

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/03/2026
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)		
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure accurate and complete pre/post Hemodialysis (HD- mechanical way of eliminating waste from the body when the kidneys no longer functioned) for 4 of 4 residents (Residents 55,11, 62, & 94) reviewed for Dialysis. This failure placed the residents at risk for unintended health consequences and decreased quality of life. Findings included. <Policy> According to a facility policy titled, HD Offsite, dated 09/16/2025, the facility would ensure each resident received care and services for the provision of HD including day of HD assessment of the resident's condition and monitoring for complications before and after dialysis treatment. <Resident 55> According to the 05/08/2026 admission Minimum Data Set (MDS &ndash; an assessment tool) Resident 55 admitted to the facility on [DATE]. The MDS showed Resident 55 had a diagnosis of End Stage Renal Disease (ESRD &ndash; a disease where the kidneys no longer function to sustain life without treatment) dependent on HD treatment and received HD during the assessment period. Review of Resident 55's health records showed a 05/05/2026 physician order for HD three times a week, every Tuesday, Thursday, and Saturday. Review of Resident 55's pre/post HD assessments showed the 05/07/2026, 05/09/2026, 05/12/2026, 05/14/2026, 05/16/2026, 05/19/2026, 05/21/2026, 05/23/2026, 05/26/2026, and 05/28/2026 assessments were incomplete and/or inaccurate. In an interview on 05/27/2026 at 9:21 AM Resident 55 stated they received HD treatments three times a week at an outside Dialysis Center. Resident 55 stated staff did not perform an assessment of their dialysis site or listen to their lungs before or after HD treatments. <Resident 11> According to the 04/14/2026 Quarterly MDS Resident 11 re-admitted to the facility on [DATE] with diagnoses of ESRD, dependence on HD, and a heart condition. Review of Resident 11's health record showed a 01/02/2026 order for HD three times a week every Monday, Wednesday, and Friday as well as supplemental treatments as needed. Review of Resident 11's pre/post HD assessments showed the 01/05/2026, 01/07/2026, 01/09/2026, 01/12/2026, (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	01/14/2026, 01/16/2026, 01/21/2026, 01/26/2026, 1/30/2026, 02/02/2026, 02/04/2026, 02/06/2026, 02/09/2026, 02/11/2026, 02/20/2026, 02/23/2026, 02/27/2026, 03/04/2026, 03/06/2026, 03/07/2026, 03/09/2026, 03/13/2026, 04/03/2026, 04/06/2026, 04/08/2026, 04/10/2026, 04/13/2026, 04/17/2026, 04/20/2026, 04/22/2026, 04/27/2026, 04/29/2026, 04/30/2026, 05/01/2026, 05/04/2026, 05/22/2026, 05/25/2026, and 05/27/2026 assessments were incomplete and/or inaccurate. In an interview on 05/28/2026 at 8:57 AM Resident 11 stated staff do not do an assessment before they leave the facility to go to dialysis, they only get vitals before they go and when they get back from the dialysis center. <Resident 62> According to the 05/07/2026 Quarterly MDS Resident 62 admitted to the facility on [DATE] with diagnoses of ESRD, dependence on HD, and muscle weakness. Review of Resident 62's health records showed a 03/25/2026 order for HD three times a week on every Monday, Wednesday, and Friday. Review of Resident 62's pre/post dialysis assessments showed the 04/24/2026, 04/27/2026, 05/01/2026, 05/04/2026, 05/06/2026, 05/08/2026, 05/11/2026, 05/13/2026, 05/15/2026, 05/18/2026, 05/20/2026, 05/22/2026, 05/25/2026, 05/27/2026, and 05/29/2026 were incomplete and/or inaccurate. <Resident 94> According to the 05/25/2026 admission MDS Resident 94 admitted to the facility on [DATE] with diagnoses including ESRD, Dependence on HD, and high blood pressure. Review of Resident 94's health records showed a 05/20/2025 order for HD on every Tuesday, Thursday, and Saturday. Review of Resident 94's pre/post dialysis assessments showed the 05/23/2026, 05/28/2026, and 05/30/2026 assessments were incomplete and/or inaccurate. In an interview on 05/29/2026 at 12:17 PM Staff F (Unit Care Coordinator) stated dialysis pre/post assessments should be completed fully as they can be a life saving process to prevent infections and catch complications related to dialysis. Staff F reviewed dialysis assessments and stated they were not completed and/or were inaccurate. In an interview of 06/03/2025 at 8:45 AM Staff B (Director of Nursing) stated dialysis pre/post assessments should include a general health assessment of the resident as well as a focused dialysis assessment to confirm the HD site does not have abnormal bleeding or signs of infection, as well as to monitor for potential complications such as low blood pressure. Staff B stated the dialysis assessments for Resident 55, Resident 11, Resident 62, and Resident 94 were not completed to expectations. Reference: WAC 388-97-1900(1)(6)(a-c).		