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	08/26/2024

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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368 Based on observation, interview, and record review, the facility failed to ensure that four-point restraints (a device used to support impaired posture that restricts a resident's freedom of movement) were applied in a safe manner, and failed to establish the medical need for the restraint, implement assessments, care planning, and supervision that focused on the specific restraint use for 2 of 2 residents (Residents 1 and 5), reviewed for physical restraints. This failed practice placed Resident 1 at serious risk of entrapment, strangulation, and death, and placed both Resident 1 and Resident 5 at risk for a decline in physical function, restriction of free movement, risk of injury, loss of dignity, and was determined to be an immediate jeopardy. On 08/23/2024 at 1:45 PM the facility was notified of an Immediate Jeopardy (IJ) at, F604 42 CFR S483. 12(a)(2) Free from physical restraints, when a resident was observed with an improperly placed four-point chest restraint. It was determined that the IJ began on 08/23/2024 and the immediacy was removed on 08/23/2024 with an onsite verification from investigators. The facility removed the immediacy by implementing education with return demonstration for nursing staff on the proper use and placement of the four-point restraint, prior to their next scheduled shift. The facility initiated a supervisory plan to ensure Resident 1 would be observed and repositioned as needed and would not be left in an unsupervised area when up in their wheelchair (w/c) while the four-point restraint was on. The measures put in place by the facility ensured that the four-point restraint would be applied correctly. Findings included . Record review of a facility policy titled Physical Restraint Use, dated 12/29/2023, showed the following: An assessment must be completed and show that: A Least restrictive alternatives was used and not effective, type of device, frequency/duration and medical reason, A physician's order must be in place to include type, condition/medical symptoms. Where and how to apply and the time and frequency the device should be released. Care plan must include and be revised quarterly and as needed: (continued on next page)

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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Type, medical symptoms that warrant use, length of time to be used, time and frequency it should be released. Monitoring and supervision during use Documentation must include: Type, Medical symptoms being treated, reason for use, effectiveness in treating medical condition. An active plan to decrease usage or for the eventual removal, Interventions, including less restrictive alternatives that were attempted but ineffective, must be reevaluated Quarterly, and education to be provided when consent is obtained and PRN <Resident 1> Review of the medical record showed that the resident was admitted to the facility with diagnoses including severe intellectual disabilities (a condition that limits a person's mental functioning and skills, such as communication, self-care and social skills), and encephalitis (a serious condition that causes inflammation of the brain, which can lead to swelling and changes in neurological function). The most recent assessment dated [DATE] showed the resident required extensive assist of two staff members for activities of daily living (ADL's) and had severe cognitive impairment. The assessment further showed no restraint was used during the assessment period. Record review of a physician's order dated 06/26/2024 showed, tilt in space w/c with harness to aid in positioning. There was no justification to show the medical symptoms for use or directions for applying the restraint or the time and frequency the restraint should be worn. Record review of Resident 1's comprehensive care plan, dated 07/25/2024, showed there were no interventions for a specific type of restraint, medical symptoms to treat and to justify the use, length of time to be used, who was able to apply and release, where and how it was to be applied and used, and the time and frequency it should be released. Review of the medical record showed no initial assessment or ongoing reassessments had been completed for the four-point restraint. An observation on 08/20/2024 at 7:35 PM, showed Resident 1 in their room, behind a closed curtain not visible from the hallway. Resident 1 was seated in their w/c; the w/c was tilted back with a four-point restraint in the shape of an X placed across the torso (the central part of the body that includes the chest and abdomen) of the resident. The top of the restraint extended into two straps, one across each shoulder. Each strap was secured to the bars on the back of the w/c. The bottom of the restraint extended into two straps, one to each side of the hip area secured to the bottom of the wheelchair midway under the seat cushion. The restraint was loose with four inches of space between the resident's chest and restraint whuch incresed the risk of strangulation without proper placement. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An observation on 08/22/2024 at 11:17 AM, showed Resident 1 in their room, behind a closed curtain not visible from the hallway. Resident 1 was seated in their w/c, tilted back, brakes unlocked with a four-point restraint to the chest attached by four black straps to the w/c. Resident 1's arms and legs were involuntarily moving which caused Resident 1 to slide down in their w/c with their bottom no longer at the back of the w/c seat cushion. The top portion of the four-point restraint was observed to be at the collar bone level and not at the chest level. The four- point restraint was loose with four inches of space between the resident's chest and restraint, placing the resident at risk for the restraint to slip up under their neck. An observation on 08/23/2024 at 9:05 AM, showed Resident 1 in their room, behind a closed curtain not visible from the hallway. Resident 1 was seated in their w/c, tilted back with a four-point restraint to the chest. The right bottom strap was not applied correctly and was over the resident's right arm (not under it) and was secured to the wheelchair. The four-point restraint was loose with five inches of space between Resident 1's chest and restraint which placed the resident at risk for the four-point restraint to slide upward under their neck. During an interview on 08/23/2024 at 9:11 AM, Staff P, Licensed Practical Nurse, (LPN)/ Unit Care Coordinator, observed Resident 1's four-point restraint and stated it was not applied correctly. Staff P released the right bottom strap and placed it under Resident 1's arm and tightened all four straps close to Resident 1's chest. Staff P stated that they had not had any training on the use or application of the four-point restraint and they should do some education with staff. Staff P further stated they had not done any ongoing assessments or tried any least restrictive devices, nor did they have a check and release schedule for Resident 1' s four-point restraint, Staff P stated, No one told me that I was supposed to. During an interview on 08/23/2024 at 9:18 AM, Staff N, Nursing Assistant (NA), stated they had not had any training on the application or use for Resident 1's four-point restraint. During an interview on 08/23/2024 at 9:31 AM, Staff M, NA, stated they had placed the four-point restraint on Resident 1 and was sure they had put the right strap under the resident's right arm and not over their arm. Staff M stated Resident 1 must have slid down in their w/c, the resident slides down a lot. Staff M stated the restraint slid up under Resident 1's chin and they had to pull the resident up. During a follow-up interview with Staff M on 08/23/2024 at 10:09 AM, Staff M stated when Resident 1 slid down and the restraint moved to the middle of Resident 1's neck, Staff M pointed to the mid windpipe area on their neck. During an interview on 08/23/2024 at 2:47 PM, Staff O, LPN, stated they were trained years ago on the four-point restraint with Resident 1's previous w/c but had no training on the new w/c and four-point restraint since it was ordered. Record review of a receipt showed Resident 1's current w/c was ordered and recieved in 2021. <Resident 5> (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the medical record showed the resident was admitted to the facility with diagnoses of cerebral palsy (a group of neurological disorders that affect a person's movement and muscle coordination), epilepsy (a chronic brain condition that causes seizures, which are brief episodes of involuntary movements), and lack of expected normal physiological development (developmentally delay in psychological development or severe developmental delay). The assessment, dated 07/17/2024, showed the resident required extensive assistance of two staff members for ADLs and had severe cognitive impairment. The assessment further showed no trunk restraint was used during the assessment period. An observation on 08/25/2024 at 12:31 PM, showed Resident 5 sitting in their w/c in the dining room. Resident 5 had a four-point restraint on with four black straps attached to their w/c. The four- point restraint was loosely placed, the top two straps which were supposed to be applied over the shoulders and attach at the top of the w/c were lying across Resident 5's upper arms. Record review of a physician's order, dated 01/15/2024 showed, tilt in space w/c with harness to aid in positioning. The order did not include included the specific type of physical restraint to be used based upon the identified for the medical use to establishthe need for the restraint. Record review of Resident 5's care plan dated 05/02/2023, showed, the resident's care plan did not reflect requirements for the restraint or have direction for use for staff to follow. Review of Resident 5's medical record showed that the required initial and ongoing assessment had not been completed for the four-point restraint. During an interview on 08/24/2024 at 1:01 PM, Staff A, Administrator, stated their expectations for any restraint would be for the least restrictive alternative to have been tried first and the four-point restraint should have been the very last resort. Staff A stated they would expect the restraint to be care planned to include interventions, placement and safety precautions. Staff A stated they would expect ongoing evaluations, trainings and assessments quarterly, as needed and with any change in condition for the four-point restraint, including a medical diagnosis/symptoms support the use of the restraint. Staff A further stated their process was not at all followed correctly for Resident 1 and 5. Reference: WAC 388-97-0620(2)(d),(4)(a)(c),(5)(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 48368 Based on observation, interview, and record review, the facility failed to ensure restorative nursing services programs including the consistent use of braces/splints were implemented for 2 of 3 residents (Resident 22 and 31), reviewed for restorative nursing and limited range of motion [(ROM) the extent the joint can move within the expected (normal) range of values]. This failure placed the residents at risk for loss of ROM, deconditioning, and contractures (a permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen). Findings included . Review of a policy titled, Restorative Nursing, revised 08/20/2024 showed the goal of the Restorative Program was to maintain or improve functioning, . Restorative program to include but not limited to ROM (Active and Passive), applying, and removing splint or braces . <Resident 22> Review of the resident's medical record showed Resident 22 admitted to the facility with diagnoses including muscle weakness and need for assistance with personal care. The 06/13/2024 comprehensive assessment showed the resident required extensive assistance of two staff members for activities of daily living (ADLs) and had impairment to both their upper and lower extremities. The assessment further showed Resident 22 had intact cognition and no restorative nursing programs in place. Record review of Resident 22's care plan, dated 08/12/2020, showed Resident 22's focus area stated that they required therapy services to maintain or attain their highest level of function however, showed no restorative nursing programs were in place. Further review showed Restorative services were discontinued on 10/25/2023. Record review of a Physical Therapy [(PT) a health professional trained to evaluate and treat people who have conditions or injuries that limit their ability to move and do physical activities] evaluation and plan of treatment dated 05/24/2024, showed Resident 22 was not evaluated or placed on restorative nursing services. During an observation and concurrent interview on 08/21/2024 at 9:04 AM, Resident 22 was lying in bed and was able to fully bend their left knee and could only wiggle the right leg back and forth, unable to bend it at the knee. Resident 22 stated they did not have anyone to assist them with exercises and tried to do them by themselves. During a follow up interview on 08/24/2024 at 9:39 AM, Resident 22 stated they would like to try and have exercises and see what that would be like. <Resident 31> (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed Resident 31 admitted to the facility with diagnoses including rhabdomyolysis (a condition that causes your muscles to break down), muscle weakness and Parkinson's disease (a chronic, progressive brain disorder that affects a person's movement and coordination). The assessment further showed Resident 31 had an intact cognition and no restorative nursing programs in place. Record review of Resident 31's care plan, dated 11/30/2023, showed Resident 31's focus area stated that they required therapy services to maintain or attain their highest level of function and showed no restorative nursing programs were in place. Further review showed an intervention dated 01/03/2024 for staff to encourage resident to wear their resting right-hand splint (a device that supports your hand and wrist in a position that is good for resting and can help reduce pain and swelling) at night. During an observation and concurrent interview on 08/24/2024 at 9:28 AM, Resident 31 was sitting on their bed with their right fingers bent at the knuckle, Resident 31 was unable to straighten their fingers or make a fist. Resident 31 stated they had a glove for the swelling and a splint that helped keep their fingers straight but did not wear it any longer due to them not being able to find the splint or the glove. Resident 31 further stated they would like to work with therapy some more, but it was stopped, and they were unsure why. During an interview on 08/25/2024 at 2:42 PM, Staff O, Licensed Practical Nurse, stated Resident 31 had not had their right-hand splint on in forever and were unsure why. During an interview on 08/25/2024 at 3:56PM, Staff A, Administrator, stated they only had one restorative nursing assistant and that would only allow up to ten residents to be on a restorative nursing program. Staff A further stated they identified during their monthly meeting whether a resident needed to be placed on a restorative program. If there were already ten residents on restorative programs, other residents that also needed that service would have to be placed on a waiting list. During an interview on 8/26/2024 at 9:00 AM, Staff U, PT stated their process for residents to be placed on a restorative nursing program was after skilled therapies ended, they wrote a restorative program for each resident to maintain their level of functioning. Long term residents were referred to therapy by nursing staff for restorative nursing programs to be written. Staff U stated all residents should be on a restorative nursing program to maintain their mobility. Staff U was not aware there were only ten restorative nursing program positions available. Staff U further stated as a therapist they felt that was not appropriate. During an interview on 08/26/2024 at 9:29 AM, Staff V, Occupational Therapist (a health care professional who helps