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	07/23/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to inform the Resident Representative (RR) of changes in the resident's pain medication regimen for 1 of 2 residents (Resident 57) reviewed for an order change for pain medication. This failure disallowed the RR to make an informed decision concerning the resident's care needs.Findings Included .<Resident 57> Review of the medical record showed the resident was admitted on [DATE] with diagnoses of a right hip fracture, muscle weakness, seizures and dementia (cognitive impairment). The 07/01/2025 nursing assessment/ care plan showed Resident 57 was totally dependent on staff for all activities of daily living to include bed mobility and transfers to a wheelchair. Resident 57's pain medication orders included a narcotic pain reliever which was discontinued on 07/10/2025. Tylenol (a non-narcotic pain reliever) was started on 07/10/2025 as needed. A 07/12/2025 order was initiated for Robaxin (a muscle relaxant) initiated three times a day on a routine basis. During an observation on 07/15/2025 at 3:02 PM, Resident 57 was up in their wheelchair with metal leg extenders connected to the resident's wheelchair where both legs rested on and extended legs forward. Resident 57 was alert but non-verbal and did not respond verbally or non-verbally when spoken to. The RR stated that they were concerned about not being notified of the new order on 07/12/2025 Robaxin order for Resident 57. The RR stated they were at the facility most of the day with Resident 57 and was not notified of the change in their Robaxin medication and felt that the Robaxin had made the resident drowsier where they could not participate in their physical therapy. During an interview on 07/15/2025 at 3:30 PM, Staff K, Licensed Practical Nurse (LPN), stated that Staff N, Advanced Registered Nurse Practitioner (ARNP) wrote the order, and it was on the Medication Administrative Record as ordered. During an interview on 07/17/2025 at 11:46 AM, Staff N stated that they wrote the order for the Robaxin and did not inform Resident 57's RR about the change. Reference: WAC 388-97-0300(3)(a)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure clinical appropriateness for safe self-administration of medication, leaving medications at bedside for 1 of 2 residents (Resident 82), reviewed for medication administration. This failure placed the residents at risk for medication errors and adverse medication interactions. Findings included .Review of the facility's policy titled, Administration of Medications, dated 09/16/2024, showed, the facility would ensure medications were administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms.<Resident 82> Review of the resident's medical record showed Resident 82 was admitted to the facility on [DATE] with diagnoses to include heart failure, diabetes (a disease in which the body does not control glucose [a type of sugar] in the blood), and dysphagia (difficulty swallowing). Review of Resident 82's comprehensive assessment dated [DATE], showed the resident's cognition was moderately impaired and required setup assistance with eating. During an observation on 07/15/2025 at 10:27 AM, Resident 82 was lying asleep, and next to the resident was a bedside table with a pitcher of water, a tube of Vaseline, and a medication cup. The medication cup contained three medications: one elongated white pill and two beige and green capsules. In an observation and concurrent interview on 07/15/2025 at 2:06 PM, Resident 82 was awake lying in bed, the bedside table had a medication cup with three medications: one elongated white pill and two beige and green capsules. The resident stated they were not aware if the medications were theirs or when they were brought into their room. During an observation on 07/16/2025 at 8:45 AM, Resident 82 was lying in bed sleeping, the resident's bedside table with a water pitcher, butter package and a medication cup with three medications. The medication cup contained three medications: one elongated white pill and two beige and green capsules. During an interview on 07/17/2025 at 12:53 PM, Staff S, Registered Nurse, stated their process for completing a medication pass depended on the resident and how they preferred to take their meds. Staff S stated they looked at the medications because physician orders get changed so quickly and then mark off the medication in computer. Staff S stated for Resident 82, they gave their medications with apple sauce. Staff S stated they could not verify the medications observed at Resident 82's bedside. Staff S stated, it would have not been me because I give their medications with apple sauce. Staff S stated they were not sure how long the medications were on the bedside table, and they did not see the medications when they were in Resident 82's room during their night shift. Staff S stated they did not usually look around the room when delivering medications but, maybe they should start doing a scan of the room with their medication pass. During an observation and concurrent interview on 07/16/2025 at 10:17 AM, Staff B Director of Nursing Services, stated the expectation was for the nurse to follow the rights during medication administration, such as the right med, the right resident, the right route etc., give medication and hand wash when done. Leaving the medications at the bedside was not the expectation. Reference: WAC 388-97-1060 (3)(k)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure quarterly financial statements for resident trust accounts were provided in accordance with generally accepted standards of accounting practice for 1 of 3 residents (Resident 6), reviewed for trust accounts. Failure to provide resident /resident representative's quarterly financial statements for the months of January, March, November and October 2024, placed the resident at risk for loss of personal funds. Findings included . <Resident 6> Review of the resident's medical record showed Resident 6 was admitted on [DATE] with diagnoses to include bipolar disorder (a brain disorder that causes changes in a person's mood, energy, or ability to function), dementia [the loss of thinking, remembering, and reasoning- to the extent that in interferes with Activities of Daily Living (ADLs)] and muscle weakness. The comprehensive assessment dated [DATE] showed the resident's cognition was severely impaired and required the assistance of two staff members with all care. In an interview on 07/16/2025 at 2:14 PM, Resident 6's Resident Representative (RR) stated the resident has a trust account with the facility. The RR stated the account did not hold much but had not received financial statements from the facility to verify if Resident 6 still had money in their account. The RR stated the facility had gone through a change in the financial department, but that they had not received a quarterly statement for the first quarter of the year 2024. In an interview on 07/22/2025 at 1:04 PM, Staff J, Business Office Manager, stated the resident had not received financial statements for the months of January, March, October and November of 2024. Staff J stated they had started as the BOM in October 2024 they realized residents had not received their financial statements, so they started a new process of sending out monthly statements. Reference: WAC 388-97-0340 (3)(a)(b)(c)

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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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure a resident received their mail for 1 of 1 resident (Resident 8) reviewed for resident rights. This failed practice put the resident at risk of not being able to make independent choices regarding their mail preferences. Findings included. <Resident 8> Review of the resident's medical records showed they admitted to the facility with diagnoses to include bipolar disorder (a mental health disorder that causes extreme mood swings) and diabetes (how the body regulates blood sugar levels). The 07/01/2025 comprehensive assessment showed the resident was cognitively intact and able to make their own decisions. During an interview on 07/16/2025 at 10:15 AM, Resident 8 stated they had not received packages they had ordered from Amazon (an online shopping retailer). Resident 8 stated they had several packages that showed as delivered but they had not received them yet. During an interview and concurrent observation on 07/17/2025 at 4:14 PM, Resident 8 stated they had still not received their packages and asked to speak to the Activities Director (AD), but they were in a meeting and were told they would come to see them after their meeting. Resident 8 stated they also called the AD's voicemail and left a message. Resident 8 stated they then called the front desk and was told by the front desk receptionist that Resident 8 did not have any packages delivered. Resident 8 then provided the confirmations of delivery for three packages that showed they were delivered to the facility's address; one had been signed by a staff member. Resident 8 provided confirmation that four additional packages had attempted to be delivered at 2:44 PM to the facility but the courier was unable to gain access to the front door. During an interview on 07/18/2025 at 9:50 AM, Staff P, Payroll, stated they were currently in charge of the front desk and had not received any packages for Resident 8. Staff P stated the routine front desk staff had started their vacation at the end of the day on 07/17/2025 so they may have talked with Resident 8 about delivered packages prior to them leaving. During an interview on 07/18/2025 at 9:56 AM, Staff Q, AD, stated they had not been able to talk with Resident 8 about missing packages and had not listened to their voice mails. Staff Q stated the Activities Assistant (AA) was who delivered mail and packages to the residents. Staff R, AA, walked in during the interview and stated they were responsible for delivering mail to the residents two to three times a week. Staff R stated they were directed by management if any packages came for Resident 8 from Amazon, they were not to accept them and return them. Staff R stated they were told Resident 8's Representative told the facility Resident 8 spent too much money and needed to quit ordering from Amazon. Staff Q did not know if Resident 8 was aware of their packages being returned. During an interview on 07/18/2025 at 10:58 AM, Staff A, Administrator, stated the Resident's Representative (RR) gave the facility the direction to return or retain Resident 8's packages from Amazon. Staff A stated the resident owed the facility money and did not have good spending habits, so the RR wanted to have the packages returned. Staff A stated they assumed the RR discussed this decision with Resident 8 but did not know for sure. Staff A stated Resident 8 gave permission to the business office to discuss Resident 8's financial situation with the RR. During an interview on 07/18/2025 at 11:06 AM, Staff J, Business Manager, stated they were told by the RR that they had talked to Resident 8 regarding the Amazon packages being returned but they did not witness that conversation nor did they talk to Resident 8 to confirm their wishes. During an interview on 07/18/2025 at 11:42 AM, Resident 8 stated they had given permission for their RR to discuss their financial situation with the business office but did not give consent for their mail or packages to be withheld from them. During this interview, the RR came to visit Resident 8, and the resident inquired about the direction to have their packages withheld. The RR stated they did give the direction to the facility to return the packages because they were spending too much money. The resident expressed to the RR that they were staying within the allotted amount the RR told them they had to spend and directed them to inform the facility to stop withholding their packages or mail. During an interview on 07/23/2025 at 9:55 AM, Staff P stated the RR informed them they were to stop holding Resident 8's packages or returning them. Reference WAC: 388-97-0180 (2)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure grievances (resident and/or resident representative concerns that can be voiced or written) conveyed during resident council meetings (a meeting of the facility's residents to communicate concerns, request improvements and keep up to date of the facility's activities/events) and individually, underwent prompt resolution through to their conclusion nor were residents appropriately updated on the voiced grievance progress/conclusion for 2 of 5 residents (Resident 77 and 69) reviewed for the grievances process. This failure placed residents at risk for unresolved concerns and unmet care needs.Findings included.Review of the facility policy titled, Grievances Program (concern and Comment), revised 01/07/2025, showed the facility would have a process in place for identification, investigation and follow-up of resident grievance/concern in a timely manner. Residents could convey grievances verbally or in writing. The policy showed that grievances would be documented on the grievance logbook, have a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the finding or conclusions and that follow-up with the resident would be completed to communicate a resolution.Review of the resident council meeting on 07/01/2025 showed residents expressed concerns around nursing assistants (NA) taking too long to respond to call lights, a door that needed to be repaired in room [ROOM NUMBER] and complications with receiving behavioral health counseling services. Additionally, Resident 77 and 69 attended the meeting.Review of the grievance log for July 2025 showed that no grievance had been documented regarding the resident council concerns with call light response times, the door that needed to be repaired nor that residents were having complications receiving behavioral health counseling services.<Resident 77> Review of the medical record showed the resident was admitted on [DATE] with diagnosis including anxiety, depression, and other complex mental health disorders. The 04/30/2025 comprehensive assessment showed the resident was cognitively intact and able to make their needs known.During an interview on 07/16/2025 at 10:39 AM, Resident 77 stated they had not received their scheduled behavioral health counseling services for the past two weeks. Resident 77 stated they had traumatic events that had taken place during the two weeks without the counseling services and the facility staff were aware of the concern.