

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of Kennewick		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922</p> <p>Based on observation, interview and record review, the facility failed to ensure visitation rights were protected for 1 of 1 resident (Resident 2) when an immediate family member was limited to specific visitation hours indefinitely. This failure placed residents at risk of isolation, depression, and a diminished quality of life.</p> <p>Findings included .</p> <p><Resident 2></p> <p>Review of the resident's medical record showed they admitted to the facility with diagnoses of a stroke (when something prevents your brain from getting enough blood flow) with a deficit to their left side and heart failure. The 04/16/2025 comprehensive assessment showed Resident 2's cognition was intact, and they were dependent on staff assistance for their activities of daily living (essential tasks that individuals perform regularly to care for their bodies and maintain overall well-being).</p> <p>(continued on next page)</p>

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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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A concurrent observation and interview on 05/21/2025 at 1:26 PM, showed Resident 2 and their Resident Representative (RR) were both visibly upset. Resident 2 had tears filled up in their eyes and when talking, their voice would become shaky. Resident 2 stated there had been an incident that involved a Nursing Assistant (NA, later identified as Staff E) at the beginning of May 2025. Resident 2 stated their RR had visited them daily since their admission on 04/12/2024, at least twice daily, and would eat dinner with them often. Resident 2 stated a week prior to the early May 2025 incident that their RR had voiced a concern while in the dining room (D/R) about dinner being late more than once that week. Resident 2 stated when the RR left for the evening, they were approached by Staff E, NA, and told if your [RR] doesn't quit complaining so much, they won't be able to come and see you anymore. Resident 2 stated the following morning they relayed that information to the RR and stated they really liked the NA and the care they provided, so to just let it go. The RR stated they had gone to Staff A, Administrator (AD), and talked to them about Staff E's comment and that it had upset Resident 2. The RR stated they were assured by Staff A that they were not in any trouble and their visitation was not in jeopardy. Resident 2 stated that no one had talked to them regarding Staff E's statement that upset them. Then, on 05/05/2025, as Resident 2 and the RR were on their way into the building from being on a walk, the RR seen Staff E in the hallway. The RR stated they were going to talk to Staff E and thank them for taking good care of Resident 2, as a way to let them know things were good between them. The RR stated as soon as they said Staff E's name, they went crazy as if they were scared of me, and started yelling in the hallway, 'HELP, I need witnesses, I am going to need to file a report against you and you will never see [Resident 2] again!' The RR stated Staff E had been up against the wall as if the RR was attacking them, then other staff showed up (later identified as Staff F, NA, and Staff G, Registered Nurse) and Staff E was asked to walk away, and then the RR was asked to calm down and go to the resident's room. The following morning, on 05/06/2025, the RR stated they came to visit as per their usual routine and was approached by Staff A very aggressively and had made accusations about the RR and said, I was intimidating, I cornered [Staff E] and threatened them. The RR stated they were not given a chance to tell their side of the story and had been cut off by Staff A and then told that they were no longer allowed to come and go for visits. Resident 2, while crying and voice shaking, stated their visitation was restricted to visiting Monday through Friday from 8:00 AM until 5:00 PM and not at all on the weekends. Resident 2 stated they had never been apart from each other and with the [RR] being [AGE] years old, they did not have much time left to spend with each other for their time together to be restricted. Resident 2 stated they had not felt safe, they increased my fear, sense of security, or that anyone gives a d**n or actually even cares about me since this incident. Resident 2 stated they did not feel like they could voice concerns for fear of retaliation and restricting the RR's visitation all together. Resident 2 stated there was another resident's RR who witnessed the incident, but the facility had failed to talk to them.</p> <p>(continued on next page)</p>		

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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/21/2025 at 3:20 PM, showed the Collateral Contact (CC) stated they had witnessed the event that transpired between Staff E, Resident 2, and the RR on 05/05/2025. The CC stated they heard yelling, so they went to the door of the resident they had visited at the facility. The CC seen the RR, Resident 2, and Staff E in the hallway, the RR was standing behind Resident 2's wheelchair, and Staff E was standing against the wall. The CC stated Staff E was yelling I don't appreciate you talking to me, I am going to write you up, and you will never see [Resident 2] again! The CC stated the RR told Staff E what are you talking about, I am just trying to talk to you. The CC stated the RR had not raised their voice until Staff E told the RR they would never see their [Resident 2] again and then the RR became very upset and yelled you're going to keep me from my [Resident 2], who do you think you are? The CC stated another staff member, Staff G, came down the hallway and told Staff E to go and take a break. The CC stated they were upset because they felt Staff E should have walked away and not engaged with the RR the way they did and this was supposed to be a calm home for the residents. The CC stated they reported the witnessed incident on 05/06/2025 or 05/07/2025 to Staff C, Resident Care Manager, who told the CC it was above their head and would let the AD know. The CC informed Staff C they would be available for a statement but never heard from the facility. The CC stated they called Staff C again that morning, 05/21/2025, to inquire why they had not received a call from the AD and was told by Staff C they must not have needed your statement but would let the AD know they called. The CC stated the incident did not affect the resident they were visiting, they just continued to watch the television.