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	09/03/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on interview and record review, the facility failed to provide resident focused care through consistent monitoring, assessment, evaluation of the resident's condition, and to implement physician orders timely to identify a change in condition for a suspected urinary tract infection (UTI) for 1 of 5 residents (Resident 1) reviewed for quality of care. Resident 1 experienced harmed when they were hospitalized in the intensive care unit for a bladder and kidney infection which accelerated into a systemic blood infection. This failed practice placed other residents at risk for unmet needs, hospitalization , and diminished quality of life. Findings included . The 06/21/2024 Admission Minimum Data Set (MDS, an assessment tool) showed Resident 1 admitted to the facility on [DATE] with a spinal fracture. Resident 1 was assessed as always incontinent of urine and required incontinence care from staff. Resident 1 was assessed to have cognitive impairment and refused care one to three days during the assessment period. The 06/27/2024 Care Plan (CP) showed Resident 1 required moderate assistance from staff to use the toilet, had impaired cognitive ability, impaired thought processes, short term memory loss, and communication deficits. The CP showed Resident 1 needed cueing, reorientation and supervision for all personal care. Review of a 07/09/2024 handwritten note from Resident 1's Representative (RR) showed a request to the facility to check Resident 1 for a urinary tract infection (UTI). Attached to the handwritten note was a communication document from nursing to the practitioner, dated 07/09/2024, which showed a request for a lab test to check Resident 1's urine for a UTI related to inappropriate behaviors. A 07/09/2024 11:07 PM nursing progress notes (PN) showed the practitioner ordered the urine lab test. The PN showed staff placed a urine collection device in Resident 1's toilet. (The MDS showed Resident 1 was assessed as always incontinent.) (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the nursing PN from 07/09/2024 to 07/15/2024 showed Resident 1 had multiple refusals of care, refusals of medications, refusing therapy, grabbing and hitting at staff, using in appropriate sexual language toward staff, hallucinating and having delusional thoughts about going to work, was a high fall risk and was standing without assistance, wandering in the halls, and sleeping in the wheelchair refusing to lie down in bed. The PNs showed Resident 1 required staff to anticipate their needs, one person to assist with personal care, and two staff to assist with transfers in/out of bed and on/off the toilet. The PNs showed Resident 1 was incontinent of bladder and bowels and used an incontinent pad. The practitioner was informed of behaviors but no new interventions were implemented. An attempt of collecting a urine sample was done on 07/11/2024 and was not successful. No other attempts to collect a urine sample were documented. A 07/15/2024 6:55 AM nursing PN showed Resident 1 was incoherent, would not drink fluids, had a change of skin color to slightly blue color, and had a change in level of consciousness. No vital signs were recorded. The staff called 911 for transport to the hospital. After Resident 1 was discharged on [DATE] (Monday) a communication document from nursing to the practitioner was scanned into Resident 1's medical record. The document was completed on 07/12/2024 (Friday) by a nurse, informing the practitioner that staff was unable to collect a urine sample due to Resident 1's refusals and incontinence. The practitioner did not review the document until 07/15/2024 (Monday, six days after the order was given to collect a urine sample and send to the lab) when it was signed, dated and the practitioner wrote Resident 1 was in ED (Emergency Department). The 07/15/2024 hospital history and physical notes showed Resident 1 was admitted to the hospital with a high temperature of 103.1 degrees Fahrenheit (F), low blood pressure 85/63, high heart rate 113, high respirations 26. (Normal range for temperature is 98.6 F, normal blood pressure is 120/70, normal heart rate is 70, normal respirations are 16-18.) Resident 1 was admitted to the intensive care unit (ICU) for severe sepsis (systemic blood infection), cystitis (bladder infection), kidney infection, and acute kidney injury. Resident 1 required intravenous antibiotics, fluids, and was not able to eat or drink given a poor mental state. In an interview on 08/06/2024 at 12:52 PM, Resident 1's RR stated they asked the nurse on 07/09/2024 if a urine test could be completed to see if Resident 1's behaviors were related to a UTI. The RR stated they were informed on 07/10/2024 that an order was received to send a urine sample to the lab. The RR stated they did not hear anything from the nurses until 07/14/2024 when they asked for an update about what the lab test showed. The RR stated the nurse said a urine sample was not collected because Resident 1 could not urinate in the collection device. The RR stated they were going to help get the urine sample, but they were not strong enough to lift Resident 1. The RR stated early the next morning they received a call from the nurse stating Resident 1 had erratic breathing and was being sent to the hospital. The RR stated at the hospital Resident 1 had a very low blood pressure and a kidney infection that turned to sepsis from the UTI. The RR stated the facility never checked the urine for an infection, Resident 1 never got antibiotics or treatment for an infection so Resident 1 ended up in the ICU. An interview on 08/12/2024 at 4:39 PM, Staff B (Director of Nursing) stated staff should monitor a resident for urinary signs and symptoms when a UTI was suspected. Staff B stated when a practitioner orders a urine sample the nurse should collect the urine and send to the lab within two days. Staff B stated when a resident refuses, or the sample was not collected, the nurse should document, report to the practitioner, and obtain further instructions. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 08/12/2024 at 4:46 PM, Staff A (Administrator) and Staff B reviewed Resident 1's medical record and were not able to locate documentation: that nursing staff monitored Resident 1 for a suspected UTI, attempted to collect any urine samples after 07/11/2024, notified the RR, asked the RR for assistance with sample collection, or notified the practitioner when urine was not collected after two days. Staff B stated there was only one attempt to collect urine on 07/11/2024, no other attempts were made. Staff A stated the order for the urine sample collection dropped out of the electronic medical record on 07/12/2024. Staff A explained when an order drops out of the system the staff is no longer prompted to collect a urine sample. Staff B confirmed Resident 1 went to the hospital for a change in their level of consciousness and decline in medical condition. REFERENCE: WAC 388-97-1060(1).