STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505372	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Canyon Lakes Rehab and Nursing Center	2702 S Ely St Kennewick, WA 99337

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to ensure grievances (resident and/or resident representative concerns that can be voiced or written) conveyed during resident council meetings (a meeting of the facility's residents to communicate concerns, request improvements and keep up to date of the facility's activities/events) underwent prompt resolution through to their conclusion or appropriately updated on the grievance progress/conclusion for 4 of 5 residents (Resident 22, 348, 350, 349) reviewed for the grievances process. This failure placed residents at risk for unresolved concerns and unmet care needs. Findings included . Review of the facility policy titled, Grievances Procedure, revised October 2021, showed the facility would . have a process in place for identification, investigation and follow-up of resident/resident representative grievances in a timely manner. The policy showed that grievances would be documented on the grievance logbook and analyzed for identifiable trends within the facility. <Resident 22> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including a bladder infection, diabetes and long-term kidney disease. The 01/06/2025 comprehensive assessment showed the Resident 22 had moderately impaired cognition but was able to make their needs known. <Resident 348> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including a left leg fracture. The 02/17/2025 comprehensive assessment showed that Resident 348 was cognitively intact and able to make their needs known. The resident was discharged from the facility on 02/24/2025. <Resident 350> (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
	505372	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Canyon Lakes Rehab and Nursing Center	2702 S Ely St Kennewick, WA 99337

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed they were admitted to the facility on [DATE] for rehab following surgery. The 11/19/2024 comprehensive assessment showed that Resident 350 was cognitively intact and able to make their needs known. The resident was discharged from the facility on 01/15/2025. <Resident 349> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including Multiple Sclerosis (a disease where the body attacks its own nervous system that can cause involuntary muscle spasms and muscle stiffness) and a neurogenic bladder (complication controlling bladder functions). The 12/16/2024 comprehensive assessment showed that Resident 349 was cognitively intact and able to make their needs known. The resident was discharged from the facility on 01/27/2025. Review of the facility's grievance logbook for January 2025 through March 2025 showed that grievances expressed through resident council meetings were not documented on the grievance log for January, February or March 2025. During an interview on 04/08/2025 at 9:01 AM Staff F, Activities Director, stated they were charged with coordination of the resident council meetings and documented the meeting minutes since December 2024. Staff F stated that for all grievances we try to solve right then and there, but that some of the grievances Staff F would have to convey to the Director of Nursing Services (DNS) who would fill out a form. Staff F stated they did not bring the resident's grievances to the facility's grievance officer, Staff D, Social Service Director (SSD) for January 2025 through March 2025 nor had they filled out the facility's official grievance form with resident specific information. During the continued interview on 04/08/2025 at 9:01 AM, Staff F stated that during the January 2025 resident council meeting Resident 350 had a grievance about a Nursing Assistant (NA) with an attitude and Resident 349 had a grievance about an NA that refused to help clean the residents face, but specifics regarding the resident's names and conversations were not documented. Staff F stated that during the February 2025 resident council meeting, Resident 348 had a grievance around medications not being administered timely and that Resident 22 had the same grievance during the March 2025 resident council meeting. Staff F stated that specifics regarding the resident's names and conversations were not documented. Staff F stated they did not have documentation that follow-up was completed for any of the residents. Staff F stated the correct grievance process had not been followed. During an interview on 04/08/2025 at 9:53 AM, Staff D, SSD, stated that all grievances were to come to them so they could be documented on the grievance log, ensure that an investigation was completed, that follow-up was done, which included, grievances during resident council meetings so that patterns/trends could be identified. Staff D stated they were not aware of Resident 22, 348, 350 or 349's grievances from the January through March 2025 resident council meetings. Staff D stated they could not ensure the correct process of a grievance resolution through to its conclusion was conducted for Residents 22, 348, 350 and 349. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505372	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Canyon Lakes Rehab and Nursing Center	2702 S Ely St Kennewick, WA 99337