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was prepared and stored under sanitary conditions in accordance with professional standards of food safety requirements for 1 of 1 facility kitchens observed. The failure to prepare ready-to-eat foods using sanitary practices and inconsistently monitoring refrigerator and freezer temperatures as required placed residents at risk for ingesting unsafe and/or contaminated food and the development of foodborne illness. Findings included <Facility Policies>The facility policy, Safe Food Handling, revised 05/26/2026, showed all foods prepared and stored were handled using accepted food-handling practices according to federal, state, and local requirements. The policy showed the facility must store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The policy showed safe food distribution processes involved refrigeration which was necessary for cold temperature control of potentially hazardous food. The policy showed the facility would ensure food temperatures did not fall in the Danger Zone (temperatures above 41 degrees Fahrenheit [F] and below 135F) for food safety and to limit the growth of pathogens such as bacteria and viral organisms capable of causing foodborne disease. The facility policy, Refrigerator/Freezer Temperature Log, revised 04/29/2025, showed the freezer temperature must remain at zero (0) F or below, and the refrigerator temperature should be maintained at or below 41F. The log showed if the temperatures were not within these ranges, the staff must notify the Director of Food and Nutrition Services or Maintenance immediately. The log showed kitchen staff were instructed to monitor and check the refrigerator and freezer temperatures twice; in the morning (AM) and evening (PM), and to log the result.<Food Preparation - Ready-To-Eat Foods>In an observation on 06/01/2026 at 11:02 AM during lunch service meal preparation, Staff P (Dietary Aide) was observed preparing three plates of garden side salad. Staff P gathered a metal pan of cheese and meats (diced cooked chicken and ham) wrapped in zip lock bags from the refrigerator and set them on top of a plastic tray. Staff P washed their hands, put gloves on, grabbed pre-cut vegetables, cheese, and meats, and placed them on the plates. Staff P moved the metal pan of cheese and meats aside from the plastic tray, touched multiple food preparation surfaces, grabbed some tomatoes, and sliced them on top of plastic tray where the metal pan previously sat on. Staff N (Food Services Director) told Staff P not to use the plastic tray and to cut the tomatoes using a cutting board. Staff P, still with their contaminated gloves on, took a cutting board and continued preparing the garden salad without washing their hands and changing their gloves. In an interview on 06/01/2026 at 11:17 AM, Staff P stated they should have removed their contaminated gloves, washed their hands, and donned new clean gloves before proceeding with the preparation of the green side salad but they did not. In an interview on 06/01/2026 at 11:22 AM, Staff N stated they expected all dietary staff to avoid cross-contamination during food preparation. Staff N stated it was important for the kitchen staff to ensure sanitary practices were observed at all times especially when handling and preparing ready-to-eat foods to prevent foodborne illness. <Refrigerator #1>In an observation and record review on 05/27/2026 at 8:41 AM, the temperature reading for Refrigerator 1 was observed to be 37F. Review of Refrigerator 1's May 2026 temperature log showed the AM refrigerator temperature was 47F on 05/06/2026 and 42F on 05/18/2026; both temperatures fell in the danger zone and were unsafe. The log showed the kitchen staff did not monitor the AM temperature on 05/24/2026 and the PM temperature on 05/25/2026. A pre-filled AM temperature of 40F for the following day (05/28/2026) was observed written on the log and was initialed by a kitchen staff. <Refrigerator (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	#2>Review of Refrigerator 2's May 2026 temperature log showed the kitchen staff did not monitor the PM temperature on 05/25/2026. <Refrigerator #3>Review of Refrigerator 3's May 2026 temperature log showed the kitchen staff did not monitor the PM temperature on 05/25/2026. <Freezer #6>In an observation and record review on 05/27/2026 at 9:19 AM, the temperature reading for Freezer 6 was observed to be -2F. Review of Freezer 6's May 2026 temperature log showed the PM temperature was 1F on 05/18/2026 which was an unsafe temperature. The logs showed the kitchen staff did not monitor the PM temperature on 05/25/2026. Pre-filled AM temperatures of 1F for 05/28/2026 and -2F for 05/29/2026 were observed written on the log and were initialed by a kitchen staff. <Freezer #7>Review of Freezer 7's May 2026 temperature log showed the AM freezer temperature was 2F on 05/18/2026 and 1F on 05/19/2026; both were outside the facility's set parameters as indicated in the log. The log showed the kitchen staff did not monitor the PM temperature on 05/18/2026. In an interview on 05/27/2026 at 9:25 AM, Staff N stated they were not notified regarding the unsafe temperatures recorded in the logs and was not aware of the inconsistent monitoring of the refrigerator and freezer temperatures. Staff N stated the kitchen staff should not pre-fill the refrigerator and freezer temperature reading in the log because it was unsafe. Staff N stated they expected the kitchen staff to consistently monitor the temperature of refrigerators and freezers and to document the actual temperature readings. Staff N stated they expected the kitchen staff to notify them if/when temperatures fell outside of the set parameters so they could act accordingly to ensure food and resident safety. REFERENCE: WAC 388-97-1100 (3), -2980.