STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505080	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Kennewick	1508 West Seventh Avenue Kennewick, WA 99336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on interview and record review, the facility failed to ensure an incident of neglect was reported to the State Agency in a timely manner as required for 1 of 3 residents (Resident 1) reviewed for neglect. Failure to report to the State Agency placed residents at risk for additional neglect. Findings included . Review of the facility's undated policy titled, Abuse - Conducting an Investigation, showed the results of all investigations were to be reported to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five working days of the incident. If it was determined that alleged abuse and/or neglect had occurred, the Administrator, Director of Nursing, or his/her designee would promptly notify officials in accordance with state and federal regulations. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses which included spinal stenosis (space around the spinal cord became too narrow which occurred most often in the lower back and neck), diabetes and urinary retention (bladder did not empty completely or at all). Resident 1 was hospitalized between 05/24/2024 to 06/07/2024 and had laminectomy surgery (created space by removal of bony growth on the edge of a bone and tissues associated with arthritis of the spine) on 05/26/2024. Review of Resident 1's comprehensive assessment, dated 06/10/2024, showed they had no cognitive impairments. Review of Resident 1's plan of care, dated 06/07/2024, showed they required one staff to assist with turning in bed, transfers and dressing. On 06/24/2024 at 11:25 AM, Resident 1 stated, they had not urinated during the day and evening shifts on 06/08/2024 and the night shift of 06/09/2024. The resident stated they had asked staff to figure out how they could urinate as they knew they had over the amount of urine needed to be catheterized. Resident 1 stated it was a horrible experience, no one was willing to help me, felt like I was going to explode with my bladder. Resident 1 stated it took forever to get the bladder scan done and to be catheterized and it hurt really bad, I even tried pushing out the urine. Resident 1 stated the Licensed Nurse the night of 06/09/2024 [Staff B] did not do an assessment on them and only came into their room to administer pain medication. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505080	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Kennewick	1508 West Seventh Avenue Kennewick, WA 99336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/24/2024 at 1:27 PM, Staff A, Nursing Assistant (NA), stated shortly after they arrived to work on 06/08/2024 at 10:00 PM, they checked on Resident 1, as they had cared for the resident the day before. Resident 1 stated they had not urinated since Staff A had cared for them the previous night. Resident 1 complained of abdominal pain. Staff A reported Resident 1's concerns to Staff B, agency Licensed Practical Nurse (LPN) and Staff C, Registered Nurse/Unit Care Coordinator, as they were both at the nursing station. Staff C then instructed Staff B to check on the resident and if they were not urinating a bladder scan (portable ultrasound device used to measure the amount of urine in the bladder) needed to be performed. The instructions by Staff C also included if Resident 1 was retaining urine the on-call physician needed to be notified to obtain orders to catheterize (insert a catheter into the bladder) the resident. Staff C then left the unit. Between 2:00 AM to 2:30 AM on 06/09/2024 Staff A again checked on Resident 1 who stated their abdomen still hurt and felt swollen. The resident still had not urinated, was sweaty and breathing hard. Staff A stated they immediately informed Staff B regarding the resident's condition. Staff A stated to Staff B, something needs to be done. At 4:00 AM on 06/09/2024 Staff A observed Resident 1 crying in pain and was extremely distressed. The resident was concerned their bladder was going to pop, and was unhappy Staff B had not done anything yet. Staff A and Staff D, NA, Resident 1's primary caregiver, questioned Staff B when they were going to do the bladder scan as per Staff C's earlier instructions. Staff B obtained assistance from Staff E, LPN and the bladder scan was completed at 5:00 AM on 06/09/2024. Staff B did not notify the on-call physician or perform the