

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Federal Way		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>44296</p> <p>Based on interview and record review, the facility failed to provide a written explanation to residents and/or their representative for a facility initiated room change for 4 of 7 residents (Residents 14, 13, 12, & 11) reviewed for room moves. The failure to discuss reasons for a room move, provide written notification, provide an opportunity for the resident to see the new location and meet the new roommate, or inform roommates of a new person moving into the room placed residents at risk for feeling frustrated, powerless, and a diminished quality of life.</p> <p>Findings included .</p> <p><Policy></p> <p>Review of the facility policy Resident Room Relocation revised 09/05/2024 showed when a resident was moved at the request of the facility, the resident and/or their representative would receive an explanation in writing of why the move was required. The policy showed the resident should be provided the opportunity to see the new location, meet the new roommate and ask questions about the move. The policy showed a resident receiving a new roommate should be given as much advanced notice as possible</p> <p><Resident 14></p> <p>Review of the 10/21/2024 Admission Minimum Data Set (MDS, an assessment tool) showed Resident 14 was cognitively intact and required therapy services at the facility.</p> <p>Review of Resident 14's medical record showed a room change occurred on 11/20/2024 from the 300 hall private room to the 200 hall shared room.</p> <p>Review of the 11/2024 progress notes showed no documentation of a discussion with Resident 14 about the need to move or a reason for moving to another room.</p> <p>Review of Resident 14's scanned records showed no written explanation staff notified Resident 14 why the room move was required.</p> <p>(continued on next page)</p>

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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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the 11/21/2024 nurse progress notes showed Resident 14 was on monitoring for a room change and on 1:1 supervision all night shift for verbalizing suicidal ideations. The note showed Resident 14 stated I was annoyed because no one was explaining to me why I was leaving my room, I am human and explaining ahead of time is very important not being tossed. The progress nurse showed Resident 14 discharged themself from the facility against medical advice on the same day.</p> <p><Resident 13></p> <p>Review of the 10/07/2024 Admission MDS showed Resident 13 was cognitively intact and required therapy services at the facility.</p> <p>Review of Resident 13's medical record showed a room change occurred on 12/20/2024.</p> <p>Review of the 12/2024 progress notes showed no documentation staff discussed a room move with Resident 13.</p> <p>Review of Resident 13's scanned records showed no written explanation to that Resident 13 was notified about the reason the room move was required.</p> <p>In an interview on 12/31/2024 at 10:15 AM, Resident 13 stated they were not given advanced notice when they had to move rooms because their insurance changed. Resident 13 stated they were in a private room and were told they had to move to a room with two other people without any advanced notice. Resident 13 stated staff just came in and moved their belongings and took them to the new room. Resident 13 stated they did not receive a written notice of why the room change was required.</p> <p>In an interview on 12/31/2024 at 10:28 AM, Resident 13's roommate was Resident 4. Resident 4 stated no one talked to them or the other roommate before Resident 13 moved into the room. Resident 4 stated they did not even get to meet the new person; the staff just moved them in and left.</p> <p><Resident 11></p> <p>Review of the 10/27/2024 admission MDS showed Resident 11 was cognitively intact and required therapy services at the facility.</p> <p>Review of Resident 11's medical record showed a room change occurred on 11/20/2024.</p> <p>Review of the 11/2024 progress notes showed no documentation staff discussed a room move with Resident 11.</p> <p>Review of Resident 11's scanned records showed no written explanation staff notified Resident 11 or their representative why the room move was required.</p> <p>In an interview on 12/31/2024 at 9:47 AM, Resident 11 stated they did not want to change rooms but they were not given a choice. Resident 11 stated they were not given notice and were just told they needed to move because the hall they were in was for sicker people. Resident 11 stated they did not receive a written notice of why the room change was required.</p> <p><Resident 12></p> <p>(continued on next page)</p>

