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	11/07/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 46471 Based on observation, interview, and record review, the facility failed to ensure incident reports were completely and thoroughly investigated for 2 of 3 residents (Residents 4 & 7) whose facility investigation reports were reviewed for injuries of unknown origin. The failure to initiate, conduct a thorough investigation, and correct alleged violations left residents at risk for unidentified abuse and/or neglect, repeated incidents, and a decreased quality of life. Findings included . <Facility Policy> Review of the Abuse - Conducting an Investigation facility policy, revised 06/17/2024, showed allegations of abuse, including injuries of unknown source, were promptly and thoroughly investigated so the facility could take appropriate corrective action as a result of the investigation findings. The policy showed the facility must have evidence to support that all alleged violations were thoroughly investigated within five working days of the incident occurring. The policy showed the written summary of the investigation should include a review of all circumstances surrounding the incident. <Resident 4> According to the 08/23/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 4 had clear speech, could respond adequately to simple, direct communication only, and had difficulty communicating some words or finishing their thoughts. The MDS showed Resident 4 had medical conditions including Alzheimer's dementia (progressive memory deficit), heart, kidney, and respiratory failure, and malnutrition. The MDS showed Resident 4 had serious mental illness including anxiety and depression, and exhibited negative behaviors during the assessment period that placed Resident 4 at significant risk for physical injury. The revised 06/06/2024 mood and behavior Care Plan (CP) showed Resident 4 had episodes of hallucinations (perception of something not present) and delusions (fixed false beliefs) because of their dementia with behaviors. The 04/24/2024 CP intervention instructed staff to explain procedures, give Resident 4 time to process, and to leave the room and re-approach when Resident 4 was combative during cares. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 11/07/2024 at 2:06 PM, Resident 4 was observed lying in bed; a long and faded, yellowish bruise was observed on the left side of their face close to their eye. Resident 4 stated the bruise did not hurt and they could not recall how they sustained it. A 10/24/2024 event progress noted showed the nursing staff discovered a 6 centimeters (cm) x 6 cm bruise on Resident 4's left upper face during care. The note showed notifications were done, Resident 4 was placed on alert monitoring, and mobility side rails were removed. Review of the October 2024 facility incident report log showed the documentation of facility incident events were incompletely recorded from 10/21/2024 until 10/31/2024. Review of the facility provided event investigation folder for Resident 4 showed a 10/28/2024 state event reporting print out regarding the resident's facial bruise of unknown origin. The folder contained several other paperwork for different facility residents. The facility was not able to provide any documentation to support Resident 4's facial bruise of unknown origin was investigated to rule out abuse and/or neglect. In a phone interview on 11/07/2024 at 3:14 PM, Staff A (Regional Director of Clinical Services) stated the Director of Nursing (DON) was responsible for keeping the facility incident report log complete and accurate. Staff A stated they presented all of the facility incident report investigations they have. In a joint interview with Staff B (Interim DON) and Staff C (Assistant DON) on 11/07/2024 at 3:44 PM, Staff B stated it was important to conduct a complete and thorough event investigation to ensure the facility identify and/or rule out resident abuse/neglect. Staff C stated a complete and accurate investigation report would help the facility in putting safety interventions in place right away to prevent reoccurrence. Staff B reviewed the facility incident report log and stated it was not completely and accurately filled out. Staff B stated Resident 4's facial bruise was reported late to the State Agency, .it [facial bruise] should have been reported when it was discovered on 10/24/2024 and not 4 days later. Staff B stated Resident 4's facial bruise should have, but was not investigated as required. <Resident 7> According to the 08/14/2024 Significant Change MDS, Resident 7 had clear speech, memory impairment, disorganized thinking, and worsening behavioral symptoms including rejection of care. The MDS showed Resident 7 had medical conditions including heart disease, dementia, and anxiety. The MDS showed Resident 7 was administered an antiplatelet (a blood thinning medication) during the assessment period. Review of the 10/30/2024 facility provided investigation report showed the nursing staff discovered a 1.5 cm x 0.5 cm bruise on Resident 7's left eye during morning medication pass. The report showed Resident 7 did not know how they sustained the bruise. The report showed the staff conducting the investigation concluded it was reasonably related to Resident 7's confusion and combativeness with cares, coupled with the resident's antiplatelet use and frail skin. The report showed the facility was unable to substantiate any abuse or neglect based on the completion of the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/07/2024 at 3:44 PM, Staff B reviewed Resident 7's incident report and stated the investigation was lacking vital and necessary information surrounding the incident in order for the facility to rule out resident abuse and/or neglect. Staff B stated the facility report should have identified safety interventions to put in place in Resident 7's CP to prevent reoccurrence as part of the investigation summary, but did not. REFERENCE: WAC 399-97-0640(6)(a)(b).