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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Kennewick	1508 West Seventh Avenue Kennewick, WA 99336

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents Preadmission Screening and Resident Review ([PASARR], an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities [ID/DD] were not inappropriately placed in nursing homes for long term care) were accurately completed prior to admission and updated when new SMIs were identified and had the required Level II (a comprehensive evaluation by the appropriate state-designated authority) referral if residents had a positive Level I (a pre-screening evaluation for identifying SMI/ID/DD) PASARR for 6 of 6 residents (Residents 9, 43, 78, 31, 6, and 58) reviewed for PASARR and unnecessary medications. This failure placed the residents at risk of not receiving the mental health care and services appropriate for their needs. Findings included. Review of the policy titled, Pre-admission Screening and Resident Review (PASARR), dated 09/26/2025, showed all applicants to the facility would have a Level I PASAAR for SMI, ID/DD, and/or related conditions prior to admission to the Nursing Home (NH) and if an SMI/ID/DD should be diagnosed after admission. If the Level I showed the resident had an SMI/ID/DD, then a Level II evaluation would be completed prior to admission. The policy additionally showed any resident who was diagnosed with a SMI/ID/DD after admission would be referred for a Level II evaluation. Resident 9Review of the resident's medical record showed they were admitted to the facility 09/03/2025 with diagnoses including anxiety (a feeling of worry, nervousness, or fear, often in anticipation of something unpleasant) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and a loss of interest in activities once enjoyed). The comprehensive assessment, dated 09/08/2025, showed Resident 9 had impaired cognition, depression, and an anxiety disorder. Review of Resident 9's PASARR dated 08/15/2025, showed Resident 9 had no SMI marked. Further review showed Resident 9's PASARR was marked no Level II evaluation required. Resident 43Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including anxiety and depression. The comprehensive assessment dated [DATE] showed Resident 43 had an intact cognition, depression, and an anxiety disorder. Review of Resident 43's PASARR dated 05/06/2025, showed Resident 43 had a positive SMI for a mood disorder. Further review showed Resident 9's PASARR was marked exempt from requiring a Level 2 evaluation due to a physician certifying that Resident 43 would be requiring less than a 30 day stay in the nursing facility. Additionally, the required Level II evaluation had not been completed as of 11/19/2025 (6 months after Resident 43's admission). Resident 78Review of the resident's medical record showed they were admitted to the facility with (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses including bi-polar disorder (a mental health condition characterized by extreme shifts in mood, energy, and activity levels that include periods of mania [highs] and depression [lows]), anxiety, and depression. The comprehensive assessment dated [DATE] showed Resident 43 had impaired cognition, bi-polar disorder, and an anxiety disorder. Review of Resident 78's PASARR dated 07/24/2024, showed Resident 78 had a positive SMI for a mood disorder and anxiety disorder. Further review showed Resident 78's PASARR was marked no Level II evaluation required. Resident 31 Review of the medical record showed Resident 31 admitted to the facility on [DATE], with diagnoses of dementia (a disease that causes the loss of thinking, remembering, and reasoning skills), affective disorder (a mental health condition characterized by prolonged and extreme shifts in mood, such as persistent sadness or excessive elation), restlessness (the feeling of being unable to relax or stay still, both physically and mentally) and agitation (a feeling of being tense, irritable, and restless, often accompanied by physical actions like fidgeting, pacing, or wringing your hands). Review of the comprehensive assessment, dated 09/15/2025, showed Resident 31 had severe cognitive impairment and required the assistance of one person for grooming, dressing, incontinent care, bathing and mobility. Review of the medical record showed a PASARR Level I dated 09/09/2025, for Resident 31, had a positive screening for SMI for the diagnosis of affective disorder, requiring a Level II evaluation. Further review of the PASARR form showed Resident 31 was marked for No Level II evaluation indicated, and the medical record showed no documentation of a completed Level II evaluation. Resident 6 Review of the medical record showed Resident 6 was admitted to the facility on [DATE] with diagnoses including anxiety, bipolar disorder, and Fragile X Chromosome (a genetic disorder that leads to intellectual disability and developmental problems). The 10/30/2025 comprehensive assessment showed Resident 6 required substantial/maximum assistance of one staff member for toileting transfers and dressing: independent with eating and oral hygiene. The assessment also showed the resident had a moderately impaired cognition. Review of the medical record showed a PASARR Level I Review