catheterization on Resident 1. On 06/09/2024 at 6:00 AM Staff A reported to Staff C the events of the night regarding Resident 1 including the resident being in pain all night and delay in treatment. On 06/24/2024 at 2:10 PM, Staff G, LPN, stated they were pulled from another unit at approximately 6:30 AM on 06/09/2024 to catheterize Resident 1. Staff G stated Resident 1 was relieved when the catheter emptied over 1200 milliliters (ml) of urine from their bladder (normal bladder capacity in adults ranged from 300 to 400 ml). Review of Progress Notes (PNs) in Resident 1's medical record, dated 06/09/2024 at 6:27 AM, by Staff F, showed the resident complained of not being able to urinate during the night shift. A bladder scan was performed at 5:00 AM on 06/09/2024 with a volume of 980 ml of urine in the bladder. The physician was notified and orders obtained to catheterize the resident. Review of Resident 1's June 2024 Medication Administration Record, showed Resident 1 was not catheterized until 7:41 AM on 06/09/2024 (8 hours and 41 minutes following the resident's initial complaints of bladder pain). Review of Resident 1's PNs between 10:00 PM on 06/08/2024 to 6:00 AM on 06/09/2024 showed there were no assessments/monitoring of the resident by Staff B despite the resident's change of condition, new admission status and alert charting policy. Review of the facility Reporting Log showed the above incident of neglect involving Resident 1 was not reported to the State Agency as required. Refer to F684 for additional information. Reference (WAC) 388-97-0640(6)(c) This is a repeat deficiency from the Statement of Deficiencies dated 09/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505080	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Kennewick	1508 West Seventh Avenue Kennewick, WA 99336

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on interviews and record review, the facility failed to thoroughly investigate incidents of neglect for 1 of 3 residents (Resident 1) reviewed for investigations. This failed practice placed all residents at risk for not identifying corrective actions to prevent further neglect. Findings included . Review of the facility's undated policy titled, Abuse - Conducting an Investigation, reviewed on 07/18/2023, showed it was the policy of the facility that allegations of abuse and neglect were promptly and thoroughly investigated. The facility would prevent further abuse and neglect from occurring while the investigation was in progress, and take appropriate corrective action, as a result of the investigation findings. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses which included spinal stenosis (space around the spinal cord became too narrow which occurred most often in the lower back and neck), diabetes and urinary retention (bladder did not empty completely or at all). Resident 1 was hospitalized between 05/24/2024 to 06/07/2024 and had laminectomy surgery (created space by removal of bony growth on the edge of a bone and tissues associated with arthritis of the spine) on 05/26/2024. Review of Resident 1's comprehensive assessment, dated 06/10/2024, showed they had no cognitive impairments. Review of Resident 1's plan of care, dated 06/07/2024, showed they required one staff to assist with turning in bed, transfers and dressing. On 06/24/2024 at 11:25 AM, Resident 1 stated, they had not urinated during the day and evening shifts on 06/08/2024 and the night shift of 06/09/2024. The resident stated they had asked staff to figure out how they could urinate as they knew they had over the amount of urine needed to be catheterized. Resident 1 stated it was a horrible experience, no one was willing to help me, felt like I was going to explode with my bladder. Resident 1 stated it took forever to get the bladder scan done and to be catheterized and it hurt really bad, I even tried pushing out the urine. Resident 1 stated the Licensed Nurse the night of 06/09/2024 [Staff B] did not do an assessment on them and only came into their room to administer pain medication. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/24/2024 at 1:27 PM, Staff A, Nursing Assistant (NA), stated shortly after they arrived to work on 06/08/2024 at 10:00 PM, they checked on Resident 1, as Staff A had cared for them the day before. Resident 1 stated they had not urinated since Staff A had cared for them the previous night. Resident 1 complained of abdominal pain. Staff A reported Resident 1's concerns to Staff B, agency Licensed Practical Nurse (LPN) and Staff C, Registered Nurse/Unit Care Coordinator, as they were both at the nursing station. Staff C then instructed Staff B to check on the resident and if they were not urinating a bladder scan (portable ultrasound device used to measure the amount of urine in the bladder) needed to be performed. The instructions by Staff C also included if Resident 1 was retaining urine the on-call physician needed to be notified to obtain orders to catheterize (insert a catheter into the bladder) the resident. Staff C then left the unit. Between 2:00 AM to 2:30 AM on 06/09/2024 Staff A again checked on Resident 1 who stated their abdomen still hurt and felt swollen. The resident still had not urinated, was sweaty and breathing hard. Staff A stated they immediately informed Staff B regarding the resident's condition. Staff A stated to Staff B, something needs to be done. At 4:00 AM on 06/09/2024 Staff A observed Resident 1 crying in pain and was extremely distressed. The resident was concerned their bladder was going to pop, and was unhappy Staff B had not done anything yet. Staff A and Staff D, NA, Resident 1's primary caregiver, questioned Staff B when they were going to do the bladder scan as per Staff C's earlier instructions. Staff B obtained assistance from Staff E, LPN and the bladder scan was completed at 5:00 AM on 06/09/2024. Staff B did not notify the on-call physician or perform the catheterization on Resident 1. On 06/09/2024 at 6:00 AM Staff A reported to Staff C the events of the night regarding Resident 1 including the resident being in pain all night and delay in treatment. On 06/24/2024 at 2:10 PM, Staff G, LPN, stated they were pulled from another unit at approximately 6:30 AM on 06/09/2024 to catheterize Resident 1. Staff G stated Resident 1 was relieved when the catheter emptied over 1200 milliliters (ml) of urine from their bladder (normal bladder capacity in adults ranged from 300 to 400 ml). On 06/24/2024 at 11:45 AM, Staff C stated, prior to them leaving the unit at 11:00 PM on 06/08/2024, NA staff had reported Resident 1 was having bladder pain and felt their bladder was full. Staff C stated they instructed Staff B at that time to do a bladder scan on Resident 1, and if needed Staff B would have to notify the on-call MD for a catheter order. Staff C also informed Staff B they had put Resident 1 on alert charting, thus the resident needed to be monitored closely. Staff C stated Staff A had reported to them the morning of 06/09/2024 that Staff B did not know how to use the bladder scanner machine. Staff F had reported they immediately notified the on-call physician when Staff F reported to work at 6:00 AM on 06/09/2024. Despite the delay in treatment and prolonged bladder pain involving Resident 1 Staff C stated an investigation was not conducted by staff and no immediate corrective action was taken by staff. On 06/24/2024 at 5:00 PM, Staff H, Administrator, stated they contacted Staff B's agency on 06/20/2024 (11 days following the incident involving Resident 1) to remove them from working at the facility. Review of Resident 1's Progress Notes (PNs) in the medical record between 10:00 PM on 06/08/2024 to 6:00 AM on 06/09/2024 showed there were no assessments/monitoring of the resident by Staff B despite the resident's change of condition and new admission status. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Progress Notes (PNs) in Resident 1's medical record, dated 06/09/2024 at 6:27 AM, by Staff F, showed the resident complained of not being able to urinate during the night shift. A bladder scan was performed at 5:00 AM on 06/09/2024 with a volume of 980 ml of urine in the bladder. The physician was notified and orders obtained to catheterize the resident. Review of Resident 1's June 2024 Medication Administration Record, showed Resident 1 was not catheterized until 7:41 AM on 06/09/2024 (8 hours and 41 minutes following the resident's initial complaints of bladder pain). Oxycodone (narcotic medication) was administered to Resident 1 at 12:08 AM on 06/09/2024 by Staff B for a pain level of 6 which was effective, and Oxycodone was administered at 3:54 AM on 06/09/2024 by Staff B for a pain level of 8, which was ineffective. Pain levels were measured on a scale of zero being no pain to 10 being severe pain. Refer to F684 for additional information. Reference (WAC) 388-97-0640(6)(a)(b) This is a repeat deficiency from the Statement of Deficiencies dated 09/21/2023.

