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Form Approved OMB
No. 0938-0391

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	07/17/2024

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to ensure the transfer of funds, from a resident trust account, were completed within 30 days following their discharge for 1 of 4 residents (Resident 316) reviewed for resident trust. This failure placed the resident and/or their representatives at risk for loss of funds and the interest accumulated. Findings included . <Resident 316> Review of the resident's medical records showed they were admitted on [DATE] with lung complications and lower back pain. Additionally, the resident was discharged [DATE]. Review of facility trust fund account reports, dated 06/21/2024, showed the remaining balances of monies ($165.01), in the form of a check, was sent to Resident 316 (37 days after the resident had discharged) through the mail. During an interview on 07/09/2024 at 8:20 AM, Staff DD, Business Office Manager, stated that resident funds were to be transferred to the resident within 30 days of discharging from the facility. Staff DD stated, missed it in this case (referring to Resident 316 transfer of remaining funds). Reference WAC: 388-97-0340 (4)(5)

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on interview and record review, the facility failed to address required documentation for Advanced Directives (AD), a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity) including incorporating ADs into the care planning process for 2 of 3 residents (Residents 22 and 35) reviewed for ADs. These failures placed the residents at risk of losing their right of having their preferences and/or decisions followed regarding their end-of-life care. Findings included . <Resident 22> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include a stroke (a medical emergency that occurs when blood flow to the brain is blocked or reduced) with left sided deficits and acute respiratory failure. The 06/06/2024 comprehensive assessment, showed the resident's cognition was intact. Additionally, the medical record showed Resident 22 did not have an AD. Review of the 06/04/2024 care plan, showed Resident 22 had no AD care plan to reflect their wishes. During an interview on 07/08/2024 at 3:35 PM, Resident 22 stated they thought they had an AD, but did not remember if they did or not and did not have a copy of one. Resident 22 stated the facility did not offer to assist them in formulating an AD, but they would like their son to be their legal representative. During an interview on 07/12/2024 at 11:16 AM, Staff G, Social Services Director, stated on admission residents were asked about ADs and if they had one, they would request a copy. If the resident did not have an AD, they would assist them in formulating one but did not document that. Staff G stated nursing was responsible for care planning the ADs. Staff G did not have a process for periodically following up to ensure the facility received a copy of the resident's ADs. Review of a document titled Social Service Assessment, dated 06/04/2024, showed the resident had a living will (a written, legal document that provides instructions for your medical care, or for the termination of medical support, in certain circumstances), no living will was found in the record. <Resident 35> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include COVID-19 (an infectious disease-causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death) and end stage kidney failure. The 06/24/2024 comprehensive assessment, showed Resident 35's cognition was intact and required staff supervision assistance for most activities of daily living (ADL). Additionally, the record showed the resident did not have an AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 06/21/2024 care plan, showed Resident 35 had no AD care plan to reflect their wishes. During an interview on 07/10/2024 at 2:14 PM, Resident 35 stated they did not have an AD and were not offered by staff to formulate one on admission. Review of a document titled Social Service Assessment, dated 06/21/2024, showed Resident 35 did not have an AD. During an interview on 07/17/2024 at 11:11 AM, Staff A, Administrator, stated the Social Services department was responsible for the ADs on admission and if they had one, the facility would request a copy. If the resident did not have an AD, the expectation would be that one was offered and assisted with if needed. Staff A further stated they would expect the AD to be care planned if they had one or not. Reference WAC: 388-97-0280 (3)(c)(i-ii)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation and interview the facility failed to maintain a quiet, comfortable and homelike environment for 1 of 1 resident (Resident 218) reviewed for homelike environment. This failure placed the residents at risk for fatigue, unwanted noise at night, and a non-homelike environment. Findings included . <Noise Level> An observation on 07/12/2024 at 3:49 AM, night shift, in the 100-hallway showed there were loud noises from TV's and music playing while the facility residents were trying to sleep. An observation on 07/12/2024 at 4:18 AM showed Resident 218 asked Staff Y, Nursing Assistant (NA)to please ask their neighbor in the next room to turn down their television. Resident 218 stated it has been on like that all night. Staff Y stated that they would try to have their neighbor turn down their TV. Staff Y went into the next room and asked the neighbor if they would turn down their TV. The neighbor did turn down their TV, but the TV continued to be loud enough to be heard from the hallway. In an interview on 07/16/2024 at 2:59 PM, Resident 218 stated their neighbors always have their tv's on very loud every night, it's hard to sleep.That's why I'm taking a nap in my chair, I can't sleep at night. The resident stated that they don't even watch their own tv because they can hear the neighbor's tv. <Environment> An observation on 07/16/2024 at 8:44 AM, of the Team 1 Nursing station desk had a large area [4 feet, (ft, a unit of measure) by 4 ft] of paneling missing and exposed sharp edges to the front of the desk. An observation on 07/16/2024 at 1:53 PM showed Resident 55 was sitting in their wheelchair and the wall behind the resident had one-inch by one-inch gouges of drywall missing that had been painted over. An observation on 07/16/2024 at 11:45 AM, in room [ROOM NUMBER] showed a white panel board placed along the lower part of the wall of three and a half feet to four feet in height, to the left of the bathroom door that was not attached to the wall. Further observation showed there were boxes and clothes pushed up against the paneling that was keeping it in place. Along a section towards the closet there was another white panel board that had a [three centimeters (cm, a unit of measure) by four cm] broken chunk of paneling hanging off the wall with sharp edges. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and concurrent interview on 07/16/2024 at 4:30 PM, accompanied with Staff Z, Maintenance Director, in room [ROOM NUMBER], there were broken and detached panels near the bathroom door, gouges in the closet doors and red sediment on the wall to the right of the sink, and the overall cleanliness of the room. Missing/broken partial brown panel that covered the front of Team 1 nurses' station was pointed out to. Staff Z stated their process for assessing rooms for repairs was that when a resident discharged , they would go in repair and/or paint the room as needed. Staff Z further stated that staff should document needed repairs in the maintenance log that were aware of at each nurse's station and the maintenance office. Staff Z stated that they reviewed the maintenance logs daily. During an interview on 07/17/2024 at 12:05 PM, Staff A, Administrator, and present Staff B, Director of Nursing Services, acknowledged there were unacceptable noise levels during night shift and thought that it had been resolved. Reference WAC 388-97-0880(1)(4)(b) 45642

