

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Richland		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of bed-hold (holding or reserving a resident's bed while the resident is absent from the facility) at the time of transfer to the hospital for 3 of 3 residents (Resident 1, 2, and 3) reviewed for hospitalization. This failure placed the residents at risk of not having the necessary information to make an informed decision regarding their ability to return to the facility. Findings included. Review of a policy titled, Bed-Hold Policy, revised 08/05/2025, showed the bed-hold policy should be given upon admission, upon transfer of a resident to the hospital (if in an emergency within 24 hours). The facility will provide written information to the resident or their representative of the nursing facility policy on bed-hold periods and the residents return to the facility, to ensure that residents are made aware of the bed-hold and reserve bed payment policy before, and upon transfer to a hospital. Resident 1 Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including healing of a broken leg, anxiety (a group of mental health conditions that cause excessive, ongoing fear and worry that are hard to control and interfere with daily life), and vision loss in both eyes. The 07/23/2026 comprehensive assessment showed Resident 1 was dependent on one to two staff members for activities of daily living [(ADLs) activities related to personal care]. The assessment also showed Resident 1 had a moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Review of nursing progress notes (PN) dated 07/28/2026 at 9:32 AM, showed Resident 1 was transferred to the hospital for evaluation for a change in condition. Record review of the medical record showed there was no documentation that a written notice of bed-hold was provided to the resident and/or their representative at the time of transfer as required. Resident 2 Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including metabolic encephalopathy (a change in how your brain works due to an underlying condition), kidney disease, and generalized muscle weakness. The 06/17/2026 comprehensive assessment showed Resident 2 required partial assistance/was dependent on one to two staff members for ADLs. The assessment also showed Resident 2 had a severely impaired cognition. Record review of a facility transfer form dated 07/26/2026, showed Resident 2 had an unplanned transfer to the hospital for uncontrollable pain. Record review of the medical record showed there was no documentation that the required notice of bed-hold was provided to the resident and/or their representative at the time of transfer. During an interview on 07/30/2026 at 12:14 PM, Resident 2's Representative stated they were present at the facility when Resident 2 was transferred to the hospital on [DATE]. They stated that they did not receive a notice of bed-hold at that time. Resident 3 Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including respiratory failure, diabetes (a condition where blood sugar levels are too high), (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and heart failure. The 07/14/2026 comprehensive assessment showed Resident 3 was dependent on one to two staff members for ADLs. The 07/20/2026 cognitive assessment showed Resident 3 had an intact cognition. Record review of a facility transfer form dated 07/14/2026, showed Resident 3 had an unplanned transfer to the hospital for evaluation related to fever, altered mental status, and pain. Record review of the medical record showed there was no documentation that the required notice of bed-hold was provided to the resident and/or their representative at the time of transfer. During an interview on 07/30/2026 at 1:36 PM, Resident 3's representative stated they did not receive a notice of bed-hold when Resident 3 went to the hospital on [DATE]. During an interview on 07/30/2026 at 2:59 PM, Staff A, Director of Nursing, stated the nurses were responsible for ensuring the notice of bed-hold was provided to the resident and/or their representative upon transfer, or within 24 hours if an emergent transfer. They stated they were unable to locate the notice of bed-hold for Resident 1, Resident 2, or Resident 3. Staff A stated the process for providing notice of bed-hold was not followed. This is a recurring deficiency previously cited in the Statement of Deficiencies dated 07/23/2025. Reference: WAC 388-97-0120(4)		

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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 interviews and record review the facility failed to provide notification to the residents' representative of a significant change in condition for 1 of 3 residents (Resident 1) reviewed for notification of changes. This failure placed the residents at risk of not having their representative involved in health care decision making for timely care and services. Findings included. Review of a policy titled, Changes in Resident's Condition or Status, reviewed 08/29/2025, showed the facility would notify the resident, their primary care provider, and their resident representative of changes in the resident's condition or status. Resident 1 Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including healing of a broken leg, anxiety (a group of mental health conditions that cause excessive, ongoing fear and worry that are hard to control and interfere with daily life), and vision loss in both eyes. The 07/23/2026 comprehensive assessment showed Resident 1 was dependent on one to two staff members for activities of daily living (activities related to personal care). The assessment also showed Resident 1 had a moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Record review of a nursing progress note (PN) dated 07/28/2026 at 9:32 AM, showed Resident 1 was sent to the hospital for evaluation. A follow up PN at 11:24 AM showed a nursing assistant had reported to Staff B, Registered Nurse, that Resident 1 was not responding to verbal stimuli (the use of words or sounds to trigger a response). Resident 1 was transferred to the hospital for further evaluation. The provider and Staff A, Director of Nursing, were notified. The PN showed Resident own responsible party. There was no documentation that Resident 1's Representative (emergency contact) was notified. During an interview on 07/30/2026 at 10:24 AM, Resident 1's Representative (RR) stated they were the emergency contact for Resident 1. They stated they were not notified of Resident 1's episode of unresponsiveness and subsequent transfer to the hospital. They stated they had received a voicemail (a digital voice message left by a caller) from the hospital at 1:30 PM on 07/28/2026, but no details were left. The RR stated they received a second call from the hospital at 8:00 PM that night and were informed at that time that Resident 1 had been hospitalized. During an interview on 07/30/2026 at 1:28 PM, Staff B stated Resident 1 was sent to the hospital because they were not responding to verbal stimuli. They stated the process for transfers included completing the paperwork transfer packet that included their medication administration record, POLST [(Physicians Orders for Life Sustaining Treatment) a binding medical order for a resident's end-of-life care wishes), and the notice of bed hold (an agreement that save a specific room or bed for a resident when they are temporarily away from a care facility). They stated they notify Staff A, the residents' provider, and the residents' Power of Attorney (a legal document that gives someone else the authority to act on your behalf). Staff B stated the resident was their own responsible party and they did not call their emergency contact to inform them of the residents' change in condition and transfer to the hospital. During an interview on 07/30/2026 at 2:59 PM, Staff A stated Staff B should have notified Resident 1's Representative. They stated Staff B did not follow the process for notification of change or transfers. This is a recurring deficiency previously cited in the Statement of Deficiencies dated 05/06/2026. Reference: WAC 388-97-0320(1)(b)(d)		