people improve their ability to perform daily tasks), stated it was their expectation that all residents were to be on a restorative nursing program, and it is rare that a resident would not be on a maintenance restorative nursing program unless it was medically unsafe. Staff V stated they were not aware only ten residents could be on a restorative nursing program at a time. Staff V stated they would expect staff to assist and monitor for proper use of Resident 31's compression glove and resting right-hand splint. Staff V further stated they were unaware the compression glove and right hand-splint were missing and had not been being used. Reference: WAC 338-97-1060 (3)(d)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368 Based on observation, interview and record review the facility failed to ensure food was served at a safe temperature for 1 of 3 resident's (Resident 48) reviewed for avoidable accidents. This failure resulted in injury and pain to Resident 48 and placed other residents at risk for serious harm and injury related to the unsafe temperatures of reheated food in microwaves. Additionally, the facility failed to ensure resident safety was maintained for 2 of 3 shower rooms in the transitional care unit (TCU and 300 hall) and 8 of 8 personal protection equipment (PPE) carts reviewed for accidents and hazards by securing potentially hazardous cleaning agents. These failures placed resident's at risk for harm in the event the cleaning agents were ingested or skin/eye exposure. The lack of a system to ensure safe food temperatures to prevent injuries from reheated food represented an immediate jeopardy. On 08/21/2024 at 3:38 PM the facility was notified of an Immediate Jeopardy (IJ) at, F689 42 CFR S483. 25(d)(1), Free from accidents, when a cook and nursing assistant failed to ensure food was at a safe temperature after being reheated in a microwave. It was determined that the IJ began on 08/21/2024 and the immediacy was removed on 08/22/2024 with an onsite verification from investigators. The facility removed the immediacy by implementing education with return demonstration for dietary aides and cooks on the proper reheating process of food in a microwave. Nursing staff was educated to not reheat food or serve food that looks or feels hot. The education was to be completed prior to their next scheduled shift. The facility initiated a plan to remove all microwaves until staff education and return demonstration was completed for kitchen staff. The measures put in place by the facility ensured that no reheated food would be served until all kitchen and nursing staff were trained with return demonstration. Findings included . Record review of a facility policy titled Food Temperature Control, revised 06/28/2024, showed that food reheated in the microwave should not be served to the resident's above 150 degrees Fahrenheit (a unit of measure). <Resident 48> Review of the medical record showed that the resident was admitted to the facility with diagnoses of stroke (a loss of blood flow to part of the brain, which damages brain tissue) and aphasia (a language disorder that makes it difficult for people to communicate effectively with others). The comprehensive assessment dated [DATE] showed the resident required extensive assistance of one to two staff members for activities of daily living and required partial to moderate assistance with eating. Record review of Resident 48's care plan, dated 04/22/2024, showed that Resident 48 required assistance with meals. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on 08/21/2024 at 12:43 PM, Resident 48 was in their wheelchair, assisted to the dining room table by their significant other. Resident 48 stated to Staff R, Nursing Assistant, (NA), they were hungry and would like their lunch. Staff R went to the kitchen and came back with a tray that had milk, juice, and a plate warmer (a hard plastic insulated cover that was placed under the plate with a lid on it to maintain the temperature.) There was steam coming from under the lid. Staff R set the tray on the table in front of Resident 48 and attempted to remove the plate from the plate warmer using their bare fingers. Staff R quickly dropped the plate back into the warmer. Staff R then again removed the hot plate from the warmer with their bare hands and placed it in front of Resident 48. Staff R did not alert Resident 48 that the food and plate were hot and walked away without assisting Resident 48 with eating. Resident 48 quickly grabbed their spoon and placed a bite of mashed potatoes and gravy in their mouth. Resident 48 immediately started flailing their arms and legs, reached for their juice and water, yelled to their significant other its, hot, its hot. Resident 48's significant other provided the resident with water and juice eight seconds after Resident 48 had placed the mashed potatoes in their mouth. Resident 48 continued to grimace in pain stating, that was hot, it burned my mouth. During an interview on 08/21/2024 at 12:48 PM, Staff S, Cook, stated they put Resident 48's plate of food in the microwave for a minute or more. Staff S stated they checked the temperature of the meat, vegetables, and mashed potatoes and all foods had a temperature of 165 degrees Fahrenheit. Staff S stated they did not log temperatures for reheated foods. Staff S further stated they did not have a process to follow for reheated food using the microwave. During an interview on 