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 44922 Based on observation, interview, and record review, the facility failed to ensure the identification of physical and verbal abuse, and the protection of residents from their Alleged Perpetrator/Alleged Perpetrators (AP/APs), after allegations of abuse were reported to the facility for 4 of 7 residents (Residents 22, 52, 45, and 54) reviewed for abuse/neglect. This failure placed the residents at risk for further abuse, fear, and unmet care and services. Findings included . <Resident 22> Review of the resident's medical record showed the resident had diagnoses to include a stroke (a medical emergency that occurs when blood flow to the brain is blocked or reduced) affecting their left side, heart failure, and acute respiratory failure. The 06/06/2024 comprehensive assessment, showed the resident's cognition was intact and required one to two staff assistance for bed mobility, transfers, and toileting. During an interview on 07/08/2024 at 3:02 PM, Resident 22 stated a few weeks ago they had gotten tangled up in their call light cord and the cord had wrapped around their neck. The resident stated they could not get the cord off their neck, and the more they tried, the tighter the cord got. Resident 22 stated they were able to push the call button on the cord and a male, described by the resident as an African American Nursing Assistant (NA), that worked night shift, entered the room. The resident told the NA what happened and asked for help, and the NA refused to help the resident because they didn't believe me when I told them the cord was wrapped around my neck and left the room. Resident 22 stated as the NA was leaving the room, the resident yelled out and threatened I will call the cops if you don't come back in here and help me and the NA then turned around and came back in to help get the cord unwrapped from their neck. Resident 22 described the NA as being male with black skin color and mostly worked the late-night shift. Resident 22 stated they reported it to the facility, and they were told they did not have to worry about it anymore. Resident 22 could not recall who they reported the allegation to but had received care from this staff member since this allegation. <Resident 52> Review of the resident's medical record showed they had diagnoses to include diabetes (a disorder in which the body has high sugar levels for prolonged periods of time), heart failure, and a urine infection related to the use of a retention catheter (R/C, a tube inserted into the bladder that carries urine out of the bladder and drains it into a drainage bag). The 05/06/2024 comprehensive assessment, showed the resident's cognition was intact, had functional impairments to their legs, and required one to two staff assistance for bed mobility, transfers, and toileting needs. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/09/2024 at 9:10 AM, Resident 52 reported an allegation that occurred a while ago regarding a NA that worked on the night shift that was consistently negligent in providing the care they required. Resident 52 stated when the NA worked, they would not come and empty their urine drainage bag, which would cause the urine to back up into their bladder and caused them pain and discomfort. Resident 52 stated one night they had dropped their earphone charger and when they asked for assistance the same NA refused to pick it up and told the resident it was nighttime and when it was time to turn the lights back on, they would pick it up, and exited the room without assisting the resident or allowing the resident to respond. Resident 52 identified the NA as an African American male with a very strong accent. Resident 52 reported the issues to a female staff member who they believed to be a nurse manager and the staff member stated they would follow up with administration. Resident 52 stated no one from administration had talked to them about their allegations and they had been assigned this NA since this allegation. During an interview with Staff C, Licensed Practical Nurse (LPN)/Unit Coordinator, stated they had no knowledge of the allegations involving Resident 22 or 52. Staff C stated they had been made aware of other residents not wanting care by, who they believed to be Staff R, NA, but not by these two residents. Staff C stated there were at least one to two residents on each hall that Staff R was not allowed to provide care to, and that Staff R was the only African American male NA that mostly worked the night shift. During an interview with Staff D, LPN/Unit Coordinator, stated they had no knowledge of the allegations involving Resident 22 or 52. During an interview on 07/10/2024 at 3:41 PM, Staff A, Administrator, stated staff had not reported Resident 22 or 52's allegations to administration and they had no knowledge of the allegations made by Resident 22 and Resident 52. <Resident 45> Review of the resident's medical record showed the resident had diagnoses to include a urine infection and Chronic Obstructive Pulmonary Disease (a lung condition characterized by persistent respiratory symptoms like progressive breathlessness and cough). The 06/28/2024 comprehensive assessment showed the resident's cognition was intact, had functional impairments to both lower extremities, required the assistance of two staff for bed mobility and transfers, and was dependent on staff for their toileting needs. During an interview on 07/15/2024 at 12:54 PM, Staff Q, NA, stated they had reported concerns regarding Staff R, NA, to their immediate supervisor whom they identified as Staff A , Administrator. Staff Q stated in 03/2024 or 04/2024, they needed to provide care to a resident and asked Staff R for assistance. Staff Q stated Staff R was angry that there were no other NAs that could assist so Staff R hesitantly followed Staff Q to Resident 45's room. Upon entering Resident 45's room, Staff Q stood on the left side of the bed while Staff R grabbed the bottom of the resident's bed and jerked the bed out, away from the wall, hitting Staff Q in their legs. Staff R then grabbed Resident 45 on their left side and pulled them roughly to their right side, causing Resident 45 to grab the wall for fear they would fall. Staff Q stated Resident 45 reported the rough handling to Staff M, LPN, and Staff Q reported it to Staff A. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/16/2024 at 10:57 PM , Staff M stated Resident 45 reported an allegation to them regarding rough handling by Staff R while they were being provided care. Staff M could not recall how long ago that was. Staff M stated when they talked with Staff R about the care, Staff R stated Resident 45 misunderstood the care they provided and denied the allegation and Staff M escorted Staff R back into the resident's room to apologize. Staff M stated their normal process when a resident made an allegation of rough handling, they would report to their supervisor, protect the resident by removing the staff member, and make a report to the state, but they did not do that in this case. Staff M stated they figured they were all grown men and since they escorted Staff R back into the room, it wasn't like they were left alone. During an interview on 07/15/2024 at 2:33 PM, Resident 45 stated they reported an allegation of rough handling during care a few months ago with a NA on night shift that the resident identified as Staff R. Resident 45 stated they needed to be provided care and Staff Q was assigned to them that night. Staff Q brought in Staff R to assist them. Staff Q stood on the left side of the bed, closest to the door, when Staff R abruptly pulled the bed outwards, away from the wall/window, towards Staff Q, so they could get in between the bed and the wall on the right side. Resident 45 stated Staff R then reached across the resident, grabbed the draw sheet (a bedding aid that helps with patient repositioning and transferring) on the side Staff Q was standing on, and abruptly yanked (to pull on something with a quick vigorous movement) Resident 45's left side of their body towards them. The resident stated they thought Staff R was trying to throw them out of the bed over a previous unreported incident they had with them, so Resident 45 took their left arm as they were being pulled to their right side and braced themselves by pushing their hand against the wall. Resident 45 stated Staff R took their hand and pulled down on the resident's arm that was braced on the wall and told the resident they did not need to do that. Resident 45 stated they told Staff R I wouldn't have had to do that If you didn't yank me out of the bed. Resident 45 stated they reported the allegation to the night nurse and identified the nurse as Staff M. Resident 45 stated Staff R had been assigned to provide them care since this allegation 45642 <Resident 54> Review of the resident's medical record showed the resident had diagnoses to include a fracture to their left lower arm, COPD, and generalized muscle weakness. The 06/19/2024 comprehensive assessment, showed the resident's cognition was intact, required substantial to maximum staff assistance with toileting hygiene, and was independent for lower body dressing. During an interview on 07/08/2024 at 10:45 AM, Resident 54 stated they had reported an allegation to Staff M a few weeks ago regarding a short black [African American] guy NA that threw a package of wipes at them when Resident 54 requested assistance after using a bed pan (a receptacle used by a bedridden patient as a toilet). Resident 54 stated Staff M told them You don't have to put up with that. During an interview on 07/15/2024 at 11:43 AM, Staff M stated Resident 54 had reported an issue regarding Staff R's care provided to them. Staff M stated the issue was regarding Staff R taking a long time answering their call light and nothing about a package of wipes being thrown at them. Staff M did not report Resident 45 or 54's allegations to the administrative staff or the state agency. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/17/2024 at 10:14 AM, Staff B, Director of Nursing Services, stated the alleged perpetrator identified in the allegations should have been removed from the facility immediately, either Staff A or Staff B should have been notified, an investigation should have been started, and a report made to the state agency. Staff B stated their staff did not follow the correct process for those reported allegations. Staff B stated, had we known that these allegations were reported to nursing staff, we could have noticed a pattern sooner than later. During an interview, on 07/17/2024 at 10:40 AM, Staff A stated they had received a statement from Staff Q and Staff R, and thought the issues were just between the two employees and had no knowledge a resident was involved in the situation. Staff A then stated after reviewing the statements, they could not decipher between what is and what isn't an allegation. Staff A stated they would provide the statements for the Surveyor to review, but never received them after two separate requests. Staff A stated they never received reports regarding Resident 45 or 54's allegations from Staff M. Reference WAC: 388-97-0640(1)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on interview and record review, the facility failed to implement 5 of 8 components (identify, protect, report, investigate, and coordinate with quality assurance performance improvement [QAPI] of their abuse/neglect policy/procedure for 4 of 7 residents (Residents 22, 53, 45, and 54) reviewed for allegations of abuse/neglect. Additionally, the facility failed to ensure the development of their abuse/neglect policy/procedure by not including Coordination with QAPI component. This failure placed the residents at risk for unrecognized abuse, and unmet care needs. Findings included . Review of the abuse policies dated 06/17/2024, showed no policy or procedures for communicating and coordinating allegations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program. Review of a policy titled Abuse-Protection of Residents dated 06/17/2024, showed the facility would prevent further abuse, neglect, or mistreatment while the allegation was being investigated. The policy additionally showed the alleged perpetrator (AP) should be removed from the alleged victim and other residents (if applicable) to provide safety and protection. Additionally, the policy showed the facility would have evidence that a thorough investigation had been completed for all alleged violations. <Resident 22> Review of the resident's medical record showed they had diagnoses to include a stroke (a medical emergency, when blood flow to the brain is blocked or reduced) affecting their left side and diabetes (a group of diseases that affect how the body uses blood sugar). During an interview on 07/08/2024 at 3:02 PM, Resident 22 stated a few weeks back they reported an incident against a Nursing Assistant, (NA) to the facility when the NA refused to help the resident get untangled from a cord that was around their neck until they threatened to phone the police. This allegation was not reported to the administration or the state agency, the AP was not identified or removed from further access to the resident, and an investigation was not completed. <Resident 52> Review of the resident's medical record showed they had diagnoses to include the use of a retention catheter (R/C, a tube inserted into the bladder that carries urine out of the bladder and into a urine drainage bag). The 05/06/2024 comprehensive assessment, showed the resident's cognition was intact. During an interview on 07/09/2024 at 9:10 AM, Resident 52 stated they had reported awhile back issues of negligent care with a night shift NA, that was identified to be African American with a strong accent. Resident 52 stated they reported the issues to a female staff member who they thought was a nurse manager, who stated they would follow up with administrative staff and had never heard anything more. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/2024 at 3:41 PM, Staff A, Administrator, was made aware of the allegations reported to the surveyor by Residents 22 and 52 and stated their staff had not reported those incidents to them and they had no knowledge of the allegations. <Resident 45> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include a urine infection. The 06/28/2024 comprehensive assessment, showed the resident's cognition was intact. During an interview on 07/15/2024 at 2:33 PM, Resident 45 stated they had reported an incident of rough handling, in 03/2024 or 04/2024, by an African American male NA, identified as Staff R, NA. Resident stated they reported the incident to Staff M, Licensed Practical Nurse. This incident was not reported by Staff M to the administrative staff or the State agency, the AP was not removed from further access to the resident, and an investigation had not been completed. During an interview on 07/17/2024 at 10:40 AM, Staff A, also present was Staff B, Director of Nursing Services, stated they had not reported or investigated the allegations the surveyor reported to them on 07/10/2024 for Residents 22 or 52 (seven days after they were reported). Staff A further stated Staff M did not report an allegation made by Residents 45 and had no knowledge of the incident. <Resident 54> Review of the resident's medical record showed the resident admitted to the facility on [DATE] for aftercare related to a lower left arm fracture. The 06/19/2024 comprehensive assessment, showed Resident 54's cognition was intact. During an interview on 07/08/2024 at 10:45 AM, Resident 54 stated they had reported an incident regarding a short black [African American] man that was a NA and worked night shift, who threw wipes at them when the resident asked for assistance after using a bed pan (a receptacle used by a bedridden patient as a toilet). Resident 54 stated they reported the incident to Staff M. This incident was not reported by Staff M to the administrative staff or the state agency, the AP was not identified and removed from further access to the resident, and the incident was not investigated. During an interview on 07/15/2024 at 1:29 PM, Staff A stated, Staff M did not report an allegation made by Resident 54 to them and had no knowledge of the incident. During an interview on 07/17/2024 at 10:14 AM, Staff B stated they would expect their staff to report, remove, and protect the residents when allegations are reported to them. Staff B stated their staff did not follow the correct process for Residents 22, 45, 52, and 54. Reference WAC: 388-97-0640 (2)

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 07/17/2024

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 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44922

Based on interview and record review, the facility failed to report allegations of abuse/neglect for 4 of 7 residents (Residents 22, 52, 45, and 54) reviewed for abuse and neglect. This failure placed the residents at risk for further and unrecognized abuse/neglect and unmet care needs.

Findings included .

Review of the policy titled Abuse-Reporting and Response dated 06/17/2024, showed the facility would report alleged violations of mistreatment .neglect, or abuse . The allegations were to be reported immediately, and no later than 2 hours if the allegation involved abuse and no later than 24 hours if the allegation did not involve abuse. The facility would report to the Administrator and the state agency.

<Resident 22>

Review of the resident's medical record showed the resident admitted to the facility on [DATE] with a stroke (a medical emergency, when blood flow to the brain is blocked or reduced) that affected their left side. The 06/06/2024 showed the resident's cognition was intact and required maximum/substantial assistance for toileting needs and bed mobility.

During an interview, on 07/08/2024 at 3:02 PM, Resident 22 stated a few weeks back they reported to facility staff an allegation involving a male, African American Nursing Assistant, (NA), who worked the night shift, who refused to help them when their call light became tangled around their neck and the more they tried to remove it themselves, the tighter the cord became. Resident 22 stated the NA left the room after not believing what the resident was telling them, and they had to yell and threaten to call the police if they didn't help them.

<Resident 52>

Review of the resident's medical record showed they admitted to the facility on [DATE] with diagnoses to include a urine infection related to the use of an indwelling catheter (a tube inserted into the bladder that carries urine out of the bladder and drains into an external bag). The 05/06/2024 comprehensive assessment showed the resident's cognition was intact and required one to two staff assistance for bed mobility,

During an interview on 07/09/2024 at 9:10 AM, Resident 52 reported allegations regarding a NA that worked on the night shift that was consistently negligent in providing the care they required. Resident 52 identified the NA as an African American with a very strong accent they reported the issues to a female I think she was a nurse manager and they stated they would follow up with administration. Resident 52 stated no one from administration had talked to them about their issues.