</p> <p>During an interview on 05/21/2025 at 3:39 PM, Staff C stated they received a report from the CC and told the CC they would pass it on to the AD. Staff C stated they passed the information given to them by the CC on the same day it was reported to them, on to the AD and the AD replied with okay. Staff C stated they were told of the incident by Resident 2 the following day, 05/06/2025 and told Resident 2 they were not present for the incident and I don't take sides. Staff C stated they did not implement any interventions for Resident 2 for the visitation restrictions placed on the RR because, it's not my business, it was just another hand in the pot [someone else involved] and at the time it was an active investigation and there was nothing that I could do. Staff C stated they monitored Resident 2 for any psychosocial harm related to the incident and placed them on alert charting when they had returned from their time off on 05/15/2025 (ten days after the incident took place). Staff C stated they did not follow-up on Resident 2 to see how they were doing because I was not instructed to by upper administration and Resident 2 had already had a lot of anxiety and tearful episodes prior to this happening.</p> <p>During an interview on 05/21/2025 at 3:58 PM, Staff D, Social Services Director, stated they were directed by Staff A to check in on the resident and when they seen the resident in the hallway, they would stop and say hello. Staff D stated Resident 2 appeared unaffected. Staff D stated they had heard in their morning meeting that a NA had reported that the incident had shaken up Resident 2 and that the resident was upset. Staff D stated they had checked on Resident 2 only once, on that Thursday following the incident, as Staff D was on their way out of the facility for the day. Staff D stated Resident 2 was upset about the visitation not the incident itself.</p> <p>(continued on next page)</p>		

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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/22/2025 at 10:19 AM, showed the Collateral Contact 2 (CC2) stated Staff A had reached out to them on 05/12/2025 (seven days after the incident) to inquire about the guidelines around limiting the RRs visitation to only while supervisory staff were in the facility. The CC2 stated they relayed to Staff A that the visitation could be limited only if there was threat to the staff. The CC2 stated after their visit with Resident 2, who was tearful and upset, they did not feel there was a threat to staff. The CC2 stated they were not given the details of the incident at the time they were asked that question and since the employee involved was no longer employed there, there was no reason to keep this resident in distress.</p> <p>During an interview on 05/22/2025 at 3:35 PM, Staff F stated on 05/05/2025 they heard an argument in the hallway. Staff F stated they heard Staff E yell out they needed a witness, so they walked towards Staff E and the RR. Staff F stated the RR was standing behind Resident 2's wheelchair, about two and a half feet away from Staff E who was standing against the wall. Staff F stated it did not appear like Staff E was in any danger of being hit or hurt by the RR. Staff F stated they heard Staff E tell the RR they would report this incident, and the RR would not be able to visit Resident 2, and the RR yelled back at Staff E. Staff F stated Staff E could have walked away from engaging with the RR, but [Staff E] did not do that. Staff F stated they had not had any issues with the RR or Resident 2, and they had not heard of any issues with other staff. Staff F stated they did not get any reports or issues from other residents after the incident was over. Staff F stated they did not feel comfortable mediating the situation so summoned Staff G for their help. Staff F stated they were not present from the beginning to the end of the incident so could not tell how or why the argument started.</p> <p>During an interview on 05/23/2025 at 12:58 PM, Staff G stated they were sitting at the nurse's station and heard yelling out in the hallway. Staff G stated they heard Staff E yell stay away from me as the RR was standing in front of Staff E, leaning forward, towards Staff E, yelling back. Staff G stated they did not know what the argument was about, but the RR stated, you guys are tag teaming me and all against me, and Staff G stated they told the RR if they had concerns, they needed to talk to the AD the following day. Staff G stated the RR had been known to be aggressive by the way they talked to the NAs when the RR did not think they were doing their jobs with Resident 2. Staff G stated they had not reported the issues with the RR or the RR's care concerns to administrative staff.