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	05/06/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to ensure timely notification of changes in a resident's condition for 1 of 5 residents (Resident 1) reviewed for falls. Specifically, a nursing assistant failed to promptly report a resident's fall, resulting in delayed assessment, monitoring, intervention, and required notifications. This failure placed the residents at risk for undetected or worsening injuries, delayed medical intervention, and serious complications.Findings included. Review of a policy titled, Change in Status, Identifying and Communicating, Long Term Care, revised 09/15/2026, showed every health care team member is responsible for communicating a resident's change in status from baseline. However, the nursing assistant is typically the first to notice a change in a resident's status because the nursing assistant usually spends more time with the resident than other health care team members.a nursing assistant who notices such status changes should immediately report them to a nurse.vague, subjective communication may lead to misdiagnosis and delayed treatment. Resident 1Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including chronic kidney disease (long term, irreversible loss of kidney function), lower back pain, and an irregular heartbeat. The 04/21/2026 comprehensive assessment showed Resident 1 was independent with activities of daily living (activities related to personal care). 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). Review of a facility investigation dated 05/06/2026, prepared by Staff C, Registered Nurse, showed Resident 1 had an unwitnessed fall as they had self-transferred from their bed to their wheelchair and slipped on the floor on 05/01/2026 at 12:00. The investigation showed the resident stated they slipped and fell, were ok and had gotten up by themselves. Resident 1 complained of hip pain rated at 10/10 on the pain scale (a tool used by healthcare providers to quantify a patient's subjective pain intensity with zero indicating no pain and 10 indicating the worst imaginable pain). They had mild confusion. The provider was notified and an order was obtained for an x-ray. Record review of a witness statement dated 05/01/2026, written by Staff D, Nursing Assistant, showed Resident 1 was getting into their wheelchair and slipped down. They documented the resident got up by themselves. Review of a nursing progress note dated 05/01/2026 at 3:01 PM, Staff C documented that the resident was self-transferring and slipped to the floor, despite their investigation initiated at 12:00 PM that same day. Record review of an emergency medical service provider report dated 05/01/2026, showed they were notified of a need for transport to the emergency room at 3:35 PM. The report showed the facility staff reported they were assisting the resident from the wheelchair to the bed when they fell to the ground and had a change in mental status. Facility staff stated there was no trauma during the fall. Record review of hospital records dated 05/01/2026 at 5:58 PM, showed Resident 1 was admitted to the hospital with diagnoses of a right femur fracture (a serious break or crack in the right thighbone, typically resulting from high-impact trauma like car crashes or falls) and acute metabolic encephalopathy (a change in how your brain works due to an underlying condition) possible from pain and fall. During an interview on 05/06/2026 at 10:16 AM, Resident 1's Representative (RR) stated they had arrived at the facility on 05/01/2026 between 11:30 AM and 12:00 PM. They stated Resident (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 had told them they had fallen earlier that morning. The RR had helped Resident 1 to the restroom because they were unable to bear weight on their right leg, which was unusual for the resident. They stated they were ready to leave the facility and needed help getting Resident 1 back into bed. The RR stated they approached Staff E, Licensed Practical Nurse/Unit Care Coordinator, and told them Resident 1 stated they fell that morning. Staff E stated they were not aware of a fall and asked Staff D (who was caring for Resident 1 that day) if Resident 1 fell that morning. The RR stated Staff D told Staff E that the resident had fallen, got back up, and told Staff D not to tell anyone they fell. During an interview on 05/06/2026 at 10:49 AM, Staff D stated they had seen Resident 1 on the floor last week. They stated they were in Resident 1's room making their bed. Staff D stated they had turned around and saw that Resident 1 had slipped and got themselves back up. They stated Resident 1 was good and had gotten back into their wheelchair. Staff D stated the incident occurred around 1:40 PM. Staff D stated they had many things going on that day and forgot to report the incident to the nurse. They stated, I should have reported it. During an interview on 05/06/2026 at 12:27 PM, Staff E stated the RR approached them around 2:30 PM on 05/01/2026 and asked if Resident 1 fell. They stated they were not aware of a fall and would check into it. Staff E stated they asked Staff C if they were aware of the fall and were told no. They stated both Staff E and Staff C approached Staff D and questioned them about Resident 1 falling. Staff D told them the resident fell around lunchtime and had gotten themselves up. Staff D stated they helped Resident 1 back into their wheelchair. Staff D also stated that Resident 1 told them not to tell a nurse that they fell. Staff E stated Staff D knew Resident 1 had fallen and had not reported it to any licensed nurse. They stated Resident 1 went without assessments from the time of the fall at approximately 11:30 AM to 12:00 PM until three hours later when they were notified of the fall. Staff E stated Staff D should have immediately called for assistance when Resident 1 fell so assessment could have been completed and treatment could have been initiated. During an interview on 05/06/2026 at 3:36 PM, Staff B, Director of Nursing, stated when a resident had a fall, the process would be to call for assistance over the radio. A licensed nurse would immediately complete an assessment to determine if they were safe to help them up, notify the provider, and send them to the emergency department if necessary. They stated the staff did not entirely follow the process and improvements should be made. During an interview on 05/06/2026 at 3:49 PM, Staff A, Administrator, stated the process should have been for Staff D to report the fall to the nurses. They stated the process was not followed. Reference: WAC 388-97-0320(1)(a)

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. Based on interview and record review, the facility failed to ensure nursing assistants were verified on the state Nurse Aide Registry prior to start of employment for 1 of 3 staff (Staff D) reviewed for staff qualification and background review. This failure placed the residents at risk for poor care, injury, and negative outcomes.Findings included. Review of a policy titled, Abuse - Screening of Employees and Residents, reviewed 04/01/2026, showed the facility may not employ individuals that had been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of property, or have a disciplinary action in effect against their professional license by a state licensure body. Record review of a personnel file for Staff D, Nursing Assistant (NA), showed they were hired on 03/26/2026. There was no documentation that they were on the Omnibus Budget Reconciliation Act registry [(OBRA) a state-operated database that tracks the credentials, training, and competency evaluations of certified nursing assistants to ensure they meet federal requirements] as required. During an interview on 05/06/2026 at 2:46 PM, Staff H, Staffing Coordinator, stated there was no record of Staff D on the state registry. They stated there had been some switching of positions at the facility and it got missed. During an interview on 05/06/2026 at 3:36 PM, Staff B, Director of Nursing, stated OBRA registry verification was completed prior to moving forward in the hiring process. They stated the verification should have been completed prior to starting orientation and were unsure of how the failure occurred. Staff B stated there should be a process in place to verify the nursing assistance OBRA status before starting work. Reference: WAC 388-97-1660(3)(c)