form was completed on 02/11/2025, 13 days after admission. The form showed Resident 6 had a positive screening for SMI indicators of bipolar and anxiety disorders and required a Level II evaluation. There was no documentation in the medical record that a Level II evaluation had been completed. Further review of the medical record showed a second PASARR Level I Review form was completed on 07/21/2025 that showed a positive screening for SMI indicators of bipolar and anxiety disorders, requiring a Level II evaluation. There was no documentation in the medical record that a Level II evaluation had been completed for the second PASARR screening. Resident 58 Review of the medical record showed Resident 58 was admitted to the facility on [DATE] with diagnoses including anxiety, depression, and necrotizing fasciitis (a severe, rapidly spreading bacterial infection). The 09/04/2025 comprehensive assessment showed Resident 58 was dependent (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on one to two staff members for ADLs: setup assistance for eating and oral hygiene. The assessment also showed Resident 58 was cognitively intact. Review of the medical record showed a PASARR Level I Review form was completed on 08/26/2025 and had a positive SMI screening for mood and anxiety disorders, requiring a Level II evaluation. There was no documentation in the medical record of a Level II evaluation. During an interview on 11/19/2025 at 3:49 PM, Staff D, Social Services Assistant, stated there was currently no formal tracking system or process in place to monitor PASARR forms, including whether Level II referrals were sent or when results were returned. Staff D stated the PASARR information was only documented in a chart note and reviewed annually at care conferences. Staff D stated there was a breakdown with the Level II referral process. During an interview on 11/19/2025 at 3:49 PM, Staff F, Social Services Director (SSD), stated the process for PASARR's was for Social Services to ensure all new residents had a completed PASARR upon admission. Staff F stated the form was reviewed to determine whether a Level II evaluation was needed, and if so, the necessary paperwork was completed and faxed to the state designated authority. Staff F confirmed that Resident 9's Level I PASARR was incorrect on admission and should have been corrected immediately, and that Resident's 9, 43, and 78 should have had Level II evaluations completed and documented in their electronic records. During an interview on 11/20/2025 at 11:35 AM, Staff B, Director of Nursing Services, stated Social Services was responsible to ensure PASARRs were correct, and Level II referrals were sent when needed. Staff B stated Social Services reviewed all PASARRs on admission, corrected any inaccuracies, and ensured referrals were made. Staff B stated that since the change in SSDs there had been a gap in the process. Reference: WAC 388-97-1915(2)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote a dignified living experience for 1 of 3 residents (Resident 73) reviewed for resident rights. This deficient practice placed residents at risk for humiliation, diminished self-worth, and infection control concerns.Findings included . Review of the facility policy, Preventative Maintenance-Wheelchair, revised on 01/11/2023, showed all facility wheelchairs were to be cleaned and inspected for proper operations at least quarterly. Resident 73Review of the medical record showed Resident 73 admitted to the facility on [DATE], with diagnoses of hemiplegia (paralysis of one side of the body) of the right side, aphasia (brain disorder that affects how you speak and understand language), bipolar disorder (mental health condition causes extreme mood swings that include emotional highs, called mania, and lows, known as depression), and need for assistance with personal care. Review of the comprehensive assessment, dated 11/13/2025, showed Resident 73 had moderate cognitive impairment and required the assistance of one to two staff members for grooming, dressing, toileting, transfers, and mobility. A concurrent observation and interview on 11/19/2025 at 11:40 AM, two flies were observed in Resident 73's room. One fly was hovering around the floor in front of Resident 73's feet and the other was sitting on the windowsill of the closed window. A fly swatter was observed on Resident 73's overbed table and when asked if there were flies in the room often, Resident 73 replied, Yep. During an interview on 11/19/2025 at 11:45 AM, a contracted Pest Control Vendor stated they came to the building monthly and had not received any complaints about flies. An observation on 11/20/2025 at 9:11 AM, showed Resident 73 sitting in their room in their wheelchair watching television, and four flies were flying around them. The flies landed on Resident 73's right leg, overbed table, and wheelchair arm rest. Resident 73's wheelchair was dirty with multiple pieces of dried white, yellow, and brown particles on the frame, wheels, foot pedals, and brakes. During an interview on 11/20/2025 at 9:35 AM, Staff H, Restorative Aide (RA), stated Resident 73 preferred to eat their meals in their room on their overbed table, and the night shift staff were responsible for washing wheelchairs. During an interview on 11/20/2025 at 9:44 AM, Staff