STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505188	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Federal Way	1045 South 308th Street Federal Way, WA 98003

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 29644 Based on observation, interviews and record review, the facility failed to protect 1 of 6 (Resident 2) sample residents' right to be free from physical abuse. The facility failed to protect Resident 2 from physical abuse when Resident 1 punched Resident 2 twice on the shoulder. The facility failed to supervise Resident 1, who had a history of verbal and physical aggressive behaviors towards residents, and failed to mitigate known triggers for Resident 1. Resident 2 experienced psychological harm, using the reasonable person concept, as a result of the physical abuse as there is an expectation that the resident would not be punched while in the facility. Theses failures placed all residents at risk for the potential of abuse, psychological harm, and diminished quality of life. Findings included . Review of the 02/02/2024 Quarterly Minimum Data Set (MDS - an assessment tool) for Resident 1 showed the resident had diagnoses to include dementia and psychotic disorder. Resident 1 was assessed as alert and oriented. Review of a 02/12/2022 Behavior Care Plan showed the goal that Resident 1 would not experience behaviors that were harmful to self and others. Interventions included directions to staff to anticipate and meet the resident's needs, assist the resident to develop more appropriate methods of coping and interacting, encourage the resident to express feelings appropriately and to intervene as necessary to protect the rights and safety of others. Review of a 03/13/2024 facility Investigative Report showed on 03/08/2024 Staff D (Social Services Director) heard yelling from their office. When Staff D stepped out of the office, they observed Resident 1 hitting Resident 2 on the shoulder. After the resident's were separated, Resident 1 was interviewed and stated they were irritated with Resident 2 because Resident 2 was too noisy and woke them up early in the morning. The 03/13/2024 investigative document showed Resident 2 was known to call out frequently and was often very vocal. Review of the 03/13/2024 facility documented conclusion showed the root cause of the incident was determined to be reasonably related to Resident 2's behaviors and Resident 1 being emotionally affected by those behaviors. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a 03/08/2024 4:38 PM Event Note, showed Resident 2 was highly confused, could be disruptive to others, and Resident 2's mood frequently changed. Staff received a report that Resident 2 was hit on the shoulder. During an interview on 04/03/2024 at 12:04 PM, Staff F (Registered Nurse, Resident Care Manager), stated that Resident 2 was confused, repeated things over and over again, and would not recall the incident if asked. During an interview on 04/03/2024 at 12:33 PM, Staff E (Social Services Assistant) stated that Resident 2 repeated the same words, sentences over and over again. Resident 1 did not like hearing the repetitive words and patted Resident 2 on the shoulder. During an interview on 04/03/2024 at 12:39 PM, Staff D (Social Services Director) stated that they saw Resident 2 in the middle of the hallway facing the wall and Resident 1 standing over and behind Resident 2. Resident 1 extended their arm up, fists clenched and punched Resident 2 twice. Staff D stated that Resident 1 did not like noises. Staff D stated at the time of the abuse, Resident 2 looked fearful. Staff D stated that when Resident 2 saw a taller nursing assistant standing over them, Resident 2 asked, Hey, are you the aid that hit me? Resident 1 was observed on 04/03/2024 at 11:22 AM to open their bedroom door, walk out independently with a walker and sit in a chair outside their doorway in the hallway. In an interview at that time, Resident 1 denied any problems with any other residents. Resident 2 was observed on 04/03/2024 at 12:09 PM in the dining room. Resident 2 was talkative and interacted with the investigator but was unable to answer specific questions. Review of the facility investigation showed during Resident interviews conducted by Staff D on 03/08/2024, Residents were asked if they felt safe around Resident 1 and three of four unnamed residents responded no. During an interview on 04/03/2024 at 2:44 PM, Staff D stated two of the resident's interviewed did not feel safe when Resident 1 yelled. When Resident 1 got upset they had a loud deep voice. When asked what the facility was doing to ensure Residents felt safe in the facility, Staff D stated they were working on moving Resident 1 out of the facility. During an interview on 04/03/2024 at 2:27 PM, Staff C (Administrator in Training) stated that Resident 2 could be very talkative, based on what others said, Resident 1 liked things quiet and if there's any disruption Resident 1 got upset. When asked since these were known behaviors, what were the preventative