<Resident 69> Review of the medical records showed the resident was admitted on [DATE] with diagnoses including anxiety, depression, and other complex mental health disorders. The 06/11/2025 comprehensive assessment showed the resident was cognitively intact and able to make their needs known.During a resident council meeting on 07/17/2025 at 10:29 AM, Resident 69 stated they had concerns that scheduled behavioral health counseling appointments were not being completed and had been unable to meet with behavioral health staff.During an interview on 07/22/2025 at 10:06 AM, Staff G, Social Service Director, stated that Residents 77 and 69 had both expressed concerns about behavioral health counseling appointments being made but then the staff were not showing up to the appointments. Staff G stated they had not logged either of the resident's voiced concerns on the grievance log form. Staff G stated they should have implemented/documented the facility's grievance process regarding Resident 77 and 69's concerns.During a continued interview on 07/23/2025 at 8:47 AM Staff G stated they were the Grievance Officer and were to be notified of grievances noted in the resident council meetings by the Activities Director but was not informed of any resident council grievance for July 2025.Reference: WAC 388-97-0460(2)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents on psychotropic medications (drugs that affect brain activities associated with mental processes, emotions and behavior) had non-pharmacological interventions (alternative treatment of a resident's symptoms that are directed toward understanding, preventing and relieving a resident's distress or loss of abilities and do not involve the use of medications) consistently attempted and were being monitored for individualized behaviors prior to psychotropic administration to reflect adequate need of the medication for 2 of 5 residents (Residents 11 and 71) reviewed for unnecessary medications. This failure placed residents at an increased risk for experiencing medication-related adverse side effects, and unmet care needs. Finding included .<Resident 11> Review of the residents’ medical records showed they were admitted to the facility with diagnoses to include anxiety (an intense, excessive and persistent worry and fear about everyday situations) and depression (a persistent feeling of sadness and loss of interest). The diagnoses list showed no diagnosis for insomnia (the inability to sleep) or sleep disturbance. The 06/26/2025 comprehensive assessment showed Resident 11’s cognition was severely impaired and received anti-depressant medication. Review of Resident 11’s July 2025 Medication Administration Record (MAR), showed Resident 11 received an order on 07/09/2025 for Trazodone (a brand of anti-depressant medication, also used for insomnia) 25 milligrams (mg, a unit of measure) at bedtime for sleep disturbance for five days, then after five days the Trazodone was increased to 50 mg at bedtime. The MAR showed another anti-depressant medication on 05/02/2025 for Celexa (a brand of anti-depression medication) 10 mg daily for depression. The May 2025, June 2025, and July 2025 MAR showed monitoring for adverse side effects but showed no monitoring for person-centered behaviors related to insomnia/sleep patterns or depression, to see if the medication was effective or ineffective. An observation on 07/21/2025 at 4:22 PM, showed Resident 11 was observed sitting up in their recliner, with their head rested on the wing of the back of the recliner, sleeping. During an interview on 07/23/2025 at 1:54 PM, Staff B, Director of Nursing Services (DNS), stated the Resident Care Managers (RCM) were responsible for ensuring residents had person-centered behaviors being monitored at the time a psychotropic medication was started. Staff B stated the process was not followed. <Resident 71> Review of the resident medical record showed they were admitted to the facility on [DATE] with diagnosis including heart complications, dementia (a progressive disease that destroys the memory and other important mental functions) pancreatic (an organ inside the body that aid in digestion and introducing hormones need for the body’s daily function) cancer and placed on comfort measures (provider orders to assist with a resident’s suffering during their end of life). The 07/09/2025 comprehensive assessment showed the resident had cognitive impairments but was awake/alert to themselves, was talking with staff and understood where they were at. Additionally, no documentation showed the resident was diagnosed with an anxiety disorder. Review of Resident 71’s provider orders showed the psychotropic Lorazepam (a specific antianxiety medication which common side effects included drowsiness, confusion, loss of balance and memory problems) could be administered every two hours as needed for anxiety and terminal agitation (a set of behaviors characterized by sudden agitation, anxiety, anger or confusion). Review of Resident 71’s care plan dated 07/05/2025 showed the resident used antianxiety medication related to an anxiety disorder, terminal agitation and to monitor for adverse reactions (undesirable or harmful response to a medication) to antianxiety medications. There was no documentation of individual behaviors to monitor or non-pharmacological interventions regarding Resident 71’s psychotropic medication. Review of Resident 71’s MAR and treatment administration record (TAR) for July 2025, showed orders for Lorazepam were given for a total of 30 administrations from 07/07/2025 to 07/16/2025. The TAR showed that nursing staff were to monitor Resident 71’s behaviors for a “loss of interest” from 07/02/2025 to 07/11/2025 and “feelings of fear” from 07/11/2025 and what non-pharmacological intervention were implemented. Nursing staff were to assess every shift and document the number of the resident’s behaviors and if they improved, worsened or were unchanged from the intervention code. No behaviors or intervention codes were assessed or implemented on the day or night shifts. Observation on 07/16/2025 at 10:08 AM showed Resident 71 in their bed, unable to wake or open eyes. During an interview on 07/18/2025 at 11:48 AM, Staff DD, Registered

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a patient-centered discharge plan by the interdisciplinary team and document required discharge information for 1 of 4 residents (Resident 45) reviewed for discharge planning. This failure placed residents at risk for unmet care needs, worsening of wounds, psychological distress, and rehospitalization. Findings included. Review of the policy titled Transfers and Discharges, dated 04/22/2025, showed the facility would document in the resident's record the appropriate information was communicated to the receiving health care provider. The policy showed the documentation would show the reasons for discharge, infection status, functional status, and risks such as fall risk. <Resident 45> Review of the resident's medical records showed they were admitted to the facility with diagnoses of left superficial femoral artery endarterectomy with bovine patch angioplasty (when plaque builds up in the artery, then gets removed and a patch is used to restore blood flow) surgery aftercare and multiple sclerosis (MS, a disease that causes breakdown of the protective covering of the nerves). Review of the 06/25/2025 comprehensive assessment showed Resident 45 was cognitively intact, had impairments to both upper/lower extremities, was dependent upon staff for lower body dressing, showering, toileting, and transfers. During a Resident Council meeting on 07/17/2025 at 10:20 AM, Resident 45 stated they were not happy about being discharged to home on [DATE]. Resident 45 stated they did not feel like they were ready and would go home, lose all of the progress they had made with their function, end up back in the hospital, and then back to the facility. Resident 45 stated this would have been their fourth time to this facility and they would not have to return if they had not discharged them so soon before. Resident 45 stated they were not able to transfer from their bed to their wheelchair unassisted or without help and they could not dress their lower part of their body without assistance. Resident 45 stated the insurance company denied the coverage to continue with skilled nursing services (services provided by insurance companies for a period of time) and appealed that denial and lost. Resident 45 stated the facility had offered them to stay but a portion of the costs would be their responsibility, and the resident stated they could not afford to do that. Review of Resident 45's Discharge summary, dated [DATE] (closed and locked on 07/17/2025), showed Resident 45's reason for discharge was has met max goals in therapy. The summary showed the physical and mental status of the resident on discharge was independent in [Resident 45's] electric w/c [wheelchair]. The summary showed not applicable (n/a) for special treatments and procedures. The summary showed Resident 45's skin conditions were a wound to their left lower extremity (LLE), redness to their buttocks with detailed dressing change instructions, and that the wound consultant would f/u [follow up]. The summary showed no physical limitations in the resident's transferring/dressing status, nor did it show on 07/15/2025 Resident 45 was diagnosed with a new infection to their wound on their LLE and was prescribed an antibiotic (a medication that fights infections) for 20 doses. During an interview on 07/17/2025 at 3:41 PM, Staff U, Physical Therapist (PT, a healthcare provider who helps you improve how your body performs physical movements), stated they felt the insurance company had discontinued services too soon on Resident 45s last admission to the facility and they did it again. Staff U stated they did not feel the resident was ready to go home because they could not transfer without assistance from a bed to their wheelchair, nor could they dress the lower half of their body on their own, it's not safe functionally. Staff U stated they did not complete any of the discharge documentation on the discharge summary for Resident 45. Staff U stated the Director of Rehab was on vacation, so they doubted any of the discharge documentation was completed by the therapy department. Review of a provider discharge visit dated 07/15/2025, showed Staff M, Medical Director, wrote Resident 45 needed to have a PT and Occupational Therapy (OT, licensed health care professional who helps individuals improve their ability to perform daily tasks and activities they need or want to do) evaluation and treatment for physical debility [physical weakness, especially as a result of illness]. strengthening, conditioning, and gait safety training (none of this information was in the discharge summary). During an interview on 07/23/2025 at 10:07 AM, Staff K, Licensed Practical Nurse (LPN), stated the medication cart LNs were the ones that went over discharge information with a resident upon discharge. Staff K stated they would review the information on the discharge summary with the residents and review the medications. Staff K stated they did not have input on the discharge summary and those were completed by the Resident Care Managers (RCMs) and Social Services Department (SSD). During an interview on 07/23/2025 at 10:16 AM, Staff E, RCM, stated the discharge summaries were to be completed by each department, Activities, SSD

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow up on written notices of bed holds (holding or reserving a resident's bed while the resident was absent from the facility) given at the time of hospital transfers, and/or failed to send a copy of the notice of transfers to the representative for 2 of 4 residents (Residents 26 and 1) reviewed for discharge process. This failure placed residents at risk of not being informed of their rights regarding a bed hold and the lack of advocacy. Findings Included . Review of the facility policy dated 04/22/2025, titled Bed-Hold policy, showed the facility would provide written information to the resident or resident representative the nursing facility policy on bed-hold periods and the residents returned to the facility to ensure that residents would be made aware of a facility’s bed-hold and reserve bed payment policy before and upon transfer to a hospital or when taking a therapeutic leave of absence from the facility. <Resident 26> Review of the medical record showed the resident was admitted to the facility 05/29/2025 with diagnoses of an infectious germ which caused inflammation of the colon (large intestine) and diarrhea, end stage renal disease with dialysis (treatment that filters waste and fluid from your blood when your kidneys are failing) and diabetes (condition where your blood sugar levels are too high because your body either does not produce enough hormone insulin or can not use insulin properly). Review of the 06/02/2025 comprehensive assessment showed the resident was alert and oriented and required substantial assistance with Activities of Daily Living (ADL). Resident 26 discharged to the hospital on [DATE] and did not return to the facility. Review of Resident 26's medical record showed they were transferred to the hospital on [DATE]. There was no documentation of a bed hold policy or notice of transfer for Resident 26. During an interview on 07/21/2025 at 2: 55 PM, Staff J, Business Office Manager (BOM) stated they were recently designated to notify the family about the bed hold policy. Staff J stated they did not notify the Resident 26 or the Resident Representative (RR) about the bed hold policy. During an interview on 07/21/2025 at 3:00 PM, Staff B, Director of Nursing Services (DNS), stated they would expect the Licensed Nurse (LN) who sent the resident to the hospital to document a bed hold notification and notice of transfer. Staff B also stated the notice of transfer, and the bed hold policy were not in the documentation in the resident's chart. During an interview on 07/21/2025 at 3:13 PM, Staff E, Registered Nurse (RN), stated that there was no discharge transfer summation notification or a bed hold notification documented in the resident's record. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 1> Review of the resident’s medical record showed Resident 1 had been admitted to the facility on [DATE] with diagnoses to include emphysema (a chronic lung condition that causes the destruction of the air sacs in the lungs), anxiety (a feeling of worry, nervousness, or unease), bipolar disorder (a brain disorder that causes changes in a person’s mood, energy, or ability to function), and dependent on oxygen. Review of the comprehensive assessment dated [DATE] showed the resident’s cognition was intact, and they were independent with care. During an interview on 07/15/2025 at 4:17 PM, Resident 1 stated that they had been transferred from the facility to the local hospital four-or five-times since they were admitted due to their breathing. Resident 1 stated they were unsure of what a bed hold was and could not recall if they had been offered a bed hold. Review of Resident 1’s medical record showed they were transferred to the local hospital for complaints of shortness of breath on 06/11/2025. There was no documentation of a bed hold or notice of transfer for Resident 1. Review of Resident 1’s medical record showed they were transferred to the local hospital on [DATE]: there was no documentation of a bed hold or notice of transfer for the resident. Review of Resident 1’s medical record showed they were transferred to the local hospital on [DATE]: there was no documentation of a bed hold or notice of transfer for the resident. During an interview on 07/22/2025 at 11:47 AM, Staff G, Social Services Director, stated they did not offer bed holds. Staff G stated that Resident Care Managers (RCMs) or the nurses on the floor would offer the bed holds before transferring of the resident. During an interview on 07/22/2025 at 12:43 PM, Staff E, RCM, stated Resident 1, has been calling 911, for shortness of breath or back pain. Staff E stated the process was whoever transferred a resident out of the facility should offer the bed hold before transferring the resident or contact their representative. During an interview on 07/22/2025 at 12:55 PM, Staff J, BOM, stated that staff worked together to offer a bed hold to a resident/resident representative before transferring out of the facility. Staff J stated that after hours the nurses on the floor would offer a bed hold to the resident and the Admissions Director would follow up with the resident/resident representative. During an interview on 07/22/2025 at 1:39 PM, Staff Z, Admissions Director, stated that they completed the initial notification and education on the bed hold policy during a resident’s admission to the facility. Staff Z stated they did inform the resident. Staff Z stated the bed policy was a way of reserving the resident’s bed while they were in the hospital and let them know that the nurse or the BOM would reach out to them. Reference: WAC 388-97-0120 (4)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the minimum data set assessment (MDS- a comprehensive assessment tool) accurately reflected the status for 2 of 10 sampled residents (Resident 10 and 35) reviewed for accuracy of assessments. This failure placed the resident at risk for unidentified care needs. Findings included . <Resident 10> Review of the resident medical record showed they were admitted to the facility on [DATE] with diagnoses including heart complications and stroke (blood flow to the brain is blocked or a blood vessel bursts). The 06/30/2025 comprehensive assessment showed the resident was taking an anticoagulant (a type of drug that prevents the blood from clotting as quickly or as effectively as normal) medication. Review of Resident 10's provider orders for June 2025 showed no medication that would meet the criteria for an anticoagulant. <Resident 35> Review of the resident medical record showed they were admitted to the facility on [DATE] with diagnoses including a stroke with right side deficits and brain aneurysms (a bulge in a blood vessel around the brain). The 06/20/2025 comprehensive assessment showed resident was taking an anticoagulant medication. Review of Resident 35's provider orders for June 2025 showed no medication that would meet the criteria for an anticoagulant. During an interview on 07/21/2025 at 3:34 PM, Staff I, Registered Nurse/MDS Coordinator, stated they completed the June 2025 comprehensive assessments for Residents 10 and 35. Staff I stated that both residents were marked as having an anticoagulant medication. When reviewing both resident comprehensive MDS assessments for June 2025 and providers orders, Staff I stated the correct process was not followed and that both residents were on clopidogrel (a medication used to prevent heart attacks/stokes) which was not an anticoagulant medication, so it had been marked it in error. Reference: WAC 388-97-1000(1)(a)

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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** Based on observation, interview and record review, the facility failed to ensure that residents requiring assistance with showers, oral care, and nail care, were provided timely assistance according to their needs and preference for 6 of 10 sampled residents (Residents 11, 35, 13, 82, 9, and 26) reviewed for activities of daily living (ADLs). This failed practice placed residents at risk of infection, decreased dignity, and a decreased quality of life. Findings Included . <Resident 11> Review of the resident’s medical records showed they were admitted to the facility with diagnoses to include Alzheimer disease (a brain disorder that slowly destroys a person’s memory and thinking skills). The 06/26/2025 comprehensive assessment showed Resident 11’s cognition was severely impaired and was dependent upon staff for bathing and personal hygiene. During an interview on 07/16/2025 at 9:13 AM, the Resident Representative (RR) of Resident 11 stated they would arrive to the facility between 6:30 AM and 7:00 AM daily and remain there all day until 3:00 PM to 4:30 PM. The RR stated they did not see Resident 11 provided with oral care and wondered if “they left it up to me to do.” Resident 11 had white substance buildup in between their teeth, and the RR was going to provide them with oral care. The RR stated they would prefer Resident 11 to shower every other day, but oral care provided twice a week was fine, if it was completed. During an observation and concurrent interview on 07/18/2025 at 11:50 AM, the RR of Resident 11 wandered the hall looking for staff. The RR stated they had been with the resident since close to 6:45 AM and Resident 11 had not been checked or changed and smelled of bowel movement and urine (five hours after RR arrived). The RR walked to the Nurse’s station and informed them Resident 11 needed to be changed. During an interview on 07/18/2025 at 12:19 PM, Staff T, Nursing Assistant (NA), stated there were a lot of showers scheduled, and it had been “stressful” and needed to take a break from them. Staff T stated there were many mechanical lift (machines used to transfer residents unable to stand or have limited mobility and required minimum of two staff) transfers that took up most of their time. Staff T stated they would no longer be the shower aide after the month of July 2025. Staff T said residents had showers scheduled for Sundays but there were no shower aides that worked on Sundays. Staff T stated they would try to review the shower list and if a resident had a shower the previous week on Saturday, they would try to fit one of the Sunday scheduled residents in their place but then would leave that resident short a shower for the week, “but I still can’t get to everyone like that.” During an interview on 07/21/2025 at 11:11 AM, the RR of Resident 11 stated they arrived at the facility at 7:00 AM and Resident 11 had not been checked or changed since their arrival. The RR stated Resident 11 had not been provided with oral care before or after breakfast. The RR stated Resident 11 did not receive a shower during the weekend and did not receive showers regularly. The RR stated at one time, Resident 11’s hair had been so oily and dirty looking they paid $28 dollars to take them to the beauty shop to have it done. (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 07/21/2025 at 12:36 PM, Staff AA, NA, stated they provided care to residents at the beginning of their shift (6:00AM), would complete ADL care, and then by the time they completed that, it would be time for breakfast. Staff AA stated after breakfast they would make another round to ensure residents were dry. Staff AA stated they checked again before residents went to the dining room for lunch. Staff AA stated they checked residents for wetness every 30 minutes, but Resident 11 was not a “heavy wetter [not having wet briefs as often as others]” so they did not get checked that often. Staff AA stated Resident 11’s RR would “accuse” them of not providing the resident care so they would bring another NA in when providing care. Staff AA stated they checked the documentation, and at 9:22 AM they checked the resident, and they were dry. Staff AA stated they did not have another NA with them when they “just checked on the resident,” only when they changed the resident. Resident 11’s hair was not groomed and appeared oily and lay flat on their face. During an observation of care for Resident 11 on 07/21/2025 at 1:23 PM, Staff AA and Staff BB, NA, assisted Resident 11 to the bathroom and removed their soiled brief. The brief and purple liner inside the brief appeared saturated with yellow and brown (indicating old urine) urine. When Resident 11 was wiped clean on their bottom and perineal-area (the region located between the anus and the genitals), the wipes had brown on them and Resident 11 did not have a bowel movement. Review of Resident 11’s bathing task for 06/21/2025 through 07/21/2025 showed Resident 11 received three showers in 30 days (out of 10 showers scheduled), 06/26/2025, 07/10/2025, and 07/18/2025. The bathing task showed Resident 11 was to receive showers on Thursdays and Sundays. During an interview on 07/21/2025 at 1:23 PM, Staff EE, NA, stated Resident 11’s showers were on Thursday and Sunday. Staff EE stated Resident 11 did not receive their shower on Sunday 07/20/2025 because there was no shower staff scheduled for Sundays. Staff EE stated there had not been shower staff scheduled on Sundays for “quite some time.” An observation on 07/22/2025 at 10:42 AM, showed Resident 11 sitting in their wheelchair, their hair was uncombed, and appeared oily. Review of Resident 11’s Care Plan (CP), showed a CP dated 12/20/2024 for toileting before and after meals and at bedtime and required the assistance of one staff. The CP showed no person-centered bathing/showering care plan or preferences. Review of the shower schedule provided by Staff EE, showed Resident 11 had Wednesday and Sundays as their scheduled shower days. The shower schedule also showed there were 20 showers scheduled on Sundays when there were no shower aides. During an interview on 01/23/2025 at 1:54 PM, Staff B, Director of Nursing Services (DNS), stated the showers that were scheduled for Sundays were to be split amongst the staff on the floor. Staff B stated they recently hired a new shower aide and had another NA on the floor to help out with showers and did not know why residents were not getting their showers. Staff B stated if residents wanted showers more often, “we would try to accommodate them as best as we can.” <Resident 35> (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 the resident’s medical records showed they admitted with diagnoses to include a stroke (blood flow to the brain is blocked or a blood vessel bursts) with deficits to their right side. Review of the 06/20/2025 comprehensive assessment showed Resident 11 was cognitively intact and required staff assistance with bathing and oral care. An observation and concurrent interview on 07/15/2025 at 4:33PM, showed Resident 35 lying in bed in their night clothes. Resident 35’s hair was uncombed, their teeth were yellow and had a white substance built up in between their teeth. An observation on 07/21/2025 at 3:42 PM showed Resident 35 in bed, with their RR at their bedside visiting. Resident 35 had white and yellow build up substance in between their teeth. Resident 35 stated they did not ask the NAs for help, and they did not offer help, “they are so busy.” During an observation and concurrent interview on 07/22/2025 at 2:35 PM, Resident 35 was lying in bed, with their robe on. Resident 35 stated they had not had their teeth brushed or oral care provided in “quite some time.” Resident 35 stated “only my [RR]” would brush their teeth. Resident 35’s teeth continued with white and yellow substance build up in between the teeth. Review of Resident 35’s CP showed on 10/25/2022 Resident 35 had missing teeth and needed assistance with their dental care. An intervention for the CP goal was to “assist [Resident 35] with oral care” with no schedule or when or how often oral care should have been provided. <Resident 13> Review of Resident 13 medical records showed the resident was admitted to the facility on [DATE] with diagnoses to include multiple sclerosis (a chronic autoimmune [a condition where the body attacks itself] disease of the nervous system), dysfunction of the bladder (difficulty passing urine), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The comprehensive assessment dated [DATE] showed Resident 13’s cognition was intact and required assistance from two staff members for dressing of their lower body transfers, and showering. During an interview and concurrent observation on 07/15/2025 at 10:42 AM Resident 13 stated it was mid-morning, and they had not been changed or cleaned up for the day. Resident 13 was lying in bed, their hair greasy, uncombed, dressed in a T-shirt and adult brief. The resident stated they had their T-shirt on from the day before. In an interview on 07/16/2025 at 8:48 AM, Resident 13 stated they arrived at the facility 13 days prior. Resident 13 stated they had only one shower since they arrived and that their hair felt greasy and looked it. The resident stated, “I'm not used to that”. (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 the undated facility shower schedule showed Resident 13’s shower days were on Tuesday and Fridays. Review of the Nursing task report dated July 2025, showed bathing/showering documentation on July 4th and July 11th, “that the activity did not occur”. There were no other documented bathing/showering for Resident 13 (12 days without bathing/showering). <Resident 82> Review of the medical records showed Resident 82 had been admitted to the facility on [DATE] with diagnoses to include diabetes (a disease in which the body does not control sugar in the blood), heart failure, and presence of an artificial left hip joint. The comprehensive assessment dated [DATE] showed the resident’s cognition was moderately impaired and required substantial assistance of one