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to ensure grievances and concerns communicated during Resident Council meetings were addressed timely, or to respond and provide a rationale for their response, for 1 of 1 Resident Council groups reviewed. This failure placed residents at risk for unmet needs, frustration, untimely resolution of grievances, and a diminished quality of life. Findings included: <Facility Policy> Review of a Resident Council policy, reviewed 09/26/2025, showed the facility must consider to review concerns in resident groups and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. The facility must be able to demonstrate their response and rationale for their response. <Resident Council> In a joint interview on 06/01/2026 at 1:16 PM, Resident 20 and Resident 51 stated the facility did not do anything about many of the complaints and recommendations brought up at Resident Council. <January 2026> Review of Resident Council meeting minutes, dated 01/21/2026, showed multiple grievances and concerns were discussed, including the following: Facility doors were locked and residents were not feeling they could go in/out of building. Residents were having difficulty reaching the Social Services department to address needs. Review of a January 2026 Grievance Log showed no Resident Council concerns were logged. <February 2026> Review of Resident Council meeting minutes, dated 02/26/2026, showed no documentation that follow-up from the January 2026 meeting was communicated to residents. Multiple new grievances and concerns were discussed, including the following: Rooms had chipped paint, scratches, and were depressing. Concerns about cold food. Requests for visitor chairs in resident rooms. A resident's family member expressed concerns about limited rehab preventing the resident from returning home. Limited availability of coffee, and cold coffee. Delayed call light response times, staff using phones, staff sleeping on shift, staff socializing instead of assisting residents. Concerns about a resident who made noise at night. Review of a February 2026 Grievance Log showed no Resident Council concerns were logged. <March 2026> Review of Resident Council meeting minutes, dated 03/18/2026, showed the prior month's meeting minutes and old business were reviewed. No documentation was provided to show how reported concerns were addressed or the facility's response, including rationale. Multiple new grievances and concerns were discussed, including the following: Reports of CNA's sitting at nurse's station, sleeping. A resident yelled all night, staff ignored them and did nothing to help calm them down. A resident reported her clothes were shrinking in the laundry. Review of a March 2026 Grievance Log showed no Resident Council concerns were logged. <April 2026> Review of Resident Council meeting minutes, dated 04/15/2026, showed the prior month's meeting minutes and old business were reviewed. No documentation was provided to show how reported concerns were addressed or the facility's response, including rationale. Multiple new grievances and concerns were discussed, including the following: No improvement with noise at night in hallways. Cold food, due to CNA's not passing trays out when meal carts arrived in hallways. A resident stated there was always something missing from their meal tray. Residents request coffee to be available throughout the day. Review of an April 2026 Grievance Log showed no Resident Council concerns were logged. <May 2026> Review of Resident Council meeting minutes, dated 05/20/2026, showed the prior month's meeting minutes and old business were reviewed. No documentation was provided to show how reported concerns were addressed or the facility's response, including rationale. Multiple new grievances and concerns were discussed, including the following: CNAs yelled down the hallways at each other during the night. CNAs were not offering snacks to residents after dinner, per the facility menu. Complaints that a dog in a resident room barked all night, and a resident (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in the same room yelled, cursed, and threw things day and night.A resident needed batteries changed for the hand sanitizer dispenser in their room.A resident who returned from the hospital did not receive all their belongings back upon return because of a room move.Review of a May 2026 Grievance Log showed no Resident Council concerns were logged.In