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	04/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection control measures intended to mitigate the transmission of Respiratory syncytial virus [(RSV) a virus that causes infections of the respiratory tract) were consistently implemented for contact precautions (infection control measures used to prevent the spread of germs that include wearing gloves and gowns when entering an isolation room, and performing meticulous hand hygiene with soap and water) and droplet precautions (infection control measures used alongside standard precautions to prevent the spread of pathogens transmitted through large respiratory droplets) for 2 of 4 staff (Staff B and Staff D) reviewed for infection control. This failure placed the residents at risk for contraction of communicable diseases, illness, and death.Findings included. Review of the U.S Centers for Disease Control and Prevention guidance titled, Viral Respiratory Pathogens Toolkit for Nursing Homes, dated 03/30/2026, showed the facility must ensure that there area sufficient resources, such as personal protective equipment [(PPE) protective clothing, helmets, goggles, or other garments designed to protect the wearer's body from injury or infection] to fully implement recommended infection prevention and control practices. To prevent the spread of the virus, apply appropriate precautions for symptomatic residents. The facility should implement universal masking (requirement for all individuals in the facility to wear a mask) for source control (physical actions taken to eliminate a focus of infection and stop the spread of pathogens). Review of a facility policy titled, Contact Precautions, revised 03/24/2026, showed contact precautions were intended to prevent transmission of pathogens spread by direct contact (person-to-person) or indirect contact with the resident or their environment, and requires the use of appropriate PPE, including gown and gloves before or upon entering the room. Prior to leaving the room, the PPE is removed and hand hygiene is performed. Review of a facility policy titled, Droplet Precautions, revised 03/24/2026, showed droplet precautions should be implemented to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Review of instructions for use for Arlington Scientific face shields, dated 06/2020, showed the face shield was a single use, one-piece face shield that should be properly disposed of after use. A general facility tour observation on 04/13/2026 at 10:38 AM, showed four PPE carts located on the 300 Hall. Each cart contained a slip of paper in the drawer that contained the face shields manufactured by Arlington Scientific, that showed Attention: Staff, use one face shield per shift, you may use same shield in two or more RSV + (positive) rooms. The same note was posted outside of the employee breakroom. During the same observation at 10:55 AM, showed a PPE cart located in the 100 Hall. There were two face shields hanging off the top of the cart, one with a staff member's name written on it, and a third face shield lying on top of the cart. During an observation on 04/13/2026 at 11:52 AM, Staff B, Nursing Assistant (NA), obtained a meal tray from a meal cart located in the 100 Hall. Staff B carried the meal tray to a resident room that was designated contact and droplet precautions. Staff B was wearing a face mask and put on a gown. They did not put eye protection (face shield or goggles) or gloves on. Staff B entered the resident's room, rearranged items on their bedside table, and set up the resident's lunch meal. Staff B walked to the door of the resident's room, removed their gown, and performed hand hygiene. As Staff B was exiting the resident room, Staff C, NA, handed them a second meal tray. Staff (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	04/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B took the meal tray to the resident on the far side of the room and placed part of their meal on their bedside table. Staff B was not wearing a gown, gloves, or eye protection. Staff B, upon exiting the room, performed hand hygiene. They did not change their face mask. During an interview on 04/13/2026 at 12:31 PM, Staff B stated their process for isolation (contact/droplet precaution) rooms included putting on a gown, gloves, and goggles. They stated they did not put on gloves when passing the meal trays in the contact/droplet precaution room because they were going to touch food and open milk for the residents. They stated when they exited a room, they removed their PPE and washed their hands; they left their goggles on. Staff B stated their goggles were reusable so they put them on top of their head. They stated they should not have taken the second meal tray from Staff C and should have put a gown on before taking it. Staff B stated the face shields hanging on the PPE cart were for staff to reuse. During an observation on 04/13/2026 at 12:15 PM, Staff D, NA, put on a gown, gloves, eye protection, and facemask outside a contact/droplet precaution resident room. They obtained a meal tray from the meal cart and entered the room. Staff D provided meal setup for the resident, exited the room, and was handed a meal tray for a neighboring room, while wearing the same PPE. Staff D used the doorknob, wearing the same soiled gloves, to open the neighboring resident room (also under contact/droplet precautions) and delivered the meal tray to the resident. Staff D removed their gown and gloves, pushed their goggles on top of their head, performed hand hygiene and left the resident room. Staff D did not change their face mask. During an interview on 04/13/2026 at 12:36 PM, Staff D stated the process should have been to take their gown off when leaving the first resident's room and putting on a clean gown before entering the second resident room. Staff D stated they were told they did not have to change their PPE if they were going from one precaution room to another. Staff D stated they should not have gone from room to room because they could reinfected the residents or spread the germs by not changing their PPE. Staff D stated they normally changed their mask between rooms but did not. During an interview on 04/13/2026 at 2:25 PM, Staff E, Infection Preventionist, stated the process for entering the contact/droplet precaution rooms included performing hand hygiene, putting on a gown, a face mask, goggles or face shield, and gloves. They stated when exiting the room, staff should remove their gloves, perform hand hygiene, then remove the gown, mask, and goggles/face shield. Upon exiting the room, staff should put on a clean face mask from the PPE cart. Staff E stated the goggles were single use and the facility ran out of them. They stated they did not have a lot of face shields and needed to make them work (reuse) until they received a new supply. Staff E stated they did not know the face shields were single use only. During an interview on 04/13/2026 at 2:39 PM, Staff A, Director of Nursing, stated the process for entering the contact/droplet precaution rooms included putting on a gown, gloves, face mask, and eye protection, either goggles or a face shield, and staff should remove all PPE prior to exiting the resident room. They stated the face shields were not reusable. Staff A stated the staff did not follow the process for infection control and PPE use. Reference: WAC 388-97-1320(2)(a)(5)(b)This is a repeat deficiency from 01/26/2026.