I, Maintenance Assistant, stated they were unaware of any resident rooms having flies. During an interview on 11/20/2025 at 9:46 AM, Staff J, Nursing Assistant (NA), stated they started working at the facility in July 2025 as a housekeeper and flies had been in Resident 73's room since they started. Staff J stated Resident 73 dropped food at times when eating and their wheelchair needed to be washed. Staff J stated they did not know what attracted the flies in Resident 73's room. A concurrent observation and interview on 11/20/2025 at 1:15 PM, showed a fly swatter and a dead fly on Resident 73's overbed table. When asked if they had killed the fly with the fly swatter, Resident 73 stated, Yep. When asked if their wheelchair had been washed recently, Resident 73 stated, Nope. When asked if it bothered them to have a dirty wheelchair and flies in their room, Resident 73 stated, Yea. During an interview on 11/21/2025 at 10:40 AM, Staff B, Director of Nursing Services, stated there was previously a wheelchair washing schedule, but further investigation showed the night shift staff were not following it. Staff B stated the staff were picking wheelchairs they thought were dirty and needed to be washed, and there was no way to determine when the last time Resident 73's wheelchair was washed. Staff B stated Resident 73's wheelchair should have been kept clean and there should not have been flies in their room. During an interview on 11/21/2025 at 11:00 AM, Staff A, Administrator, stated they would be upset if they had to live with flies in their room and it's something no resident should have to deal with. During an interview on 11/21/2025 at 11:20 AM, Staff K, Maintenance Director, stated they recalled being told about flies in Resident 73's room a while ago, maybe in September, and was probably the one who gave them (Resident 73) the fly swatter. Staff K stated they had not received any further reports about flies and they did not go back to see if they were gone. Reference: WAC 388-97-0180(2)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure psychotropic (drugs that affect how the brain works, and cause changes in mood, awareness, thoughts, feelings, or behavior) medications were monitored for effectiveness using individualized, resident-specific targeted behaviors for 3 of 5 residents (Resident 9, 43, and 31) reviewed for unnecessary medications. This failure placed residents at an increased risk for experiencing medication-related adverse side effects and unmet care needs.Findings included . Review of a policy titled, Psychotropic Medication, Informed Consent Policy, dated 04/22/2025, showed behavior interventions were to be individualized, non-pharmaceutical approaches to care that were provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating residents' distress, as well as maintaining or improving a resident's mental, physical, or psychosocial well-being. Resident 9 Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including anxiety (a feeling of worry, nervousness, or fear, often in anticipation of something unpleasant) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and a loss of interest in activities once enjoyed). The comprehensive assessment dated [DATE] showed Resident 9 had impaired cognition, depression, and an anxiety disorder. Further review showed Resident 9 required the assistance of one to two staff members for activities of daily living (ADLs). ^ During an observation and concurrent interview on 11/21/2025 at 11:09 AM, Resident 9 was lying in bed watching television. Resident 9 stated they were sad at times related to their vision problems. Resident 9 stated when they felt down and sad, they needed people to talk to. Resident 9 stated they would like the staff to call their family when they were feeling sad because they always make me happy.^ Review of Resident 9's September 2025, October 2025, and November 2025 Medication Administration Records (MAR), showed a physician's order on 09/03/2025 for Sertraline (a brand of antidepressant medication) to be given for a diagnosis of major depressive disorder. Review of Resident 9's Care Plan (CP) dated 09/18/2025, showed Resident 9 had a mood problem related to a diagnosis of depression and staff were to monitor for any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions, or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing medications or therapies, sense of hopelessness or helplessness. Review of Resident 9's September 2025, October 2025, and November 2025 MARs showed a physician's order to monitor Resident 9 for loss of interest only. Further review showed no individualized, resident specific targeted behaviors were identified or monitored for effectiveness of the psychotropic medication. Resident 43 Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including anxiety and depression. The comprehensive assessment dated [DATE], showed Resident 43 had an intact cognition, depression, and an anxiety disorder. Further (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review showed Resident 43 required assistance of one staff member for ADLs. During an observation and concurrent interview on 11/21/2025 at 11:15 AM, Resident 43 was lying in bed eating a snack and watching television. Resident 43 stated they were depressed and sad at times. Resident 