an interview on 06/01/2026 at 2:13 PM, Staff V (Activities Director) stated they helped arrange Resident Council meetings and wrote the minutes. Staff V stated when a concern was brought up that warranted a grievance card, the resident would take the initiative to write one. Staff V stated the only time they would write a grievance card was when a resident could not write it themselves. Staff V stated immediately after Resident Council meetings, they went to Staff A's (Administrator) office or the Social Services office and reviewed their notes. Meeting minutes were sent to the various departments, managers, and QAPI (Quality Assurance & Performance Improvement) committee for review and follow-up.In an interview on 06/03/2026 at 8:01 AM, Staff A (Administrator) stated it was their expectation that when concerns were reported at Resident Council, staff would offer the resident a grievance card or offer to complete one for them. Concerns were to be logged into the Grievance Log and follow the grievance process, with documentation to show how the concern was resolved or the facility's response with rationale when it could not be resolved. Staff A stated staff should inform the Resident Council at each meeting of the facility's actions taken to resolve the prior month's concerns. Staff A stated their Resident Council process needed to be better, and they planned to educate staff on the need to document reported concerns and actions taken. REFERENCE: WAC 388-97-0920(5).		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASRR or PASARR- a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment) Level 2 referrals were coordinated timely for 2 of 3 residents (Residents 12 & 56) reviewed for PASRRs and 1 of 5 residents (Resident 38) reviewed for Unnecessary Medications. This failure placed residents at risk of inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs. Findings included. <Facility Policy> According to the 09/26/2025 Pre-admission Screening and Resident Review (PASARR) policy, the facility would ensure potential admissions were screened for possible serious mental disorders or intellectual disabilities and related conditions. The initial pre-screening (PASRR Level 1) was to be completed prior to admission to the facility. If the PASRR Level 1 screening was positive, an in-depth evaluation of the potential resident (PASRR Level 2) was to be completed by the state-designated authority prior to admission to the facility. Recommendations from the PASRR Level 2 determination and evaluation report were to be incorporated into the residents' Care Plan (CP). <Resident 12> According to the 05/04/2026 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 12 re-admitted to the facility on [DATE], was severely cognitively impaired, had unclear speech, and had diagnoses including depression and stroke with weakness to one side of their body. The MDS showed Resident 12 demonstrated verbal and physical behaviors toward others and received antipsychotic, antianxiety, and antidepressant medications during the assessment period. Observation and interview on 05/27/2026 at 11:01 AM showed Resident 12 was lying in their bed awake and did not respond to any questions. Observation and interview on 05/28/2026 at 9:42 AM showed Resident 12 was sitting up in a wheelchair in the hallway. During interview at this time, Resident 12 smiled and responded with unclear speech, stating they were fine. Review of a 10/20/2025 Level 1 PASRR completed by hospital staff showed no serious mental illness (SMI), and a Level 2 referral was not required. Review of a 12/29/2025 Level 1 PASRR completed by the facility Staff showed Resident 12 had a significant change in condition on 10/29/2025 and Resident 12 had SMI. No box was checked to show which SMI Resident 12 had. Section 4 on the Level 1 PASRR form showed a Level 2 evaluation referral was required for significant change for Resident 12. Review of Resident 12's record on 06/01/2026 showed no evidence that a PASRR Level 2 evaluation was completed. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/01/2026 at 9:15 AM, Staff G (Social Services Director) acknowledged the Level 1 PASRR did not accurately reflect Resident 12's SMI (depression). Staff G stated Resident 12 was admitted to hospice care on 10/29/2025 and the facility updated the PASRR Level 1 on 12/29/2025 with the significant change. Staff G stated they sent a Level 2 referral form to the State authority for evaluation on 12/29/2025 and did not follow up for any recommendations. Staff G stated they should follow up for Level 2 evaluations every month, but they did not. <Resident 56> According to the 04/24/2026 admission MDS, Resident 56 admitted to the facility on [DATE] with multiple diagnoses including bipolar disorder (a mental health condition that causes extreme, cyclical shifts in mood, energy, and activity levels). In an observation and interview on 05/27/2026 at 10:17 AM, Resident 56 became tearful when they discussed wanting to visit their family member. Resident 56 stated they were stressed out and it