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	03/04/2026

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide copies of medical records within two working days as required for 1 of 1 resident (Resident 5), reviewed for access to medical records. Additionally, the facility failed to ensure its medical records policy was consistent with regulations pertaining to skilled nursing facilities. This failure placed the residents and/or representative at risk of not being fully informed of services and treatments provided and violated their rights.Findings included. Review of the facility undated policy titled, Release of Resident Medical Records, [NAME], showed when the facility received a request for medical records, they were to have an authorization form completed and provide records for active resident within two working days and records for those who were not active residents within 15 days. Review of the medical record showed Resident 5 was admitted with diagnoses including after care for right hip dislocation, dementia (a progressive mental decline affecting memory, thinking and reasoning), and malnutrition (deficiency in nutrition intake). The 11/03/2025 comprehensive assessment showed Resident 5 required partial/dependent assistance of one to two staff members for activities of daily living and moderate impaired cognition. During an interview on 01/29/2026 at 5:46 PM, Resident 5's representative (RR), stated they had requested Resident 5's records and the facility would not provide them. Review of an email dated 02/04/2026, showed the RR requested Resident 5's records and they were not provided. Review of a facility document titled Authorization for Release of Information, showed the RR completed the document and provided to the facility on [DATE]. Further review of the documents showed the facility provided Resident 5's records on 02/21/2026, nine days later, despite being verbally requested prior to 01/29/2026. During an interview on 03/04/2026 at 1:52 PM, Staff M, Medical Records Director, stated the process for a records request was when a resident was a current resident the facility had two days to provide them. Staff M stated when the resident was no longer a current resident the facility had 30 days to provide the records. Staff M stated when they received the verbal request, they would provide the release of records form to be filled out and when the form was returned, they would process the records. During an interview on 03/04/2026 at 3:12 PM, Staff A, Administrator, stated they were unsure of the regulations for record requests. Reference WAC: 388-97-0300(2)(a)(b)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent a resident-to-resident sexual altercation for 2 of 3 residents (Residents 1 and 2) reviewed for abuse. This failure placed residents at risk of abuse, psychosocial harm and emotional distress.Findings included. Review of the policy titled, Abuse-Prevention, reviewed 05/06/2025, showed the facility would prevent and prohibit all types of abuse, and have protocols to prevent sexual abuse. Resident 1Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a progressive disease that affects memory, thinking, and behaviors) anxiety and depression. The 12/22/2025 comprehensive assessment showed they were dependent on one to two staff members for activities of daily living (ADLs) and severe impaired cognition. Resident 2Review of the medical record showed Resident 2 was readmitted to the facility on [DATE] with diagnoses including diabetes, chronic obstructive pulmonary disease (COPD- a group of lung diseases that block airflow and make it difficult to breathe), and heart failure. The 04/11/2025 comprehensive assessment showed they required supervision/dependent for ADLs, used a wheelchair for ambulation and had an intact cognition. Review of a facility investigation report dated 02/25/2026, showed an investigation was initiated on 02/04/2026 when a witnessed resident to resident altercation occurred when Resident 1 had walked up to Resident 2 and grabbed their left breast at Team 3 nursing station. During an interview on 02/19/2026 at 1:41 PM, Staff L, Licensed Practical Nurse, stated they were present when Resident 2 spoke to Resident 1, then Resident 1 reached out and squeezed Resident 2's left breast. Staff L stated they removed Resident 1 from the altercation and walked them back to their hall and assisted them to a chair. During an interview on 02/19/2026 at 3:06 PM, Resident 2 stated when they were at the nurse's station Resident 1 had reached out and grabbed their left breast. Resident 2 stated they told Resident 1 do not do that and don't touch my breast and pushed Resident 1's hand off their breast. Resident 2 stated were angry during the altercation and felt violated. During an interview on 03/04/2026 at 2:36 PM, Staff B, Director of Nursing, stated Resident 2 did not have intent for Resident 1 to touch them and it was unwanted contact. Reference WAC: 388-97-0640(1)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement written abuse policies and procedures for identification, protection and prevention of abuse for 4 of 6 residents (Residents 1, 2, 3, and 4) reviewed for abuse. This failure placed residents at risk of unidentified abuse, continued exposure to abuse and psychosocial harm. Findings included. Review of a policy titled, Unsafe Wandering and Elopement Prevention, reviewed 09/25/2025, showed the facility would implement interventions to mitigate and reduce identified risks. Additionally, the policy identified unsafe wandering to include entering into another resident's room could lead to an altercation. Review of a policy titled, Abuse-Prevention, Protection of Residents, reviewed 05/06/2025, showed the facility would identify, assess, care plan for appropriate interventions, and monitor residents with behaviors that may lead to conflict including wandering into another resident room or space. Additionally, the facility would ensure that all residents were protected by assuring ongoing safety and protection was provided for the alleged victim and other residents. Resident 1Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses including Dementia with severe agitation (a progressive condition that causes confusion, restlessness, and aggression) anxiety and depression. The 12/22/2025 comprehensive assessment showed they were dependent on one to two staff members for activities of daily living (ADLs) and severe impaired cognition. Review of progress notes (PN) dated 12/31/2025, showed Resident 1 was found wandering freely on multiple occasions through the halls and nursing staff were notified. Review of a PN dated 01/04/2026, showed Resident 1 had wandered into resident rooms and they were uncomfortable with that. The PN also showed Resident 1 required a staff member to sit with them one-to-one for the duration of the shift. Review of a PN dated 01/05/2026, showed Resident 1 needed redirected on multiple occasions back to their room after wandering freely, unassisted into other resident rooms. Review of a PN dated 01/06/2026, showed Resident 1 was redirected over a dozen times including other resident rooms, who were confused and concerned about why Resident 1 was in their rooms. The PN also showed Resident 1 was found in a resident's room standing over them in their bed. Review of a PN dated 01/15/2026, showed Resident 1 had entered many resident rooms from 6:00 PM to 10:00 PM non-stop. Staff attempted to redirect and it was difficult to get Resident 1 to leave other residents' rooms. Review of a PN dated 01/20/2026, showed Resident 1 had been wandering all day and entered a resident's room on more than one occasion and upset that resident. The resident wanted a Stop sign barricade across their doorway to prevent Resident 1 from entering. Resident 1 resisted redirection each time. Review of a PN dated 01/23/2026, showed multiple residents had complained that Resident 1 was wandering into their rooms. During an observation on 02/18/2026 at 1:07 PM, Resident 1 was seen sitting in a chair at the Team 2 nursing station. After 15 minutes, Resident 1 stood up and began to wander down the hall and turn the corner out of sight (no staff member accompanied). During an interview on 02/19/2026 at 1:29 PM, Staff C, Registered Nurse, stated Resident 1 paced and wandered the halls often. Staff C stated Resident 1 would enter other resident rooms and staff were to redirect them back to their hall. Staff C stated Resident 1 has grabbed residents belongings before and for other residents' rooms the facility put up a stop sign barricade across their doorways to try and prevent Resident 1 from entering. During an interview on 02/19/2026 at 3:41 PM, Staff D, Nursing Assistant, (NA), stated they were to redirect Resident 1 when they observed them wandering back to their hall or their room. Staff D stated they were unaware of any incidents with Resident 1 and other residents. During an interview on 02/19/2026 at 3:50 PM, Staff E, Resident Care Manager, stated Resident 1 did wander and enter resident rooms and staff were to redirect them back to their hall. Staff E stated once Resident 1 was back to their hall or room they would get up and wander again. During an interview on 02/20/2026 at 1:49 PM, Staff F, Activities Director, stated Resident 1 constantly wanders into resident rooms. The staff attempted to redirect and remove them from the rooms. Staff (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F stated that when these incidents occurred, it would be upsetting for some of the residents. Staff F stated the female residents were more concerned about Resident 1 being in their room as there was more vulnerability and Resident 1 was very tall and could be dominant in appearance. Staff F stated they would document the occurrences in a progress note and also discuss them at the next morning staff stand-up meetings. Staff F stated the direction provided from the meetings was to continue to monitor and redirect Resident 1. Additionally, Staff F stated they had a separate encounter with Resident 1 when they attempted to redirect them, and Resident 1 followed them and put their hands on Staff F's forearms and stated, you are not going to like what I am about to do. Staff F stated they were able to radio for