43 stated they liked to go outside, feel the fresh air, and call their children when this happened. Resident 43 stated these things help them when they were in the pits (depressed/sad). Review of Resident 43's September 2025, October 2025, and November 2025 MARs, showed a physician's order dated 05/15/2025 for bupropion (a type of anti-depressant medication) to be given for a diagnosis of depression. Review of Resident 43's CP dated 05/22/2025, showed the resident had a mood problem related to a diagnosis of depression and staff were to monitor for any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions, or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing medications or therapies, sense of hopelessness or helplessness. Review of Resident 43's September 2025, October 2025, and November 2025 MARs showed an order to monitor Resident 43 for withdraw only. Further review showed no individualized, resident specific targeted behaviors were identified or monitored for effectiveness of the psychotropic medication. Resident 31 Review of the medical record showed Resident 31 admitted to the facility, on 09/09/2025, with diagnoses of dementia (a disease that causes the loss of thinking, remembering, and reasoning skills), affective disorder (a mental health condition characterized by prolonged and extreme shifts in mood, such as persistent sadness or excessive elation), restlessness (the feeling of being unable to relax or stay still, both physically and mentally) and agitation (a feeling of being tense, irritable, and restless, often accompanied by physical actions like fidgeting, pacing, or wringing your hands). Review of the comprehensive assessment, dated 09/15/2025, showed Resident 31 had severe cognitive impairment and required the assistance of one person for grooming, dressing, incontinent care, bathing and mobility. Review of Physician's Orders for November 2025 showed Resident 31 was prescribed Sertraline 50 milligrams [(mg) unit of measure] daily for depression (a mood disorder characterized by persistent feelings of sadness, a loss of interest in activities, and low self-esteem that interfere with daily life) and Risperidone [an antipsychotic (a type of medicine used to treat conditions that affect a person's ability to tell what is real and what is not) medication] one mg twice daily for bipolar disorder (mental health condition causes extreme mood swings that include emotional highs, called mania, and lows, known as depression). Review of the MARs for September 2025, October 2025, and November 2025 showed Resident 31 was monitored for behaviors of restless and withdraw. Review of the care plan updated on 09/23/2025, showed Resident 31 received antipsychotic medication related to their dementia and the interventions included monitoring for behaviors (no specific or individualized behaviors identified) and side effects to the medications. During an interview on 11/21/2025 at 11:15 AM, Staff G, Licensed Practical Nurse/Unit Manager, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the behaviors monitored for a resident should match those identified on the resident's care plan. Staff G stated each resident receiving a psychotropic medication should be monitored with individualized, resident-specific targeted behaviors. Staff G stated staff were using the same generic behaviors and the same monitoring checklist for all residents on all psychotropic medications, regardless of diagnosis, symptoms, or intended therapeutic effect, instead of identifying and monitoring individualized, resident-specific targeted behaviors. Staff G stated the behaviors were not individualized for Residents 9, 43, and 31 and should have been.^ During an interview on 11/21/2025 at 11:35 AM, Staff B, Director of Nursing Services, stated behavior monitoring must be individualized and specific for each resident and each resident should have individualized targeted behaviors documented. Staff B stated the additional behaviors in the resident's care plans were auto populated and not individualized. Staff B stated Residents 9, 43, and 31 did not have individualized behaviors monitored and lacked specific interventions and the process was not followed.^ Reference: (WAC) 388-97-1060(3)(k)(i)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to follow professional standards of practice related to adding a new mental health diagnosis for 1 of 5 residents (Resident 31) reviewed for psychotropic (drugs that affect how the brain works, and cause changes in mood, awareness, thoughts, feelings, or behavior) medication use. This deficient practice placed residents at risk for unnecessary medications and unmet care needs.Findings included . Resident 31Review of the medical record showed Resident 31 admitted to the facility, on 09/09/2025, with diagnoses of dementia (a disease that causes the loss of thinking, remembering, and reasoning skills) and affective disorder (a mental health condition characterized by prolonged and extreme shifts in mood, such as persistent sadness or excessive elation). Review of the comprehensive assessment, dated 09/15/2025, showed Resident 31 had severe cognitive impairment and required the assistance of one staff member for grooming, dressing, incontinent care, bathing and mobility. Review of Resident 31's admission orders dated 