<Resident 45>

(continued on next page)

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 07/17/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include a urine infection and Chronic Obstructive Pulmonary Disease (COPD, a lung condition characterized by persistent respiratory symptoms like progressive breathlessness and cough). The 06/28/2024 comprehensive assessment showed the resident's cognition was intact, and required the assistance of two staff for bed mobility. During an interview on 07/15/2024 at 2:33 PM, Resident 45 stated they had reported an allegation a while back with a NA on night shift that Resident 45 identified by first name, as Staff R, NA. Resident 45 stated Staff R handled them roughly while assisting another NA with cares and felt like Staff R was trying to throw them off the bed in retaliation to a previous incident the resident and Staff R had. Resident 45 stated they reported the allegation to the night nurse and identified the nurse by first name as Staff M, Licensed Practical Nurse. During an interview on 07/16/2024 at 10:57 PM, Staff M stated they did not report Resident 45's allegation to the administrative staff or the state agency because the resident misunderstood the care being provided by Staff R and the NA apologized to the resident. During an interview on 07/10/2024 at 3:41 PM, Staff A, Administrator, stated they were unaware of the allegations reported to staff by Residents 22 and 52. Additionally, on 07/17/2024 at 10:14 AM, Staff A, also present, Staff B, Director of Nursing Services, stated they were unaware of Resident 45's allegation and had not been reported to them by Staff M. Staff A stated they had not reported or started the investigations into Resident 22 and 52's allegations. 45642 <Resident 54> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include a fracture to their lower left arm and COPD. The 06/19/2024 comprehensive assessment showed the resident's cognition was intact and required partial/moderate assistance for bed mobility and substantial/maximum assistance with toileting needs. During an interview on 07/08/2024 at 10:45 AM, Resident 54 stated they had reported an allegation regarding a NA that was a short black [African American] guy who was busy and in a hurry. Resident 54 stated they felt guilty for asking for assistance but needed supplies to clean themselves up. Resident 45 stated the NA entered the room and threw a bag of wipes at me to clean themselves up after using a bed pan (a receptacle used by a bedridden patient as a toilet). Resident 54 stated they reported the allegation to Staff M who stated to the resident you don't have to put up with that. During an interview on 07/15/2024 at 11:43 AM, Staff M stated they did not report Resident 54's allegation to the administrative staff or the state agency because the resident reported the allegation as the NA took too long to answer their call light. Staff M further identified that staff member as Staff R. During an interview on 07/15/2024 at 1:29 PM, Staff A stated they were unaware of an allegation reported to Staff M regarding Resident 54, nor did Staff M report the allegation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the reporting incident log, dated for the months of 02/01/2024 through 07/14/2024, showed there were no allegations for Resident 22, 45, 52, or 54 logged or reported by the facility. Reference WAC: 388-97-0640 (5)(a)

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NAME OF PROVIDER OR SUPPLIER: Life Care Center of Richland		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 44922 Based on interview and record review, the facility failed to ensure a complete and thorough investigation had been completed, nor did they ensure the residents were protected from their alleged perpetrator (AP) by not removing the AP from having any further contact with those residents during the investigation phase of the reported allegations of abuse/neglect for 4 of 7 residents (Residents 22, 52, 45, and 54) reviewed for abuse and neglect. The failure to conduct a thorough investigation to rule out root cause, contributing factors, and identifying preventative measures of the abuse/neglect allegations placed the residents at risk for further unmet care needs and psychosocial harm. Review of a policy titled Abuse-Protection of Residents dated 06/17/2024, showed the facility would Prevent further potential abuse, neglect ., or mistreatment while the investigation is in process. The policy further showed the resident should be examined for injury and the AP should be removed from the alleged victim and other residents for ongoing safety and protection. Review of a policy titled Abuse-Conducting an Investigation dated 06/17/2024, showed the facility would promptly and thoroughly investigate allegations of abuse, neglect, and mistreatment. The policy showed the results of the investigation would be reported to the State agency within five working days of the allegations. <Resident 22> Review of Resident 22's medical record showed the resident had diagnoses to include a stroke (when the blood supply to part of the brain is blocked or reduced) affecting their left side. The 06/06/2024 comprehensive assessment showed the resident's cognition was intact and required substantial to maximum staff assistance with bed mobility. During an interview on 07/08/2024 at 3:02 PM, Resident 22 stated they had reported an allegation of abuse/neglect to the facility a few weeks back regarding an African American male Nursing Assistant (NA) that worked the late-night shift. <Resident 52> Review of the resident's medical record showed the resident had diagnoses to include diabetes. The 05/06/2024 comprehensive assessment , showed the resident's cognition was intact. During an interview on 07/09/2024 at 9:10 AM, Resident 52 stated they had made a report to the facility a female nurse manager regarding consistently negligent care received by a NA that was an African American male with a very strong accent that worked the night shift. During a telephone interview on 07/10/2024 at 3:41 PM, Staff A, Administrator, stated they were not made aware of the allegations reported to their staff by Residents 22 and 52. Upon follow-up with Staff A on 07/17/2024 at 10:35 AM, no investigations had been started (seven days after allegations were reported by the surveyor). <Resident 45> (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed the resident diagnoses to include diabetes. The 06/28/2024 comprehensive assessment, showed the resident's cognition was intact and required substantial to maximum staff assistance with bed mobility and transfers. During an interview on 07/15/2024 at 2:33 PM, Resident 45 stated they reported to the facility an allegation regarding an NA that worked the late-night shift, identified as Staff R, NA. Resident 45 stated Staff R, while assisting Staff Q, NA, with care, was rough handling them and Resident 45 thought Staff R was going to throw them out of the bed in retaliation over a previous incident they had. Resident 45 stated they reported the allegation to Staff M, Licensed Practical Nurse. During a telephone interview on 07/16/2024 at 10:57 PM, Staff M stated they recalled the allegation with Resident 45 and the resident reported Staff R had been rough with them when assisting to turn them. Staff M stated they did not remove the staff member from care of this resident, allowed further access to this resident, and would normally report to their supervisor and protect the resident but did not in this case. Staff M further stated they did not ask the resident if it was okay for Staff R to come in to apologize and figured we are all grown men, and I was in there with them so it wasn't like they were left alone. Staff M did not remove the staff member from resident care, nor did they start an investigation. During an interview on 07/17/2024 at 10:40 AM, Staff A stated the allegation had not been reported to them by Staff M. Therefore, no investigation had been completed nor was the AP removed to protect the resident. 45642 Review of the resident's medical record showed the resident had a diagnosis of a fracture to their lower left arm. The 06/19/2024 comprehensive assessment, showed the resident's cognition was intact and required substantial to maximum staff assistance for toileting hygiene. During an interview on 07/08/2024 at 10:45 AM, Resident 54 stated they reported an allegation that occurred since they had been there regarding a short black [African American] guy, a NA, that worked the night shift. Resident 54 stated they had used the bed pan (a receptacle used by a bedridden patient as a toilet) and needed assistance and the NA who was busy and hurried, threw a package of wipes at me so that I could clean myself and then left. Resident 45 reported the allegation to Staff M who stated to the resident that they don't have to put up with that. During an interview on 07/15/2024 at 12:54 PM, Staff M stated Resident 54 had reported a few weeks back a NA that had been assigned to them had taken too long to answer their call light but nothing regarding a package of wipes being thrown at them. Staff M identified that NA as Staff R. Staff M did not remove the staff involved nor did they start an investigation. During an interview on 07/17/2024 at 10:14 AM, Staff B, Director of Nursing Services, stated they would have expected staff to immediately remove the staff member from the facility, call Staff B or Staff A so they could start an investigation, and report to the State agency. Staff B stated their staff did not follow the correct process for the allegations that were reported. Reference WAC: 388-97-0640 (6)(a)(b)

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NAME OF PROVIDER OR SUPPLIER: Life Care Center of Richland		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on interview and record review the facility failed to provide a written notice to the resident and/or their representative of the discharge for 2 of 2 residents (Residents 14 and 51) reviewed for hospitalization . In addition, the facility failed to properly notify the Office of the State Long-Term Care (LTC) Ombudsman (a person who advocates for residents in nursing homes). This failure placed the residents at risk for unmet discharge needs. Findings included . Review of the policy titled Transfers and Discharges dated 06/28/2024, showed the facility would provide a transfer and/or discharge notice to the resident or the resident's responsible party. The policy did not show the notice needed to be sent to the Office of the State LTC Ombudsman as well. <Resident 14> Review of the resident's medical record showed the resident was readmitted to the facility on [DATE] with diagnoses of a recent heart attack, diabetes and cardiac disease. Resident 14's most recent comprehensive assessment dated [DATE] showed they required substantial assistance with all activities of daily living (ADLs) and was cognitively intact. Further review of Resident 14's medical record showed the resident was transferred to the hospital on 05/21/2024 with shortness of breath, nausea and vomiting. There was no notice of transfer/discharge issued to the resident and/or their representative in the medical record. Further review showed no notice of transfer/discharge to the LTC Ombudsman. <Resident 51> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include heart failure, end stage kidney failure, and respiratory failure. The 02/08/2024 comprehensive assessment, showed the resident's cognition was intact. Review of a 02/08/2024 nursing progress note, showed the resident returned from an outside appointment with complaints of feeling dizzy and nauseous and their heart rate was at 32 beats per minute (normal heart rate is 60-100 beats per minute). The provider was contacted and wanted the resident to be sent to the hospital for an evaluation, but the resident refused. A short while later, the resident became increasingly uncomfortable and began yelling out that they wanted to go to the hospital. The resident was then sent to the hospital. Further review of Resident 51's medical record showed there had been no transfer and/or discharge notification given to Resident 51, their representative, or the Office of the State LTC Ombudsman for Resident 51's facility-initiated transfer to the hospital. (continued on next page)

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	07/17/2024

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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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/12/2024 at 11:16 AM, Staff G, Social Services Director, stated they were informed by the Office of the State LTC Ombudsman (the agency the copy of transfer/discharge gets sent to) informed them they did not have to report hospital transfers, so they had not been reporting facility-initiated transfers to the hospital to the State LTC Ombudsman's Office. During an interview on 07/17/2024 at 11:06 AM, Staff A, Administrator, stated they were unsure of the regulation to report hospital transfers to the Office of the State LTC Ombudsman and would have to review the regulation. Reference WAC: 388-97-0120 (2)(a-c) 44922

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 07/17/2024
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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on interview and record review, the facility failed to issue a written notice of bed hold (holding or reserving a resident's bed while the resident was absent from the facility) at the time of a hospital transfer for 3 of 3 residents (Residents 14, 19 and 51) reviewed for hospital transfers. This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed and any monetary charges associated with the bed hold while in the hospital. Findings included . Review of the policy titled Bed-Hold Policy dated 08/09/2023, showed the facility would provide the bed-hold policy to the resident upon admission, transfer to a hospital, or if the resident goes on therapeutic leave. <Resident 14> Review of the medical record showed Resident 14 was readmitted to the facility on [DATE] with diagnoses including cardiac disease, diabetes and depression. The Resident's comprehensive assessment dated [DATE] showed Resident 14 required substantial assistance of one to two staff members for all activities of daily living (ADL's) and was cognitively intact. Review of the medical record showed Resident 14 was transferred to the hospital on 05/21/2024. There was no documentation to show a notice of a bed hold was offered in the medical record. <Resident 19> Review of the medical record showed Resident 19 was readmitted to the facility on [DATE] with diagnoses including a right hip replacement, diabetes and cardiac disease. The resident's comprehensive assessment dated [DATE] showed Resident 19 required substantial assistance for bed mobility and transfers and was cognitively intact. Review of the medical record showed Resident 19 was transferred to the hospital on 02/28/2024. There was no documentation to show a notice of a bed hold was offered in the medical record. <Resident 51> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include end stage kidney failure and respiratory failure. The 02/08/2024 comprehensive assessment showed the resident's cognition was intact. Review of a 02/08/2024 nursing progress note showed the resident returned from an outside appointment not feeling well and was later transferred to the hospital for evaluation and treatment. Review of the medical record showed no documentation that Resident 51 nor the Resident's Representative (RR) were offered a bed hold. (continued on next page)

