1 stated the first day and throughout their first night at the facility, they had requested their oxycodone for pain. They stated they were told the facility did not have the medication and it would be a lengthy process to get it. Resident 1 stated they did not receive any oxycodone until the next day. During an interview on 01/08/2026 at 3:20 PM, Staff E, Licensed Practical Nurse (LPN), stated Resident 1 had requested their pain medication the morning of 01/03/2026. They stated the facility did not have the oxycodone available to administer. Staff E stated the pharmacy had not sent the medication and they needed to wait for the provider to send a prescription to the pharmacy. Staff E stated they were not able to obtain the medication from the pyxis (a locked, automated medication dispensing system that requires an authorization code to open) because they did not have an authorization code. Staff E stated they did not call the on-call provider (available 24 hours a day, seven days a week) because they were already contacted. During an interview on 01/15/2026 at 9:22 AM, Staff F, Registered Nurse, stated on 01/02/2026, they had received report from the licensed nurse that worked that evening that Resident 1's medications were not available. They stated Resident 1 had an order for oxycodone, and it was available in the pyxis, but they could not get an authorization code from pharmacy to open the pyxis. They stated unless the resident was admitted with a hard copy of the prescription or the pharmacy spoke to the provider directly, they would not be able to get the medication. Staff F stated, when in that situation, the process would have been to call the provider and have them contact the pharmacy in order to provide the medication. Staff F stated they did not call the on-call provider because calls had already been made to the on-call provider. Staff F stated Resident 1's order for thyroid medication showed levothyroxine and that was what was in the medication card. They stated Resident 1 had told them they took Synthroid. Staff F stated they saw Resident 1's bottle of Synthroid in their drawer and told the resident they could not take it from them and to have a loved one take it home for them. Staff F stated they informed Resident 1 they would need to speak to their provider about changing the order from levothyroxine to Synthroid. During an interview on 01/15/2026 at 11:39 AM, Staff C, LPN/Unit Care Coordinator, stated they usually reviewed the list of home medications with the resident and made necessary changes on the day of admission. They stated they verbally reviewed home medications with Resident 1 on 01/02/2026 and they had no concerns and there were no changes needed. They stated Resident 1 did not mention the levothyroxine order. Staff C stated when there was a specific medication, such as the use of the brand name medication, they would receive an alert from the pharmacy. They stated they did not recall receiving any alerts for Resident 1. Staff C stated the process for transcribing provider orders included one licensed nurse entering the orders into the electronic medical record, and a second licensed reviewing them for accuracy. Staff C stated they entered the initial orders and had not seen the additional note on the levothyroxine order that stated to use brand name Synthroid only. Staff C stated the process for obtaining the oxycodone for Resident 1 would have included calling the on-call provider if the medication was not available, obtain a verbal order, and obtain an authorization code from the pharmacy to pull the medication from the pyxis. Staff C stated they were unsure why the process had not been followed. During an interview on 01/15/2026 at 12:35 PM, Staff B, Director of Nursing Services, stated the process for obtaining the oxycodone would have been for the licensed nurse to contact the provider on-call to eScribe (a system that allows a provide to electronically transmit prescription requests to the pharmacy) a prescription to the pharmacy, which would allow the licensed nurse to obtain an authorization code for the pyxis to administer the medication. Staff B stated the licensed nurses should have followed that process. They stated medications were only kept at the bedside once an assessment was completed, a physician order was obtained, and the care plan was (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updated. They stated once it was determined a resident was able to self-administer medications, they would be provided with a lock box with a key to ensure the medications were properly stored. Staff B stated the process and importance of reviewing home medications with the resident was to ensure accuracy. During an interview on 01/15/2026 at 1:18 PM, Staff A, Administrator, stated the facility needed to follow the regulatory requirements for medication reconciliation and administration. Reference: WAC 388-97-1620(1)(2)(i)(ii)(6)(i)(ii)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician ordered physical therapy (PT) was received in a timely manner for 2 of 3 residents (Residents 1 and 2) reviewed for specialized rehabilitation services. This failure placed the residents at risk for decline in function and/or not achieving the highest practicable level of physical, mental, and functional well-being. Findings included . Review of a policy titled, Specialized Rehabilitative Services, revised 09/04/2025, showed the facility would ensure that each resident received specialized rehabilitative services to assist them to attain, maintain, or restore their highest level of physical, mental, functional and psychosocial well-being. Resident 1Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses including respiratory failure with hypoxia (a serious condition where body tissues don't get enough oxygen), metabolic encephalopathy (a change in how your brain works due to an underlying condition), and anxiety. The 01/05/2026 comprehensive assessment showed Resident 1 required set-up to partial assistance of one staff member for activities of daily living (ADLs) and supervision/touch assistance of one staff member for transfers. The assessment also showed the resident had an intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Record review of the Skilled Nursing Facility Transfer Orders dated 01/02/2026, showed an order for physical therapy (PT) and occupational therapy evaluation and treat. Record review of the medical record showed Resident 1 received their initial PT and OT evaluations and treatment plan on 01/06/2026, five days after their admission to the facility. During an interview on 01/08/2026 at 10:57 AM, Resident 1 stated they were not getting much therapy and would be better off at home doing their own therapy. Resident 2Review of the medical record showed Resident 2 was admitted to the facility on [DATE] with diagnoses including care following hip replacement surgery, long term use of anticoagulants (a medication used to slow down the blood clotting process), anxiety, and depression. The 01/05/2026 comprehensive assessment showed Resident 2 required substantial assistance of one staff member for showers, lower body dressing, and transfers. The assessment also showed Resident 2 had a moderately impaired cognition. Record review of the medical record showed Resident 2 received their initial PT evaluation and treatment plan on 01/05/2026, four days after their admission to the facility, and their initial OT evaluation and treatment plan on 01/06/2026. Resident 2 discharged home on [DATE] after receiving one 37-minute PT treatment on 01/06/2026, and one 30-minute OT treatment on 01/07/2026. During an interview on 01/08/2026 at 11:56 AM, Resident 2 stated they were admitted to the facility after having their hip replaced. They stated they received their first physical therapy session on Monday (01/05/2026) and that had put them back a few days. Resident 2 stated they wished they had physical therapy starting on Friday (day of admission). They stated the facility staff told them Staff E, Director of Rehabilitation, was not there on Friday and they could not have therapy that day. During an interview on 01/15/2026 at 10:49 AM, Staff E stated the facility was short PT staff. They stated their full-time PT staff work Monday through Thursday and if a resident were admitted on a Friday, they would have to wait until Monday for their therapy evaluations. Staff E stated the professional standard for therapy evaluations was to complete them within 3 days of admission. During an interview on 01/15/2026 at 1:06 PM, Staff A, Administrator, stated their expectation was to complete therapy evaluations in a timely manner, within the capacity of the facility to provide them. Staff A stated their understanding was to have therapy evaluations completed within the first three days of admission. They stated they were aggressively trying to obtain additional therapy staff to ensure the residents were receiving their therapy evaluations within the regulatory requirement. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC: 388-97-1280(1)(a)(b)(2)