09/09/2025, showed they were to receive Risperidone [an antipsychotic (a type of medicine used to treat conditions that affect a person's ability to tell what is real and what is not) medication] 1 milligram [(mg) unit of measure] by mouth twice daily for dementia without behavioral disturbance. Review of the medical provider visit Progress Notes (PN) dated 09/10/2025, 09/16/2025, and 10/10/2025, showed Resident 31 was evaluated to establish care as a new admission to the facility and review of their current medication management. There were no changes to Resident 31's medication regime or diagnosis list. Review of the Pharmacist Consultation Report dated October 2025, showed a recommendation to clarify the indication for use diagnosis for Resident 31's current order for Risperidone, as the one listed (dementia without behavioral disturbance) was not appropriate. Staff L, Advanced Registered Nurse Practitioner (ARNP) wrote the diagnosis bipolar on the report followed by their initials. Review of Resident 31's Physician's Orders dated October 2025, showed a new order was placed on 10/31/2025 for Risperidone 1 mg twice daily for the diagnosis of bipolar disorder. Review of the medical provider visit PN dated 11/11/2025 showed Resident 31 was evaluated for a routine follow-up with medication review. New orders were placed to discontinue Resident 31's thyroid medication, calcium, and vitamin supplements due to Resident 31's refusals. There were no changes made to Resident 31's diagnosis list. Review of the medical record dated 11/21/2025 showed there was no monitoring for behaviors related to the diagnosis bipolar disorder. During an interview on 11/21/2025 at 10:00 AM, Staff L stated they had not evaluated Resident 31 specifically for mental health when they added the diagnosis of bipolar disorder. Staff L stated the facility policy did not allow the use of antipsychotic medications to treat dementia, and they chose a diagnosis that was considered acceptable. During an interview, on 11/21/2025 at 10:40 AM, Staff B, Director of Nursing Services, stated the standard of practice was for residents to receive a mental health evaluation in order to add new mental health diagnoses, and that process did not happen for Resident 31. Reference: WAC 388-97-1620(2)(b)(i)(ii)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician ordered physical therapy (PT) was received in a timely manner for 1 of 3 residents (Resident 34) reviewed for specialized rehabilitation services. This failure placed the resident at risk for decline in function and/or not achieving the highest practicable level of physical, mental, and functional well-being. Findings included . Review of a policy titled, Specialized Rehabilitative Services, revised 09/04/2025, showed the facility would ensure that each resident received specialized rehabilitative services to assist them to attain, maintain, or restore their highest level of physical, mental, functional and psychosocial well-being. Resident 34 Review of the medical record showed Resident 34 was admitted to the facility on [DATE] with diagnoses including cellulitis (a bacterial infection of the skin and underlying tissues) of the right lower leg, muscle weakness, and difficulty walking. The 10/08/2025 comprehensive assessment showed Resident 34 required moderate/maximum assistance of one staff member for activities of daily living. The assessment also showed Resident 34 had a moderately impaired cognition. Record review of a physician's order dated 09/12/2025, showed Resident 34 had an order for PT evaluation and treatment. Record review of the medical record showed Resident 34 received their initial PT evaluation and treatment plan on 09/17/2025, five days after their admission to the facility. During an interview on 11/20/2025 at 8:11 AM, Staff E, Director of Rehab Services, stated Resident 34 received their PT evaluation on 09/17/2025. They stated they did not have enough staff at the time of Resident 34's admission to complete the new admission evaluations. Staff E stated receiving an evaluation five days after admission was not the normal process, which included completing the evaluations within 24 to 48 hours after admission. During an interview on 11/21/2025 at 9:56 AM, Staff B, Director of Nursing Services, stated the process and their expectation for PT evaluations included completing them within 48 hours of admission, unless the resident was admitted on Friday, then the evaluation would be completed on the following Monday. They stated the facility was short on therapists at that time which caused the delay in obtaining the PT evaluation and treatment. During an interview on 11/21/2025 at 10:22 AM, Staff A, Administrator, stated PT evaluations should be completed within 24 to 48 hours of admission. They stated it was not an acceptable practice to complete a PT evaluation five days after a new admission. Reference WAC: 388-97-1280(1)(a)(b)(2)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer and/or provide an influenza (a common viral infection that attacks the lungs, nose, and throat) immunization for 1 of 5 residents (Resident 58) reviewed for immunizations and infection control. This failure placed the residents at risk for illness and transmission of communicable diseases. Findings included . Review of a