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	05/01/2026

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a policy and procedures to assess and manage pain for 1 of 3 Residents (Resident 1) reviewed for pain management. The failure to thoroughly assess resident pain on admission, develop an individualized care plan (CP) in collaboration with the resident, their representative and practitioner, implement the CP, monitor for adverse consequences, notify the resident representative of medication changes, and document resident conditions, placed residents at risk for untreated pain, medication overdose, hospitalization, and diminished quality of life.Findings included.<Facility Policy>Review of the 09/23/2025 revised Pain Assessment and Management Policy showed all residents would be assessed for pain indicators on admission, quarterly, and with any change in condition; an individualized pain management CP would be developed and initiated when pain indicators were identified. The policy showed the facility would collaborate with the prescriber, the resident and/or the resident representative (RR) to develop, implement, monitor, and revise resident-specific interventions to manage pain using medication and non-pharmacological approaches, monitor for effectiveness and side effects. Residents who were prescribed opioid medication would be assessed for the risk of overdose and dependance, when opioids were combined with benzodiazepines the facility would identify and document clinical indications and implement close monitoring for adverse consequences.<Resident 1>Review of the 04/13/2026 admission nursing assessment showed Resident 1 had cognitive impairment, English was not their primary language, was wheelchair bound, required total assistance by staff for mobility and hygiene, had no pain at the time of assessment, and was prescribed an opioid pain medication as needed. The pain assessment did not show a diagnosis for pain, location, effects on quality of life, or non-pharmacological methods of pain relief.Review of the April 2026 care plan for Resident 1 showed no focus area or interventions for Resident 1's pain management.Review of the April 2026 Medication Administration Record (MAR) showed Resident 1 was admitted on [DATE], had diagnoses of pain in one hip, both knees and unspecified bilateral leg pain, and was on pain monitoring every shift. Medications prescribed on admission were routine medication for neurological leg pain, a routine topical pain patch for legs, a mild analgesic as needed and an opioid medication every six hours as needed. The opioid medication was administered three times, twice on 04/14/2026 for pain level 8/10 and 7/10, both doses were documented as effective, one dose on 04/15/2026 for pain level 10/10 and was documented as effective.Review of a 04/15/2026 practitioner initial evaluation note showed a review of past medical history including leg pain. The practitioner assessment note showed Resident 1 was in bed, no acute distress, alert and oriented, able to make needs known, pain level of 2 that morning, with plan of continuing current pain management with opioid and neurological pain medication and noted a medication for anxiety in the medication class of benzodiazepines. The note concluded that nursing had no concerns and directed continued monitoring of Resident 1.Review of a 04/15/2026 medication order change showed the opioid medication as needed was discontinued and changed to a routine opioid dose three times a day.Review of the nursing progress notes from 04/15/2026 to 04/17/2026 showed no documentation of change of condition in Resident 1's pain or reason for change in the pain medication directions.Review of the April 2026 MAR showed the opioid (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain medication was changed to three times per day, scheduled at 8:00 AM, 2:00 PM and 8:00 PM. The first routine dose was given on 04/15/2026 at 2:00 PM. Resident 1 had two doses on 04/15/2026, and three doses on each day 04/16/2026 and 04/17/2026.Review of a 04/17/2026 nurse progress note showed Resident 1 was confused, had pain in back and abdomen, and oxygen saturation was low. The note showed the oxygen dose was increased, pain medication was administered, practitioner was informed and directed to send Resident 1 to the hospital, RR arrived, and RR called 911. Medics took over at bedside then transferred Resident 1 to the hospital for advanced medical care.Review of the 04/17/2026 hospital critical care admission note showed Resident 1 arrived at the emergency department due to unresponsiveness, low oxygen level, and low pulse. The note showed Resident 1 required an opioid antagonist medication through an intravenous (IV) tube into their blood stream administered by the medics to reverse the opioid reaction. Resident 1 was diagnosed with unintentional opioid overdose with respiratory failure