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 07/17/2024
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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/11/2024 at 12:46 PM, Staff C, Licensed Practical Nurse/Unit Coordinator, stated it was the nurse's responsibility to offer the bed hold policy to the resident prior to being discharged to the hospital, unless it was emergent. then they would attempt to get it to them by the next day. Staff C stated they did not locate a bed-hold policy for Resident 51. During an interview on 07/16/2024 at 3:25 PM, Staff B, Director of Nursing Services, stated they could not locate a bed-hold policy for the Residents 14, 19, and 51 and the nursing staff did not follow the correct process. Reference WAC: 388-97-0120 (4) 44922

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 07/17/2024
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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on interview and record review, the facility failed to complete the Minimum Data Set (MDS, a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status) discharge assessment upon discharge, within the required 14-day time period, for 5 of 5 residents (Residents 1, 15, 33, 49, and 51). This failed practice placed residents at risk for not having their needs met upon discharge. Findings included . <Resident 1> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include diabetes (a disorder in which the body has high sugar levels for prolonged periods of time) and pneumonia (An infection of the air sacs in one or both the lungs). The record showed the resident discharged from the facility on 04/30/2024 and a comprehensive discharge assessment had not been completed. <Resident 15> Review of the resident's medical record showed they admitted to the facility on [DATE] with diagnoses to include a stroke (when the blood supply to part of the brain is blocked or reduced) affecting their left side and anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome). The record showed Resident 14 discharged from the facility on 04/24/2024 and a comprehensive discharge assessment had not been completed. <Resident 33> Review of the resident's medical record showed they admitted to the facility on [DATE] with diagnoses to include diabetes and kidney disease. The record showed the resident discharged from the facility on 02/04/2024 and a comprehensive discharge assessment had not been completed. <Resident 49> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include a urine infection and a right knee replacement. The record showed the resident discharged from the facility on 03/27/2024 and a comprehensive discharge assessment had not been completed. <Resident 51> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include end stage kidney and heart failure. The record showed the resident discharged on [DATE] and a comprehensive discharge assessment had not been completed. (continued on next page)

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 07/17/2024
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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/11/2024 at 3:51 PM, Staff E, Registered Nurse/MDS Coordinator, stated a discharge assessment should be done within 14 days after the resident discharges. Staff E stated they remembered to complete the resident's end of therapy assessments and missed the discharge assessments for Residents 1, 15, 33, 49, and 51. During an interview on 07/17/2024 at 10:40 AM, Staff A, Administrator, stated they would have expected the MDS discharge assessments to be completed and timely. Reference WAC: 388-97-1000 (5)(a)(e)(iii)

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 07/17/2024
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on interview and record review the facility failed to review and validate the Preadmission Screening and Resident Reviews ([PASARR], an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) were correct on admission and corrected/updated as needed for 3 of 5 residents (Resident 19, 30 and 46) reviewed for unnecessary medications. This failure placed the residents at risk for not receiving the care and services appropriate for their needs. Findings included . Review of the facility policy dated 09/25/2023, titled Pre-admission Screening and Resident Review (PASARR) showed the facilities procedure was to ensure PASARR Level I screening had been completed on potential admissions prior to admission. <Resident 19> Review of Residents 19's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of the comprehensive assessment dated [DATE], showed the resident was independent in decision making. Review of Resident 19's 05/21/2024 PASARR Level I, showed on admission under section I, SMI/ID all diagnosis were marked as no and the diagnosis of depression was not included. The Level I PASARR reviewed by the facility was incorrect on admission and had not been corrected and any new diagnosis that were added after admission had not been updated with a new PASARR level 1 screening to see if additional services were needed. <Resident 30> Review of Resident 30's medical records showed the resident admitted to the facility on [DATE] with diagnoses to include bi-polar disorder (a brain disorder that causes changes in a person's mood, energy, or ability to function), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), insomnia (a sleep disorder that makes it hard to fall asleep, stay asleep, or get quality sleep), cognitive communication deficit and dementia (the loss of thinking, remembering, and reasoning- to the extent that in interferes with ADLs). Review of the comprehensive assessment dated [DATE], showed the resident's cognition was moderately impaired. Review of Resident 30's 09/13/2023 PASARR Level I, showed on admission under section I, SMI/ID all diagnosis were marked as no and the diagnosis of anxiety disorder (a feeling of worry, nervousness, or unease) was not included. The Level I PASARR reviewed by the facility was incorrect on admission had not been corrected and any new diagnosis that were added after admission had not been updated with a new PASARR Level 1 screening to see if additional services were needed. <Resident 46> (continued on next page)

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 07/17/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Richland		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Goethals Drive Richland, WA 99352	

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 46's medical records showed the resident admitted to the facility on [DATE] with diagnoses to include bipolar II disorder (a brain disorder that causes changes in a person's mood, energy, or ability to function), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a feeling of worry, nervousness, or unease). Review of the comprehensive assessment, dated 4/09/2024, showed the resident's cognition was moderately impaired and was independent for bed mobility, transfers, and walking. Review of Resident 46's 09/13/2023 PASARR Level I, showed on admission under section I, SMI/ID the diagnosis of anxiety disorder had not been included. The PASARR Level I reviewed by the facility was incorrect on admission, had not been corrected and any new diagnosis that were added after admission had not been updated with a new PASARR Level 1 screening to determine if additional services were needed. In an interview 07/12/2024 at 11:04 AM, Staff C, Licensed Practical Nurse/Unit Coordinator, stated the admissions staff reviewed the PASARRs. Staff C stated they reviewed them after admission and if they noticed a further screening was required, they notified Social Services to review and contact the required individuals. In an interview on 07/17/2024 at 11:09 AM, Staff A, Administrator, stated their expectation was for the Social Services to review the PASARR for accuracy and if incorrect, they would contact the PASARR Coordinator and get them corrected, or complete a new one that was corrected. Reference: WAC 388-97-1915 (1)(2)(a-c) 45642

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Life Care Center of Richland	44 Goethals Drive Richland, WA 99352

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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 44922

Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission that had the minimum requirements documented for dietary orders, physician orders, and treatment plans for 3 of 4 residents (Residents 19, 35, and 50) reviewed for recent admissions. The failed practice placed the resident at risk of not receiving continuity of care and resident centered care needs.

Findings included .

<Resident 19>

Review of the medical record showed Resident 19 was readmitted to the facility on [DATE] with diagnoses including a right hip replacement, diabetes and cardiac disease. The resident's comprehensive assessment dated [DATE], showed Resident 19 required substantial assistance for bed mobility and transfers and was cognitively intact.

During an interview with Resident 19 on 07/09/2024 at 11:23 AM, they stated they were discharged from the facility on 02/28/2024 and returned on 03/07/2024 following a scheduled hip replacement. Resident 19 stated they could not recall a care conference within 48 hours of them returning to the facility or the discussion of plans going forward .

Review of Resident 19's medical record showed no documentation that a 48-hour care plan was completed when Resident 19 returned from the hospital with updated orders.

During an interview with the Staff G, the Social Services Director (SSD), on 07/11/2024 at 11:05 AM, they stated either the Resident Care Managers (RCM) or the Admission Nurse were responsible for completion of the 48-hour care plans and provide written summaries to the residents or their representatives when they admit or readmit to the facility. Staff G further stated, If Resident 19 doesn't have one, we must have missed it.

<Resident 35>

Review of the resident's medical record showed that the resident admitted to the facility on [DATE] with diagnoses to include COVID-19 (an infectious disease-causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death) and end stage kidney failure with dialysis (a treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to). The 06/24/2024 comprehensive assessment showed Resident 35's cognition was intact, required supervision or touching assistance of one staff for toileting and transfers.

Review of a 06/21/2024 baseline care plan, showed the care plan was missing physician orders, did not identify what days the resident received dialysis, where they received dialysis, or how they were to be transported to dialysis, and no diet orders specific to the resident.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/16/2024 at 2:04 PM, Staff E, Registered Nurse, stated they did not always document the diet orders or treatment orders in the baseline care plan, but they should have. Staff E stated they reviewed the baseline care plan and a copy to the resident and/or the Resident Representative (RR) during their initial care conference which was normally scheduled for 72 hours after admission. During an interview on 07/16/2024 at 2:12 PM, Staff D, Licensed Practical Nurse /Unit Coordinator, stated if the baseline care plan was not reviewed with the resident on admission, they would review it with them during the initial care conference that was within 72 hours of admission. Staff D stated they reviewed home medication and physician orders with the resident using the Home Medication assessment. Review of a 06/21/2024 home medication document, showed no physician orders or home medications were listed, only documentation that the medication list is consistent with home list. During an interview on 07/17/2024 at 10:14 AM, Staff B, Director of Nursing Services (DNS), stated the admissions nurse should be completing the baseline care plans and was not aware the baseline care plan did not have the least minimum required components. Staff B stated they should reconcile physician orders with home medication orders by completing the home medication list and the lists should be filled out and not left blank. <Resident 50> Review of Resident 50's medical record showed that the resident was admitted to the facility on [DATE] with the diagnoses include malignant neoplasm of maxillary sinus (benign or cancerous tumors that occur in the nose or sinuses), anxiety (a feeling of worry, nervousness, or unease), muscle weakness, nausea with vomiting, difficulty walking, and dysphagia (difficulty swallowing). The 06/10/2024 comprehensive assessment showed that Resident 50's cognition was intact and required supervision or touching assistance for bed mobility, transfers and was dependent for eating. Review of a 06/25/2024 baseline care plan, showed the care plan did not contain physician orders, diet orders and did not identify the resident was dependent on staff for eating, In an interview on 07/08/2024 at 2:47 PM, Resident 50 stated they received their tube feedings three times a day. In an interview on 07/16/2024 at 11:53 AM, Staff K, Dietician, stated they were notified of residents admitting with tube feedings, before the resident arrived at the facility. Staff K stated they entered the tube feeding orders prior to the resident arriving but not in the baseline care plan. Reference WAC: 388-97-1020 (3) 35676 45642