expectations of staff, Staff C stated they were working on a discharge plan for Resident 1. Interviews and record reviews showed no interim plan to protect residents from abuse while working on Resident 1's discharge from the facility. REFER TO WAC 388-97-0640(1)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 29644 Based on interview and record review the facility failed to ensure one of four abuse allegations reviewed were identified as such and reported to the State Survey Agency as required. The facility failed to report an allegation of abuse by Resident 4 towards Resident 3. Failure of the facility to report allegations of abuse placed residents at risk for additional abuse. Findings included . Review of the facility Abuse - Reporting and Response policy, revised 10/13/2023 showed the facility would report alleged violations related to abuse and report the results of all investigations to the proper authories within prescribed timeframes. The facility would ensure that all alleged violations involving abuse, and/or neglect were reported immediately, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury to the facility administrator and other officials, including to the State Survey Agency in accordance with state law through established procedures. During an interview on 04/03/2024 at 11:42 AM Resident 3 stated the other night they were lying in bed and Resident 4 threw a plate and it hit me in the eye. Resident 3 stated they were hit on the toe the same time they were hit on the eye. Review of Resident 3's record showed a Care Management note dated 03/20/2024 at 1:39 PM which showed Resident 3 alleged their roommate (Resident 4) threw a tray on them. Resident 3 stated when they grabbed their walker, Resident 4 pushed the tray which fell on Resident 3's big toe. Resident 4 denied the allegation. The Certified Nursing Assistant stead they saw Resident 3 in Resident 4's space and the television remote was on the floor, but they did not know about the tray. Review of a 03/20/2024 3:24 PM Behavior Note showed Resident 3 was upset because her roommate threw things at her. Review of the March 2024 Reporting Log showed no Resident to Resident altercation entered for Resident 3 or Resident 4. During an interview on 04/03/2024 at 2:50 PM, Staff B (Director of Nursing) stated, The incident did not occur. During an interview on 04/03/2024 at 3:07 PM Staff A (Administrator) stated the allegation should have been on the log. REFER TO WAC 388-97-0640(2)(b)(5)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 29644 Based on interview and record review the facility failed to ensure allegations of abuse were thoroughly investigated for two of four abuse allegations reviewed. The facility failed to investigate an allegation of abuse by Resident 4 towards Resident 3, failed to conduct a thorough investigation of abuse of Resident 2 by Resident 1 and failed to identify or implement preventative measures. Failure of the facility placed residents at risk of continued abuse and a diminished quality of life. Findings included . <Residents 3 & 4> During an interview on 04/03/2024 at 11:42 AM Resident 3 stated the other night they were lying in bed and Resident 4 threw a plate and it hit them in the eye. Resident 3 stated they were hit on the toe the same time they were hit on the eye. Resident 3 stated if Resident 4 wanted something and did not get it they threw stuff, which hit them. Resident 3 stated one night Resident 4 threw a whole tray with food, silverware, etc. Resident 3 stated they try to get out of the way, they usually just get up and leave the room. Resident 3 stated they were afraid to close their eyes. When asked what staff do in response, Resident 3 stated when Resident 4 screams and throw things the staff go in the room and attend to Resident 4, some come and act like its funny. Resident 3 stated, I guess it's ok for her to throw things at me, and They're not doing anything to protect me. Resident 4 was observed in bed on 04/03/2024 at 11:52 AM. Resident 4 was heard calling out, Please, Please . When asked what they needed, Resident 4 stated, I don't know .please, please. In an interview at that time, Resident 4 denied throwing things when they became upset. Review of Resident 3's record showed a Care Management note dated 03/20/2024 at 1:39 PM which showed Resident 3 alleged their roommate (Resident 4) threw a tray on them. Resident 3 stated when they grabbed their walker, Resident 4 pushed the tray which fell on Resident 3's big toe. Resident 4 denied the allegation. The Certified Nursing Assistant said they saw Resident 3 in Resident 4's space and the television remote was on the floor, but they did not know about the tray. Review of a 03/20/2024 3:24 PM Behavior Note showed Resident 3 was upset because their roommate threw things at them. Review of Resident 4's record showed a Behavior Note dated 03/20/2024 at 3:29 PM which showed Resident 4 denied their roommate's allegation. Resident with history of behaviors and not getting along with other roommates. Further review of Resident 4's record showed an 11/30/2023 Behavioral Health Note that Resident 4 had a diagnosis that meant they experienced word retrieval difficulty which caused them a lot of frustration. Resident was exhibiting some behaviors like getting easily agitated and recently threw a shoe at one of the staff members. Resident 4 was not able to keep a roommate because of their behavior. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/03/2024 at 11:56 AM, Staff F (Registered Nurse, Resident Care Manager) stated Resident 4 had issues in the past with previous roommates and wanted to be in a private room. Staff F stated Resident 4 threw things at people in the past. Staff F stated Resident 4 had a recent decline in condition and was not currently able to be interviewed regarding specific instances. Staff F stated they did not hear of any issues in the last couple of weeks when the roommates were arguing over Resident 4's space. Staff F stated they were not familiar with the alleged incident, and after reading the 03/20/2024 notes in the Residents' records, Staff F stated they would expect to find an incident report and facility investigation, but one was not completed. During an interview on 04/03/2024 at 12:22 PM Staff E (Social Services Assistant) stated that Resident 3 complained their roommate, Resident 4, allegedly threw a tray and it hit Resident 3's toe. Staff E stated they had the nurse check on the toe but there was no injury to the Resident's toe. Staff E stated Resident 3's story changed to the tray hit their head. Staff E stated they were not sure if Resident 4 threw a tray, it landed on the floor, or what happened, but there was no injury. Staff E stated that according to a nursing assistant, Resident 3 was in Resident 4's personal space. Staff E stated Resident 4 denied throwing anything. Staff E stated Resident 4 did not have a history of physical or verbal behaviors towards others. Staff E stated they did not initiate an incident report, but did report the incident to individuals who should have. During an interview on 04/03/2024 at 2:50 PM, Staff B (Director of Nursing) stated that Staff E notified them and together with Staff C (Administrator in Training) they went down to the residents' room. The meal tray was in front of Resident 4 and a nursing assistant picked up trays, so there were not any trays out of place. Staff B stated the Residents had a disagreement, Resident 4 was fussing at Resident 3 because they don't want a roommate. Resident 3 was at the privacy curtain separating the beds when an aid went into the room. Staff B stated Resident 4 could not have hit Resident 3's foot because Resident 3 was seen walking down the hall fine and went back into the room to see why they were going in. When asked why an incident report and investigation was not conducted, Staff B stated, The incident did not occur. During an interview on 04/03/2024 at 3:00 PM Staff C stated Resident 4 had the plate, meal tray and the privacy curtain was drawn. Staff C stated both residents denied the incident occurred. During an interview on 04/03/2024 at 3:07 PM Staff A (Administrator) stated the facility should have completed an incident report and investigation. <Residents 1 & 2> Review of a 03/13/2024 facility Investigative Report showed on 03/08/2024 Staff D (Social Services Director) heard yelling from their office. When Staff D stepped out of the office, they observed Resident 1 hitting Resident 2 on the shoulder. After the resident's were separated, Resident 1 was interviewed and stated they were irritated with Resident 2 because Resident 2 was too noisy and woke them up early in the morning. Review of the facility investigation showed during Resident interviews conducted by Staff D on 03/08/2024, Residents were asked if they felt safe around Resident 1 and three of four unnamed residents responded no. Two of the three with negative responses had when he yells documented next to the Resident's room numbers. There was no documention to show additional investigative actions were taken in response. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 03/13/2024 facility Investigative Report showed no interviews were conducted with the staff on duty to determine the events leading up to the 03/08/2024 abuse incident, or if there were any other witnesses. During an interview on 04/03/2024 at 2:27 PM, Staff B did not know if Resident 2 exhibited early morning behaviors. Staff B stated that the nurse on duty at the time said they did not hear anything, only that Staff D came yelling at them. When asked, Staff B did not know which staff were on duty at the time of the abuse incident. During an interview on 04/03/2024 at 2:27 PM, Staff C stated Resident 1 was in their room, Resident 2 was in the hallway, the nurses were at the nurses' station, and the nurses did not see the incident. Staff C stated they needed to obtain more interviews from staff. Refer to F600 - Free from Abuse and Neglect. Refer to F609- Reporting of Alleged Violations. REFER TO WAC 388-97-0640(6)(a)