help and Resident 1 was moved away from them. Resident 2Review of the medical record showed Resident 2 was readmitted to the facility on [DATE] with diagnoses including diabetes, chronic obstructive pulmonary disease (COPD- a group of lung diseases that block airflow and make it difficult to breathe], and heart failure. The 04/11/2025 comprehensive assessment showed they required supervision/dependent for ADLs, used a wheelchair for ambulation and had an intact cognition. During an interview on 02/19/2026 at 3:06 PM, Resident 2 stated they were aware of Resident 1 wandering into other resident rooms, as it was talked about in the facility. Resident 2 stated they had an altercation with Resident 1 at a nurse's station when they said good morning to Resident 2 and they walked up and grabbed their left breast. Resident 2 stated they did not want Resident 2 to grab them and told them to not to do that. Resident 2 stated staff came and escorted Resident 1 back to their hall. Resident 3Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including Post-Traumatic Stress disorder (PTSD, a mental health condition that's caused by an extremely stressful or terrifying event), anxiety and depression. The 01/15/2026 comprehensive assessment showed Resident 3 required dependent/setup assistance for ADLs of one to two staff members and had an intact cognition. During an interview on 02/19/2026 at 1:22 PM, Resident 3 stated Resident 1 had entered their room and sat on their bed. Resident 3 stated Resident 1 had pulled their blanket up and looked at their legs and they felt scared. Resident 3 stated they had a prior history of sexual trauma and Resident 1 gave them a weird feeling and they did not want them in their room. Resident 3 stated Resident 1 had entered their room on more than one occasion but had only sat on their bed once. Resident 4Review of the medical record showed Resident 4 was admitted to the facility with diagnoses including heart failure, anxiety and depression. The 02/06/2026 comprehensive assessment showed Resident 4 required substantial/maximal assistance of one to two staff members for ADLs and had intact cognition. During an interview on 02/19/2026 at 4:18 PM, Resident 4 stated Resident 1 had entered their room on multiple occasions and they called the police. Resident 4 stated they did not know who Resident 1 was and told them to leave their room and they would not. Resident 4 stated they felt unsafe and afraid because of Resident 1 and they wanted to cry. During an interview on 02/19/2026 at 4:02 PM, Staff M, NA, stated Resident 1 was very difficult to watch. Staff M stated Resident 1 should have one staff member assigned to them every day to watch them. Staff M stated Resident 1 had continued to invade other resident rooms that would make the other residents upset and afraid. Staff M stated Resident 4 had become so afraid they called the police. Staff M stated they had informed nursing management of the concern Resident 4 had shared with them. Staff M stated the staff were consistently attempting to redirect Resident 1 away from resident rooms and back to their room and/or hallway by the nursing station. During an interview on 02/20/2026 at 1:59 PM, Staff G, NA, stated they were aware Resident 1 wandered into other resident rooms. Staff G stated they would redirect when they heard the other residents either yell or ask for Resident 1 to leave their room. Staff G stated they did not think that was a type of suspected abuse. During an interview on 02/20/2026 at 2:26 PM, Staff I, Maintenance Assistant, stated Resident 1 wandered a lot through the halls and even entered other resident rooms. Staff I stated the resident rooms Resident 1 entered would sometimes scare the other residents and they would redirect Resident 1 back to the nurse's station in their hall. Staff I further stated they did not inform anyone the other residents stated they (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were scared. During an interview on 03/04/2026 at 2:09 PM, Staff K, NA, stated types of abuse were verbal, physical, mental, financial, sexual and resident to resident could be if it was physical or verbal. Staff K stated unwanted touching may be sexual abuse and they would report to a nurse. Staff K stated residents who could not speak for themselves, staff would not know when an incident occurred with a wandering resident. During an interview on 02/20/2026 at 11:15 AM, Staff B, Director of Nursing, stated the initial investigation into Resident 1 and Resident 2's resident to resident altercation was not completed correctly as there were no residents that were interviewed. Staff B stated they continued the investigation and identified additional residents that had altercations with Resident 1 who had entered their rooms and did not feel safe. Staff B stated they placed the identified residents on psychosocial monitoring and updated care plans and trauma assessments. During an interview on 03/04/2026 at 3:12 PM, Staff A, Administrator, stated the facility did not follow the correct process for implementing the abuse prohibition policies. Reference WAC: 388-97-0640(1)(2)(6)(b)