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on interview and record review the facility failed to assist ensure an effective, resident-centered discharge plan was in place for 1 of 1 resident (Resident 46), reviewed for discharge planning. The failure to initiate a discharge plan consistent with the resident's needs and/or the resident representative's expressed discharge goals, placed the resident at risk for unmet care needs, decreased self-worth, and a diminished quality of life. Findings included . Review of the facility's policy titled Transfers and Discharges dated 06/28/2024 showed, the facility may initiate transfer or discharge of a resident, the documentation that must be included in the medical record, and who was responsible for making the documentation. Additionally, the facility would ensure the information that must be conveyed to the receiving provider for residents being transferred or discharged to another healthcare setting was provided. <Resident 46> Review of Resident 46's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include a history of falls, bipolar II disorder (a brain disorder that causes changes in a person's mood, energy, or ability to function), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), need for assistance with personal care, muscle weakness, heart disease, anxiety (a feeling of worry, nervousness, or unease). Review of the comprehensive assessment dated [DATE] showed the resident's cognition was moderately impaired and was independent for bed mobility, transfers and walking. Review of Resident 46's care plan dated 06/05/2024 showed the resident discharge plan was to remain in the facility for long term care until family could secure a bed in a facility located closer to them. The care plan focus was initiated on 09/13/2023 and revised on 04/09/2024 by social services. Review of Resident 46's progress notes dated 05/11/2024 to 07/15/2024 did not show any transfer/discharge information to reflect that the facility had ongoing conversations with the resident and/or resident representatives regarding a discharge plan. In an interview on 07/09/2024 at 9:14 AM, Resident representative (RR), stated they have asked the facility to assist them in getting Resident 46 closer to the family as they were the only family the resident had. RR stated they still did not know where they were with the discharge or if the facility had made any referrals. Additionally, they had a conversation about discharge possibilities at the last care conference in January of 2024. In an interview on 07/16/2024 at 3:59 PM, Staff H, Social Services Assistant, stated that Resident 46 was a long-term resident and that family lived out of town. Resident 46's Representative stated they could not find another facility down there for the resident. Staff H stated no, I have not sent out any referrals. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/17/2024 at 11:17 AM, Staff G, Social Services Director, stated when Resident 46 first admitted to the facility the plan was long-term stay. Staff G stated they had conversation with the Representative about discharging closer to family. Additionally, that they had discussed for the family look for facilities due to Staff G being unfamiliar with the area the resident wanted to discharge to. Staff G stated they had not sent out any referrals. Reference WAC: 388-97-0080

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on observation, interview, and record review, the facility failed to ensure 5 of 5 residents (Residents 5, 6, 13, 14, and 22) reviewed for activities of daily living (ADLs), received adequate showers, grooming, and oral care according to the residents' care plans. This failure placed the residents at risk for unmet hygiene needs. Findings included . Review of the facility's policy titled Activities of Daily Living (ADLs) dated 02/12/2024 showed, the resident would receive assistance as needed to complete ADLs). Any change in the ability to perform ADLs would be reported to the nurse. <Resident #5> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including a stroke with right sided weakness, cardiac disease and depression. Resident 5's most recent comprehensive assessment dated [DATE] showed they required substantial assistance of one to two caregivers with bed mobility, transfers, dressing and personal hygiene and their cognition was intact. During an interview with Resident 5 on 07/08/2024 at 11:22 AM they stated they had difficulty brushing their teeth because of their limited mobility with their right arm. They stated they needed help with both set up and assistance in brushing their teeth, but it never happened. Resident 5 stated I cannot do it myself, so it just doesn't get done. Review of Resident 5's care plan last revised on 11/07/2023, showed Resident 5 required extensive assist of one staff member with personal hygiene and routine oral in the morning, after meals, and before bed. The interventions showed the staff were to brush teeth, clean gums, and rinse mouth. <Resident 14> Review of the resident's medical record showed they were readmitted to the facility on [DATE] with diagnoses including cardiac disease, diabetes, a right below the knee amputation and depression. Resident 14's most recent comprehensive assessment dated [DATE] showed they required substantial assistance of one to two caregivers with all ADLs and was cognitively intact. During an interview with Resident 14 on 07/09/2024 at 9:13 AM, they stated they were supposed to get a shower twice a week but had only been getting one once a week for the past several months. They stated when they returned from the hospital on 05/31/2024 they did not receive a shower for over two weeks. Review of Resident 14's care plan showed they were to receive a shower every Monday and Thursday and required total assistance of one staff member. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 14's Nursing Assistant (NA) flow sheets from 06/01/2024 through 06/15/2024 showed no shower was documented as given. 45642 <Resident 6> Review of Resident 6's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include heart failure, muscle weakness, history of falling and a need for assistance with personal care. Review of the resident's comprehensive assessment dated [DATE] showed the resident had not been exhibited rejection of care. Review of the Resident 6's care plan dated 6/10/2024 showed the Resident had an ADL self-care performance deficit related to their activity intolerance. Additionally, the resident required assistance of one staff member for bathing, bed mobility, dressing, personal hygiene, and transfers. Review of Resident 6's NA task sheets showed the resident preferred to have showers on Tuesdays and Fridays. Further review of the NA task sheets dated 06/26 /2024 to 07/04/2024 showed the resident went nine days without a shower. During an interview on 07/15/2024 at 10:08 AM, Staff HH, NA, stated Resident 6 required one staff member to assist them and the use of a sit to stand to transfer them from bed to chair, and the resident never refused care. <Resident 13> Review of Resident 13's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include myoneural disorder (a condition that causes muscles to become weaker than normal due to improper communication between nerves and muscles), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (a feeling of worry, nervousness, or unease), and need for assistance with personal care. Review of Resident 13's comprehensive assessment dated [DATE], showed the resident had not been exhibited rejection of care. Review of Resident 13's care plan dated 06/24/2024, showed the Resident had an ADL self-care performance deficit related to their activity intolerance. Further showed the resident required assistance of one staff member for showering, assistance of one to two staff members for bed mobility, dressing, and transfers. Review of Resident 13's NA task sheets showed the resident preferred to have showers on Mondays and Thursdays. The NA task sheets dated 05/07/2024 to 05/31/2024 showed the resident went twenty-four days without a shower. The NA task sheet for 06/07/2024 to 06/19/2024 showed the resident went thirteen days without a shower, and from 06/21/2024 to 06/30/2024 ten days without a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NA task sheets dated 07/01/2024 to 07/16/2024, showed the resident had not received a shower for fifteen days. During an interview on 07/11/2024 at 1:12 PM, Staff FF, Nursing Assistant (NA) stated they wrote out a list of showers for the day from the computer list. Staff FF stated if a resident refused a shower, they would fill out a refusal form, give the form to a nurse for a signature. The refusal forms were then placed in the shower book for the unit nurse to reference and document in the computer. During an interview on 07/11/2024 at 1:46 PM, Staff GG, NA stated we only have one shower aide. Staff GG stated they don't have many shower refusals maybe one or two at the most. Staff GG stated they also fill out a form, have the resident and the nurse sign so the unit nurse is aware the shower was attempted. During an interview on 07/16/2024 at 9:54 AM Staff T, Restorative Nursing Assistant (RNA), stated Resident 13 required one staff member for bed mobility and required two staff members to transfer. Staff T stated they encouraged Resident 13 to do their own grooming and set up the resident for those tasks. Staff T stated Resident 13 had not refused any care, never had any trouble with the resident, or heard of any refusals. During an interview on 07/17/2024 at 11:35 AM Staff C, LPN/Unit Coordinator (LPN/UC), stated their expectation were that the residents were dressed appropriately and that they were clean and look good, Staff C stated the showers were an issue and they were working on a plan. Staff C also stated they expected the showers to be done on the resident's preferred day. 44922 <Resident 22> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include a stroke (occurs when blood flow to the brain is blocked or reduced) affecting their left side of their body and diabetes (a disorder in which the body has high sugar levels for prolonged periods of time). The 06/06/2024 comprehensive assessment showed the resident's cognition was intact and required one to two staff assistance for ADLs. A concurrent observation and interview on 07/08/2024 at 10:34 AM, Resident 22 stated they were unlucky with showers and today was the day they were scheduled to receive a shower but was not going to get one. The resident stated they missed their showers often because the shower aide called in sick, or the hot water was not working. Resident 22 pointed to an organizer on their sink that displayed a sign to show their shower days were on Mondays and Thursdays. Today was a Monday. Review of a shower schedule document, undated, showed Resident 22 received showers on Mondays and Thursdays. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/15/2024 at 3:07 PM, Resident 22 stated I am mad, I didn't get a shower again today [Monday]. Resident 22 stated they were told they would get their shower later this afternoon, but it was already later this afternoon and still had not received one. Resident 22 was lying in bed, still in their night gown, and stated they had been in bed all day waiting for their shower. The resident had a purple customer concern card (grievance) that had been given to them by a staff member and was going to fill it out and turn it into administration. An observation on 07/15/2024 at 3:31 PM, Staff A, Administrator, entered Resident 22's room to discuss their room being too warm. Resident 22 preceded to tell Staff A that they were really upset which was probably making them warmer than normal. Staff A continued to discuss the air conditioning in the room without asking the resident why they were upset then exited the room. Resident 22 had the purple customer concern form sitting in front of them on the bedside table. During an interview on 07/16/2024 at 10:55 AM, Staff T, RNA, stated a shower aide had called in for this morning shift, so they only had one shower aide. Staff T stated the NAs who were currently working tried to get the missed residents their showers but only if they had the time while someone else monitored their halls. A concurrent observation and interview on 07/16/2024 at 10:57 AM, showed Resident 22 lying in bed, in a hospital gown, hair unkempt, and stated they never received their shower on 07/15/2024. Resident 22 stated they were told they would receive one in the evening last night (07/15/2024) and again this morning, but never did. Resident 22 stated they had turned in the purple customer concern (grievance) form. During an interview on 07/16/2024 at 11:40 AM, Staff W, NA, stated they had just reported to their nurse manager that they had a resident that wanted a shower, and they could have assisted them with one but needed someone to watch their hall. Staff W stated both shower aides had called in for 07/16/2024 and they only had one shower aide for the afternoon of 07/15/2024 due to call ins. Staff W stated the shower aides would call in often, so the Director of Nursing Services (DNS) scheduled different aides to rotate them out and not always use the same ones, but it seemed like it continued to happen often. During an interview on 07/16/2024 at 1:14 PM, Staff D, LPN/UC, stated they had plenty of staff to provide showers to the residents but if one did not show up, it threw the whole schedule off. The normal process would be for other NAs to jump in and try to get the showers completed or the nursing staff would group together to assist the NAs to ensure the residents got their showers. Staff D stated the NAs needed to communicate those needs so others could help. During an interview on 07/16/2024 at 2:36 PM, Resident 22 stated they still had not received their shower and that no staff had talked with them concerning their written customer concern. During an interview on 07/17/2024 at 10:28 AM, Staff B, DNS, stated they were in the process of fixing the shower aide schedules because what was currently in place was not working. Staff B stated they did have a shower room that had not been working on Monday, 07/15/2024, and stated they were down to one shower room while the other one was being repaired. Staff B stated the plumber was called out and the second shower room opened back up on Tuesday morning and they were playing catch-up with the resident showers. (continued on next page)

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	505070	A. Building B. Wing	07/17/2024

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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC: 388-97-1060 (2)(c)

