

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/27/2026
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 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. Based on interview and record review, the facility failed to protect the resident's rights to be free from verbal and physical abuse by Resident 1, for 2 of 7 residents (Resident 2 and 3) reviewed for abuse. This failure placed the residents at risk for additional verbal and physical abuse, serious pain and injury, and emotional distress. Findings included. Review of a policy titled, Abuse - Identification of Types, reviewed 04/01/2026, showed abuse was defined as the willful infliction of injury with resulting physical harm, pain, or mental anguish, that included, but was not limited to, hitting, slapping, punching, biting, and kicking. Verbal abuse may be considered a type of mental abuse that includes the use of oral, written, or gestured communication or sounds, to residents within hearing distance. It has the potential to cause the resident to experience humiliation, intimidation, fear, shame, or agitation. Verbal Abuse Resident 1 Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including left sided paralysis (weakness) following a stroke (death of brain tissue caused by an interrupted blood supply to the brain), ataxia (lack of muscle coordination that causes poor balance and speech changes), and delusional disorders (a mental health condition that causes false beliefs based on an incorrect interpretation of reality). The 06/04/2026 comprehensive assessment showed Resident 1 was independent with activities of daily living [(ADLs) activities related to personal care]. The assessment also showed Resident 1 had no memory problems and were able to make their needs known. Resident 2 Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including diabetes (a group of diseases that result in too much sugar in the blood), peritoneal abscess (a walled-off pocket of pus inside the abdominal cavity), and an anxiety disorder (a mental health condition that caused intense, ongoing worry, fear, and physical tension). The 06/30/2026 comprehensive assessment showed Resident 2 was independent with ADLs. The assessment also showed Resident 2 had an intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Record review of an investigation dated 07/19/2026, showed Resident 2 reported that on 07/18/2026, Resident 1 verbally attacked, threatened, sexually harassed, and yelled at them in the main dining room. They stated they felt threatened by Resident 1 and when they passed Resident 1 in the hallway, they called him a derogatory term referring to sexual orientation. Record review of a grievance form titled, Concern & Comment Form, dated 07/19/2026 at 8:00 AM, showed Resident 2 reported on July 18th, 2026, (Resident 1) verbally attacked, threatened, sexually harassed, and yelled at me in the main dining room. I feel threatened by (Resident 1) and when I pass them in the hallway, (Resident 1) calls me a (derogatory term referring to sexual orientation). During an interview on 07/27/2026 at 11:24 AM, Resident 2 stated Resident 1 was really abusive and very threatening. Resident 2 stated there was an altercation with Resident 1 when they went into the main dining room after their meal to watch television. They stated there were no staff in the dining room at that time. (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
--	-------	-----------

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/27/2026
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 entered the dining room and began yelling at Resident 2, telling them to get out of the dining room. Resident 1 stated that was not the first time Resident 1 had been abusive toward them, however they did not report the previous incident to the staff. They stated during the first incident, both Resident 1 and Resident 2 were in the dining room and Resident 1 shoved a table into their abdomen and grabbed a television remote out of their hand. Resident 2 stated they were afraid at that time because they did not know what Resident 1 was capable of. Resident 2 stated the day after the second incident, the verbal abuse in the dining room, they were walking past Resident 1's room, and Resident 1 yelled out a derogatory term regarding their sexual orientation. Resident 2 stated they were angry, upset, and frustrated with Resident 1's behavior and filed a grievance with the staff. They stated Resident 1 had been removed from the facility for a little bit and they felt relieved. Resident 2 stated I felt verbally threatened and abused; it frustrating that I can't go in there (main dining room) after dinner without being called names. Physical Abuse Resident 3 Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including heart failure, kidney disease, and dementia (a decline in memory, thinking, and reasoning that interferes with daily life). The 07/07/2026 comprehensive assessment showed Resident 3 requires supervision/maximum assistance of one staff member for ADLs. The assessment also showed Resident 3 had a severely impaired cognition. Record review of an investigation witness statement dated 07/24/2026, showed Staff C, Registered Nurse, heard yelling and observed Resident 3 in the doorway of Resident 1's room. Resident 1 kicked Resident 3 in the leg. During an interview on 07/29/2026 at 8:41 AM, Staff C stated they were in the medication room and heard yelling in hall. They went to the residents with another nurse to attend to the residents. Staff C stated, I saw Resident 1 kick Resident 3. During an interview on 07/27/2026 at 3:26 PM, Staff B, Interim Director of Nursing, stated verbal abuse was the intent to cause psychosocial harm or threaten someone to cause bodily harm. They stated the grievance form reported by Resident 2 showed the incident was verbal abuse. During a follow-up interview on 07/29/2026 at 11:51 AM, Staff B stated the resident-to-resident altercation between Resident 1 and Resident 3 was physical abuse; Resident 1 was purposefully kicking to prevent Resident 3 from entering their room. During a concurrent observation and interview on 07/27/2026 at 3:55 PM, Staff A, Administrator, reviewed Resident 2's grievance form and stated the allegations listed on the form were incidents of verbal abuse. Staff A stated they were unsure if the resident-to-resident altercations were preventable. Reference: WAC 388-97-0640(1)		