staff member for transfers, dressing and showering. In an observation on 07/15/2025 at 2:06 PM, Resident 82 was lying in bed resting their hands on their chest and their fingernails long (extended over the finger), with a dark substance underneath the fingernails on both hands. During an interview and concurrent observation on 07/18/2025 at 10:34 AM, Resident 82 was lying in bed, covered with a blanket with their hands grasping the blanket. Resident 82 stated their nails were long, and that they did not like to have their nails that long. Resident 82 stated “these are women nails”, “too long”. Resident 82 stated, but they did not have a nail clipper to take care of them. In an observation on 07/18/2025 at 4:33 PM Resident 82 was sleeping, both of their hands outside of blankets and their fingernail extended over their fingers on both hands with dark substance underneath the fingernails on both hands. Review of the resident’s medical record showed the resident was to receive diabetic nail care weekly. Review of the 06/09/2025 physician orders for Resident 82, showed the resident was to receive diabetic nail care weekly every dayshift, every Monday. (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 82’s July 2025 medication administration record showed nursing documentation on 07/14/2025 that the resident had received diabetic nail care. <Resident 9> Review of the medical records showed Resident 9 had been admitted to the facility on [DATE] with diagnoses to include muscle weakness, quadriplegia (a condition where there’s a partial or complete loss of function in arms, legs and torso), and epilepsy (a neurological condition characterized by recurrent, unprovoked seizures). The comprehensive assessment dated [DATE], showed the resident required assistance of two staff members for transfers, dressing, and showering. During an observation and concurrent interview on 07/15/2025 at 3:07 PM, showed Resident 9 lying in bed reading, the resident’s hair greasy, they were wearing a left wrist splint wrapped with an ace bandage. The resident stated it had been a while since their last shower, that sometimes staff will get pulled off their duties if they are short staffed. Resident 9 stated they were scheduled to have showers on Thursdays and Sundays. Review of the June 2025 Nursing task report showed there were no bathing/showering documented for Resident 9. The Nursing task report for July 2025, there was no documentation of bathing/showering from July 10th through July 16th, (six days without bathing/showering). During an interview on 07/23/2025 at 1:17 PM, Staff B, DNS, stated the expectation was for nursing staff to document all cares and follow orders. Staff B stated they were a new team and could see they had some education to do for sure. <Resident 26> Review of the medical record showed the resident was admitted to the facility 05/29/2025 with diagnoses including an infectious germ which caused inflammation of the colon (large intestine) and diarrhea, end stage renal disease with dialysis (treatment that filters waste and fluid from your blood when your kidneys are failing) and diabetes (condition where your blood sugar levels are too high because your body either does not produce enough hormone insulin or can not use insulin properly). Review of the 06/02/2025 comprehensive assessment showed the resident was alert and oriented and dependent on staff for bathing, toileting, transfers and personal care. The 05/29/2025 bath schedule showed Resident 26 had been on Sundays and Wednesdays. Resident 26 discharged to the hospital on [DATE]. During an interview on 07/10/2025 at 2:45 PM, Resident 26's RR stated the resident did not receive their baths and had been unclean. The RR stated Resident 26 had experienced diarrhea and was nauseated and vomiting while there and was sent to the hospital. Review of Resident 26's documented baths showed they received baths on 06/01/2025 and 06/04/2025 only. There were no other documented baths for Resident 26 (16 days without a bath). During an interview on 07/18/2025 at 1:05 PM, Staff T, NA stated they were part of the bath team and that Resident 26 was scheduled for baths on Wednesdays and Sundays. Staff T stated they stopped giving baths on Sundays since the second week in June 2025. (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 07/21/2025 at 11:45 AM Staff E, Registered Nurse, stated we do not do baths on Sundays and have not for a while. Reference: WAC 388-97-1060(2)(c)

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F 0684 Level of Harm - 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** Based on observation, interview, and record review the facility failed to 1) recognize a change in condition for 3 of 6 residents (Residents 39, 9 and 35) reviewed for quality of care, and 2) ensure residents received treatment and care in accordance with professional standards of practice and physician orders for 2 of 5 residents (Resident 8 and 71) reviewed for unnecessary medications. This failure placed residents at risk for a delay in treatment, unmet care needs, and negative health outcomes. Resident 39 experienced harm when the facility failed to recognize the immediacy of a change of condition and did not notify the physician with a resident who exhibited signs and symptoms of change in orientation, oxygen level, blood pressure and pulse which resulted in hospitalization. Resident 9 experienced harm when their nephrostomy tube (a flexible tube inserted through the skin into the kidney to drain urine externally when normal drainage is blocked) became obstructed, resulting in hospitalization intervention. Findings included . Review of a policy titled Changes in Resident's Condition or Status, dated 09/05/2024, showed the facility would notify the resident's Primary Care Provider and the resident or Resident's Representative (RR), the resident would be thoroughly assessed, and the facility would monitor the resident for changes. The policy showed the Licensed Nurses (LNs) would communicate with other team members for continuity of care and were to document their assessments and monitoring.<Resident 39> Review of the medical record showed Resident 39 initially admitted to the facility on [DATE] then readmitted to the facility from the hospital on [DATE] with diagnoses including a Urinary Tract Infection (UTI) with Septic Shock (life threatening infection which arises when the body responds to infection causes injury to the body), respiratory issues with use of continuous oxygen, and heart disease. Resident 39 previously sustained a fracture of the upper back and sternum (breastbone or flat T-shaped bone in the middle of the chest), and wore a hard plastic neck collar for stability. The 06/30/2025 comprehensive assessment showed the resident was alert and oriented and able to make their needs known and required substantial assistance with toileting and hygiene and was dependent on staff with dressing. During an interview on 07/15/2025 at 10:15 AM, Resident 39 was seated on their recliner in their room. The resident had a house coat on with a large plastic neck collar around their neck. The resident stated they had an episode of confusion and severe pain at the facility on 07/03/2025 when they had not been feeling well for a few days and ended up in the hospital with an infection and stayed in the hospital for 12 days. Resident 39 stated they were admitted back to the facility for physical therapy before they could discharge home. Review of the 07/02/2025 nurses progress notes showed that the physician had ordered laboratory testing for Resident 39 which showed an elevation in the resident’s white blood cell count (which is used to measure the amount of these cells in the blood which may determine infection) and other laboratory results. Additionally, the physician ordered a chest x-ray and increased Resident 39’s pain medication. Review of the 07/03/2025 progress notes showed the following changes were charted for Resident 39 which showed at 8:58 AM the resident who was on continuous oxygen, had an oxygen level of 79% (normal is 90% to 100%), at 9:53 AM the resident had an increase of severe pain, at 12:38 PM the resident’s pulse was 117 (normal is 60-100 beats per minute). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the 07/03/2025 at 2:55 PM nurses progress notes showed Resident 39 was sent to the emergency room (ER) due to abnormal vital signs (blood pressure and pulse), increased lethargy (lack of energy), and oxygen level drop despite increases of oxygen administered. Resident 39's blood pressure was 62/48 (120/80 normal range). The resident was clammy and speech was slurred/difficult to understand. The paramedics (emergency medical service) were called, while the resident was on the phone with Resident Representative (RR) at that time. RR asked Staff H and then the paramedics to take Resident 39 to the ER as the resident was not themselves for the last three days. There was no change of condition assessment completed by the licensed nurse. During an interview on 07/16/2025 at 11:20 AM, Resident 39 stated they had not experienced that type of infection before and had no recollection about being asked to go to the hospital or any memory about that day. Resident 39 stated they did not recall speaking with their RR at that time. The resident stated they woke up in the hospital in the Intensive Care Unit (ICU) and were there for two weeks. Review of the hospital 07/03/2025 emergency room intake encounter notes stated the resident was not able to answer questions and resident’s representative stated the resident had not been eating and had changes over the last two to three days at the facility. The resident was admitted to ICU for management. Review of the 07/13/2025 hospital discharge summary showed the resident was admitted to the hospital on [DATE] through 07/13/2025 and readmitted to the facility on [DATE]. Admitting diagnoses to the hospital were Septic shock due to bacterial urinary tract infection, heart failure, lung issues and diabetes (chronic condition where the body cannot regulate blood sugar levels). The summary showed that resident was admitted to ICU with significant low blood pressure that required medication with intravenous (IV) fluids. Additionally, the resident received four different antibiotics IV for their bladder infection. During an interview on 07/17/2025 at 10:30 AM, Staff H, Registered Nurse, (RN) stated Resident 39 started having issues around 9:00 AM on 07/03/2025 where they had so much pain that it would not respond to the pain medication given to them. Staff H stated that Resident 39’s oxygen level dropped to 79%. Staff H stated turned the oxygen up and the oxygen level was okay then dropped down again. Staff H stated the resident did not want to go to the hospital. Staff H stated the resident was in and out of falling asleep and Staff H did not want to disturb the resident. Staff H stated this change of condition continued and the resident who was a full code did not want to go to the hospital. Staff H stated Resident 39 called their RR and decided to go to the hospital around 2:45 PM. Staff H stated they felt they could not make the resident go to the hospital even though they had significant changes. Resident 39 was on the phone with their RR and the RR asked Staff H that Resident 39 be sent to the hospital due to the resident’s decrease in orientation and increased pain. Staff H called the paramedics around 2:55 PM and documented they notified the nurse practitioner. (continued on next page)

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	505070	A. Building B. Wing	07/23/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/17/2025 at 1:08 PM, Resident 39’s RR stated they had concerns with the resident on 07/01/2025 when people visited the resident, they noticed a change in the resident’s memory and felt they were confused. Resident 39 complained of not feeling well. On Tuesday 07/01/2025 the resident had a change in condition the resident was pale and looked bad.” On Wednesday 07/02/2025 the resident was not coherent, and the nurse did not think anything was wrong. Resident 39 did not know what time of day it was and was confused. While the RR was talking to Resident 39 on the phone and Staff M, Medical Director (MD), who was in the resident’s room ordered a chest X-ray and blood work on 07/02/2025 and increased the residents pain medication. The RR stated they had spoken to on 07/02/2025 that afternoon to Staff F, RN, who was informed of Resident 39’s change in their ability to think clearly and not being themself when expressing our concerns. Staff F stated they attributed Resident 39’s complaints to participation in physical therapy and medication. During an interview on 07/17/2025 at 1:55 PM, Staff M stated if they had known about those changes in vital signs on 07/03/2025 and Resident 39’s change in condition they would immediately have had the resident transferred to the hospital. During an interview on 07/18/2025 at 11:44 AM, Staff N, Advanced Registered Nurse Practitioner (ARNP) stated they did not receive a call from the facility concerning Resident 39’s change of condition or decreased on oxygen level. If that information was communicated to them, they would immediately have admitted the resident to the hospital. During an interview on 07/21/2025 at10:18 AM, Staff I, RN, stated after the morning meeting on 07/03/2025 at 10:00 AM they saw that Resident 39 had a 79% oxygen level on their computer. Staff I went to Resident 39’s room with a pulse oximeter to check the resident’s oxygen level. Staff H stated to Staff I that they increased the resident’s oxygen from 1 liters (unit of measure) to 4 liters and the oxygen level improved to 90% at that time. Staff I asked Staff H to notify the physician about the change made by increased oxygen from 1 liter to 4 liters of oxygen to Resident 39. <Resident 9> Review of Resident 9’s medical record showed they were admitted to the facility on [DATE] with diagnoses to include epilepsy (a brain disease where nerves cells do not signal properly, which causes seizures), neuromuscular dysfunction of the bladder (condition where the bladder cannot properly store or release urine due to nerve damage) and pyelonephritis (a bacterial infection causing inflammation of the kidneys). Review of the resident’s comprehensive assessment dated [DATE] showed Resident 9’s cognition was intact and able to make their needs known. Resident 9 required assistance from two staff members for mobility and activities of daily living. During an observation and concurrent interview on 07/15/2025 at 3:07 PM, Resident 9 stated they had a nephrostomy tube (a flexible tube inserted through the skin into the kidney to drain urine externally when normal drainage is blocked) to help with their kidneys. The nephrostomy drainage bag had a yellow-colored liquid within the bag. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 9’s physician orders showed the resident had a nephrostomy tube that required monitoring for signs infection and the monitoring of the resident’s output into the bag twice a day. During an observation and a concurrent interview on 07/18/2025 at 9:27 AM, Resident 9 was lying in bed, the nephrostomy tube laid to their left side empty on the bed. The resident stated their bag was emptied during the night shift and was unsure how often the staff emptied the bag and that the tube hurt when it was moved too much. During an observation and concurrent interview on 07/22/2025 at 10:05 AM, Resident 9 was fully dressed, with a blanket on their lap, sitting in their wheelchair at the front desk stated they were going for a scheduled appointment and would be back that afternoon. During an observation and concurrent interview on 07/22/2025 at 3:26 PM, Resident 9 was lying in their bed speaking to paramedics in their room. The resident’s representative (RR) also in the room, stated “I'm making this happen. The RR stated the resident had texted them the night before, about their pain. The RR stated the pain was in their abdomen and were also complaining of some burning with their urine. The RR stated the last time Resident 9 went through that type of pain and burning, was a few months ago and the resident had to stay in the hospital intensive care for three days, as they had sepsis (a serious condition in which the body responds improperly to an infection) which cause them to have grand-mal seizures (a type of seizure that causes a sudden loss of consciousness, stiffening of the body, and jerking movements). Review of the nursing treatment administration record (TAR) dated July 2025 showed the licensed nurses were to document nephrostomy tube output twice a day. On 07/13/2025 there had been no output documented for the evening shift. Further review of the documentation showed on 07/18/2025 with zero output documented for the day shift. On 07/19/2025 zero output was documented for the evening shift. On 07/20/2025 through 07/22/2025, zero output had been documented for both shifts. During an interview on 07/23/2025 at 8:40 AM, Staff O, Licensed Practical Nurse (LPN), stated Resident 9 had been admitted to the local hospital with sepsis. Staff O stated they had received that in a report from the prior shift nurse but had not followed up with the hospital. During an interview on 07/23/2025 at 9:02 AM, Staff C, LPN, stated Resident 9 had refused to go to their appointment. Staff C stated the resident became nauseated and vomited, so they gave the resident an antinausea medication and went back to their med cart. Staff C stated the next thing they saw were Paramedics, RR, and the Resident Care Manager (RCM) in Resident 9’s room, and the resident being sent out to the local hospital to be evaluated. During an interview on 07/23/2025 at 9:10 AM, Staff E, LPN/RCM, stated Resident 9 had pain to the abdomen that radiated to their back, and that they had talked with their primary physician who told Resident 9 to get to the hospital. Staff E then stated the RR was also in the room and verified the information from the resident. Staff E stated Resident 9 had been admitted to the local hospital but unsure why they had been admitted , and they would need to call for an update. Staff E stated they did not document the conversation they had with the resident or RR. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 07/23/2025 at 10:42 AM, Resident 9’s RR stated that the resident was admitted to the local hospital on [DATE], due to their nephrostomy tube being blocked, a UTI and abnormal labs. The RR stated the resident had requested pain medication but, the nurse stated could only administer a small dose due to the blood pressure being low, The RR stated, “I kept watching the blood pressure waiting for it to drop, I was scared”. The RR stated, it was the third time that the resident had to be seen by the local hospital. The RR stated on 07/20/2025 the resident had contacted them about significant pain; staff did not seem to listen to Resident 9’s concerns. Review of the local hospital admission note dated 07/22/2025, showed Resident 9 was admitted to the hospital with the diagnoses of a complicated urinary tract infection and sepsis. In an interview on 07/23/2025 at 11:21AM, Staff O, LPN, stated the nurses documented in the TAR for Resident 9’s nephrostomy drain output. Staff O stated if the drain did not put anything out, they would call the doctor. Staff O stated the prior shift report would let them know how much output the resident had from the nephrostomy drain. Staff O stated they had not informed the physician for the resident’s zero output. In an interview on 07/23/2025 at 11:32 AM, Staff E, LPN/RCM, stated the expectation of the nurses on the floor was for the nurse to call the doctor for any signs of infection and when there was zero output from Resident 9’s nephrostomy drainage bag. Staff E stated that the nurses did not follow the orders to monitor the output and did not contact the doctor about the lack of output. During an interview on 07/23/2025 at 1:17 PM, Staff B, DNS stated the expectation was for nursing to document and follow doctor orders. Staff B stated they had reviewed the documentation of Resident 9’s nephrostomy tube output and acknowledged that the doctor had not been notified of the zero output from the resident’s nephrostomy. <Resident 35> Review of the resident’s medical records showed they were admitted to the facility with diagnoses to include a stroke (blood flow to the brain is blocked or a blood vessel bursts) with right side deficits and brain aneurysms (a bulge in a blood vessel). The 06/20/2025 comprehensive assessment showed Resident 35 was cognitively intact and their vision was not impaired. During an interview and concurrent observation on 07/15/2025 at 4:18 PM, Resident 35 stated they had trouble seeing, their vision was blurry, and they experienced dizziness. Resident 35 stated they informed the staff and asked to speak to the provider. Resident 35 stated the provider, a Contracted Nurse Practitioner (CNP), had seen them on 07/14/2025 and the resident informed the CNP of their vision issues. Resident 35 stated they informed the CNP that they had a history of having three brain aneurysms, and these were some of the symptoms they had experienced and requested imaging to ensure that was not the issue. Resident 35 stated they were told by the CNP that they did not feel that was the issue and would have to discuss with the facility whether imaging was appropriate or not and asked them if they “really wanted to put your body through that…are you even going to be here next year.” Resident 35 stated they had not heard anymore about it. Resident 35 was observed squinting at the television, with the left eye smaller than the right (this was normal per the resident), and complained of head pain over the left eye and some dizziness. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/16/2025 at 12:08 PM, Resident 35 was lying in bed and stated they felt like their vision was “better today but not much.” Resident 35 stated they had not talked to the nurse regarding their vision changes, only the CNP and had not heard anything about the imaging being ordered. During an interview on 07/18/2025 at 3:42 PM, Resident 35 stated they had not heard anything regarding the imaging. Resident 35 stated they felt like their vision symptoms were coming and going and had “nauseous waves going over me [feelings of being sick to your stomach that come and go].” Resident 35 stated when they would lay flat, they would feel pressure in their head but if they elevated the head of their bed, the pressure seemed to relieve. Resident 35 stated they informed Staff F, RCM, about the pressure when lying flat and vision changes. Resident 35 stated Staff F informed them they had received an order from the CNP for a Computed Tomography (CT, a type of imaging that can visualize details inside the body) scan and they would get that scheduled. Review of the July 2025 Physician orders showed an order on 07/14/2025 for Resident 35 to be scheduled for a CT scan. The order showed a reason for the CT scan was for “visual changes and dizziness. ” The order showed it was discontinued on 07/17/2025. Review of Resident 35’s progress notes showed no documentation from the CNP for the 07/14/2025 visit, no LN documentation as to who ordered the CT scan or why it was ordered, and no documentation that showed Resident 35’s current vision changes, dizziness, nausea, or increased pressure to their head had been monitored or assessed. The review also showed no notification to the provider regarding the increased pressure to Resident 35’s head when lying flat. During an interview on 07/22/2025 at 3:28 PM, Staff E, RCM, stated they knew about Resident 35’s concerns with their vision changes and dizziness and knew the CNP had ordered a CT scan for the resident. Staff E stated they were unaware Resident 35 had experienced feeling pressure to their head while lying flat and had not seen any nursing documentation regarding those concerns. Staff E stated Resident 35 should have been put on alert charting so they could monitor the symptoms they were having but they did not do that. Staff E stated they did not see the CNP’s progress note from their visit on 07/14/2025 in Resident 35’s medical record and would call to request them. Staff E stated they “assumed” the order was discontinued because “maybe it had been scheduled.” Review of the CNP’s progress note provided by Staff E, dated for 07/21/2025 at 4:16 PM, showed Resident 35 reported they had “vague vision/dizziness” complaints and had experienced “waves” of lightheadedness and dizziness that would last seconds before resolving. The note showed the television appeared “more blurry” and was concerned their symptoms were related to their history of brain aneurysms. The note further showed the CNP educated and reassured Resident 35 that their symptoms were “unlikely related” to the aneurysms because of the intermittent dizziness. The note showed a CT scan had been ordered and the RCM had been notified. The note was signed and dated 07/22/2025 at 4:16 PM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/23/2025 at 12:48 PM, Staff F stated they had received an order from the CNP through an electronic mail (email) on 07/14/2025. Staff F stated they had processed the order on 07/14/2025 and faxed the order over but the order was not completed correctly so needed to amend the order and resend it. Staff F stated they had been “busy” and had not done that yet “I will probably get to that today.” Staff F further stated when they received the email they should have placed Resident 35 on alert charting to monitor for any worsening of their symptoms, and they did not do that. Staff F stated they did speak to the resident regarding their symptoms but were unaware they had pressure in their head when lying flat. Staff F stated the order they received was not an emergent order. Review of a note that was emailed on 07/14/2025 at 4:33 PM, sent to Staff F by the CNP, showed they had seen Resident 35 and would be ordering a CT scan. The note showed Resident 35 had complained of on and off dizziness and “brain zaps [brief electric shock-like sensations in the head],” and worsening vision symptoms that were related to their brain aneurysms. The note showed since symptoms were improving the CNP assured Resident 35 that it was unlikely related to the brain aneurysms, and even if it was, they would most likely not be a candidate for surgery, “so what’s the point of doing imaging,” but Resident 35 insisted. During an interview on 07/23/2025 at 1:54 PM, Staff B, DNS, stated when a resident experienced a change in their health condition, the LNs should assess the resident, notify the provider, notify the family, update the care plan as needed, and put the resident on alert charting. Staff B stated the alert charting would have remained in place until the resolve of symptoms or as ordered. Staff B stated Staff E and Staff F should have placed the resident on alert charting when they became knowledgeable Resident 35 had vision changes, dizziness, or increased pressure to their head. <Resident 8> Review of the resident’s medical records showed they were admitted to the facility with diagnoses to include lumbar spondylopathy (wear and tear to the lower back region) and nerve pain. The 07/01/2025 comprehensive assessment showed the resident’s cognition was intact and they received routine and as needed pain medication. Review of the 05/19/2025 through 05/31/2025 Medication Administration Records (MAR), showed an order dated 05/19/2025 for Oxycodone (a brand of medication used for pain) five milligrams (mg, a unit of measure), give one tablet every four hours as needed (PRN) for a pain level of six or seven (a pain scale of 0-10 with zero meaning no pain at all and 10 meaning the most excruciating pain ever felt). The record showed an order dated 05/19/2025 for Oxycodone five mg, give two tablets for a pain level of eight, nine, or ten. Both orders showed pain location and non-pharmacological (does not involve medication) interventions were to be documented in a progress note. The order for one tablet was administered three times with one administration given outside of the parameters ordered (pain level of ten). The order for two tablets was administered 12 times with one administration given outside of the parameters ordered (pain level of seven). Review of the June 2025 MARs showed the same Oxycodone orders (05/19/2025) as the May 2025 MAR did. The records showed the order for one tablet of Oxycodone was administered seven times, with five of those administrations given outside of the ordered parameters (greater than a pain level of seven). The record showed the order for the two tablets of Oxycodone was administered 38 times, with 22 of those administrations given outside of the ordered parameters (for pain levels of five to seven). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the 07/01/2025 through 07/21/2025 MAR showed the same Oxycodone orders (05/19/2025) as the May 2025 MAR. The record showed the order for one tablet was administered three times with one of those administrations given outside of the ordered parameters (pain level of eight). The record showed the order for two tablets was administered 23 times and 15 of those administrations were given outside of the ordered parameters (pain levels of four to seven). Review of the nursing progress notes from 05/19/2025 through 07/21/2025 showed no non-pharmacological interventions had been documented prior to administering the PRN Oxycodone and two notes on 05/25/2025 and 05/26/2025 that showed the location of Resident 8’s pain. During an interview on 07/23/2025 at 10:03 AM, Staff K, LPN, stated their process for administering PRN medication was to assess the resident’s pain level and location, attempt to see if a non-pharmacological intervention would help, and then administer the pain medication if that was not effective. Staff K stated they then would document in a progress note. During an interview on 07/23/2025 at 10:14 AM, Staff O, LPN, stated they would ask the resident what their pain level was and give them their pain medication. Staff O stated the residents “know what they want and just tell me what to give them.” Staff O stated they would document where their pain location was in the progress notes. During an interview on 07/23/2025 at 1:54 PM, Staff B stated they would expect the LNs to follow physician orders as they were written. Staff B stated if the pain medications were not effective, they would expect the LNs to notify the provider for additional directions or to lower or increase the pain levels ordered or change the medication. Staff B stated the LNs should have documented their location assessment and the non-pharmacological interventions they attempted prior to administering the PRN pain medication. <Resident 71> Review of the resident medical record showed they were admitted to the facility on [DATE] with diagnosis including heart complications, dementia (a progressive disease that destroys the memory and other important mental functions) pancreatic (an organ inside the body that aid in digestion and introducing hormones need for the body’s daily function) cancer and placed on comfort measures (provider orders to assist with a resident’s suffering during their end of life). The 07/09/2025 comprehensive assessment showed the resident had cognitive impairments but was awake/alert to themselves, was talking with staff and understood where they were at. Review of Resident 71’s provider orders showed Lorazepam (a specific antianxiety medication belonging to a group of drugs that affect brain activities associated with mental processes, emotions and behavior. The common side effects include drowsiness, confusion, loss of balance and memory problems) could be administered every two hours as needed for anxiety and terminal agitation (a set of behaviors characterized by sudden agitation, anxiety, anger or confusion). Review of Resident 71’s care plan dated 07/02/2025 showed the resident was at risk for rehospitalization that timely communication to the provider was needed regarding any change in the resident’s condition. Additionally, Resident 71 was at risk for falls, and the goal was for the resident to not have an injury that would require them to be hospitalized . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a progress note on 07/09/2025 showed that on 07/08/2025 at 8:30 PM Resident 71 was found after a fall on the floor of their room with blood where the resident’s head was resting. Staff L, LPN, noted Resident 71 was weak, unable to sit up on their own and their range of motion was “ .limited due to weakness.” Staff L documented that neurological checks (a comprehensive evaluation of a person’s nervous system, to assess brain/nerve function to help diagnose potential neurological disorders that may require emergency treatment and would be needed following a head injury, increased confusion or change in behavior) were started and that the facility’s provider was notified. No documentation showed that the Resident 71’s representative was notified after the fall. Review of the facility’s investigation into Resident 71’s 07/08/2025 unwitnessed fall, showed the resident was bleeding from a head injury after being found on the floor of their room. The neurological checks showed no evaluation was conducted until 07/09/2025 at 8:00 AM (11 and a half hours after Resident 71’s fall) and Lorazepam was administered due to Resident 71 becoming “ .very restless and was trying to get out of bed .” The investigation showed the cognitive assessment of the resident on 07/09/2025 was “ .nonverbal and very hard to arouse (to wake up) .” Additionally, Resident 71’s resident representative was notified of the unwitnessed fall on 07/11/2025 (three days after the residents fall). Review of Resident 71’s MAR for July 2025, showed Lorazepam was administered on 07/08/2025 at 9:40 PM and 07/09/2025 at 12:00 AM, 5:00 AM, 7:20 AM, 3:33 PM and 8:30 PM. Observation on 07/16/2025 at 10:08 AM showed Resident 71 in their bed, unable to wake or open eyes. During an interview on 07/18/2025 at 12:40 PM, Staff F, RCM, stated the process for a resident having an unwitnessed fall and hitting their head would be to start neurological checks to assess for complications that may require emergency treatment and to notify the provider and Resident 71’s representative. Staff F stated that neurological checks were to be started right after a resident had been found and performed every 15 minutes (min) for one hour, then every 30 min for two hours, then every hour for four hours, and then every four hours for the next 24 hours. Staff F stated that Resident 71 was unable to make care decisions due to their cognitive ability and the resident’s representative would need to be notified after Resident 71s fall. Staff F stated they would be unable to assess changes in the Resident 71’s mentation nor accurately evaluate neurological checks since the resident was being administered their Lorazepam medication. Staff F stated that neurological checks should have been completed per the facility process, and they were not per Resident 71’s neurological assessment documentation and the provider/resident representative would have needed to be involved in a discussion on continued care interventions with the residents unwitnessed fall, head injury, and Lorazepam administration. During an interview on 07/18/2025 at 3:21 PM, Staff L, LPN, stated they had notified the on-call provider about Resident 71’s fall, but did not communicate that it was an unwitnessed fall, that the resident had hit their head, or clarify orders with completion of neurological checks versus Lorazepam medication administration. Staff L stated they did not notify Resident 71’s representative of the fal

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure restorative therapy services, including the use of an orthotic (a device designed to support, align, or correct function of movable parts of the body) were consistently implemented for 2 of 3 residents (Residents 8 and 35) reviewed for restorative therapy. This failure placed the residents at risk for loss of range of motion (ROM, the amount of movement that a joint can achieve in a specific direction), deconditioning (a decline in physical health from prolonged inactivity or illness), and contractures (a permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen). Findings included. Review of the policy dated 11/19/2024, titled Restorative Nursing, showed the Restorative Nursing program was to promote a resident's ability to adjust and adapt to live as independent and safe as they possibly could. The policy showed . measurable objective and interventions must be documented in the care plan and medical record and the trained Nursing Assistant (NA) would document the techniques used.<Resident 8> Review of the resident's' medical records showed they admitted with diagnoses to include a surgery procedure to their lower back due to wear and tear, nerve pain, and muscle weakness. The 07/01/2025 comprehensive assessment showed Resident 8 was cognitively intact and received three days of the seven days reviewed for their Restorative therapy program. During an interview on 07/15/2025 at 11:40 AM, Resident 8 stated they had Physical (therapy that improves mobility and function) and Occupational (therapy that improves performing daily tasks) Therapy when they admitted and had been changed to some program provided by the nursing assistant. Resident 8 stated the program was not consistent because the NA would be pulled to the floor to cover when other NAs called in or they were short staffed (not enough staff to provide care). Resident 8 stated they were supposed to have exercises six times a week but would receive it maybe two to three times a week. Review of Resident 8's 06/04/2025 Care Plan (CP), showed Resident 8 had limitations with their physical mobility due to weakness. The CP showed Resident 8 was to receive an active range of motion (AROM, exercises performed without assistance/help) program to both of their upper extremities for 15 minutes six times a week. The CP also showed bed mobility exercises that included sitting to lying and lying to sitting for 15 minutes six times a week. During an interview on 07/21/2025 at 11:18 AM, Resident 8 stated they had received their exercises one-time last week (since 07/15/2025). Resident 8 stated Staff Y, Restorative Nursing Assistant (RNA), was too busy covering the floor and was not able to get them done. <Resident 35> Review of the residents' medical records showed they admitted with diagnoses to include a stroke (blood flow to the brain is blocked or a blood vessel bursts) with deficits to their right side. The 06/20/2025 comprehensive assessment showed Resident 35 was cognitively intact and required staff assistance for activities of daily living (ADLs, basic self-care tasks that individuals perform daily to maintain their personal care and overall well-being). The assessment showed Resident 35 received their Restorative program on four of the seven days reviewed and did not require splint/brace assistance. During an interview on 07/15/2025 at 10:45 AM, Resident 35 stated they had recently been on a program with OT but were no longer doing that. Resident 35 stated they were on a Restorative program but that had not been consistent. Resident 35's roommate spoke up during the interview and stated [Staff Y] gets pulled to the floor a lot, and Resident 35 agreed. Resident 35 stated they wore a brace to their right hand but had not had that put on in some time. Resident 35's right hand appeared turned inward at the wrist in a fixed position. Review of Resident 35's CP showed Resident 35 was on an AROM program for hand exercises 15 minutes a day, six days a week, an AROM program for an orthotic to their right hand six times a week, and an out of bed activity program to be out of bed and in their wheelchair two to three times a week (Resident 35 resumed their Restorative programs after the end of OT on 06/19/2025 per progress notes). During an interview on 07/22/2025 at 10:59 AM, Staff Y stated their work schedule was Tuesday through Saturday day shift and they had Restorative programs for approximately15 residents at a time and that could vary. Staff Y stated they had residents that were scheduled for six times a week but there were no other NAs scheduled for the Restorative programs for that sixth day when they were not working. Staff Y stated the facility hired and trained someone to help them but then they moved them to cover NAs on the floor, because they were short staffed. Staff Y stated they often were not able to complete the Restorative programs because they too were pulled to cover the floor at the least three times a week. Staff Y also stated on Tuesdays they would assist with wound rounds before starting the Restorative programs and that would take away time from the program. Staff Y stated they were only able to complete the Restorative programs for Resident 8 once since

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	505070	A. Building B. Wing	07/23/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 1 of 2 residents (Resident 97) reviewed for hydration were consistently monitored and received adequate hydration fluids as per physician orders. This failure placed residents at risk for dehydration, constipation, urinary tract infections (UTI), and other health complications including worsening cognitive impairment and behavioral changes. Findings included . Review of the facility's policy, titled Infusion Therapy-Hypodermoclysis (Subcutaneous Fluids), dated 09/16/2024, showed the facility assures that each resident receive care and services consistent with professional standards of practice. Provide safe administration of infusion fluids by qualified staff, including monitoring the resident status. Review of the Lippincott's journal of nursing titled, Hypodermoclysis (HDC) in Home and Long-term Care Settings dated January 2009, showed Lippincott's standards of practice in nursing were as follows: (1) monitoring the infusion site for complications for signs of infection every shift or more frequently during infusion. (2) monitoring patient fluid intake and output, weight changes, and vital signs to assess hydration status and detect fluid overload. (3) assessing the patient's response to the therapy, including comfort levels and any changes in mental status. (4) Documentation, thorough documentation of the procedure, including site location, type of dressing, infusion type and rate, complications, interventions taken, and patient response. <Resident 97> Review of the medical record showed Resident 97 was admitted to the facility on [DATE] with diagnoses to include heart disease, kidney disease, dementia (the loss of thinking, remembering, and reasoning- to the extent that in interferes with daily living) and anxiety (a feeling of worry, nervousness, or unease). The comprehensive assessment dated [DATE] showed Resident 97's cognition was severely impaired and required assistance from one staff member for care and transfers. During an observation and concurrent interview on 07/16/2025 at 12:05 PM, Resident 97 was lying in bed covered with a blanket, had an indwelling catheter (a thin flexible tube inserted into the bladder to drain urine) and the drainage bag with dark red urine in it. Resident 97 stated they had it placed due to not being able to urinate. Further observation showed the resident had an infusion bag of fluids connected to them, no pump to indicate the infusion rate. The infusion bag had no label to indicate when it was started, what rate was to be infused, when the fluids were to stop and who started the infusion. Review of Resident 97's physician's