08/21/2024 at 12:52 PM, Staff R, NA, stated Did you see me burn my fingers on that plate? It was hot. Staff R stated there was no process for reheated foods coming out of the kitchen they just assume it was the right temperature. Staff R stated that the plate was pretty hot, it burned my fingers. Staff R further stated they should have taken the tray back to the kitchen and not served a plate that was that hot to the resident. A concurrent observation and interview on 08/21/2024 at 1:27 PM, showed the Advanced Registered Nurse Practitioner (ARNP) performed an examination on Resident 48's mouth. Resident 48 stated to the ARNP they felt a burning sensation in their mouth. The facility provider examined Resident 48's mouth and stated, I see a little area that had contact. There will be some sensitivity over the next two-three meals, and I will order you some mouthwash. A concurrent observation and interview on 08/22/2024 at 10:07 AM, showed a slight reddened, raised area to the right side of Resident 48's tongue. Resident 48 stated their sensitivity and pain was located on the right side of their tongue. Resident 48 stated their pain level was at a 1 out of 10 (a score of 0 means no pain, and 10 means the worst pain you have ever felt.) Resident 48 further stated they had to use milk in their oatmeal at breakfast to cool it off because their mouth was still sensitive. Record review of a provider visit dated 08/22/2024, showed Resident 48 was examined by [NAME] Basin Denture Care to follow up on the 08/21/2024 incident. The provider note showed Patient stated (their)denture does not hurt at all, (they) said (they) burnt (their) tongue when trying to eat (their) mashed potatoes. Facility scheduled the appointment to have them have (their) denture checked, gums look within normal limits. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/25/2024 at 12:22 PM, Staff A, Administrator, stated there were missed steps in their process, and it would be good to fix it. <Shower Rooms> During an observation on 08/20/2024 at 7:45 PM, the TCU shower room showed the door was unlocked and open to the resident hallway. In the shower room were cleaning agents (Oxivir TB - a cleaning agent that is hazardous if consumed or has contact with the eyes) solution in a spray bottle in an unsecured cupboard. On the floor in the shower room was also a container of Oxivir TB wipes. During an observation on 08/20/2024 at 8:10 PM, the shower room in the 300 hall showed an unlocked door. In the shower room was an unsecured bottle of Oxivir tb solution and a container of Oxivir tb wipes on the floor. Multiple follow up observations of the shower room in the 300 hall on 08/21/2024 at 8:30 AM, at 2:45 PM, at 4:55 PM, and on 08/22/2024 at 10:28 AM, showed the shower room door was unlocked with the Oxivir TB cleaning solution and wipes unsecured. <PPE Carts> An observation on 08/20/2024 at 7:55 PM, showed eight of eight PPE carts in the resident halls with Sani-Cloth Bleach Germicidal Disposable wipes (a hazardous cleaning agent) stored unsecured on the tops of the carts. Record review of the safety data sheet for the wipes showed the wipes posed a risk of injury to the eyes or skin if they came into contact with these areas. During multiple follow up observations of the PPE carts showed on 08/21/2024 at 10:19 AM, 08/22/2024 at 3:10 PM, 08/23/2024 at 10:46 AM, and 08/24/2024 at 4:30 PM, eight of eight PPE carts had unsecured Sani-Cloth Bleach Germicidal wipes stored on top of the carts in the resident halls. During an interview on 08/24/2024 at 4:45 PM, Staff B, Director of Nursing, stated all the cleaning agents should be stored in a secured manner such as in locked areas so that the residents were not able to get into contact with them. Reference: (WAC) 388-97-1060(3)(g)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on interview and record review, the facility failed to ensure dialysis services met professional standards of care for 2 of 2 residents (Residents 9 and 44) reviewed for dialysis (the kidneys no longer function and require a process to remove waste and excess fluids from the blood stream). The facility did not have an effective or coordinated process for communication between the facility and the offsite dialysis center for continuity of care. This failure placed residents receiving dialysis at risk for complications and unmet care needs. Findings included . Review of a facility policy titled, Hemodialysis Offsite, dated 08/2023, showed The care of the resident receiving dialysis services must reflect ongoing communication, coordination and collaboration between the facility and the dialysis staff. The communication process and responses will be documented in the medical record. <Resident 9> Review of the resident's medical record showed they were readmitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD-the kidneys no longer work) with dialysis and diabetes (a disease which decreases the bodies ability to breakdown blood sugar). Record review of Resident 9's physicians orders dated August 2024, showed the resident received dialysis three times weekly at an offsite dialysis center. Review of the facility's pre/post dialysis communication forms for July and August 2024 showed the resident had five incomplete dialysis communication forms dated, 07/06/2024, 07/11/2024, 07/27/2024, 08/06/2024, and 08/13/2024. The forms showed no documentation about the resident's condition while at the