would be nice to talk to someone. Resident 56 stated they were offered therapy for mental health, but nothing had been done to date. Review of a PASRR Level 1 Pre-admission Screening, dated 04/17/2026, showed a hospital social worker completed the screening and determined Resident 56 showed indicators of serious mental illness and required a Level 2 evaluation referral. Review of an e-mail communication, dated 04/17/2026, showed a state agency received the PASRR Level 2 referral. Review of Resident 56's record on 06/03/2026 showed no documentation of a PASRR Level 2 determination or evaluation report. In an interview on 06/03/2026 at 8:52 AM, Staff G stated a hospital social worker sent Resident 56's PASRR Level 2 referral to a state agency, and Staff G did not know what happened from there. Staff G said the facility was now using a different state agency for their PASRR Level 2 evaluations, and Resident 56's may not have been transferred over to them. Staff G stated they did not follow up on the status of the PASRR Level 2 but should have. <Resident 38> According to the 04/09/2026 Quarterly MDS, Resident 38 admitted to the facility on [DATE] with diagnoses including stroke, anxiety, and bipolar disorder. The MDS showed Resident 38 had hallucinations and physical behaviors directed toward others in the review period. Review of Resident 38's health record showed a hospital-submitted PASSR, dated 01/08/2026, with an exemption not requiring a Level 2 evaluation. Resident 38's health records showed a corrected PASSR was submitted on 01/12/2026 requiring a PASSR Level 2 evaluation. There were no notes indicating follow up with the PASSR evaluator, an evaluation being completed, or a PASSR Level 2 determination on file for Resident 38. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/01/2026 at 12:31 PM, Staff G stated Resident 38's Level 2 referral was sent to the PASSR evaluator in January 2026, though no evaluation had occurred and no Level 2 determination was on file. Staff G stated they had not followed up with the PASSR evaluator but should have. REFERENCE: WAC 388-97-1915(4).		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure residents who were dependent on staff for daily cares received the assistance they were assessed to require for 5 of 9 sample residents (Residents 5, 10, 12, 21, & 25) reviewed for Activities of Daily Living (ADL). The failure to provide nail care, oral care, bathing, and shaving assistance left residents at risk for embarrassment, poor personal hygiene, and other negative health outcomes. Findings included . <Facility Policy> The facility policy titled, ADLs, revised 09/04/2025, showed the facility must ensure residents received treatment and care in accordance with professional standards of practice, the resident's comprehensive and person-centered Care Plan (CP), and the resident's choices. The policy showed a resident who was unable to carry out ADLs would be provided the necessary assistance to maintain good personal and oral hygiene.<Resident 5> According to the 03/06/2026 Quarterly Minimum Data Set (MDS &ndash; an assessment tool), Resident 5 had no memory impairment. The MDS showed Resident 5 required maximum assistance with showers and was dependent on staff for complete transfer to shower assistance. The assessment showed Resident 5 had diagnoses of general muscle weakness and adult failure to thrive. Review of a 01/10/2025 ADL self-care performance deficit CP showed Resident 5's bathing preferences were showers twice weekly and required two staff assist with transfers to shower. Review of Resident 5's May 2026 bathing documentation showed no shower was offered or provided since 05/12/2026. In an interview on 05/28/2026 at 9:26 AM, Resident 5 stated staff did not offer or provide a shower per their preference for three weeks. Resident 5 stated they asked staff when they could get a shower and staff told them Tuesday, but they still had not been offered one. Resident 5 stated they preferred showers at least twice a week and expressed that to several staff members. In an interview on 06/01/2026 at 2:03 PM, Staff B (Director of Nursing) stated they expected staff to offer and provide showers per shower schedule and residents preferences per their CP. Staff B reviewed Resident 5's health records and stated staff did not offer or provide a shower since 05/12/2026 but should have. Staff B stated it was important to offer and provide showers per resident preference for resident rights. In an interview on 06/02/2026 at 8:12 AM, Staff E (Unit Care Coordinator) stated Resident 5 was scheduled to receive a shower every Tuesday and Friday. Staff E reviewed Resident 5's health records and stated staff had not offered or provided a shower since 05/12/2026 but should have per the residents' preferences in their CP. Staff E stated it was important to follow resident preferences for bathing to ensure staff were compliant with resident's rights. <Resident 10> According to the 05/11/2026 admission MDS, Resident 10 had impaired memory and required substantial to maximal assistance with bathing and personal hygiene. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 05/05/2026 ADL self-care performance deficit CP showed Resident 10 required two-person assistance with their personal hygiene. The CP included directions for staff to check Resident 10's nail length, clean and trim them during Resident 10's bath day and as needed. Observation on 05/27/2026 at 3:30 PM showed Resident 10 had long, dirty fingernails. Resident 10's fingernails extended past the tip of their fingers and had black debris under the nail beds. This observation showed Resident 10's toenails were long and chipped. On 05/28/2026 at 10:27 AM, Resident 10 was observed lying in their bed and fingernails remained untrimmed. Review of Resident 10's medical record showed there was no documentation Resident 10 preferred long nails or refused nail care. In an interview on 06/01/2026 at 12:41 PM, Staff E stated they expected staff to provide ADL assistance to all residents including personal hygiene. Staff E stated staff should clip Resident 10's fingernails and toenails on shower days and as needed, but they did not. <Resident 12> According to the 05/04/2026 Quarterly MDS, Resident 12 had a stroke with left-sided weakness and was totally dependent on staff for their personal hygiene. The assessment showed Resident 12 had impaired memory, impaired vision, and had rejection of care during the assessment period. The 02/05/2026 revised ADL self-care performance deficit CP showed Resident 12 was totally dependent on staff for their personal hygiene. The CP interventions included instructions for staff to check Resident 12's nail length, clean and trim them during Resident 12's bath day and as necessary. Observations on 05/26/2026 at 11:21 AM and on 05/28/2026 at 8:21 AM showed Resident 12 was lying in bed in their room and had long and dirty fingernails. On 05/29/2026 at 12:02 PM and on 06/01/2026 at 9:03 AM, Resident 12 was observed sitting up in their wheelchair in the hallway and their fingernails were long and dirty with black dirt under the nail beds. In an interview on 06/01/2026 at 12:20 PM, Staff E stated they expected staff to provide ADLs to all residents during routine morning care including personal hygiene. Staff E stated if residents refuse care, staff should document in resident's record. Staff E confirmed Resident 12 had long dirty fingernails and was unable to provide any refusal of nail care for Resident 12. Staff E stated staff should clip Resident 12's fingernails on bath days, but they did not. In an interview on 06/03/2026 at 9:55 AM, Staff B stated they expected staff to provide ADL assistance to all residents every morning and as needed. Staff B stated nail care should be provided to all residents on their shower/bath day and as needed. <Resident 21> According to the 05/14/2026 Quarterly MDS, Resident 21 was alert, capable of verbalizing their needs, and had medical conditions including a chronic, progressive neurological disorder affecting (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their movement. The MDS showed Resident 21 had functional limitations in their range of motion in both their upper arms and was assessed to be dependent on staff their personal hygiene/grooming needs. Review of the revised 03/13/2026 ADL CP showed Resident 21 had self-care performance deficit and was dependent on staff for all their ADL cares. A 02/06/2026 CP intervention instructed the staff to check Resident 21's nail length, and to trim and clean them during bath days and as necessary. In an observation and interview on 05/27/2026 at 1:29 PM, Resident 21's fingernails on both hands were observed long, thick, and curling up. Resident 21 stated they would like their nails trimmed to prevent them from digging into their skin. Observation on 05/29/2026 at 10:11 AM showed Resident 21's fingernails remained in the same state as previously observed on 05/27/2026. In an observation and interview on 05/29/2026 at 10:30 AM, Staff F (Unit Care Coordinator) stated they expected the nursing assistants to cut/trim the fingernails of dependent residents. Staff F looked at Resident 21's fingernails and stated the staff should have trimmed and provided nail care to the resident, but they did not. <Resident 25> According to the 03/24/2026 admission MDS, Resident 25 did not have the ability to communicate verbally, did not speak English, and had medical conditions including a brain injury, memory deficits, heart failure, and generalized muscle weakness. The MDS showed Resident 25 was assessed to be dependent on staff for their personal hygiene needs including combing their hair, shaving, and oral hygiene. Review of the revised 03/31/2026 ADL CP showed Resident 25 had self-care performance deficit because of right-sided weakness from their brain injury and was totally dependent on staff for personal hygiene and oral care. Review of Resident 21's physician orders showed a 03/1/2026 order instructing staff to provide the resident oral care twice daily every morning and at bedtime. Observations on 05/27/2026 at 10:40 AM, on 05/28/2026 at 2:14 PM, and on 05/29/2026 at 8:12 AM showed Resident 25 was lying in bed and observed with matted and unruly hair, long facial hair (mustache and beard), and dry, chapped lips. Resident 25's lower lip was peeling off in several areas. In an interview on 05/28/2026 at 10:00 AM, Resident 21's representative stated the resident used to be a Buddhist monk; bald, clean cut, and would prefer to be shaven. In an observation and interview on 05/29/2026 at 8:29 AM, Staff M (Certified Nursing Assistant) went in Resident 21's room and confirmed the resident's needed grooming and oral care. Staff M stated Resident 21 needed their hair combed, facial hair shaved, and mouth/lips cleaned and moisturized. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/29/2026 at 10:30 AM, Staff F stated they expected the staff to provide ADL care because it made residents feel they were cared for, their basic needs met, and for residents to have good quality of life. REFERENCE: WAC 388-97-1060(2)(c).		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide restorative/functional maintenance services for 4 of 7 residents (Residents 56, 41, 21 & 48) reviewed for limited mobility and Restorative Nursing Program (RNP). This failure placed residents at risk for further decline in their Range Of Motion (ROM) and mobility, loss of function, and/or permanent immobility. Findings included. <Facility Policy> According to an Area of Focus: Restorative Nursing policy, reviewed on 12/02/2025, the facility provided a RNP that focused on achieving and maintaining optimal physical, mental, and psychosocial functioning. The RNP included nursing interventions that promoted the resident's ability to adapt and adjust to living as independently and safely as possible, and included walking, range of motion, and splint or brace assistance. The policy showed evidence of periodic evaluation by the licensed nurse must be present in the medical records. <Resident 56> According to a 04/24/2026 admission Minimum Data Set (MDS &ndash; an assessment tool), Resident 56 admitted to the facility on [DATE] with multiple diagnoses including wounds to both feet, muscle weakness, and difficulty walking. The MDS showed Resident 56 was able to understand and to be understood. In an interview on 05/27/2026 at 10:17 AM, Resident 56 stated when they first came to the facility, they worked with the therapy department on walking, going upstairs, and balance. Resident 56 stated they had not had any exercises for over three weeks. Resident 56 stated they were told they would have RNP three times weekly, but it did not happen. Review of a Physical Therapy (PT) Discharge Summary, dates of service 04/21/2026 to 05/07/2026, showed PT recommended the RNP for sit-to-stand to walker, and ambulation with walker with stand-by assist and follow with wheelchair for 50 to 75 feet. Review of an Occupational Therapy (OT) Discharge Summary, dates of service 04/21/2026 to 05/07/2026, showed OT recommended the RNP, with plan to follow. Review of a 05/07/2026 Restorative Nursing Communication Tool showed PT and OT requested Resident 56 have RNP three days per week with a goal of maintenance. Exercises included sit-to-stand to walker, ambulation with walker with stand-by assist and follow with wheelchair for 50 to 75 feet, and Omnicycle (a motorized rehab system that uses a smart motor to help residents exercise arms and legs when they have limited strength, endurance or muscle control) for 15 minutes. Review of a Restorative Residents listing provided on 06/02/2026 showed Resident 56 was not included in the RNP case load. Review of Resident 56's Care Plan (CP) on 05/29/2026 showed no evidence of an RNP. Staff were to assist Resident 56 with transfers to a wheelchair. No interventions were included for nursing to (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ambulate with Resident 56, or to use an Omnicycle. In an interview on 06/02/2026 at 8:18 AM, Staff C (Assistant Director of Nursing) stated typically the therapy department determined appropriate RNP activities and gave the nursing department a referral. Staff C checked Resident 56's records and found no evidence of RNP, no RNP assessments, and no RNP interventions in the CP. Staff C stated it was hard to see if RNP was supposed to be ordered for Resident 56. In an interview on 06/02/2026 at 11:21 AM, Staff T (Director of Rehabilitation) stated PT and OT did refer Resident 56 for the RNP on 05/07/2026 and it should have been started. Staff T stated they gave the referral form to a Resident Care Manager (RCM) that no longer worked at the facility and did not know what happened after that. <Resident 41> According to a 04/02/2026 admission MDS, Resident 41 admitted to the facility on [DATE] with multiple diagnoses including muscle weakness and history of falls. Resident 41 was able to understand and to be understood and was able to walk with supervision or touching assistance. In an interview on 05/27/2026 at 12:31 PM, Resident 41 stated when they first came to the facility, they exercised every