order on 07/15/2025 showed sodium chloride Intravenous Solution 0.9 % (Sodium Chloride), inject two liters subcutaneously (layer underneath the skin) one time only for dehydration, for one day via hypodermoclysis (a method of fluid administered where fluids are injected into the layer just underneath the skin). During an observation on 07/17/2025 at 3:06 PM, Resident 97 was lying in bed and had an infusion bag that was being infused. The infusion bag had no date, time or initials on the infusion bag. Review of the resident's progress note dated 07/15/2025 showed a verbal order for hypodermoclysis for two liters of sodium chloride to run at 70 milliliters ([ml] a measure of volume) /per hour. During an observation and concurrent interview on 07/17/2025 at 3:18 PM Staff FF, Licensed Practical Nurse (LPN), stated they had received a report from the night shift nurse that Resident 97's infusion was subcutaneous and located in their left lower abdomen. Observation of the resident's abdomen showed a needle underneath the skin with a clear dressing holding it in place. There was no date, time or initials on the dressing or infusion bag. Staff FF stated without the information they were unable to verify when the infusion was started. In an interview on 07/17/2025 at 3:33 PM, Staff FF, stated the night shift nurse had reported the dial flow (a medical device that is used when regulating the flow of a fluid for an infusion) was set at 70 ml/hr for Resident 97's infusion. Staff FF showed the dial flow was set between 50 ml and 70 ml/hr. Staff FF stated they needed to assess the rate to ensure the resident was receiving the proper rate by counting the drops. Staff FF then stated the rate was 10 drops per minute, Staff FF double checked the resident physician orders and stated that the infusion was ordered at the rate of 70ml/hr. Staff FF stated would speak to the Resident Care Manager (RCM) because the infusion was not running per physician orders at that time. In an interview on 07/17/2025 at 3:44 PM, Staff F, RCM, stated they were aware of Resident 97's infusion, and would have to read the physician orders. Staff F read the order dated 07/15/2025 and verified Resident 97 was to receive two liters at 70 ml/hr for one day. Staff F stated there was no nursing documentation in the progress note to show there had been a problem with the resident's infusion nor a physician's order for the infusion to go slower. Staff F acknowledged Resident 97 continued the infusion at a lower rate for two days without a physician's order. In an interview on 07/23/2025 at 1:17 PM, Staff B, Director of Nursing Services, stated their expectation

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate staffing levels in order to provide care and services needed for 8 of 10 residents (Residents 11, 35, 13, 82, 9, 26, 8, and 18) reviewed for activities of daily living (ADLs), restorative therapy, and specialized therapy services (therapy that improves performing daily tasks, mobility and function). This failed practice placed residents at risk for an undignified existence and unmet care and service's needs. Findings included.<ADLs><Resident 11>Review of the resident's medical records showed they were admitted to the facility with diagnoses to include Alzheimer's disease (a brain disorder that slowly destroys a person's memory and thinking skills). During an interview and concurrent observation on 07/16/2025 at 9:13 AM, showed Resident 11 had a build up of a white substance between their teeth and the Resident Representative (RR) stated they wanted the resident to receive showers more than twice a week. The RR stated they felt the staff left it up to them to provide the resident their daily oral care. During an interview and concurrent observation on 07/18/2025 at 11:50 AM, the RR was observed wandering the halls looking for assistance before they took Resident 11 to the dining room for lunch. The RR stated the resident smelled of bowel movement and had not been checked or changed since the RR arrived at 6:45 AM (more than five hours later). During an interview on 07/21/2025 at 11:11 AM, the RR stated they arrived to the facility at 7:00 AM and Resident 11 had not been checked or changed (more than four hours later), no oral care had been provided before or after breakfast, and Resident 11 did not receive their shower over the weekend. <Resident 35>Review of the resident's medical records showed they were admitted to the facility with diagnoses to include a stroke (blood flow to the brain is blocked or a blood vessel bursts) with weakness to their right side. An observation on 07/15/2025 at 4:33 PM and 07/22/2025 at 2:35 PM, showed Resident 35's hair was uncombed, and their teeth were yellow with a buildup of a white substance in between their teeth. During an interview on 07/15/2025 at 10:45 AM, Resident 35 stated the facility needed to hire more help. Resident 35 stated they each had 15-20 rooms each and they would have to wait up to an hour to get up and ready and would have to sit in their wet urine and bed. During an interview and concurrent observation on 07/21/2025 at 3:42 PM, showed Resident 35's had not been provided oral care and stated they did not ask the Nursing Assistants (NAs) for help, nor did the NAs offer help they are so busy. <Resident 13>Review of the resident's medical records showed they were admitted to the facility with diagnoses to include multiple sclerosis (a chronic autoimmune [a condition where the body attacks itself] disease of the nervous system). During an interview and concurrent observation on 07/15/2025 at 10:42 AM, Resident 13 stated they had not been provided with ADL care. Resident 13 had greasy, uncombed hair. During an interview on 07/16/2025 at 8:48 AM, Resident 13 stated they had been at the facility for 13 days and had only received one shower I am not used to that. <Resident 82>Review of Resident 82's medical records showed they admitted to the facility with diagnoses to include diabetes (a disease in which the body does not control sugar in the blood). During an observation on 07/15/2025 at 2:06 PM, showed Resident 82's fingernails were long and had a dark substance underneath the nails. During an interview and concurrent observation on 07/18/2025 at 10:34 AM, Resident 82 stated they had women nails, and they were too long, and they did not like having nails that long. Resident 82's nails extended over their fingers on both hands. <Resident 9>Review of Resident 9's medical records showed they admitted to the facility with diagnoses to include muscle weakness. During an interview and concurrent observation on 07/15/2025 at 3:07 PM, showed Resident 9 had greasy hair and stated they had not had a shower in a while. Resident 9 stated staff get pulled from their duties when they are short of staff. Review of Resident 9's shower task records showed in June 2025 they received no showers, and from 07/10/2025 through 07/16/2025 showed Resident had not received a shower. <Resident 26>Review of Resident 26's medical records showed they admitted to the facility with diagnoses to include end stage kidney failure with dialysis (treatment that filters waste and fluid from your blood when your kidneys are failing). During an interview on 07/10/2025 at 2:45 PM, the RR stated Resident 26 had not received their baths and they were unclean. Review of Resident 26's shower tasks from 06/01/2025 through discharge date of 06/25/2025 showed Resident 26 received a bath/shower on 06/01/2025 and 06/04/2025 (16 days without a bath/shower). During an interview on 07/17/2025 at 2:23 PM, Staff HH, Nursing Assistant (NA), stated they had just started working at this facility. Staff HH stated they worked at the sister facility in Kennewick and were asked to come to this facility and help out until the end of

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted professional principles and discard medications when medications were not in use and when medications have expired on 2 of 2 medication carts (Team 1 and 2 medication carts) and 1 of 2 medication rooms (Team 2), reviewed for medication storage. This failure placed the residents at risk for receiving compromised or ineffective medication. Findings included. Review of the facility's policy titled, Storage and Expiration Dating of Medications and Biologicals dated 12/01/2007, showed the facility should ensure medications and biologicals: (1) have an expired date on the label, (2) have been retained longer than recommended by manufacturer or supplier guidelines, and (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. <Team 1> An observation of the Team 1 medication cart on 07/22/2025 at 11:00 AM, with Staff D Licensed Practical Nurse (LPN), showed as follows: one Rezvoglar insulin (a brand of medication used to control sugar in the blood) Kwik pen, had no label to identify who the medication was for, no dosage, or an open date to ensure efficacy (effectiveness) of the medication. one Tresiba insulin Flex touch pen had no label identifiers, no dosage, or an open date. one Novolin insulin Flex pen had no label identifiers, no dosage, no open date. one Lyumjev insulin Kwik pen had no label identifiers, no dosage, but had an open date 5/20/25. (38 days past manufacturer recommended for medication storage at room temperature) one vial of Humulin R had no label identifiers, no dosage for administration, and1 had an opened date of 6/4/25 (17 days past manufacturer recommended medication storage at room temperature) one bottle Potassium tablets 99 milligrams (mg) that expired on 05/2025. (60 days past expiration date) Further review of the medication cart showed a locked narcotic (a drug or substance that affects mood or behavior, relieves pain, induces drowsiness, and insensibility) drawer, within the narcotic drawer were medications of residents that had been discharged from facility and residents whose medications orders had changed: one opened bottle of liquid morphine sulfate had 12 milliliters (ml) in bottle, one unopened bottle of liquid morphine, and one unopened bottle of lorazepam. Staff D stated Resident 71 had passed away. one card of oxycodone 5 mg tablets that had 8 tablets. Staff D stated Resident 97 had been discharged from the facility. one card of oxycodone 5 mg tablets that had 27 tablets. Staff D stated Resident 83 was in the facility, but the resident's order had changed. one card of oxycodone 10 mg tablets that had 16 tabs left in the card. Staff D stated Resident 45 was in the facility, but the resident's order had changed. During an interview on 07/22/2025 at 11:10 AM, Staff D stated they were unsure who the insulin pens belonged to, and they were aware of medications within their cart that needed to be destroyed or sent back to the pharmacy. Staff D stated they usually destroyed the medications with a Registered Nurse or the Director of Nursing Services. <Team 2> An observation of the Team 2 medication cart on 07/22/2025 11:29 AM, with Staff C, LPN, showed as follows: one Lantus insulin Kwik pen for Resident 86 showed the pen had no open date to ensure efficacy of the medication. one Lantus insulin Kwik pen for Resident 20 showed the pen had no open date to ensure efficacy of the medication. one Lantus insulin Kwik pen for Resident 74 showed the pen had no open date to ensure efficacy of the medication. one Lantus insulin Kwik pen for Resident 3 showed the pen had no open date to ensure efficacy of the medication. one Lispro insulin Kwik pen for Resident 20 showed the pen had no open date to ensure efficacy of the medication. one Lispro insulin Kwik pen for Resident 87 had no open date to ensure efficacy of the medication. During an interview on 07/22/2025 at 11:41 AM Staff C, LPN stated they believed the insulin pens were kept at room temperature for 30 days per pharmacy recommendations but would need to verify the information. <Team 2 Medication Room> A concurrent observation and interview on 07/22/2025 at 10:13 AM, with Staff E, Resident Care Manager, they stated the Team 2 medication room had been cleaned up by pharmacy recently. The Team 2 med room had one bottle of Potassium that expired 05/2025 (60 days ago). Staff E stated the night shift nurses were responsible for cleaning the medication room, rotating (rotate to be used before expiration) the medications and returning medications to the pharmacy if a resident had been discharged or orders had changed. Staff E acknowledged expired medications in the medication carts and in the medication room. Staff E stated they needed to educate the nurses in the storage of medications. WAC Reference: 388-97-1300(2)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure physician ordered Occupational (OT, specialized therapy that improves performing daily tasks) or Physical therapy (PT, specialized therapy that improves mobility and function) was received for 2 of 4 residents (Residents 13 and 18) reviewed for therapy services. This failure placed the residents at risk for decline in function, decreased independence, and the worsening or development of contractures (a permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen). Findings included. Based on observation, interview, and record review, the facility failed to ensure physician ordered Occupational (OT, specialized therapy that improves performing daily tasks) or Physical therapy (PT, specialized therapy that improves mobility and function) was received for 2 of 4 residents (Residents 13 and 18) reviewed for therapy services. This failure placed the residents at risk for decline in function, decreased independence, and the development or worsening of contractures (a permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen). Findings included… <Resident 13> Review of Resident 13’s medical records showed the resident was admitted to the facility on [DATE] with diagnoses to include multiple sclerosis (a chronic autoimmune [a condition where the body attacks itself] disease of the nervous system), neuralgia (a sharp, shocking pain that is due to irritation or damaged nerve) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The comprehensive assessment dated [DATE] showed Resident 13’s cognition was intact and required assistance from two staff members for dressing of their lower body and transfers. During an interview and concurrent observation on 07/16/2025 at 9:19 AM, Resident 13 was lying in bed with a t-shirt and brief. The resident stated they had been in the facility for sixteen days and had not had any therapy. Review of the facility’s admission assessment dated [DATE] showed the reason for admission was therapy services (PT, OT, and speech therapy [ST/specialized therapy that helps with communication and swallowing difficulties]), and all three were all checked on the assessment form. Review of Resident 13’s transfer orders dated 07/01/2025 showed orders for OT three times a week for four weeks and PT three times a week for up to 45 days. Review of Resident 13’s physician orders dated 07/03/2025, showed the resident had an order for ST. There were no orders for OT or PT for the resident. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/2025 at 4:34 PM, Staff G, Social Services Director, stated they were able to access therapy notes and print them if needed. Staff G stated they were unable to obtain therapy notes for Resident 13 and stated the resident did not have any notes from therapy within the facility’s system. During an interview on 07/18/2025 at 12:55 PM, Staff E, Resident Care Manager (RCM), stated when a new resident was admitted to the facility, the nursing department would enter the standard orders in the system. Staff E stated two nurses reviewed the medication orders and entered the orders in the computer. Staff E stated that would include PT, OT and ST. Staff E stated the process would be the same with transfer orders. Staff E stated they were unsure of Resident 13’s therapy orders. During an interview on 07/18/2025 at 1:55 PM, Staff E stated they received clarification on Resident 13’s therapy insurance coverage, that the resident had exhausted their therapy covered days at the prior facility and that was the reason the resident had not received the therapy. Staff E stated there was no documentation to show the resident had been evaluated by therapy in the facility. During an interview on 07/18/2025 at 2:09 PM, Staff B, Director of Nursing Services, stated the expectation of the staff were to clarify orders, especially when staff were confused about an order. Staff B stated the resident should be discussed in their interdisciplinary team (IDT/ a group of healthcare professionals from different disciplines to help people receive the care they need) meeting to ensure staff had the right plan for the resident. <Resident 18> Review of the resident’s medical record showed the resident admitted to the facility on [DATE] with diagnoses to include repeated falls and peripheral neuropathy (when the nerves that are located outside of the brain and spinal cord (peripheral nerves) are damaged). The 04/11/2025 comprehensive assessment showed Resident 18 was cognitively intact and required partial to moderate staff assistance for toileting and transfers. The assessment also showed Resident 18 did not receive OT/PT services. During an interview on 07/16/2025 at 12:24 PM, Resident 18 stated they had been at the facility since April 2025 and had requested side rails be placed on their bed to help reposition themselves and still had not received them. Resident 18 stated they had purchased their own slide board (a flat board that is used to transfer from one surface to another) but needed the side rails to assist them. Resident 18 stated they asked to use a transfer pole (a long, sturdy pole with a grip on one end and a flat surface on the other that is used to assist someone with limited mobility) but was told they needed to be evaluated by PT. Resident 18 stated they asked PT, and they told them they needed to have a referral from a provider. Resident 18 then stated they asked the provider for PT, and they told them that it was up to therapy, and they would put in an order for the evaluation. Resident 18 stated they were currently working with Staff Y, Restorative Nursing Assistant, who provided them exercises “here and there.” Review of Resident 18’s 04/07/2025 hospital transfer orders showed an order for Resident 18 to be evaluated by PT and OT. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/21/2025 at 4:12 PM, Resident 18 stated they were told by the facility (unknown who they talked to) that “long term patients [residents who are going to stay longer than expected or permanently]” did not receive specialized therapy services. Resident 18 stated they talked with their Licensed Nurse (LN), and they told them they needed a referral from the provider. Resident 18 stated they wanted to be able to transfer independently without using a sit-to-stand (a mobility aid designed to assist individuals who have some weight-bearing ability but need support when transitioning from a seated to a standing position) but without the therapy to increase their strength in their legs and feet, they would not be able to do it. Review of provider notes showed: 04/14/2025, Resident 18 had “significant” bilateral (both hands) peripheral neuropathy in their hands and had some “contracture developing.” 04/21/2025, Resident 18 admitted with orders for PT/OT and when asked the provider when they would be evaluated, the provider told them “that would be a question for therapy.” 05/27/2025, Resident 18 requested a transfer pole and bed rails 06/02/2025, Resident 18 requested PT to work on transfers with a transfer pole and slide board and for side rails on their bed. Review of physician orders showed on 04/09/2025 an order for an OT evaluation and treatment that was discontinued seven days later. Review of a 06/02/2025 order showed an order for a PT/OT evaluation for the use of durable medical equipment (transfer pole, slide board, and side rails for their bed) Review of OT therapy notes showed on 04/23/2025, Resident 18 was referred to OT for a “power wheelchair assessment.” Review of another therapy note on 04/23/2025 showed Resident 18 was placed on a Restorative nursing program (a program to assist with maintaining current functional abilities) to “maintain current level of function.” The note showed Resident 18 would have an active range of motion (AROM, exercises performed without assistance/help) program for their upper extremities and “hand exercises, theraputty (a resistive material, much like silly putty, that has a range of resistances depending on the color of the putty).” The notes showed no exercises to maintain lower body mobility. The notes showed no other evaluations had been completed as ordered on admission. Review of PT notes from 04/09/2025 to 07/22/2025 showed no evaluations had been completed as ordered on admission or on 06/02/2025. During an interview on 07/22/2025 at 10:10 AM, Staff V, Director of Rehab (DOR), stated Resident 18 had talked to them regarding wanting therapy services but stated they had issues with obtaining therapy staff. Staff V stated they had one therapy staff out of the country and another that had been injured. Staff V stated they did not know Resident 18 had PT/OT orders on admission and would have to check to see what their coverage would allow, then get it approved. Staff V stated they informed Resident 18 “I’ll try to squeeze you in.” Staff V stated Resident 18 was not on a Restorative program. Staff V stated they were not aware that Resident 18 had a contracture. (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	07/23/2025

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 18’s 04/24/2025 care plan (CP) showed Resident 18 had a Restorative program and received AROM three times a week, and hand exercises six times a week. The CP showed no specialized therapy services for PT or OT or identified the contracture that was identified by the provider. During an interview on 07/22/2025 at 3:19 PM, Staff E, RCM, stated they entered PT/OT orders when Resident 18 was admitted and they were discontinued on 04/11/2025 by Staff B, Director of Nursing Services. The discontinued order showed the reason for the order being discontinued was “Medicaid (a government program that provides health insurance for adults and children with limited income and resources). Resident E stated it was “common practice to not give therapy to residents on Medicaid so they get put on a Restorative program instead.” Staff E stated they were present on 06/02/2025 when the resident asked for the therapy referral from the provider and processed the order themselves. Staff E stated they informed the DOR, and they took it from there. Staff E stated they were not aware Resident 18 never received those services on admission or on 06/02/2025 as ordered. Staff E stated they were not aware of the contracture to Resident 18’s right hand. During an interview on 07/23/2025 at 2:02 PM, Staff B stated Medicaid residents received the same treatment as any other newly admitted resident, regardless of their insurance status. Staff B stated they discontinued the admission PT/OT orders because once the orders were communicated in the daily team meeting (which included the therapy staff), the evaluations should have been done. Staff B stated they were aware of the therapy staff shortage but “assumed” and expected the evaluations to be completed as ordered and were not told otherwise. Staff B stated they were not aware of Resident 18’s contracture to their right hand and the RCMs were responsible for reading the provider’s visit notes and following up on them. Reference WAC: 388-97-1280 (1) (a)(b)

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	505070	A. Building B. Wing	07/23/2025

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. (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	07/23/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement effective measures of their infection prevention and control antibiotic stewardship program (ASP) regarding monitoring of residents prescribed antibiotics to ensure appropriate antibiotic use for 1 of 2 residents (Resident 33) reviewed for antibiotic stewardship. This failure increased the risk for development of multidrug-resistant organisms (MDRO/a bacteria that are resistant to many antibiotics), and unmet care needs related to infections. Findings included .Review of the facility's policy titled, ASP, dated May 2019, showed that the facility was to .implement a system for monitoring and reviewing antibiotic orders and antibiotic usage to aide in the responsible use of antibiotics . and that the Infection Preventionist (IP) would be responsible for oversight on the ASP. The policy stated that the IP would, verify that antibiotic orders were in compliance with the Loeb Criteria (a checklist that evaluates the resident's signs and symptoms to see if they indicate the need for an antibiotic), review cultures/sensitivity (C/S, a test to diagnose a bacterial infection and what antibiotics would be best to treat the infection) completed on residents' infections, and conduct an antibiotic time-out checklist (An assessment of an antibiotic medication that occurs 48 to 72 hours after the first administration, taking into account C/S testing results, residents response to therapy, and resident condition). Review of the facility's policy titled, Infection Control Program, dated April 2019, showed the facility would monitor and investigate causes of infection and how they might have spread. The policy showed that it would maintain records of resident infections which included each resident with an infection, the date of the infection, the causative agent (the organism that caused the infection), the site of infection and the intervention that were taken to control the spread of infection. Review of the facility's policy titled, Antibiotic Stewardship, revised 05/16/2024, showed that the Infection Preventionist (IP) would be responsible for oversight on the ASP. The policy showed that tracking/monitoring of antibiotics included communication with the facility's provider following initiation of an antibiotic for a change in a resident's condition and feedback regarding antibiotic resistance/laboratory (also known as lab) tests ordered/resulted. The policy showed that after 72 hours after a resident's antibiotic was initiated, or after the first dose was administered in the facility, an antibiotic time-out would be completed. Review of the facility's policy titled, Antibiotic Stewardship (ABX Timeouts), revised 11/20/2024, showed the ASP was a set of commitments and activities designed to optimize the treatment of infections with antibiotic use. The policy showed the antibiotic time-out was a reassessment of the consideration of the antibiotic need for a resident and included a review of the lab results, the resident's response to the antibiotic therapy and the resident's condition. <Resident 33>Review of the medical record showed the resident was admitted on [DATE] with diagnoses including multiple heart complications, kidney disease (a condition where the kidneys are damaged and unable to filter blood effectively) and a history of Urinary Tract Infections (UTI, (a condition where pathogens like bacteria can enter through the urinary meatus [a passage or opening leading to the interior of the body] and cause an infection in the kidneys or bladder) with an indwelling urinary catheter (IUC, a tube placed in the bladder which drains urine out into a collection bag). The 05/04/2025 comprehensive assessment showed the resident had moderate cognitive impairments, was able to make their needs known and had an indwelling urinary catheter (IUC, a tube placed in the bladder which drains urine out into a collection bag). Review of a progress note on 07/01/2025 showed the facility's provider ordered a urinalysis (a sample of urine that is tested in a lab) and it had been completed and sent out to be tested. Review of the facility's provider progress note and orders for Resident 71, dated 07/05/2025, showed Cephalexin (a specific antibiotic) medication was ordered due to possible UTI for seven days. The provider noted the residents UA preliminary finding showed a UTI with unknown organism (bacteria, viruses or other disease-causing organisms). The provider stated that due to the final culture (the lab testing of a resident urine sample that identifies the organism causing the infection and then a sensitivity that shows which antibiotic should be used to treat the identified organism) results from Resident 33's UA not being back yet they were going to start the resident on an antibiotic. Review of a progress note on 07/16/2025 at 3:00 PM, showed the resident was becoming lethargic (feeling unusually tired, sluggish, lacking in energy and can be a sign of an infection in the body). Review of a progress note on 07/21/2025 at 7:03 PM showed Resident 33's urine was cloudy (a sign that can indicate a UTI) and a UA was collected and sent to the lab for testing. During an interview on 07/22/2025 at 1:51 PM, Staff D, Infection Preventionist (IP), and Staff C Resident Care Manager/IP, stated the process for when a resident was suspected of having a UTI would be for