</p> <p>During a telephone interview on 05/29/2025 at 4:53 PM, Staff E stated after the incident on 05/05/2025 they were not afraid or scared of the RR. Staff E stated they were removed from the care of Resident 2 and was told to avoid the RR when they came to visit. Staff E stated they were not approached by the administrative staff regarding the incident and was told by the staffing coordinator to email a statement of the incident that occurred and that was the witness statement dated 05/06/2025 at 6:22 PM. Staff E stated they only knew about the restricted visitation from an in-service that was put out for the staff to read and sign. Staff E denied making comments to Resident 2 or to the RR regarding their visitation with each other prior to the incident on 05/05/2025 or during the incident on 05/05/2025. Staff E stated if they had known about the comments, they supposedly had made to Resident 2 the week prior to this incident, that would explain why the RR was so upset with them, it all makes sense now. Staff E stated prior to this incident they had never had any issues with Resident 2 or the RR and was shocked that the RR acted the way they did. Staff E stated they last worked at the facility on 05/12/2025 and was no longer an employee due to the facility's lack of leadership.</p> <p>(continued on next page)</p>		

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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a statement written on 05/06/2025 by Staff A after interviewing the RR showed, the RR approached Staff E in the hallway to let them know that Resident 2 and the RR were happy with the care they provided. Staff A stated when the RR approached Staff E, they put their hands up and asked them not to approach them. Staff A stated the RR admitted to raising their voice and questioning Staff E as to why they told lies about them, but the RR did not advance on Staff E or corner them.</p> <p>During an interview on 05/22/2025 at 4:12 PM, Staff A stated it was reported to them that the RR of Resident 2 sought out [Staff E] and cornered [Staff E] and had a verbal argument in the hallway. Staff A stated the RR told them they did seek Staff E out, they did yell at Staff E, and that they argued. Staff A stated the week prior to this incident, the RR stopped the Director of Nursing Services (DNS) in the hallway, upset and agitated, and informed the DNS that Staff E had told Resident 2 something about the RRs visitation with Resident 2 and it upset Resident 2. Staff A stated during this conversation between the DNS and the RR, Staff A approached the situation, calmed the RR down and explained to them that there were no issues with their visitation with Resident 2. Staff A stated they thought everything had been resolved and then the incident on 05/05/2025 took place. Staff A stated they did not follow-up with the RR's concern about Staff E's statement upsetting Resident 2 (the week prior to the 05/05/2025 incident). Staff A stated the RR approached Staff E on 05/05/2025 to tell them they had no problems, and it escalated from there. Staff A stated they did not treat the incident between the RR and Staff E as a formal investigation because it involved a [RR] and not the resident. Staff A stated they did get a statement from Resident 2 but could not provide documentation to show that because they had cleaned their office and could not find it. Staff A stated they had asked the SSD and the RCM to follow-up with Resident 2 to ensure they were okay with the limitations on their visitation with the RR, and they had not reported any issues. Staff A stated they did not call the CC because why would I call someone who was going to give me the same information I already had. Staff A stated they were not aware the CC had differing statements regarding the incident on 05/05/2025. Staff A stated they had other issues brought forward by other staff besides this incident that involved the RR in the past but could not provide any documentation to show that. Staff A confirmed Resident 2's visitation with the RR had been restricted to Monday through Friday 8:00 AM to 5:00 PM, and no visitation on the weekends, in order to protect the staff involved. Staff A confirmed that Staff E was no longer an employee there and that they left because they were afraid of the RR. Staff A stated the Resident could always go home for a visit with the RR if they wanted additional time together.</p> <p>Reference WAC: 388-97-0520 (1)(g)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>44922</p> <p>Based on observation, interview, and record review the facility failed to report allegations of abuse and/or neglect to the State Agency for 2 of 4 residents (Residents 3 and 4) reviewed for grievances. This failed practice placed residents at risk for not receiving care and services and unidentified and on-going abuse and/or neglect.</p> <p>Findings included .</p> <p>Review of the policy dated 11/19/2024, titled Abuse and Neglect, showed the facility would report alleged violations of abuse, neglect, exploitation, or mistreatment no later than two hours if there was abuse or serious bodily injury and no later than 24 hours if the allegation did not involve abuse and did not result in bodily injury. The policy showed the report was to be made to .the administrator of the facility and .to the state agency.</p> <p><Resident 3></p> <p>Review of the resident's medical records showed they admitted with diagnoses to include bipolar disorder (a mental health condition characterized by extreme mood swings that include emotional highs and lows) and epilepsy (a brain condition that causes recurring seizures [sudden surge of electrical activity in the brain]). The 05/16/2025 comprehensive assessment showed Resident 3's cognition was moderately impaired, experienced verbal behaviors directed at others which significantly interfered with Resident 3's participation in activities or social interactions, significantly intruded on other's privacy or activities, and significantly disrupted other resident's care or living environment.