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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the 11/08/2024 admission MDS showed Resident 12 was cognitively intact and required therapy services at the facility.</p> <p>Review of Resident 12's medical record showed a room change occurred on 12/17/2024.</p> <p>Review of the 12/2024 progress notes showed no documentation staff discussed a room move with Resident 12.</p> <p>Review of Resident 12's scanned records showed no written explanation staff notified Resident 12 why the move was required.</p> <p>In an interview on 12/31/2024 at 10:02 AM, Resident 12 stated they were moved from the 300 hall private room to the current shared room in the 200 hall. Resident 12 stated they were not given a choice to move or given any notice to move. Resident 12 stated the staff just moved me. Resident 12 stated they did not receive any written notice of why the room change was required.</p> <p>In an interview on 12/31/2024 at 10:35 AM, Staff L (Social Services Director) stated the facility completed a Room Change Notification form when moving a resident from one room to another room. The form showed the reason for the move, notification of resident, representative and roommates. Staff L stated residents were given three days of notice before moving, a copy of the form was provided to the resident, and another copy was scanned into the resident's record.</p> <p>In an interview on 12/31/2024 at 10:50 AM, Staff M (Medical Records Coordinator) stated all documents should be scanned into the resident's record. Staff M was asked to provide the Room Change Notification form for Resident's 14, 13, 12 and 11. Staff M looked for the requested information and stated the forms could not be located.</p> <p>In an interview on 12/31/2024 at 10:55 AM, Staff K (Regional Director of Clinical Services) stated there were no Room Change Notification forms for Residents 14, 13, 12 and 11. Staff K stated the staff did not know the requirements for moving residents to different rooms and did not follow the facility policy.</p> <p>REFERENCE: WAC 388-97-0580.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>44296</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement a system to assess resident's need for the use of an air mattress, determine required settings of the air mattress, recognize or assess risk factors of the use of an air mattress, inform and educate residents or their representatives of the risks of using an air mattress including falls and/or injury, obtain informed consent from the resident or their representative for the use of an air mattress, implement a resident-directed care plan for the use of an air mattress, monitor the mattress function, condition, and individualized pump settings, re-evaluate the ongoing use of air mattresses for each resident to ensure necessity of use, and train staff to use the air mattress and assessed settings during care to ensure resident safety for 7 of 7 residents (Residents 1, 2, 3, 4, 5, 6, & 7) reviewed for accidents and hazards. This failure placed 11 current residents observed using air mattresses at risk of falls, injury, hospitalization, unable to make informed choices about their care, and unable to maintain their highest practicable physical, mental and psychosocial well-being.</p> <p>Findings included .</p> <p><Resident 1></p> <p>Review of the 11/05/2024 Quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 1 was on hospice services, was dependent on staff to move in bed, was always incontinent of bowels and bladder, had functional mobility limitations, poor range of motion in both of their arms, did not have any pressure ulcers, and had a pressure reducing device for their bed.</p> <p>Review of a 10/29/2024 Physician Order showed Resident 1 used a device called a LAL mattress (Low-Air-Loss mattress, an air filled mattress that had a pump on the end of the bed with varied settings how to move the air in the mattress for medical treatments). The order instructed nurses to monitor Resident 1's position in the bed and function of the mattress for safety every shift. There were no settings listed on the order for the nurse to monitor the type of therapy settings.</p> <p>Review of the 11/15/2024 comprehensive care plan (CP) with revisions showed Resident 1 was at risk for skin impairment and had a history of a pressure ulcer. The CP showed a discontinued intervention for a LAL pressure reducing mattress initiated on 07/03/2024 and discontinued on 10/21/2024. The CP was not updated to show the LAL mattress was restarted by the physician order written on 10/29/2024.</p> <p>Review of Resident 1's scanned records showed no documents that risks were reviewed or consent was given by Resident 1 or the RR to use an air mattress.</p> <p>Review of the 11/2024 Kardex (care instructions to the caregivers) showed Resident 1 required two person assistance with bed mobility and incontinence care. The Kardex did not show Resident 1 used a specialized air mattress.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a 11/22/2024 facility investigation showed Resident 1 had a fall out of bed during incontinence care and sustained a leg fracture and head injury. The investigation concluded the fall occurred because the caregiver did not follow Resident 1's CP and did not use two people to provide care in bed. The facility investigation did not identify that Resident 1 was lying on an air mattress at the time of the fall.