dialysis center or their weight after treatment. During an interview on 08/22/2024 at 12:18 PM, Staff T, Licensed Practical Nurse (LPN), stated the pre/post dialysis communication form was started at the facility with the pre-dialysis assessment and sent to the dialysis center with the resident. When the resident returned, if the form was not completed by the dialysis center, the nurses call the center for any orders and the residents weight, which is documented in the resident's record. Record review of the Resident 9's progress notes from 07/01/2024 to 08/23/2024, showed that no documented attempts had been made by the nurses to contact the dialysis center and obtain the missing information related to the treatment the resident had received at the dialysis center. <Resident 44> Review of Resident 44's medical record showed they were admitted to the facility on [DATE] with diagnoses including ESRD with dialysis and congestive heart failure (a condition in which the heart cannot keep up with the demands of the body). Review of the most recent comprehensive assessment, dated 08/05/2024, showed the resident had mild cognitive impairment. (continued on next page)

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	505080	A. Building B. Wing	08/26/2024

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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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 44's physician orders for August 2024, showed the resident received dialysis from an offsite center three times a week until 08/16/2024 when the resident's dialysis treatments were discontinued. Resident 44 transitioned to end of life care (care is focused on providing comfort during the end stages of life). Review of the pre/post dialysis communication forms dated 07/01/2024 to 08/14/2024, showed the resident had an incomplete dialysis communication form on 08/10/2024. Review of the resident's PN showed no documentation of contact with the dialysis center to obtain the missing information from the 08/10/2024 treatment while at the center. Additionally, two forms dated 07/17/2024 and 07/22/2024 were sent with the resident to the dialysis center without the facility completing a pre-assessment to communicate the resident's condition prior to their dialysis treatment. During an interview on 08/24/2024 at 10:28 AM, Staff O, LPN, stated the process for the dialysis pre/post communication form was to complete an assessment at the facility to communicate the resident's condition and send it with them. If the form comes back from dialysis blank, then we call them and document the information in their chart. During an interview on 08/24/2024 at 3:10 PM, Staff B, Director of Nursing, stated their expectation was that the pre/post dialysis communication form should be started at the facility by the nursing staff and sent with the resident to the dialysis center. Staff B further stated if the form was returned and incomplete, their expectation was that the unit nurse contacted the dialysis center, obtain the information, and document it in the resident's record to ensure continuity of care. Reference: WAC 388-97-1900(1)(6)(a-c)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 48368 The facility failed to coordinate a referral for denture services for 1 of 1 resident (Resident 33), reviewed for dental services. This failure placed the resident at risk for altered self-image and weight loss. Findings included . <Resident 33> Review of the medical record showed Resident 33 was admitted to the facility with diagnoses including a stroke (loss of blood flow to part of the brain, which damages brain tissue), malnutrition (lack of sufficient nutrients in the body), and depression. The 07/19/2024 comprehensive assessment showed Resident 33 required setup/cleanup assistance of one staff member for oral care and had an intact cognition. Record review of the care plan dated 10/21/2022, showed Resident 33 was edentulous (lacking teeth), with interventions that included coordinating arrangements for dental care, transportation as needed/as ordered. During an interview on 08/21/2024 at 11:36 AM, Resident 33 stated they wanted dentures and had not seen a dentist since their admission to the facility. Resident 33 stated it kind of bums you out when you don't have teeth. During a follow-up interview on 08/22/2024 at 1:23 PM, Resident 33 stated they had told the staff they would like teeth, having teeth would make it easier to eat. During an interview on 08/22/2024 at 1:35 PM, Staff Q, Social Services Assistant, stated Resident 33 had been seen on 04/04/2024 by the dentist and had received a referral to a denturist. Staff Q stated they had not scheduled that referral appointment. Staff Q further stated the process for appointment referrals was to complete the scheduling within one month of receiving the referral. During an interview on 08/24/2024 at 1:18 PM, Staff A, Administrator, stated they expected a dental referral to be completed sooner than four months. Reference: WAC 388-97-1060(3)(vii)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 45117 Based on observation, interview, and record review, the facility failed to maintain essential equipment in working condition, including 1 of 1 washing machine (Washer 2) and 1 of 1 kitchen exhaust fan (janitor closet fan), reviewed for functional essential equipment. The failure to ensure Washer 2 was in working condition placed the residents