</p> <p>During review of an incident witness statement, dated 05/06/2025 at 6:22 PM, titled Incident report 5/5/2025 [name of facility] showed Staff E, Nursing Assistant (NA), had been approached in the breakroom on 05/05/2025 at approximately 7:30 pm by Resident 3 and told that a Resident Representative (RR) of another resident in the facility had lost their balance and started to lean all the way onto Resident 3 while they sat in their wheelchair. Staff E wrote that Resident 3 continued to look concerned with their facial expressions and when asked, Resident 3 stated they had felt the RR had fallen on them intentionally and on purpose. Staff E stated they asked Resident 3 if they felt the [RR] assaulted you .you have the right to call the police. Resident 3 then replied that they had talked to their RR and decided they would call the police. Staff E wrote they told the police that Resident 3 not only felt like they were assaulted but felt like it was retaliation from a past incident that had occurred between the RR and Resident 3. Staff E did not report the assault to the State Agency.</p> <p>Review of the Reporting Log dated May 2025, showed on 05/09/2025 an incident was logged for Resident 3, the date and time of the incident was 05/05/2025 at 7:00 PM, and the nature of the occurrence was documented as a skin issue. The log showed no incident for Resident 3 for their allegation of assault.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/23/2025 at 3:21 PM, Staff A, Administrator, along with Staff B, Assistant Director of Nursing Services, stated they did not know Resident 3 had stated they were assaulted. Staff A and Staff B stated during their interview with Resident 3 the following day, Resident 3 stated the RR accidentally fell on them while walking down the hallway. Staff A stated they read Staff E's incident witness statement and must have missed the part where Resident 3 felt they were assaulted. Staff A stated they would have expected Staff E not to wait on the administration staff to come in the following day to report a resident being assaulted.</p> <p><Resident 4></p> <p>Review of the resident's medical records showed they admitted with diagnoses to include a fracture to their right hip and bipolar disorder. The 05/07/2025 comprehensive assessment showed Resident 4's cognition was moderately impaired and required substantial to maximum staff assistance for toileting hygiene, dressing of their lower body, and chair to bed transfers.</p> <p>Review of Staff I, Nursing Assistant (NA), personnel file showed a grievance that was dated 05/16/2025. The grievance showed Staff I was snappy, rude, and didn't want to help the resident. The grievance showed Staff I had made Resident 4 cry because their memory was not good anymore and told Resident 4 I thought you could do this by yourself. The grievance showed Resident 4 stated Staff I made me feel helpless and depressed. The grievance was written by Staff K, Assistant Rehab Director.</p> <p>Review of the grievances requested for May 2025 showed no grievance for Resident 4 and Staff I.</p> <p>Review of the Reporting Log for May 2025 showed no incident had been logged for Resident 4 and Staff I.</p> <p>During an interview on 05/23/2025 at 2:48 PM, Staff K stated they walked with Resident 4 down the hallway and passed Staff I, after passing Staff I, Resident 4 stated that Staff I is not nice to me. Staff K stated they asked Resident 4 what they meant by that and when they got back to the resident's room the resident told them when they would turn their call light on, they felt like Staff I did not want to help them. Resident 4 stated Staff I would stand at the door and tell them I thought you could do this yourself; do you need anything else, is there anything else I can do for you in a rude, snappy manner and just stand there at the door. Staff K stated Resident 4 started crying while telling them about Staff I and stated to Staff K they felt helpless and depressed. Staff K stated this incident took place approximately three days prior to Resident 4 reporting to Staff K.</p> <p>During an interview on 05/29/2025 at 5:07 PM, Staff I stated they had answered Resident 4's call light and stated they had to use the restroom. Staff I stated Resident 4 made very minimal effort to help themselves, so they encouraged Resident 4 to do some stuff for themselves. Staff I stated they had instructed Resident 4 to move their legs on their own and stated that Resident 4 had responded with minimal effort, was emotional, didn't want to do anything, and wasn't even trying to help. Staff I stated these were things the resident had previously been able to do on their own and did not know why they were acting as if they could not do them. Staff I stated they did not report the change in Resident 4 to anyone because I did not genuinely feel like there was a change in their condition nor did they report that Resident 4 was emotional. Staff I stated Resident 4 told the therapist Staff I was rude to them and another NA reported that information to Staff I. Staff I stated when they heard this, they went to Resident 4 and apologized.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/23/2025 at 3:21 PM, Staff A, also present was Staff B, stated they had no knowledge of the grievance regarding Resident 4 and Staff I. Staff A stated after reviewing the grievance, that the grievance should have been elevated to an investigation to rule out abuse and neglect. Staff B stated they were aware of the grievance but did not recognize the grievance as an allegation of abuse and/or neglect, therefore it was not reported.</p> <p>Reference WAC: 388-97-0640 (5)(a)</p>		