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 07/17/2024
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review the facility failed to ensure residents received medications or supplements that were physician prescribed and monitored as ordered for 1 of 1 resident (Resident 21) reviewed for insulin. This failed practice had the potential to cause the resident to experience adverse side effects and ineffective medication needs. Findings included . <Resident 21> Review of the resident's medical record showed they admitted to the facility on [DATE] with diagnoses to include diabetes (a disorder in which the body has high sugar levels for prolonged periods of time) and morbid obesity. The 04/12/2024 comprehensive assessment showed the resident's cognition was intact and required one to two staff assistance for activities of daily living. A concurrent observation and interview on 07/08/2024 at 11:42 AM, Staff L, Licensed Practical Nurse (LPN) was checking Resident 21's blood sugar levels prior to lunch being served. Staff L stated to Resident 21 that their blood sugar had recently been running lower than normal and today it was at 74 milligrams per deciliter (mg/dL, a unit of measure) normal blood sugar levels for people with diabetes are between 80-130 mg/dL before meals. Review of a 07/08/2024 nursing progress note, showed Staff L documented the resident's blood sugar levels had been very low for about a week. Staff L documented when questioning the resident if their eating habits had changed and the resident stated they had been taking a supplement called sugar defender [a dietary supplement that supports and balances blood sugar in the body). The note additionally showed the provider had been notified but no other follow up was documented. Resident 21 stated they would normally receive insulin but had not needed any in a few days because their blood sugars had been running low. During an interview on 07/10/2024 at 10:21 AM, Resident 21 stated they had been taking a dietary supplement to help them lose weight. Resident 21 stated they had been using the supplement for a month already. Resident 21 retrieved the supplement from their bedside drawer, it was a brown 60 milliliter (a type of measurement) bottle of liquid with a dropper and the directions showed the dose was two full droppers daily. The bottle was labeled Sugar Defender blood sugar support formula. Resident 21 stated they were only taking two drops out of one full dropper. Review of Resident 21's Nursing blood sugar task report (vital signs portion of the medical record) dated 05/10/2024 to 06/9/2024, showed the resident's blood sugars fell below 100 mg/dL on three out of 117 opportunities. Review of blood sugars from 06/10/2024 to 07/09/2024 (the approximate time frame the resident had been taking the dietary supplement) showed the resident's blood sugars fell below 100 mg/dL twenty eight out of 101 opportunities, with some of those 28 as low as 64 mg/dl (07/08/2024), 74 (07/07/2024), and 56 (07/01/2024). (continued on next page)

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 07/17/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Richland		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Goethals Drive Richland, WA 99352	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/2024 at 9:18 AM, Staff L stated they did not remove the supplement from the resident's room when they discovered it but probably should have. Staff L stated the provider did not give them any new orders when they informed them of the low blood sugars or the supplement the resident had been taking and had assumed the provider seen them on rounds and talked to them because their blood sugars had come back up. During review of the provider's notes from 07/08/2024 to 07/16/2024, showed there was no note from the provider that they had seen or spoken to the resident regarding their use of the dietary supplement. During an interview on 07/17/2024 at 10:14 AM, Staff B, Director of Nursing Services, stated they would have expected Staff L to retrieve the dietary supplement until the provider reviewed that it was safe for the resident to take and obtain orders for it. Staff B stated Staff L did not follow the correct process. Reference WAC: 388-97-1060 (3)(k)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to provide outside vision services for 1 of 1 resident (Resident 52), reviewed for experienced changes to their vision. This failed practice put the resident at risk for unmet vision needs and the ability to maintain their independence. Findings included . <Resident 52> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include diabetes (a disorder in which the body has high sugar levels for prolonged periods of time) and heart failure. The 05/06/2024 comprehensive assessment showed the resident's cognition was intact and required substantial to maximum staff assistance for bed mobility and was independent on staff for their transfers. The assessment further showed the resident wore glasses. During an interview on 07/09/2024 at 1:11 PM, Resident 52 stated they had experienced seeing double vision for the past month or longer and reported it to a nurse manager. The resident stated they were told that they were unable to see an eye doctor until they were no longer on Medicare (a U.S. government health insurance program for people 65 or older, younger people with disabilities, and patients with end-stage renal disease). Resident 52 stated they worried if they went too long without getting their vision assessed, they would lose their vision. During an interview on 07/17/2024 at 9:23 AM, Staff C, Licensed Practical Nurse/Unit Coordinator, stated residents were given a choice to see their own outside providers when they requested to do so. Staff C stated, a good month to six weeks ago, Resident 52 reported to them they had some blurryness or it could have been double vision and wanted to see an eye doctor. Staff C stated they wrote themselves a reminder note and passed the note on to Staff G, Social Services Director, who was responsible for arranging vision appointments. During an interview on 07/17/2024 at 11:27 AM, Staff G stated they did not receive a note from Staff C regarding arranging a vision appointment for Resident 52 and no vision appointment had been made. During an interview on 07/17/2024 at 10:14 AM, Staff B, Director of Nursing Services, stated they would have expected a vision appointment to have been scheduled right away, no matter what the resident's payer source was and that the correct process was not followed. Reference WAC: 388-97-1060 (3)(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interviews, and record review the facility failed to complete skin assessments or obtain treatment orders to manage pressure ulcers to prevent the development and/or worsening of pressure ulcers for 1 of 1 (Resident 52) reviewed for pressure ulcers. This failure placed the resident at risk for developing and/or worsening of pressure ulcers and increased pain. Findings included . Review of the National Pressure Injury Advisory Panel's (NPIAP, the leading expert in PIs/wounds) guidelines and definitions, dated September 2016, defined pressure injury stages as follows: Stage 1 PI has intact skin with a localized area of non-blanchable erythema (redness). Stage 2 PI is a partial thickness skin loss with exposed dermis (the top inner layers of skin). Stage 3 PI is a full thickness loss of skin, in which adipose (fat) tissue is visible in the ulcer. Slough (dead tissue) and or eschar (dried blood and tissue) may be visible, granulation tissue and epibole (rolled or curled under edges) may include with undermining (a pocket of dead space under the visible wound edges) and tunneling (a passageway under the wounds surface which may be shallow or deep and impairs wound closure). <Resident 52> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include diabetes (a disorder in which the body has high sugar levels for prolonged periods of time) and post Laminectomy (a surgical procedure that removes a portion of a vertebra [small bones forming the backbone]) . The 05/06/2024 comprehensive assessment showed the resident's cognition was intact, required one to two staff assistance with activities of daily living, had functional impairments to both of their lower legs, and was at risk for developing pressure ulcers. During an interview on 07/09/2024 at 9:39 AM, Resident 52 stated they had a sore on their bottom that the staff had applied cream to for the past three weeks and a sore in the crease of their buttocks. Resident 52 stated they were told by staff they had been referred to the wound care doctor and would be seeing them on Wednesday, 07/10/2024. A concurrent wound observation and interview on 07/11/2024 at 2:46 PM, showed the resident had a dime sized opened area to their right buttock that had the top layers of skin missing, the outer edges were moist, white, and stringy. In the crease of Resident 52's buttocks there were four, 0.5 centimeters (cm, a type of measurement) by 0.5 cm opened areas that were missing the top layers of skin, were red in color, and moist, and at the bottom of the laminectomy surgical incision to the spine, there was an opened area, the size of the tip of a pen in depth, with hard brownish green edges. Staff T, Restorative Director, and Staff U, Nursing Assistant, both stated the wounds on the bottom had been there for awhile and the nursing staff were aware they were there. Staff T stated when new skin issues are observed, they were to report them to the nurses right away so they could assess them. Resident 52 stated the wound care physician did not see the resident on 07/10/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing progress note on 07/14/2024, showed Resident 52 reported open skin on their right buttock and between their buttocks. The note showed there was an open area slightly larger than a dime and was oval shaped to the right buttock that measured 1.5 cm by one cm and had no depth, weeping, or bleeding. Between the buttocks there was an open wound that was 2.5 cm in length with serosanguineous (normal drainage of fluid from a wound or incision site) drainage. The note additionally showed the provider was notified and a risk assessment was initiated. Review of the resident's Medication Administration Records (MARs) dated 07/01/2024 to 07/15/2024, showed an order dated 05/02/2024 for weekly skin assessments to be obtained on Saturdays during the night shift and were to be completed on the user defined assessment (UDA) form. The last two assessments showed nursing had signed the skin assessments were completed on 07/06/2024 and 07/13/2024. Review of Resident 52's UDA skin assessments, showed the resident had not had a skin assessment completed since 06/15/2024, even though nursing staff had signed they had been completed. (The resident should have had four skin assessments completed from 06/15/2024 to 07/15/2024). Review of Resident 52's wound observation assessments showed the last wound assessment completed was 06/01/2024 for a wound to their groin area. During an interview on 07/15/2024 at 2:43 PM, Resident 52 stated a female nurse looked at all their skin issues over the weekend and they had also found a new sore to their penis believed to be from the urinary retention catheter (a tube inserted into the bladder that carries urine outside of the body to a drainage bag) tubing. Review of the resident's Treatment Administration Records (TARs) dated 07/01/2024 to 07/15/2024, showed the resident did not receive any treatment to their skin nor did they have skin issues that were being monitored or treated. During an interview on 07/16/2024 at 4:04 PM, Staff B, Director of Nursing Services stated they were notified by a weekend nurse that Resident 52 had skin issues on their right buttock, their crease of their buttock and a risk management had been started. Staff B stated the resident would be seen during wound rounds. Staff B further stated they would have expected there to be treatment orders and monitoring initiated, but after reviewing the record, stated that process had not been followed. Staff B additionally stated their expectation would be for the nurses to follow the skin assessment orders and complete their skin assessments as the order directed them to do. Staff B stated that process was not followed. Reference WAC: 388-97-1060 (3)(b)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview and record review, the facility failed to ensure residents were free of unnecessary psychotropic (medications capable of affecting the mind, emotions, and behavior) medications for 1 of 5 residents (Resident 30) reviewed for unnecessary medications. The facility failed to ensure psychotropic medications had a gradual dose reduction (GDR, is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) to determine continued need and use of a medication, nor were person-centered behaviors being monitored to reflect adequate need of the medication. These failures placed the resident at an increased risk for receiving medications they no longer needed and/or increased behaviors due to inadequate dosing of medication. Findings included . <Resident 30> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include bi-polar (serious mental illness characterized by extreme mood swings), depression (persistent feelings of sadness and loss of interest) and no GDR had been attempted since admission. A concurrent observation and interview on 07/12/2024 at 10:22 AM, showed Resident 30 in their wheelchair self-propelling up and down the hallway. The resident was clean, dressed, groomed, smiling, and able to conversate. Resident 30 would attempt but was unable to answer questions appropriately and mid-sentence, would change the subject often. Resident 30 would stop talking if the Surveyor attempted to acknowledge their answers, and their eyebrows would turn down, scrunch their eyes, and take deep breaths as if they were annoyed. Review of Resident 30's July 2024 Medication Administration Record showed as follows: On 04/16/2024 - do not taper Seroquel [a brand of antipsychotic [treat psychosis, a collection of symptoms that affect your ability to tell what's real and what isn't] medications] order for delusional (fixed, false conviction in something that is not real or shared by other people) disorder. On 03/19/2024, give Seroquel 50 milligrams (a type of measurement) by mouth daily at bedtime for bi-polar disorder. (This order had no changes to the dose, route, or frequency since admission on 07/23/2023). On 04/24/2024, an order to monitor for delusions- with no behaviors documented in April 2024, one shift of delusions in May 2024, no behaviors in June 2024, and no behaviors from 07/01/2024 to 07/11/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Pharmacist review dated 04/08/2024, showed a recommendation to attempt a GDR for the Seroquel and the provider's response was the [patient] pt. needs to continue [Seroquel] due to [their] delusional disorder. Review of Resident 30's 01/01/2024 to 07/14/2024 Treatment Administration Record showed an order on 11/24/2023 to monitor for extreme highs or lows, as evidenced by sadness or mania (abnormally elevated, extreme changes in your mood or emotions, energy level or activity level). The documentation showed as follows: January 2024 - no behaviors and three shifts of missing documentation. February 2024 - no behaviors and five shifts of missing documentation. March 2024 - no behaviors and five shifts of missing documentation. April 2024 - one shift of delusional behaviors, and no other behaviors. May 2024 - no behaviors and three shifts of missing documentation. June 2024 - six shifts of behaviors, and two shifts no documentation. 07/01/2024 to 07/11/2024- no behaviors. During an interview on 07/12/2024 at 10:33 AM, Staff C, Licensed Practical Nurse/Unit Coordinator, stated Resident 30 had behaviors that consisted of them talking to themselves out loud or yelling out oooh or ahhhh while in the presence of other residents. The resident would not be directing their yelling out to other residents, but the other residents were not aware of that, and it would startle them causing them to become irritated with Resident 30, at times, causing altercations between them. Staff C stated Resident 30 would also bang on the walls or the sides of the medication carts and become annoyed if they were interrupted while talking. Resident 30's behaviors would be distressing to other residents, not themselves so the medications kept them safe. Staff C further stated they did not believe the behaviors that were being monitored were individualized to Resident 30 and they should be more specific so the nursing staff could document appropriately to show the medications were needed, if needed. Staff C stated if the resident was not showing behaviors, then a GDR should have been completed. During an interview on 07/17/2024 at 10:14 AM, Staff B, Director of Nursing Services, stated their expectation would be to monitor the behaviors the residents were currently experiencing and updating them as needed. Staff B stated they reviewed resident behaviors in the psych meeting once a month and with the team's input, it was determined whether the resident would be appropriate for a GDR or not. Staff B stated the team did not feel Resident 30 was appropriate for a GDR due to behaviors that were not being documented. Reference WAC: 388-97-1060 (3)(k)(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45642 Based on observation, interview and record review, the facility failed to ensure expired medications were destroyed in 1 of 1 medication room (Team 1 med room) and 1 of 2 medication carts (Team 2 med cart). These failures placed residents at risk for receiving expired medications and negative health outcomes. Findings included . <Team 1 Med Room> A concurrent observation and interview of the Team 1 medication room on 07/11/2024 at 11:00 AM with Staff C, Licensed Practical Nurse Unit/Coordinator showed the following expired medications and medical supplies: A bottle of Megestrol Acetate (an oral medication used to stimulate the appetite) with an expiration date of 04/01/2024. A Wixela inhaler (a medication used to control and prevent wheezing and shortness of breath caused by lung disease such as asthma and chronic obstructive lung disease (COPD) with an expiration date of 12/01/2024. A Spiriva Respimat inhaler (a medication used for maintenance treatment of long-term lung disease such as asthma and COPD) with an expiration date of 01/23/2024. A Fluticasone-Salmeterol inhaler (a medication used to prevent asthma attacks and to treat COPD with an expiration date of 01/09/2024. 1 vial of Lispro insulin (an injectable medication used to lower levels of sugar in the blood of persons with diabetes) with an opened date of 01/30/2024 and expiration date of 28 days after opening. Six bottles of Piperacillin/Tazobactam (an injectable penicillin antibiotic used to treat bacterial infections in the body) unmixed vials with expiration dates of 04/2024. 1 pen of Basaglar insulin (an injectable long-acting insulin that helps lower high blood sugar levels in persons with diabetes) with an opened date of 02/11/2024 and an expiration date of 28 days after opening. 1 glucagon tablets with an expiration date of 05/23/2023. Question? What type of glucagon tablets and how much? a bottle? Research of glucagon tablets says glucagon is not active when taken orally only in a nasal spray or injectable so don't know how to define. Did you mean Glucose tablets? (a medication used to treat low blood sugar levels) (continued on next page)