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/08/2025 at 10:48 AM, Staff B, DNS, stated grievance concerns conveyed by Staff F from the January 2025 through March 2025 resident council meetings were not towards any one resident or staff member and Staff B saw the grievance as a whole and not specific. Staff B stated they did not know the names of the specific residents that had conveyed the grievances during the January 2025 through March 2025 resident council meetings. Staff B stated they did not interview the specific residents or follow-up with the residents on the grievance resolution/conclusion. During an interview on 04/09/2025 at 8:08 AM, Staff A, Administrator, stated they had realized that grievances from the resident council meetings were not being documented on the facility grievance log. Staff A stated they did not know that Residents 22, 348, 350 and 349 were involved in the specific grievances from January 2025 through March 2025 resident council meetings. Staff A stated the correct process was not followed for the Resident 22, 348, 350 and 349's grievances. Reference: WAC 388-97-0460(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505372	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Canyon Lakes Rehab and Nursing Center	2702 S Ely St Kennewick, WA 99337

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368 Based on interview and record review, the facility failed to review and validate the Preadmission Screening and Resident Reviews ([PASARR], an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) had the required Level 2 referral sent when residents had a positive Level 1 PASARR and were an exempted hospital discharge in the facility for more than 30 days or had a change in condition in which a new Level 1 PASARR would require completion for 2 of 5 residents (Resident 24 and 2) reviewed for PASARR. This failure placed the residents at risk of not receiving the mental health care and services appropriate to their needs. Findings included . Review of the Department of Social and Health Services, Dear Nursing Home Administrator Letter, guidance titled, Clarification to the Pre-Admission Screening and Resident Review (PASARR or PASRR) Level 1 Screening Process, dated 07/06/2024, showed a positive Level 1 PASARR screen (that would then require a referral for a Level 2 PASARR) was Any of the questions in Section 1A (1, 2, and/or 3) are marked Yes: or sufficient evidence of SMI is not available, but there is a credible suspicion that a SMI may exist; and the requirements for exempted hospital discharge do not apply . Additionally, if requirements for exempted hospital discharge were met but the residents stay changed from less than 30 days to exceeding 30 days, then the facility's responsibility would be to send out positive Level 1 screenings to be evaluated. <Resident 24> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnosis including chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems) and anxiety (a feeling of worry, nervousness, or fear, often in anticipation of something unpleasant). The comprehensive assessment dated [DATE] showed Resident 24 had a mildly impaired cognition and an anxiety disorder. Review of Resident 24's PASARR, dated 02/21/2025 showed Resident 24 had a positive SMI for a mood disorder. Further review showed Resident 24's PASARR was marked exempt from requiring a Level 2 evaluation due to a physician certifying that Resident 24 would be requiring less than a 30 day stay in the nursing facility. Additionally, the required Level 2 evaluation had not been completed as of 04/08/2025 (46 days after Resident 24's admission). During an interview on 04/08/2025 at 12:52 PM, Staff D, Social Service Director (SSD), stated when a resident was admitted with an exemption marked on the PASARR for a stay of less than 30 days, and the stay was likely going to be longer, the social service assistant would be responsible for sending out for the Level 2 required screening prior to the 30-day mark. During an interview on 04/09/2025 at 9:50 AM, Staff I, Social Service Assistant, stated they were unable to confirm whether Resident 24's PASARR had been sent out for the required Level 2 screening. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505372	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Canyon Lakes Rehab and Nursing Center	2702 S Ely St Kennewick, WA 99337