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Life Care Center of Kennewick	1508 West Seventh Avenue Kennewick, WA 99336

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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 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** 00242 Based on interview and record review, the facility failed to provide timely care and services and perform assessments for 1 of 3 residents (Resident 1) reviewed for changes in condition. Resident 1 experienced harm when they had prolonged bladder pain due to urinary retention with a delay in treatment. Findings included . Review of the facility undated policy titled, Alert Charting, showed alert charting was to occur in the event of acute change in condition and was to be continued every shift for 72 hours. The alert charting list included new admissions. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses which included spinal stenosis (space around the spinal cord became too narrow which occurred most often in the lower back and neck), diabetes and urinary retention (bladder did not empty completely or at all). Resident 1 was hospitalized between 05/24/2024 to 06/07/2024 and had laminectomy surgery (created space by removal of bony growth on the edge of a bone and tissues associated with arthritis of the spine) on 05/26/2024. Review of Resident 1's comprehensive assessment, dated 06/10/2024, showed they had no cognitive impairments. Review of Resident 1's plan of care, dated 06/07/2024, showed they required one staff to assist with turning in bed, transfers and dressing. On 06/24/2024 at 11:25 AM, Resident 1 stated, they had not urinated during the day and evening shifts on 06/08/2024 and the night shift of 06/09/2024. The resident stated they had asked staff to figure out how they could urinate as they knew they had over the amount of urine needed to be catheterized. Resident 1 stated it was a horrible experience, no one was willing to help me, felt like I was going to explode with my bladder. Resident 1 stated it took forever to get the bladder scan done and to be catheterized and it hurt really bad, I even tried pushing out the urine. Resident 1 stated the Licensed Nurse the night of 06/09/2024 [Staff B, agency Licensed Practical Nurse (LPN)] did not do an assessment on them and only came into their room to administer pain medication. On 06/24/2024 at 11:37 AM, Resident 1's representative (RR), stated the resident was calling them at home several times during the night shift between 06/08/2024 to 06/09/2024. The RR stated the resident had so much pain in their bladder, which put additional pressure on their back surgical area. It was a couple of hours following the bladder scan before Resident 1 was catheterized. The RR stated the resident's bladder pain started at 11:00 PM on 06/08/2024. (continued on next page)

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Life Care Center of Kennewick	1508 West Seventh Avenue Kennewick, WA 99336

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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 0684 Level of Harm - Actual harm Residents Affected - Few	On 06/24/2024 at 11:45 AM, Staff C, Registered Nurse/Unit Care Coordinator, stated prior to them leaving the unit at 11:00 PM on 06/08/2024, NA staff had reported Resident 1 was having bladder pain and felt their bladder was full. Staff C stated they instructed Staff B at that time to do a bladder scan on Resident 1, and if needed Staff B would have to notify the on-call MD for a catheter order. Staff C also informed Staff B they had put Resident 1 on alert charting, thus the resident needed to be monitored closely. Staff C stated Staff B never informed Staff C they did not know how to operate the bladder scanner. Staff C stated Staff A, Nursing Assistant (NA), reported to them the morning of 06/09/2024 that Staff B did not know how to use the bladder scanner. Staff F, agency Licensed Practical Nurse, had reported they immediately notified the on-call physician when Staff F reported to work at 6:00 AM on 06/09/2024. On 06/24/2024 at 1:27 PM, Staff A, stated shortly after they arrived to work on 06/08/2024 at 10:00 PM, they checked on Resident 1, as they had cared for the resident the day before. Resident 1 stated they had not urinated since Staff A had cared for them the previous night. Resident 1 complained of abdominal pain and stated in the past they had to have a catheter (flexible tube used to empty the bladder) for not being able to urinate. Staff A reported Resident 1's concerns to Staff B, and Staff C, as they were both at the nursing station. Staff C then instructed Staff B to check on the resident and if they were not urinating a bladder scan (portable ultrasound device used to measure the amount of urine in the bladder) needed to be performed. The instructions by Staff C also included if Resident 1 was retaining urine the on-call physician needed to be