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	08/14/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure staff implemented fall prevention interventions identified on the resident's care plan for 1 of 3 residents (Resident 1) reviewed for falls. This failure placed the residents at risk for repeated falls and injuries.Findings included. Review of a policy titled, Person Centered Care Planning, dated 09/05/2024, showed each resident would have a person-centered comprehensive care plan developed and implemented to meet their preferences and goals, that addresses the resident's medical, physical, mental, and psychosocial needs. The care plan would be developed and implemented to ensure consistency with implementation across all shifts. <Resident 1>Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including a brain injury with loss of consciousness, stroke (damage to the brain from an interruption of blood flow), and history of falling. The 06/30/2025 comprehensive assessment showed Resident 1 required substantial assistance of one staff member for activities of daily living. The assessment also showed Resident 1 had a memory problem and had a severely impaired cognition. Record review of a Fall Risk Evaluation dated 03/25/2025 showed Resident 1 was identified as high fall risk. Record review of Resident 1's care plan dated 03/25/2025, showed they were at risk for falls, with interventions including anticipating the resident's needs, placing the call light within reach, using a mechanical lift for transfers, and continuing to work with therapy for strength and balance. A care plan revision dated 06/13/2025 showed the nursing assistants (NA) would ensure the resident was kept in supervised areas while they were up in their wheelchair. Record review of a facility investigation dated 06/20/2025, showed a NA found Resident 1 on the floor in their room. The investigation showed the root cause of the fall was due to Staff B, a newly hired NA, that had left Resident 1 up in their wheelchair, unsupervised. During an interview on 08/14/2025 at 1:14 PM, Staff A, Director of Nursing, stated all NAs were trained to review the Kardex (a quick reference tool used by nursing staff to access vital patient information) for directives and updates to resident care. Staff A stated Staff B was newly hired and had just completed their orientation. They stated all new nursing staff received training towards reviewing the care plan and Kardex during their orientation and while training on the floor with other NAs. Staff A stated Staff B should have reviewed Resident 1's Kardex prior to providing care. Reference: WAC 388-97-1020(3)

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