policy titled, Influenza Vaccine Policy for Residents, revised 09/23/2025, showed residents would be offered an influenza immunization between October 1st through March 31st annually, unless the immunization was medically contraindicated or the resident had already been immunized during that period. The resident's medical record would include documentation that the resident or their representative was provided education regarding the benefits and potential side effects of the immunization and that the resident either received or refused the immunization. Resident 58 Review of the medical record showed Resident 58 was admitted to the facility on [DATE] with diagnoses including anxiety, depression, and necrotizing fasciitis (a severe, rapidly spreading bacterial infection). The 09/04/2025 comprehensive assessment showed Resident 58 was dependent on one to two staff members for ADLs: setup assistance for eating and oral hygiene. The assessment also showed Resident 58 was cognitively intact. Record review of Resident 58's medical record showed no documentation of consent or refusal for the annual influenza immunization, no record that the immunization had been administered, and no education had been provided. During an interview on 11/20/2025 at 4:47 PM, Staff C, Infection Preventionist, stated the process for ensuring residents received the annual influenza immunization included offering it upon admission to the facility and/or during influenza season. During a follow up interview on 11/21/2025 at 9:19 AM, Staff C stated Resident 58 was not offered the influenza immunization upon admission because they were admitted in July. They stated they were unsure why Resident 58 was not offered the immunization in September when all residents were offered it. They stated they were unable to locate any documentation related to a consent or refusal for the influenza immunization. During an interview on 11/21/2025 at 9:53 AM, Staff B, Director of Nursing Services, stated the influenza immunization was offered to all residents on admission and during the respiratory season. They stated the process included obtaining consents from all long-term care residents prior to the start of the influenza season. Staff B stated Staff C should keep a spreadsheet of which residents were offered and/or received the immunization. They stated Resident 58 was missed because they were in and out of the hospital when the long-term care resident consents were obtained. Reference WAC: 388-97-1340(1)(2)(3)

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	11/21/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program that ensured insects (flies) were not congregating in rooms or on persons for 1 of 4 residents (Resident 73) reviewed for environment. This deficient practice placed residents at risk of infection and contributed to a less than homelike environment.Findings included. Review of the facility policy, Pest Control, revised on 07/09/2025, showed the facility's pest control program would provide frequent treatments to keep the facility free of pests, the facility's staff would monitor the environment for potential concerns, and all pest control problems would be reported to the Director of Maintenance promptly. Resident 73Review of the medical record showed Resident 73 admitted to the facility with diagnoses of hemiplegia (paralysis of one side of the body) of the right side and aphasia (brain disorder that affects how you speak and understand language). Review of the comprehensive assessment, dated 11/13/2025, showed Resident 73 had moderate cognitive impairment and required the assistance of one to two staff members for grooming, dressing, toileting, transfers, and mobility. An observation on 11/19/2025 at 11:40 AM, showed two flies in Resident 73's room, one hovering around the floor in front of their feet and the other sitting on the windowsill of the closed window. A fly swatter was observed on the overbed table. During an interview on 11/19/2025 at 11:45 AM, a contracted Pest Control Vendor stated they had not received any complaints about flies. An observation on 11/20/2025 at 9:11 AM, showed Resident 73 in their room watching television and four flies flying around them. The flies were observed landing on Resident 73's right leg, overbed table, and wheelchair. During an interview on 11/20/2025 at 9:44 AM, Staff I, Maintenance Assistant, stated they were not aware of resident rooms having flies. During an interview on 11/20/2025 at 9:46 AM, Staff J, Nursing Assistant (NA) stated they began working as a housekeeper in July 2025 and Resident 73's room had flies since then. An observation, on 11/20/2025 at 1:15PM, showed a fly swatter and a dead fly on Resident 73's overbed table. During an interview on 11/21/2025 at 11:00 AM, Staff A, Administrator, stated they were surprised to learn Resident 73's room had flies for that length of time and was something they should not have to endure. During an interview on 11/21/2025 at 11:20 AM, Staff K, Maintenance Director, stated they were aware of flies in Resident 73's room maybe in September and probably gave Resident 73 the fly swatter. Staff K stated they had not received additional reports about flies, and they did not follow up to see if the flies were gone from Resident 73's room.Reference: WAC 388-97-3360(1)