notified to obtain orders to catheterize (insert a catheter into the bladder) the resident. Staff C then left the unit. Staff B checked on Resident 1 and stated the resident just seemed anxious. Pain medication was then given to Resident 1. Between 2:00 AM to 2:30 AM on 06/09/2024 Staff A again checked on Resident 1 who stated their abdomen still hurt and felt swollen. The resident still had not urinated, was sweaty and breathing hard. Staff A stated they immediately informed Staff B regarding the resident's condition. Staff A stated to Staff B, something needs to be done. Staff B responded they would check on it. At 4:00 AM on 06/09/2024 Staff A observed Resident 1 crying in pain and was extremely distressed. The resident was concerned their bladder was going to pop, and was unhappy Staff B had not done anything yet. Staff A and Staff D, NA, Resident 1's primary caregiver, questioned Staff B when they were going to do the bladder scan as per Staff C's earlier instructions. Staff B then got the bladder scan machine and asked Staff A if they knew how to operate the machine. Staff A replied it was not in their scope of practice. Staff B then obtained assistance from Staff E, LPN, who was working on another unit. The bladder scan was completed at 5:00 AM on 06/09/2024. Staff B did not notify the on-call physician or perform the catheterization on Resident 1. On 06/09/2024 at 6:00 AM Staff A reported to Staff C the events of the night regarding Resident 1 including the resident being in pain all night and delay in treatment. (continued on next page)

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Life Care Center of Kennewick	1508 West Seventh Avenue Kennewick, WA 99336

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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 0684 Level of Harm - Actual harm Residents Affected - Few	On 06/24/2024 at 1:50 PM, Staff D, stated as soon as they reported to work on 06/08/2024 at 10:00 PM Resident 1's call light was on. Upon responding to the call light Resident 1 complained about pain in their bladder, feeling miserable and uncomfortable. Staff D reported Resident 1's concerns to Staff C, who stated Staff B was going to do a bladder scan on the resident and if there was a large amount of urine the physician would be notified. Staff C then left the unit at approximately 11:00 PM. Thirty minutes later Resident 1 stated they were in much pain and felt pressure to their bladder area. Staff D informed Staff B of the resident's concerns. Resident 1 activated their call light every 30 minutes during the night asking what was going to be done regarding their bladder pain. At one point Resident 1 wanted to know the exact time Staff B was going to check on them. Staff B initially informed Staff D they did not know what time they would be completed with medications and treatments for other residents, but then stated 15 to 20 minutes. Staff D stated they did not know exactly what time Staff B saw Resident 1 but pain medication was administered to Resident 1 by Staff B. At approximately 4:00 AM on 06/09/2024 Resident 1 stated they were still in pain and had not urinated. Staff D reported the information to Staff B, who then went to get the bladder scanner machine. At 5:00 AM on 06/09/2024 the bladder scan was performed on Resident 1. The morning of 06/09/2024 Staff D stated they and Staff A reported to Staff C regarding the resident's pain throughout the night, delay in performing the bladder scan and the lack of knowledge Staff B had regarding the scanner. On 06/25/2024 at 9:43 AM, Staff B, stated they recalled NA staff reporting at 11:00 PM on 06/08/2024 that Resident 1 was having a hard time urinating. Staff B stated when Staff C left the unit at 11:00 PM on 06/08/2024, they instructed Staff B to monitor Resident 1, do a bladder scan if the resident continued to have difficulty urinating and notify the on-call physician to get an order for catheterization. Staff B stated they were unable to recall when they assessed Resident 1 as they had things to do with other residents that night. Staff B stated at some point during the night of 06/09/2024 NA staff had asked what time Staff B would be in to see Resident 1. Staff B stated they informed the NA they would see Resident 1 when they were finished with another resident. Staff B stated they did recall Resident 1 having bladder pain and stated they had not urinated for a long time. Staff B stated they asked Staff A if they knew how to operate the bladder scanner as they had never used the machine before. Staff B recalled the number on the scanner being high (showed large amount of urine in the resident's bladder), but they had not notified the on-call physician as the day shift Licensed Nurse had done that. On 06/24/2024 at 12:25 PM, Staff F, agency LPN, stated the bladder scan on Resident 1 was done at 5:00 AM on 06/09/2024 by Staff B with assistance from Staff E. Staff F stated they notified the on-call physician right after reporting to work at 6:00 AM on 06/09/2024. On 06/24/2024 at 2:10 PM, Staff G, LPN, stated they were pulled from another unit at approximately 6:30 AM on 06/09/2024 to catheterize Resident 1. Staff G stated Resident 1 was relieved when the catheter emptied over 1200 milliliters (ml) of urine from their bladder (normal bladder capacity in adults ranged from 300 to 400 ml). Staff G stated prior to the catheterization they had palpated the resident's bladder and it was rock hard, (possibly indicative of a problem with how the bladder muscle worked). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's June 2024 Medication Administration Record, showed Resident 1 was not catheterized until 7:41 AM on 06/09/2024 (8 hours and 41 minutes following the resident's initial complaints of bladder pain). Oxycodone (narcotic medication) was administered to Resident 1 at 12:08 AM on 06/09/2024 by Staff B for a pain level of 6 which was effective, and Oxycodone was administered at 3:54 AM on 06/09/2024 by Staff B for a pain level of 8, which was ineffective. Pain levels were measured on a scale of zero being no pain to 10 being severe pain. Review of Progress Notes (PNs) in Resident 1's medical record, dated 06/09/2024 at 6:27 AM, by Staff F, showed the resident complained of not being able to urinate during the night shift. A bladder scan was performed at 5:00 AM on 06/09/2024 with a volume of 980 ml of urine in the bladder. The physician was notified and orders obtained to catheterize the resident. Review of Resident 1's PNs between 10:00 PM on 06/08/2024 to 6:00 AM on 06/09/2024 showed there were no assessments/monitoring of the resident by Staff B despite the resident's change of condition, new admission status and alert charting policy. Reference (WAC) 388-97-1060(1) This is a repeat deficiency from the Statement of Deficiencies dated 03/20/2024.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on interviews and record review the facility failed to ensure 1 of 1 Licensed Nurse (Staff B), reviewed for competency, demonstrated competency in caring for Resident 1, who was experiencing a change of condition. In addition, the facility failed to ensure Staff B was evaluated by the facility for competency with skills and techniques prior to working. This failure placed Resident 1 at risk for clinical complications. Findings included . <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses which included spinal stenosis (space around the spinal cord became too narrow which occurred most often in the lower back and neck), diabetes and urinary retention (bladder did not empty completely or at all). Resident 1 was hospitalized between 05/24/2024 to 06/07/2024 and had laminectomy surgery (created space by removal of bony growth on the edge of a bone and tissues associated with arthritis of the spine) on 05/26/2024. Review of Resident 1's comprehensive assessment, dated 06/10/2024, showed they had no cognitive impairments. Review of Resident 1's plan of care, dated 06/07/2024, showed they required one staff to assist with turning in bed, transfers and dressing. On 06/24/2024 at 11:25 AM, Resident 1 stated, they had not urinated during the day and evening shifts on 06/08/2024 and the night shift of 06/09/2024. The resident stated they had asked staff to figure out how they could urinate as they knew they had over the amount of urine needed to be catheterized. Resident 1 stated it was a horrible experience, no one was willing to help me, felt like I was going to explode with my bladder. Resident 1 stated it took forever to get the bladder scan done and to be catheterized and it hurt really bad, I even tried pushing out the urine. Resident 1 stated the Licensed Nurse the night of 06/09/2024 [Staff B] did not do an assessment on them and only came into their room to administer pain medication. On 06/24/2024 at 11:45 AM, Staff C stated, prior to them leaving the unit at 11:00 PM on 06/08/2024, NA staff had reported Resident 1 was having bladder pain and felt their bladder was full. Staff C stated they instructed Staff B at that time to do a bladder scan on Resident 1, and if needed Staff B would have to notify the on-call MD for a catheter order. Staff C also informed Staff B they had put Resident 1 on alert charting, thus the resident needed to be monitored closely. Staff C stated Staff B never informed Staff C they did not know how to operate the bladder scanner. Staff C stated Staff A had reported to them the morning of 06/09/2024 that Staff B did not know how to use the bladder scanner. Staff F had reported they immediately notified the on-call physician when Staff F reported to work at 6:00 AM on 06/09/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505080	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Kennewick	1508 West Seventh Avenue Kennewick, WA 99336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/24/2024 at 1:27 