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 07/27/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure adequate supervision to prevent resident-to-resident altercations with Resident 1, for 2 of 7 residents (Resident 2 and 3) reviewed for accidents. This failure placed the residents at risk for continued resident-to-resident altercations, abuse, and dissatisfaction with their homelike setting. Findings included. Record review of a policy titled Incident and Reportable Event Management, revised 02/24/2026, showed the facility strives to provide an environment free from accident hazards and provides supervision to each resident to prevent avoidable accidents. An avoidable accident may have occurred because the facility failed to implement interventions, including adequate supervision, consistent with resident's goals, needs, care plan, and current professional standards of practice in order to eliminate or reduce the risk an accident. The facility would monitor the effectiveness of the interventions and modify the care plan as necessary, according to current professional standards of practice. Resident 1 Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including left sided paralysis (weakness) following a stroke (death of brain tissue caused by an interrupted blood supply to the brain), ataxia (lack of muscle coordination that causes poor balance and speech changes), and delusional disorders (a mental health condition that causes false beliefs based on an incorrect interpretation of reality). The 06/04/2026 comprehensive assessment showed Resident 1 was independent with activities of daily living [(ADLs) activities related to personal care]. The assessment also showed Resident 1 had no memory problems and were able to make their needs known. Resident 2 Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including diabetes (a group of diseases that result in too much sugar in the blood), peritoneal abscess (a walled-off pocket of pus inside the abdominal cavity), and an anxiety disorder (a mental health condition that caused intense, ongoing worry, fear, and physical tension). The 06/30/2026 comprehensive assessment showed Resident 2 was independent with ADLs. The assessment also showed Resident 2 had an intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 3 Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including heart failure, kidney disease, and dementia (a decline in memory, thinking, and reasoning that interferes with daily life). The 07/07/2026 comprehensive assessment showed Resident 3 requires supervision/maximum assistance of one staff member for ADLs. The assessment also showed Resident 3 had a severely impaired cognition. Record review of Resident 1's care plan dated 02/19/2026, showed Resident 1 was to be monitored when in the hallway for interactions with others. Record review of a facility investigation dated 07/19/2026, showed Resident 1 and Resident 2 had a verbal altercation on 07/18/2026, while alone in the dining room. Resident 2 was verbally attacked, threatened, sexually harassed, and yelled at by Resident 1. Record review of a facility investigation dated 07/24/2026, showed Resident 1 and Resident 3 had a physical altercation on 07/24/2026 at the entrance of Resident 1's room, where Resident 1 kicked Resident 3 in the leg. During an interview on 07/27/2026 at 2:20 PM, Staff E, Registered Nurse, stated when the resident-to-resident altercation occurred between Resident 1 and Resident 3 on 07/24/2026, they were at the nurse's station with their back to the hallway. They stated they heard the commotion between the two residents, turned around, and saw Resident 3 in the hallway with Resident 1, near Resident 1's room. They stated they were aware that Resident 1 had been in altercations with other residents in the past. Staff E stated they did not know if there were any interventions on Resident 1's care plan or Resident 3's care plan related to (continued on next page)		

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 07/27/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervision or prevention of resident-to-resident altercations. During an interview on 07/29/2026 at 8:41 AM, Staff C stated they were in the medication room and heard yelling in hall. They went to the residents with another nurse to attend to the residents. Staff C stated, I saw Resident 1 kick Resident 3. Staff C stated they were a newer nurse and was unsure if there were interventions in either Resident 1 or Resident 3's care plan for interventions related to supervision or prevention of resident-to-resident altercations. Staff C stated they tried to keep Resident 3 at the nurse's station because they followed staff and wandered in the hallways. During an interview on 07/27/2026 at 2:55 PM, Staff D, Nursing Assistant, stated on 07/18/2026, they were at the nurse's station and heard arguing in the dining room. They went to the dining room and saw Resident 1 yelling obscenities at Resident 2. There were no staff monitoring the residents in the dining room at that time. They stated Resident 1 was aggressive and intimidating towards Resident 2. Staff D stated there was nothing on the care plan or Kardex for interventions when Resident 1 had behaviors. They stated there were two residents (one being Resident 3) that resided in the same hall as Resident 1 that wandered. They stated they were so scared that Resident 1 would get their hands on those residents and hurt them. During an interview on 07/27/2026 at 3:26 PM, Staff B, Interim Director of Nursing, stated staff should have followed the care plan for Resident 1 to prevent the resident-to-resident verbal altercation with Resident 2. Staff B stated they did not agree that the resident-to-resident physical altercation between Resident 1 and Resident 3 could have been prevented. Cross reference to F600 for further information. Reference: WAC 388-97-1060(3)(g)		