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	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An intravenous bag of Ceftriaxone (an antibiotic used to treat bacterial infections) with an expiration date of 03/12/2024. 1 Nasopharyngeal influenza swab (a cotton swab used to collect a specimen from the nose or throat) with expiration date of 07/21/2023. Staff C stated that the Team 1 med room did not get cleaned as often as it should, and they were responsible for the organization of the medication room, we need a better system. <Team 2 med cart> A concurrent observation and interview of the Team 2 med cart on 07/16/2024 at 10:18 AM with Staff II, Licensed Practical Nurse (LPN), showed the following expired medication: Lorazepam 0.5mg tablets (a medication used for short term relief of anxiety) discontinued date of 07/01/2023 there were 12 tablets left in the card, (twelve months after discontinuation). Staff II, LPN, stated the medication (lorazepam) needed to be destroyed. Staff II explained that the managers do the destroying. During an interview on 07/16/2024 at 1:36 PM, Staff B, Director of Nursing Services, stated if medications were discontinued, they were removed. Staff B stated that medications should have been destroyed weekly and the medication (lorazepam) came from a different place, and it was overlooked. Reference WAC: 388-97-1300 (1)(b)(ii), (c)(ii-iv)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on observation, interview, and record review, the facility failed to ensure foods were labeled and dated, expired foods were removed, and proper temperatures were consistently monitored for 2 of 2 snack/nourishment refrigerators (Teams 1 and 2) reviewed for infection control. This failed practice placed residents at risk for food borne illness. Findings included . Review of the policy titled .Sanitation and Food safety dated [DATE], showed a temperature monitoring log will be maintained, and a designated staff member will document refrigerator temperatures daily. The facility staff will check individual food items for expiration dates and discard outdated food. All food will be labeled and dated to monitor for food safety. All food items should be consumed or discarded after three days. All food items unmarked or unlabeled containers should be labeled with contents, and the date the food item was stored. Any food suspected to be contaminated or with visible signs of contamination should be discarded immediately. During an interview on [DATE] at 9:14 AM, Staff JJ, Licensed Practical Nurse (LPN), stated the nurses checked the temperatures of the medication and nutrition room refrigerators. Staff JJ stated the nurse's documented temperatures on the logs posted to the front of the refrigerators. During an interview on [DATE] at 8:26 AM, Staff KK, Housekeeping Director, stated that the facility nurses were responsible for documenting temperatures of the unit refrigerators, but not for the cleaning of the refrigerators. Staff KK stated that housekeeping will do the cleaning of the breakroom refrigerator but do not clean the medication room refrigerator. The Kitchen staff were responsible for the cleaning the unit refrigerators. During an observation on [DATE] at 9:11 AM, the Team 2 snack/nourishment refrigerator had two large undated/unmarked gray grocery bags filled with perishable food items, an undated/unmarked pizza box sitting on top of the gray grocery bags. Staff II, LPN, stated they were unsure who the grocery bags belonged to or where they came from. An observation of Team 2's nourishment/snack refrigerator-freezer temperature logs, dated [DATE], showed there were three dayshifts, and six evening shifts without temperature readings. The [DATE] refrigerator-freezer temperature log showed two dayshifts, and two evening shifts without temperature readings. An observation of the Team 1's nourishment/snack refrigerator-freezer temperature logs, dated [DATE], showed three dayshifts and four evening shifts without temperature readings. The [DATE] refrigerator-freezer temperature log showed three dayshifts without temperature readings. During an interview on [DATE] at 10:58 AM, Staff J, Dietary Manager, stated they stocked the nutrition rooms with snacks twice a day. Staff J stated they wiped out the inside of the refrigerators in the nutrition rooms and checked the food supply and expiration dates every Tuesday. The nurses were responsible for the temperature logs and ensuring the temperatures were appropriate. (continued on next page)

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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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC: [DATE] (3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 43280 Based on observation, interview and record review the facility failed to ensure staff maintained components of an infection prevention control program to prevent the development and transmission of infections with, 1) hand hygiene and glove change for 6 of 6 staff (Staff F, T, U, V, LL, and OO) reviewed during resident cares, and isolation precautions requiring hand washing, 2) improper use of Personal Protective Equipment (PPE) in infection isolation rooms (rooms that require the use of PPE), when sorting facility residents laundry, and with self-testing of infectious diseases for 6 of 6 staff (Staff F, T, N, HH, KK, and PP) reviewed for standard precautions with PPE, 3) cleaning and disinfecting of the facility's isolation precaution room (a process used to reduce the transmission of infectious bacteria and organisms in the healthcare setting) without an Environmental Protection Agency (EPA) registered disinfectant for 1 of 2 staff (Staff QQ) reviewed for environmental cleaning and disinfecting. These failures placed residents at an increased risk for exposure to cross contamination (harmful spread of diseases) and transmission of infectious diseases. Findings included . Review of Centers for Disease Control and Prevention (CDC) recommendations titled, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 02/27/2024 showed that hand hygiene was to be implemented to reduce the harmful spread of infections in the healthcare setting. Common situations that required staff to perform hand hygiene were before/after contact with a resident, before handling clean or soiled dressings, before moving from a contaminated body site to a clean body site during resident care, after touching a resident or their surroundings, and immediately after glove removal. Review of the undated facility guidelines titled, Enhanced Barrier Precautions [(EBP) an isolation room that requires the use of PPE], showed that all staff were to perform hand hygiene before entering and when leaving a room. Staff were to .wear gloves and a gown for the following high-contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use . Review of the facility guidelines titled, Contact Enteric (related to or occurring in the intestines of the body) Precautions, dated 05/30/2019, showed anyone that entered the enteric, also known as Clostridium Difficile (C. Diff, a type of bacterium that causes an infection of the colon, the longest part of the large intestine) must clean hands with sanitizer when entering room .wash with soap and water upon leaving room . and that a gown and gloves need to be worn when entering the precaution room. Review of the facility policy titled, Laundry Services, updated 06/04/2024 showed that facility staff would handle all used laundry as potentially contaminated and use standard precautions with appropriate PPE. Further the policy showed that when separating/sorting laundry staff were to don (to put on) a gown, gloves and when it was possible to have splashing of resident fluids then a face mask and eye protection would be worn. (continued on next page)

