

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  12/17/2025
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)
F 0842  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.  (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:  505080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/17/2025
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to maintain resident medical records that were complete, accurate, readily accessible, and systematically organized for 4 of 9 residents (Resident 1, 2, 3, and 4) reviewed for resident records. This failure placed the residents at risk for receiving care and services based on inadequate/inaccurate information. Findings included. Review of a policy titled, Health Information Management, reviewed 05/15/2025, showed the facility ensured all medical records were complete, readily accessible, and systematically organized. The Executive Director or a designee had overall responsibility for ensuring health information management records were maintained and completed in accordance with accepted professional standards and applicable law. The health information management record would reflect the total condition of the resident throughout their stay in the facility from admission to discharge. Resident 1Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive disease that destroys memory and other important mental functions), moderate protein-calorie malnutrition (reduced availability of nutrients that leads to changes in body composition and function), and diabetes (a group of diseases that result in too much sugar in the blood). The 10/17/2025 comprehensive assessment showed Resident 1 was dependent on one to two staff members for activities of daily living (ADLs) and had a severely impaired cognition. The assessment showed Resident 1 was receiving hospice care while in the facility. Review of the medical record showed Resident 1 was admitted to hospice services on 10/13/2025. The record showed there were hospice visit notes dated 10/13/2025, 10/21/2025, 10/23/2025, 10/24/2025, 10/31/2025, and 11/06/2025. There were no additional notes despite Resident 1's continued weekly hospice visits. Additionally, there were no facility provider progress/visit notes in Resident 1's medical record. Resident 2Review of the medical record showed Resident 2 was admitted to the facility on [DATE] with diagnoses including diverticulitis of the intestine (inflammation of irregular bulging pouches in the wall of the large intestine), heart failure, and muscle weakness. The 11/13/2025 comprehensive assessment showed Resident 2 required substantial/maximum assistance of one to two staff members for ADLs. The assessment also showed the resident had an intact cognition. During an interview on 12/16/2025 at 3:06 PM, Resident Representative for Resident 2 stated they did not receive any communication from the facility regarding the care Resident 2 was receiving. Review of Resident 2's medical record showed no facility provider physician progress/visit notes. Further review of Resident 2's demographic information showed no contact information for their representative/emergency contact. Record review of Resident 2's admission referral dated 11/05/2025, showed they listed their representative as their emergency contact with their name, address, and phone number. During an interview on 12/17/2025 at 12:47 PM, Staff F, Admissions Director, stated they were responsible for entering a resident's demographic information. After reviewing Resident 2's admission referral, Staff F stated the emergency contact information listed on Resident 2's admission referral should have been entered into the system. Resident 3Review of medical record showed Resident 3 was admitted to the facility with diagnoses including encephalitis (inflammation of the brain), severe intellectual disabilities, and difficulty swallowing. The 12/05/2025 comprehensive assessment showed Resident 3 was dependent on one to two staff members for ADLs. The assessment also showed Resident 3 had a severely impaired cognition. Review of Resident 3's medical record showed the most recent facility provider progress/visit note was dated 10/24/2023. Resident 4Review of the medical record showed Resident 4 was admitted to the facility on [DATE] with diagnoses including respiratory failure, heart failure, and diabetes. The 12/08/2025 comprehensive assessment showed Resident 4 required substantial/maximal assistance of one to two staff members for ADLs. The assessment also showed Resident 4 had an intact cognition. Review of Resident 4's medical record showed no documentation of a facility provider visit or progress note. During a concurrent observation and interview on 12/17/2025 at 11:43 AM, Staff E, Medical Records Director, stated the normal process for ensuring records were complete, accurate, and organized included receiving documents such as physician orders and lab results after the clinical team had reviewed them. Staff E stated after receiving the documents, they scanned them into the medical record. They stated for new admissions, they would receive their admission packet that contained the consent to treat and immunization consents, along with other additional admission documents. Staff E pointed to boxes of documents in their office and stated they were about six months behind with scanning documents. Staff F stated the medical records process was badly</p>		

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  12/17/2025
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 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>(continued on next page)</p>		