and was admitted to the intensive care unit.In an interview on 04/30/2026 at 3:42 PM, Resident 1's Representative (RR) stated Resident 1 had chronic pain and took an opioid medication as needed and could take a dose every six hours. The RR stated on 04/17/2026, they called Resident 1who did not answer the phone, so they called the facility and asked staff to assist Resident 1 to answer the phone. When talking with Resident 1 they were not making sense, the phone was on speaker, so they asked the staff in the room what was happening. The RR stated they were told Resident 1 could not hold the phone and kept dropping it. The RR stated they asked staff to get the nurse to see Resident 1 right away. RR stated they drove to the facility while on the phone with Resident 1 trying to keep them awake and engaged in conversation. The RR stated Resident 1 was not making sense, was hallucinating, and very confused. The RR stated when they arrived at the facility Resident 1 was barely awake, was slumped to one side in the bed, their speech did not make sense, Staff E was in the room and would not call 911. RR stated they called 911 and were very scared about Resident 1's condition. RR stated when the medics arrived, they had to administer an opioid antagonist medication and took Resident 1 to the hospital. RR stated Resident was still at the hospital, now 13 days later.In an interview on 05/01/2026 at 12:44 PM, Staff C (Certified Nursing Assistant) stated on 04/17/2026 Resident 1 had been sleepy since the start of their shift at 2:00 PM. Staff C stated Resident 1 did not eat dinner because they were sleepy. Staff C stated when the RR called, Resident 1 could not hold on to the phone, seemed more confused than usual, and was talking in their primary language with RR. Staff C stated the RR asked for the nurse to see Resident 1. Staff C stated they went and got Staff E and brought them to the room. Staff C stated Resident 1's vital signs were checked, and the oxygen level was low in the 50's (normal range 90-100) so Staff E turned their oxygen setting up. Staff C stated the RR arrived in a panic and asked to have 911 called, then called 911 themself. Staff C stated they were not in the room when the medics arrived.In an interview on 05/01/2026 at 1:10 PM, Staff D (Certified Nursing Assistant) stated they worked with Resident 1 on 04/17/2026 on the day and evening shift. Staff D stated Resident 1 was sleepy during the day, was awake and talking when the staff exchanged beds before dinner. Staff D stated they checked on Resident 1 when they were on the phone with RR speaking their primary language. Staff D stated the RR asked Staff D to get the nurse because Resident 1 was hallucinating. Staff D stated they notified Staff E, and Staff E went to Resident 1's room. Staff D stated the RR arrived in Resident 1's room and Staff D left the room.In an interview on 05/01/2026 at 1:22 PM, Staff A (Administrator) stated Staff E no longer worked at the facility for another reason. Staff E could not be interviewed.In an interview on 05/01/2026 at 2:41 PM, Staff B (Director of Nursing) stated Staff E called on 04/17/2026 to notify that Resident 1 was sent to the hospital. Staff E explained to Staff B that RR stated Resident 1 was more confused, Staff E checked on Resident 1 and found them alert and responsive, vital signs were stable, oxygen level was good and there were no abnormal findings on their assessment. Staff E stated the RR arrived and the oxygen saturation was low, so they increased the oxygen setting. Staff E stated they talked with the practitioner and were told to send Resident 1 to the hospital. Staff E stated they were going to call 911 but the RR had already called. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff E stated Resident 1 was responsive when they left the facility with the medics and the RR.In an interview and record review on 05/01/2026 at 2:47 pm, Staff B reviewed Resident 1's electronic medical records and stated there was not a complete pain assessment on admission, there was not a care plan for pain, Resident 1 was prescribed a benzodiazepine with an opioid which could be contraindicated, the opioid pain medication was as needed on admission on [DATE] and changed on 04/15/2026 to scheduled administration three times a day, there was no pain assessment for a change in pain levels on 04/15/2026, there was no documentation of notification of the practitioner of pain level change on 04/15/2026, there was no documentation for why the opioid order changed on 04/15/2026, there was no documentation of notification of the RR, there was no alert monitoring initiated for the change in opioid pain medication, and the instructions when to administer the as needed opioid antagonist medication were unclear. Staff B stated all these steps should have been, and were not, followed by staff.Reference: WAC 388-97-1060(1)(4), -1620(2)(b)(i)(ii).