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 07/17/2024

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Centers for Disease Control and Prevention (CDC) recommendations titled, Guidelines for Environmental infection control in Health-Care Facilities, updated July 2019, showed that cleaning and disinfecting environmental surfaces is fundamental in reducing their potential for transmission of diseases. Environmental surfaces can be medical equipment surfaces or .housekeeping surfaces (e.g., floors, walls, and tabletops), and need to go through a cleaning and disinfecting process. Environmental surface disinfectants are regulated by the EPA and labeled with an EPA registration number. <Hand Hygiene, PPE> During a concurrent observation and interview on 07/08/2024 at 2:29 PM, showed the soiled linen area of the laundry room had unlabeled and/or designated soiled bins used when sorting resident laundry. Staff PP, Housekeeping Assistant (HA), stated they sorted all the facility's linen/resident laundry into separate bins three times a day and would don gloves and mask. Staff PP stated that no other precautions were implemented when handling the current COVID-19 positive or C. Diff positive residents' linen. An observation on 07/09/2024 at 12:28 PM, Staff HH, Nursing Assistant (NA), entered Resident 43's room who had EBP sign up without putting on the appropriate PPE. Staff HH stated they should have donned their PPE before going into the room, they just forgot what they were doing. During a concurrent observation and interview on 07/10/2024 at 9:08 AM showed Staff QQ, HA, cleaning an isolation precaution room. Staff QQ stated they were starting with the C. Diff positive isolation room first and then would move on to clean the other resident rooms after. During cleaning, staff QQ touched multiple soiled surfaces in the room (bathroom toilet/sink, bedside table, nightstand) and made three trips back and forth (from their housekeeping cart in the hallway outside of the room) with the same soiled gloves that were donned when they first entered the resident room to begin cleaning and never changed them. Staff QQ touched items on the housekeeping cart (locked door that was opened/closed when grabbing chemicals, broom/dustpan) which were not disinfected afterwards. Staff QQ wore a wrist band with their housekeeping cart keys (used to open and close the lock door on their cart) on the outside of their gown when cleaning the isolation precaution room which scraped across surfaces as Staff QQ was cleaning. During the cleaning process staff QQ proceeded to touch the back of their shirt (not covered by their gown) and hair (that was in a ponytail) with soiled gloves as they cleaned the isolation precaution room. Staff QQ used the neutral floor cleaner, to clean the C. Diff isolation room floor. Additionally, Staff QQ did not wash their hands with soap and water after exiting/doffing (to take off) their soiled gloves when they had finished cleaning the C. Diff isolation room. A concurrent observation and interview on 07/10/2024 at 9:13 AM, showed Staff F, Registered Nurse, walking down the 300 hallway holding a used COVID-19 (an infectious disease-causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death) testing nasal swab folded in a testing solution card (the process that is used after self-testing for COVID-19) without the proper PPE on. Staff F stated their normal process was to test themselves in their office, without any PPE, and then place the tests in a designated area for the Infection Preventionist (IP) to read. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 07/10/2024 at 9:42 AM showed Staff PP, HA, in the laundry room sorting resident linens. Staff PP donned gloves and a mask before starting the task of sorting the linen. Staff PP was observed grabbing, opening plastic linen bags and placing the linen into the soiled bins. Staff PP was unable to identify which bag of linen came from the COVID-19 or the C. Diff positive isolation rooms. During an interview on 07/10/2024 at 11:27 AM, Staff KK, Housekeeping Director (HD), stated they should have a system to identify if the bags of resident linen came from a COVID-19 or C. Diff positive isolation room so they can be washed separately. Staff KK stated that Staff PP did not follow the correct process and should have donned a gown and face shield in addition to their gloves and mask. During an interview on 07/10/2024 at 2:31 PM, Staff I, IP, stated all laundry staff should be wearing a gown, gloves, face mask, and face shield when sorting residents' linen. Staff I stated that Staff PP did not follow the correct process and that C. Diff/COVID-19 linen should be placed in a biohazard bag (a red or yellow bag that indicates a biological or chemical substance that is dangerous to humans is inside of it) and sorted into a different soiled bin so they can be washed separately. An observation and interview on 07/10/2024 at 2:28 PM, showed Staff T, Restorative Nursing Assistant, entered Resident 365's room, with EBP in place, without PPE on. Staff T helped Resident 365 with drinking fluids and repositioned them in bed, including positioning their legs and removing soiled linen. Staff T did not perform hand hygiene prior to or after providing care, nor did they wear gloves. Additionally, at 2:30 PM. Staff T stated they would put on all PPE if they were going to be emptying Resident 365's urinary catheter (a tube inserted into the bladder and carries urine outside of the bladder into a drainage bag) or working with their wound. Staff T stated they should have performed hand hygiene prior to and after care and should have worn gloves. An observation on 07/10/2024 at 2:49 PM, Staff V, NA, was observed entering in and out of resident rooms on the 300 hall, obtaining their soiled water cups, bringing them out in to the hall, using an ice scooper to scoop ice out of an ice chest, resting the ice scooper on the rim of the soiled cup, and then filling the cup with a pitcher of water. This process continued for all residents on the 300 hall without Staff V wearing gloves or performing hand hygiene in between residents or resident rooms. During an observation on 07/10/2024 at 3:56 PM, Staff NN, Housekeeping Assistant, exited an isolation room that contained C. Diff. with soiled gloves removed a bag from their cart and removed their gloves without performing hand hygiene with soap and water. Staff NN replaced their gloves, reached into their pocket, and grabbed the cart keys. An observation on 07/11/2024 at 12:26 PM, during dining, Staff LL, NA, removed the plate warmer from the plate, opened the resident soda, and walked down the hall with the tray uncovered, without performing hand hygiene. Staff LL stated they did not realize they had not performed hand hygiene. An observation and concurrent interview on 07/11/2024 at 12:35 PM, Staff MM, Physical Therapy Assistant, exited an isolation room stated they removed their PPE and came out to perform hand hygiene with hand sanitizer instead of soap and water. Staff MM stated that they did not know they had to use soap and water in a C-Diff isolation room. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 07/11/2024 at 2:46 PM, Staff U, NA, was observed providing incontinent care to Resident 52. Staff U cleansed Resident 52's bowel movement with wipes, removed soiled gloves and donned (put on) new gloves without performing hand hygiene. Resident 52 had opened wounds on their buttocks. An observation on 07/12/2024 at 4:08 AM, Staff OO, NA, donned gloves and provided incontinent care to Resident 9. Staff OO cleansed Resident 9 with wipes then with the same gloves, applied a clean brief, pulled up the resident's pajamas, repositioned them in bed with pillows, pulled their blankets up over them, removed their gloves, and performed hand hygiene. Staff OO then grabbed Resident 9's soiled water cup, carried it out to the hallway, filled it with ice, resting the ice scoop on the lip of the cup, filled the cup with a pitcher of water, replaced the ice scoop, and returned the cup to Resident 9 without wearing gloves or performing hand hygiene. Staff OO completed this same process with Resident 309's water cup. An observation on 07/12/2024 at 4:15 AM, Staff OO provided incontinent care to Resident 366, Staff OO donned gloves, cleansed the resident's bottom and genitals, applied a clean brief, removed the soiled gloves, and no hand hygiene was performed. Staff OO donned new gloves, changed the resident's urine-soaked linens, replaced with clean linens, removed gloves, and performed hand hygiene for less than six seconds. An observation and concurrent interview on 07/12/2024 at 5:39 AM, Staff N, LPN, entered an EBP isolation room without donning PPE. Staff N stated they entered Resident 55's room to reposition the resident in bed. Staff N stated, I know, I should have had my PPE on. An observation on 07/12/2024 at 9:30 AM, Staff HH entered Resident 43's room that was an EBP room, without donning PPE. Staff HH laid Resident 43 down in bed and used the bed control to adjust the resident in bed. Staff HH stated they did not realize they were in an isolation room. During an interview on 07/16/2024 at 4:16 PM, Staff I, IP, stated they had trained staff with return demonstration on the proper self-testing process and Staff F did not follow the correct process. Staff I stated they would expect staff to be washing their hands between dirty and clean tasks, when providing care in any isolation room, or anytime they have physical contact with a resident, their belongings, or entering/exiting rooms. Staff I further stated staff should not bring resident cups out into the hallway to fill them up, and if they did, they should have followed the correct hand hygiene process. Staff I stated if staff forgot which PPE to don for isolation rooms all they had to do was read the sign posted. Staff I stated staff did not follow the correct process. < Environment/Isolation Precautions> During an interview on 07/08/2024 at 3:04 PM, Staff QQ, HA, stated they did not clean resident rooms in any specific order, and did not have a process to clean/disinfect COVID-19 or C. Diff positive isolation rooms after all other resident rooms were cleaned. Additionally, the chemical used to clean all the floors in resident rooms, regardless of isolation precautions was a neutral all-purpose cleaner or the defend disinfectant (a specific chemical) for regular surfaces in a resident room or Virex tuberculosis (Virex TB, a specific chemical that can kill TB) for highly touched surfaces. Staff QQ was not aware of the need to have an EPA registered disinfectant to kill C. Diff. (continued on next page)

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	505070	A. Building B. Wing	07/17/2024

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Concurrent observations and interviews on 07/08/2024 at 3:16 PM showed Staff KK, HD, showed a bottle of Neutral All-Purpose Cleaner/Degreaser, that was utilized when cleaning all the floors of the facility. The neutral all-purpose cleaner/degreaser did not have an EPA number that registered it as a disinfectant for COVID-19 or C. Diff. Staff KK showed a bottle of Defend disinfectant, EPA registered number 1839-95. Staff KK stated it was used on regular surfaces in resident rooms and Virex TB, EPA 70627-2 used on high touched surface areas in the resident environments. Review of Centers for Disease Control and Prevention (CDC) recommendations titled, EPA's Registered Antimicrobial Products Effective Against C. diff Spores [List K], updated 06/03/2024 showed neutral all-purpose cleaner/degreaser, defend disinfectant nor the Virex were an EPA registered disinfectant that would kill C. Diff. During an interview on 07/08/2024 at 3:20 PM Staff NN, HA, stated they used the neutral all-purpose clean on all the floors in the facility, regardless of the resident's isolation precautions status. When asked their process with the order of cleaning resident rooms, Staff NN stated they had already cleaned the one COVID-19 positive resident room and still had six more rooms to clean for their shift. Staff NN confirmed they used the same chemicals when cleaning resident rooms as Staff QQ. Staff NN was not aware of the need to have an EPA registered disinfectant to kill C. Diff. During an interview on 07/10/2024 at 11:27 AM, Staff KK, HD, stated that Staff QQ should have used bleach when cleaning all the surfaces in the C. Diff isolation room. Staff QQ stated they were unaware that an EPA registered disinfectant like bleach (a chemical used to kill C. Diff) was to be used in an isolation precaution room and they should have been using it. Staff KK stated they were using the defend disinfectant or the Virex TB which were not effective in killing C. Diff. Staff KK stated that Staff QQ did not follow the correct process when cleaning the isolation precautions room and should have washed their hands with soap and water. Staff KK stated the COVID-19 positive resident room had been taken off isolation precautions on 07/10/2024 at 12:00 AM, but they were unaware that an enhanced terminal clean was to be completed after a resident had come of isolation precautions/transferred out of an isolation room. During an interview on 07/10/2024 at 2:31 PM, Staff I, IP, stated that Staff QQ did not follow the correct process for cleaning/disinfecting an isolation precaution room and they should have been using an EPA registered disinfectant to kill C. Diff. Staff I stated Staff QQ should have washed their hands with soap and water when exiting the room and should have wiped disinfected their housekeeping cart after touching it with soiled gloves. Staff I further stated that all isolation precaution rooms should have an enhanced terminal cleaning completed after the resident leaves the room or when isolation precautions were stopped. Reference WAC: 388-97-1320 (1)(c), (2)(a) 44922