PM, Staff A, Nursing Assistant (NA), stated shortly after they arrived to work on 06/08/2024 at 10:00 PM, Staff A checked on Resident 1, as Staff A had cared for them the day before. Resident 1 stated they had not urinated since Staff A had cared for them the previous night. Resident 1 complained of abdominal pain. Staff A reported Resident 1's concerns to Staff B, agency Licensed Practical Nurse (LPN) and Staff C, Registered Nurse/Unit Care Coordinator, as they were both at the nursing station. Staff C then instructed Staff B to check on the resident and if they were not urinating a bladder scan (portable ultrasound device used to measure the amount of urine in the bladder) needed to be performed. The instructions by Staff C also included if Resident 1 was retaining urine the on-call physician had to be notified to obtain orders to catheterize (insert a catheter into the bladder) the resident. Staff C then left the unit. Staff B checked on Resident 1 and stated the resident just seemed anxious. Pain medication was then given to Resident 1. Between 2:00 AM to 2:30 AM on 06/09/2024 Staff A again checked on Resident 1 who stated their abdomen still hurt and felt swollen. The resident still had not urinated, was sweaty and breathing hard. Staff A stated they immediately informed Staff B regarding the resident's condition. Staff A stated to Staff B, something needs to be done. At 4:00 AM on 06/09/2024 Staff A observed Resident 1 crying in pain and was extremely distressed. The resident was concerned their bladder was going to pop, and was unhappy Staff B had not done anything yet. Staff A and Staff D, NA, Resident 1's primary caregiver, questioned Staff B when they were going to do the bladder scan as per Staff C's earlier instructions. Staff B then got the bladder scan machine and asked Staff A if they knew how to operate the machine. Staff A replied it was not in their scope of practice. Staff B then obtained assistance from Staff E, LPN, who was working on another unit. The bladder scan was completed at 5:00 AM on 06/09/2024. Staff B did not notify the on-call physician or perform the catheterization on Resident 1. On 06/25/2024 at 9:43 AM, Staff B, stated they recalled NA staff reporting at 11:00 PM on 06/08/2024 that Resident 1 was having a hard time urinating. Staff B stated when Staff C left the unit at 11:00 PM on 06/08/2024, they instructed Staff B to monitor Resident 1, do a bladder scan if the resident continued to have difficulty urinating and notify the on-call physician to get an order for catheterization. Staff B stated they were unable to recall when they assessed Resident 1 as they had things to do with other residents that night. Staff B stated at some point during the night of 06/09/2024 NA staff had asked what time Staff B would be in to see Resident 1. Staff B stated they informed the NA they would see Resident 1 when they were finished with another resident. Staff B stated they did recall Resident 1 having bladder pain and stated they had not urinated for a long time. Staff B stated they asked Staff A if they knew how to operate the bladder scanner as they had never used the machine before. Staff B recalled the number on the scanner being high (showed large amount of urine in the resident's bladder), but they had not notified the on-call physician as the day shift Licensed Nurse had done that. On 06/24/2024 at 2:10 PM, Staff G, LPN, stated they were pulled from another unit at approximately 6:30 AM on 06/09/2024 to catheterize Resident 1. Staff G stated Resident 1 was relieved when the catheter emptied over 1200 milliliters (ml) of urine from their bladder (normal bladder capacity in adults ranged from 300 to 400 ml). Review of Resident 1's June 2024 Medication Administration Record, showed Resident 1 was not catheterized until 7:41 AM on 06/09/2024 (8 hours and 41 minutes following the resident's initial complaints of bladder pain). (continued on next page)

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	505080	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Progress Notes (PNs) in Resident 1's medical record, dated 06/09/2024 at 6:27 AM, by Staff F, showed the resident complained of not being able to urinate during the night shift. A bladder scan was performed at 5:00 AM on 06/09/2024 with a volume of 980 ml of urine in the bladder. The physician was notified and orders obtained to catheterize the resident. Review of Resident 1's PNs between 10:00 PM on 06/08/2024 to 6:00 AM on 06/09/2024 showed there were no assessments/monitoring of the resident by Staff B despite the resident's change of condition, new admission status and alert charting policy. Review of Staff B's personnel file showed there was no specific competencies and skills sets, which included documented demonstrations, necessary to safely and efficiently perform care to meet residents' needs. Refer to F684 for additional information. Reference (WAC) 388-97-1080(9)(10)(c)