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/2025 at 9:53 AM, Staff B, Director of Nursing Services, stated the process for sending out the required Level 2 PASARR screening for a resident who came into the facility exempt was that social services were to send it prior to the 30-day mark. Staff B stated that it was not completed for Resident 24. 43280 <Resident 2> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including heart complications, depression, and anxiety. The comprehensive assessment dated [DATE] showed Resident 2 was readmitted on [DATE] with a significant change (a deterioration or improvement in the physical or mental conditions of a resident) in their health status. Review of Resident 2's PASARR, last completed on 10/25/2021 by Staff D, SSD, showed the resident had SMI of depression and anxiety, and no Level 2 was required at the time the assessment was completed (no Level 1 PASARR had been updated after the resident's change in condition on 12/30/2024). During an interview on 04/09/2025 at 2:32 PM, Staff D, stated the facility's process was to complete a new Level 1 PASARR if a resident had a physical or mental change in their condition. Staff D stated they were not aware Resident 2 had a change in condition around the 12/26/2024 significant comprehensive assessment. Staff D stated the correct process was not followed and that a new Level 1 PASARR should have been completed and a referral sent for a Level 2 PASARR evaluation. During an interview on 04/09/2025 at 3:20 PM, Staff A, Administrator, stated the correct process was not followed regarding Resident 2's change in conditions and a new Level 1 PASARR should have been completed/sent out for an evaluation. Reference: WAC 388-97-1975(5)(7)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505372	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Canyon Lakes Rehab and Nursing Center	2702 S Ely St Kennewick, WA 99337

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on observation, interview and record review, the facility failed to ensure nursing staff implemented appropriate infection control practices in the prevention of urinary tract infections (a condition were pathogens like bacteria enter through the urinary meatus [a passage or opening leading to the interior of the body] and infect the kidneys or bladder) with residents indwelling urinary catheter (IUC, a tube placed in the bladder which drains urine out into a collection bag) care for 1 of 2 resident (Resident 17), reviewed for infection control. This failure placed the residents at risk of developing an IUC associated UTI and unmet care needs. Findings included . <Resident 17> Review of the resident's medical records showed they were admitted on [DATE] with diagnoses including stroke, neuromuscular dysfunction of the bladder (complication controlling bladder functions) and obstructive reflux uropathy (an obstruction in the urinary tract causing urine to back up into the kidneys). The 03/10/2025 comprehensive assessment showed that Resident 17 had moderately impaired cognition and an IUC. Review of Resident 17's care plan showed the resident had a suprapubic catheter (a specific type of IUC that is inserted through a small incision in the abdomen) in place as was to receive IUC care every shift by nursing staff. Observations on 04/07/2025 at 1:09 PM showed Staff E, Nursing Assistant (NA) and Staff G, NA, performing an incontinence brief change and IUC care on Resident 17. Staff E and Staff G performed hand hygiene and put on gloves prior to starting the resident's care. Staff E started perineal care (cleaning and maintenance of the private areas of the body) on the resident's buttocks and a small wound that had a scant amount of blood was noted. Staff E utilized the same wipe, that had just been soiled from wiping the resident's perineal area, to wipe the blood from the resident's wound. Staff E did not perform hand hygiene or put on new gloves and then assisted in turning and replacing the old, soiled brief with a new clean one. Staff E proceeded to clean the resident front perineal area with the same soiled gloves and then move onto the resident's IUC care without performing a glove change or hand hygiene. During an interview on 04/07/2025 at 1:45 PM, Staff G, NA, stated their process for perineal care would be to remove their soiled gloves and perform hand hygiene after completing care on the resident buttocks area and after care of the resident's frontside perineal area. Staff G stated they would then put on new gloves to continue with IUC care. During an interview on 04/07/2025 at 1:49 PM, Staff E stated they should have completed hand hygiene/changed gloves in between each area of the resident's perineal care and then before moving onto Resident 17's IUC care. Staff E stated they did not follow the correct infection control process for IUC care and could have potentially contaminated the residents IUC. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505372	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Canyon Lakes Rehab and Nursing Center	2702 S Ely St Kennewick, WA 99337

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	During an interview on 04/09/2025 at 3:42 PM, Staff C, Infection Preventionist, and Staff B, Director of Nursing Services, stated that Staff E did not follow the correct infection control process for Resident 17's IUC care and that hand hygiene/change in gloves should have been performed in between each area of the resident's body to prevent the potential spread of infectious pathogens. Reference: WAC 388-97-1320(1)(a)(c)