at risk for ineffective cleaning of laundry, lack of clean laundry, and cross contamination of infectious disease. Additionally, the failure to ensure the janitor closet fan was in working condition placed residents and staff at risk for inhalation of chemical fumes that could cause illness or breathing issues. Findings included . <Washer 2> A concurrent observation and interview on 08/25/2024 at 9:59 AM, showed Staff D, Laundry Assistant in the soiled laundry area in the laundry room. There were two yellow bins of laundry that were filled to the top. Staff D stated the laundry was soiled resident laundry. The observation and interview continued to the main washing area. There were three large commercial size washing machines. There was a piece of yellow paper taped to the center washing machine (Washer 2) that showed it was out of service. Staff D stated Washer 2 had been broken for maybe a month. They stated it would not drain the water and if they used it, they would have to repeat the rinse and spin cycle several times before it would drain. Staff D stated they had reported the broken washing machine to Staff C, Maintenance Director, about a month ago but had not heard back. Staff D stated they had the two other machines to wash clothes and linens but had to run all day to get the laundry done. During an interview on 08/25/2024 at 10:33 AM, Staff C stated Washer 2 had been out of service for about a month. They stated the part to repair Washer 2 was on order. During a follow-up interview, Staff C stated the part for Washer 2 had not been ordered, they were waiting for approval from administration to order the part. At 11:02 AM, Staff C stated they had called an outside vendor to make repairs to Washer 2 on 06/20/2024. They stated the outside vendor assessed the washer on 06/24/2024 and recommended replacement parts. Staff C stated the outside vendor came to the facility again on 08/06/2024 for a separate issue with a dryer, and Staff C had asked the outside vendor about the necessary repairs for Washer 2. Staff C stated the outside vendor failed to send the facility order for approval and that caused the delay in repairs. They stated their normal process for following up on repair concerns with outside vendors would have been to follow-up with the outside vendor within a week or two of their initial assessment of the repair needs. They stated they had not heard from the outside vendor from 06/24/2024 until they saw the outside vendor on 08/06/2024. Staff C stated they were unable to say why their process was not followed. They stated they had written the need for repairs on their calendar but did not follow up on it. During an interview on 08/26/2024 at 7:59 AM, Staff E, Nursing Assistant, stated the residents were always short on clothing; yesterday a resident didn't have pants, not because they don't have enough clothing, but because the washer was broken. Staff E stated they were always short of towels and linens. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review showed the facility had received a quote for repair parts for Washer 2 dated 08/09/2024, with a shipping date to be determined and noted sign and email or fax back with your approval signature and parts will be ordered. During an interview on 08/25/2024 at 12:50 PM, Staff A, Administrator, stated they had received the quote about a week ago. They stated they had put the request for parts purchase into the system for corporate approval, as it was considered a capital expense. Staff A stated the process for repairs included Staff C calling an outside vendor for repairs, obtain a quote for the repairs, and present the quote to Staff A in a timely manner so the quote could be presented to corporate for approval. 31168 <Kitchen> During an observation and concurrent interview on 08/21/2024 at 8:25 AM, Staff F, Food Service Director, showed the janitor's closet located in the kitchen, which had stored chemicals for disinfection and cleaning, mops and a mop bucket. During the inspection of the janitor's closet there was an odor of chemical fumes. When the testing for the exhaust vent for the janitor's closet was done (used a paper towel to see if the exhaust vent had suction/venting to remove chemical vapors) there was no suction and the motor was not working. Staff F stated they were unaware of the exhaust fan not working and was unaware when it stopped working. Staff F stated that the kitchen staff were not responsible for periodic inspection of the kitchen's janitor's closet functioning exhaust fan. Staff F stated if they were aware of the non-functioning fan they would report it to the maintenance department. During an interview on 08/21/2024 at 12:51 PM, Staff C, Maintenance Director, stated that they did not know the motor was out in the kitchen's janitor's closet and there was no exhaust venting in the closet. Additionally, they did not regularly inspect the exhaust fan in the kitchen's janitor's closet to ensure the exhaust fan was functioning. During an interview on 08/25/2024 at 2:00 PM, Staff A, Administrator stated that not having a functional exhaust fan could cause fumes from the cleaning and disinfecting chemicals stored in the kitchen's janitor closet. Additionally, Staff A stated that a non-functioning exhaust fan could potentially cause problems with inhalation of chemical fumes due to build up of potential gases; it could cause illness or breathing issues. Reference: WAC 38-97-2100(1)