</p> <p>In an interview on 12/19/2024 at 4:50 PM, Staff F (Registered Nursing Assistant) stated they worked with Resident 1 prior to their fall and Staff F was familiar with Resident 1's care needs. Staff F stated Resident 1 was supposed to have two people for care because Resident 1 had an air mattress.</p> <p>In an interview on 12/19/2024 at 4:52 PM, Staff G (Registered Nurse) stated the nurses monitor the mattress and caregivers do not touch the pump for the air mattress, if it alarms then they can tell the nurse. Staff G stated the caregivers are expected to know each resident's CP and follow the CP. Staff G stated Resident 1 was a two person assist for all care because they had an air mattress and that placed them at risk for falls out of bed.</p> <p>In an interview on 12/19/2024 at 5:14 PM, Staff B (Float Director of Nursing) reviewed Resident 1's MDS and stated Resident 1 required two person assistance for bed mobility and depended on staff for all care. Staff B reviewed Resident 1's CP and stated they did not see anything on the CP about an air mattress. Staff B was asked to provide a policy, procedure, protocol or process how the facility assessed, care planned, implemented monitoring for resident use of medical devices including an air mattress. Staff B stated they would need to check with someone from the corporation for the policy.</p> <p>In an interview on 12/19/2024 at 5:22 PM with Staff B, Staff C (Assistant Director of Nursing), and Staff E (Resident Care Manager), Staff E stated Resident 1 had an air mattress a long time ago but was not sure Resident 1 had an air mattress at the time of the fall. Staff E reviewed records on their laptop and stated Resident 1 did not have any pressure ulcers, did not have a consent form for an air mattress and it was not on the CP. Staff E stated without that information, Staff E did not think Resident 1 had an air mattress. Staff C reviewed records on their laptop and stated Resident 1 had an order for a LAL mattress dated 10/29/2024. Staff E verified in the records Resident 1 did not have a consent form. Staff C stated a consent form should have been completed for residents using an air mattress and one was not in the record for Resident 1.</p> <p>In an interview on 12/19/2024 at 5:41 PM, Staff H (Central Supply Coordinator) joined the conversation with Staff B, C, and E. Staff H stated Resident 1 used to have a LAL mattress provided by hospice on 07/12/2024. Staff H stated Resident 1 was changed to a new brand of air mattress on 10/18/2024. Staff H stated they personally coordinated maintenance staff, housekeeping staff, and caregivers to remove the LAL mattress and replace with the new air mattress. Staff H stated the facility was directed by the corporate entity that the new brand of air mattresses were the only air mattresses to be used in the facility. Staff H provided two manufacturer booklets for the new brand air mattresses. Staff H stated there was no training of staff how to use the new brand mattresses or the air pumps for the mattresses since the corporate entity directed the use of the new brand air mattress. Staff B, C, E and H stated they did not know who assessed the residents to use the new brand of air mattresses.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the undated owner's manual for the new brand of air mattress showed a description of the control pump functions. There was a button to choose the therapy mode: Float (air filled tubes with equal pressure) and Alternating (air filled tubes with air pressure increasing and decreasing in alternating tubes). There were two buttons to adjust the comfort level from level one, soft, to level five, firm. There was an audible alarm button to turn alarm sound off and on. There was an auto firm button that would provide uniform support and added firmness for transfer in/out of bed and providing care.</p> <p>In an interview on 12/19/2024 at 6:04 PM, Staff I (Certified Nursing Assistant) stated caregivers are not to touch the air mattress pump settings. Staff I stated they have not received any training to modify care provided to a resident on an air mattress or how to change settings on the air pump.</p> <p>In an interview on 12/19/2024 at 6:05 PM, Staff J (Certified Nursing Assistant) stated caregivers do not change the settings on the pump. Staff J stated they have not received any training to modify care provided to a resident on an air mattress or how to change settings on the air pump. Staff J stated if a resident was using an air mattress the staff are always to use two caregivers when care was provided.</p> <p>In an interview on 12/19/2024 at 6:20 PM, Staff D (Licensed Practical Nurse) stated they were the nurse in charge on the night Resident 1 fell. Staff D stated the caregiver was by themselves and rolled Resident 1 in bed to provide incontinence care and Resident 1 fell out of bed onto the floor. Staff D stated the caregiver did not follow the CP and did not have a second person to help with care. Staff D stated Resident 1 was using an air mattress at the time of the fall and should have two caregivers when a resident was using an air mattress. Staff D stated there were settings on the air pump that allowed the mattress to be firm during care. Staff D stated they worked for the facility for four years and in that time, there was no training provided to nursing staff to modify care to residents using an air mattress, assessment of air pump settings, or when to change pump settings.