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  12/17/2025
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 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to identify a designated interdisciplinary [(IDT) a group of healthcare professionals from different disciplines to help people receive the care they need] team member, appointed as the responsible party for coordinating care and communication with hospice, and implement the written agreement that ensured effective communication, collaboration, and coordination of care between the facility and the hospice (a specialized type of care focused on providing comfort and support to individuals nearing the end-of-life) provider for 1 of 1 residents (Resident 1) reviewed for hospice services. This failure placed the residents at risk of not receiving necessary care and services at end-of-life. Findings included. Review of a policy titled, Hospice Coordination of Care, revised 09/03/2025, showed the facility must ensure that, under a written agreement with the hospice provider, the resident's facility plan of care included the most recent hospice of care and a description of the services furnished by the facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility must designate an IDT member to communicate and collaborate with hospice representatives and other healthcare providers participating in the provision of care for the resident. The facility must obtain from hospice, the most recent hospice plan of care, hospice election form, and physician certification/recertification (documentation of a terminal illness with a life expectancy of six months or less) of the terminal illness. The resident's attending physician must write an order referring the resident to hospice and an order to admit the resident to hospice services. Resident 1 Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including dementia (a progressive disease that destroys memory and other important mental functions), moderate protein-calorie malnutrition (reduced availability of nutrients that leads to changes in body composition and function), and diabetes (a group of diseases that result in too much sugar in the blood). The 10/17/2025 comprehensive assessment showed Resident 1 was dependent on one to two staff members for activities of daily living and had a severely impaired cognition. The assessment showed Resident 1 was receiving hospice care while in the facility. Record review of nursing progress notes (PN) dated 10/07/2025 at 11:34 AM, showed the Resident's Representative (RR) had agreed to initiate hospice services and a provider order was faxed to the hospice provider. A second PN dated 10/13/2025 at 11:06 AM, showed the hospice provider had admitted Resident 1 to hospice services and provided the facility with medications for Resident 1. Record review of Resident 1's medical record showed no documentation of a physician's order to admit to hospice services, physician certification of a terminal illness, Resident 1's hospice election form, or a plan of care that coordinated care between the facility and hospice services that identified the provider responsible for performing each/any specific services that were agreed upon. Record review of nursing PN's dated 11/21/2025 at 1:24 PM, showed Resident 1 was seen by hospice services. An assessment and wound care were completed. The record showed no hospice services were provided and/or documented after 11/21/2025. Record review of the facility wound care provider PN's dated 10/14/2025, showed they were providing wound care and treatments, including excisional debridement (cutting away of damaged, infected, or dead tissue) to Resident 1's left heel. The PN showed the facility wound care provider also provided wound cleaning and dressing orders for Resident 1's left heel, right heel, and right knee wounds. Record review of the facility's wound care provider PN's dated 11/25/2025, showed they continued to provide wound care and dressing change orders for Resident 1's right and left heel wounds. Additionally, they provided excisional debridement to Resident 1's buttock and tuberosity (the bones at the bottom of the pelvis that bear weight when sitting) regions. The PN showed additional dressing change orders for Resident 1's buttock, tuberosity, and dorsum (top surface) foot wounds. Record review of hospice wound care orders dated 11/25/2025, showed care and treatment of the right hip (tuberosity) wound included cleansing the area with wound cleanser or normal saline. Pat dry with a clean gauze and apply skin protectant around the wound. Apply a calcium alginate pad (a specialized pad that contains silver to inhibit bacterial growth and absorbs drainage from a wound) to the wound bed. Cover with one bordered super absorbent or dry dressing. A concurrent observation and interview on 12/16/2025 at 11:33 AM, showed Staff B, Resident Care Manager/LPN, and Staff C, Registered Nurse, completing wound care on Resident 1's tuberosity wound. There was a table in Resident 1's room that held a large quantity of wound care supplies. Staff B stated those were hospice supplies and the facility did not use them for wound care. Staff B stated the facility wound care provider had seen Resident 1 that morning and had obtained measurements of the wound. Staff C stated hospice services came twice a week to provide nursing care for</p>		