</p> <p>In an interview on 12/19/2024 at 6:34 PM, Staff B stated they checked with the corporate entity and there was no corporate policy or process for the use of an air mattress. Staff B stated the facility did not get consent from the resident or RR to use an air mattress because it was not a restraint. Staff B stated an air mattress was a specialty device. Staff B stated there should be a physician order and the use of the air mattress should be on the CP. Staff B stated there could be risks for using an air mattress and falling out of bed could be a risk. Staff B stated they did not know if the air pump settings should be adjusted when staff provided care to residents using an air mattress. Staff B reviewed the manuals for the brand mattress the facility used. Staff B stated they read in the manual that there was an auto firm feature on the pump that could be used for added stability of the mattress during care. Staff B stated they needed to call the vendor for more information and the staff needed additional training how to use the air mattresses.</p> <p><Resident 2></p> <p>In an interview on 12/31/2024 at 9:38 AM, Resident 2 was observed in bed, awake, and the room was dark. Resident 2 was lying on an air mattress that had an air pump on the foot board. The settings on the pump were set to comfort level three and therapy level was float. Resident 2 stated they did not know why they had an air mattress. Resident 2 stated they did not know there was a risk of falling out of bed and did not recall signing any consent form agreeing to the use of the air mattress.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the 11/08/2024 revised CP showed Resident 2 required one person substantial assistance for repositioning and turning in bed and two person assistance with pulling Resident 2 up in bed. The CP showed a 09/27/2024 intervention that Resident 2 should have a pressure reducing mattress. There was no information on the CP that Resident 2 used an air mattress.</p> <p>Review of the 12/2024 Kardex did not show Resident 2 used a specialized air mattress.</p> <p>Review of Resident 2's scanned records showed no signed forms that risks were reviewed or consent was given by Resident 2 or their RR to use an air mattress.</p> <p>Review of the 12/2024 physician orders showed no order for why Resident 2 had an air mattress or direction to nurse staff to monitor the functions of the air mattress.</p> <p><Resident 3></p> <p>In an interview and observation on 12/31/2024 at 10:12 AM, Resident 3 was sitting in bed with the head of bed elevated. Resident 3 had an extra wide bed, enabler bars, and an air mattress. The pump was set at comfort level 3 and therapy setting was alternating. Resident 3 stated they did not know why they had an air mattress or that there was a risk of falling off the air mattress.</p> <p>Review of the 12/17/2024 revised CP showed Resident 3 required two person assistance for bed mobility. The CP showed a 02/23/2024 intervention that Resident 3 should have a pressure reducing mattress. The CP showed a 01/24/2024 intervention that Resident 3 should have an extra wide bed with enabler bars to assist with bed mobility, positioning and promote safety and comfort. There was no information on the CP that Resident 3 used an air mattress.</p> <p>Review of the 12/2024 Kardex did not show Resident 3 used a specialized air mattress.</p> <p>Review of Resident 2's scanned records showed no documentation that risks were reviewed or consent was given by Resident 2 or their RR to use an air mattress.</p> <p>Review of the 12/2024 physician orders showed no order for why Resident 3 had an air mattress or direction to nurse staff to monitor the functions of the air mattress.</p> <p><Resident 4></p> <p>In an observation and interview on 12/31/2024 at 10:28 AM, Resident 4 was sitting in bed with the head of the bed elevated. Resident 4 was awake watching TV and lying on an air mattress. The pump was set at comfort level 5 and therapy setting was alternating. Resident 4 stated they had an air mattress because they were bed bound and could not move. Resident 4 said a couple times they were close to the edge of the bed and felt like they may fall off the bed. Resident 4 stated they were not informed of the risk of injury or falls using an air mattress.</p> <p>Review of the 12/11/2024 revised CP showed Resident 4 required two person assistance with bed mobility. The CP showed a 02/23/2024 intervention that Resident 4 should have a pressure reducing mattress. There was no information on the CP that Resident 4 used an air mattress.</p> <p>Review of the 12/2024 Kardex did not show Resident 4 used a specialized air mattress.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 12/31/2024 at 10:55 AM, Staff K (Regional Director of Clinical Services) stated the facility and corporate entity did not have a policy or procedure for the use of air mattresses. Staff K stated air mattresses should be assessed, have a documented reason for use, have interventions on the CP, risks and benefits reviewed with the resident or RR, obtain consent, staff should monitor the mattress function and the pump settings to document on the treatment record, and staff should be trained how to safely use an air mattress during resident care. Staff K stated the staff needed training how to use the air mattresses and pumps.</p> <p>Refer to F689 Free from Accident Hazards / Supervision / Devices</p> <p>REFERENCE: WAC 388-97-1060(1)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>44296</p> <p>Based on interview and record review the facility failed to ensure staff provided care according to the resident's care plan to prevent accidents for 1 of 3 residents (Resident 1) reviewed for falls. Resident 1 experienced harm when facility staff did not use two caregivers as planned when providing incontinence care, they rolled off an air mattress bed and sustained an inoperable leg fracture. Failure to follow resident's care plans placed all residents at risk for injury, falls, and diminished quality of life.</p> <p>Findings included</p> <p>Review of the 11/05/2024 Quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 1 was on hospice services, was dependent on staff to move in bed, was always incontinent of bowels and bladder, and had functional limitations and poor range of motion in both of their arms.</p> <p>Review of Resident 1's physician and nursing orders showed a 10/29/2024 order for a low-air-loss mattress (a mattress filled with air to reduce pressure on a person's skin) to promote Resident 1's skin integrity. The order directed staff to monitor Resident 1's position in bed and the function and safety of the air mattress.</p> <p>The comprehensive care plan (CP) revised on 11/15/2024 showed Resident 1 required two caregivers to assist with bed mobility. The CP showed Resident 1 wore incontinence briefs and required two caregivers to assist with incontinence care. The care plan did not show Resident 1 used an air mattress until the CP was revised on 12/02/2024.</p> <p>Review of the 11/15/2024 Kardex (care instructions to the caregivers) showed two caregivers were required for Resident 1's bed mobility and incontinence care. The Kardex showed no information that Resident 1 used an air mattress. The Kardex showed no instructions to the staff for Resident 1's safety while moving them on the air mattress.</p> <p>Review of a 11/22/2024 nurse progress note showed Resident 1 fell on the floor during care at 4:30 AM. The note showed Resident 1 was bleeding from the back of their head, had pain, and limited movement in their right knee. The note showed Resident 1 was sent to the emergency room for further assessment of injuries.</p> <p>Review of the 11/22/2024 facility investigation of Resident 1's fall showed the caregiver raised the bed to waist height and started to provide incontinence care to Resident 1. The caregiver did not have a second person to assist with care which was required according to the instructions on Resident 1's CP. The caregiver rolled Resident 1 to their side, out of the bed, and Resident 1 fell on the floor. The facility investigation concluded the fall occurred because the caregiver did not follow Resident 1's CP. The facility investigation did not identify that Resident 1 was lying on an air mattress at the time of the fall.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Federal Way		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's 11/2024 daily documentation by the caregivers on the evening shift showed 11 shifts where staff provided only one caregiver, instead of two caregivers, for bed mobility. The caregiver documentation for the night shift showed 14 shifts provided one caregiver, instead of two caregivers, for bed mobility.</p> <p>In an interview on 12/19/2024 at 6:04 PM, Staff D (Licensed Practical Nurse) stated they were working on the shift when Resident 1 fell . Staff D stated the caregiver was in the room yelling help when Staff D responded. Staff D stated the caregiver was performing incontinence care by themselves and Resident 1 rolled out of the bed, away from the caregiver, and landed on the floor. Staff D stated Resident 1 required two staff for care in bed because Resident 1 could not move by himself. Staff D stated there were enough staff on duty on 11/22/2024 night shift. Staff D stated the caregiver should have asked for help before providing incontinence care. Staff D stated the caregiver did not follow the care plan and Resident 1 fell out of bed, sustained an injury on their head which was bleeding, and had to be transferred to the emergency room where a leg fracture was diagnosed .</p> <p>In an interview on 12/19/2024 at 6:41 PM, Staff B (Float Director of Nursing) stated staff was expected to follow the resident's CP. Staff B was not aware of Resident 1 using an air mattress at the time of the fall. Staff B stated according to the facility investigation on Resident 1's 11/22/2024 fall the staff did not follow Resident 1's CP and Resident 1 fell out of bed.</p> <p>Refer to F684 Quality of Care.</p> <p>REFERENCE: WAC 388-97-1060(3)(g).</p>		