day and walked, but not anymore. Resident 41 stated if they were feeling strong, they walked down the hallway by themselves, but most of the time they stayed on their bed with no exercise. Resident 41 stated they felt like they walked better when they first came to the facility than they do now. Review of a 04/24/2026 progress note showed Staff G (Social Services Director) responded to Resident 41's request for some sort of exercise or rehab, educated Resident 41 of the potential for the RNP, and stated Resident 41 was excited about starting it. Staff G stated they spoke with an RCM to enroll Resident 41 in the RNP. Review of a Restorative Residents listing provided on 06/02/2026 showed Resident 41 was not included in the RNP case load. Review of Resident 41's CP on 06/02/2026 showed no evidence of an RNP. In an interview on 06/03/2026 at 8:28 AM, Staff C stated Staff G wrote a progress note regarding an RNP for Resident 41, but Staff C wasn't sure what communication happened after that. Staff C stated the previous RCMs no longer worked at the facility, and there should have been documentation to show the decision on whether to implement Resident 41's RNP and what the program would include, but there was not. In an interview on 06/03/2026 at 8:52 AM, Staff G stated they talked to an RCM about starting an RNP for Resident 41, but the RCM no longer worked at the facility. Staff G stated there was no form to fill out, it was a verbal conversation. Staff G stated they did not know what happened with the RNP after that. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 21> According to the 05/14/2026 Quarterly MDS, Resident 21 was alert, capable of verbalizing their needs, and had medical conditions including a chronic, progressive neurological disorder affecting their movement. The MDS showed Resident 21 had functional limitations in ROM in both their upper and lower limbs and was provided two days of active ROM (AROM) during the look back period. Review of the revised 03/13/2026 functional CP showed Resident 21 had limited physical mobility, weakness, and contractures. A 02/26/2026 RNP CP intervention directed staff to provide passive ROM (PROM) to Resident 21's bilateral upper and lower extremities three times a week to prevent further deformities. Review of the 05/29/2026 Kardex (a visual bedside report used by staff in providing daily care) showed the staff were to put splints on Resident 21's bilateral hand/wrist and were kept on for up to six hours as tolerated. In an observation and interview on 05/27/2026 at 8:41 AM, Resident 21 was lying in bed and was observed to have very minimal ability to move independently. A left hand splint was observed applied on Resident 21's hand/wrist and their right hand was stiff, balled up, and contracted. Resident 21 stated they were supposed to have a splint on each hand but only the left splint was being applied routinely. Observations on 05/28/2026 at 8:07 AM and 2:29 PM, and on 05/29/2026 at 9:22 AM and 10:30 AM showed Resident 21 did not have a splint on their right hand. In an observation and interview on 05/29/2026 at 10:31 AM, Staff F (Unit Care Coordinator) confirmed Resident 21 did not have a right hand/wrist splint on. Staff F stated Resident 21's right hand needed to have at least a rolled towel on to prevent moisture build-up or fungal infection from developing. In an observation and interview on 05/29/2026 at 1:19 PM, Resident 21 was observed without a right hand/wrist on. Staff K (Certified Nursing Assistant & CNA) stated they work as a Restorative CNA when coverage was needed. Staff K stated they provided Resident 21 PROM and applied the right hand/wrist splint on around breakfast time. Resident 21 stated a nursing staff took the splint off and did not put it back on after providing morning care. Review of Resident 21's RNP flow sheets showed: On the week of 03/29/2026 & 04/04/2026, staff provided AROM twice on 03/30/2026 and 04/03/2026; on the week of 04/05/2026 & 04/11/2026, no AROM was provided; and on the week of 04/12/2026 & 04/18/2026, no AROM was provided. There was no PROM or splint/brace RNP documented as provided to Resident 21 by the restorative staff from 03/27/2026 through 05/29/2026. In an interview on 06/02/2026 at 10:52 AM, Staff B (Director of Nursing) stated they expected the restorative staff to provide RNP to residents who were assessed to require them in order to prevent mobility and functional decline. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/03/2026 at 9:50 AM, Staff C reviewed Resident 21's RNP documentation and stated the ROM program was set-up wrong in the facility's software system; it was outlined under the AROM category and it should be under PROM which was what Resident 21 was assessed to need. Staff C stated the interventions listed regarding Resident 21's splint/brace RNP was not accurate. Staff C stated they expected the restorative staff to provide RNP's frequency according to the CP. <Resident 48> According to the 04/30/2026 Quarterly MDS, Resident 48 was alert, capable of verbalizing their needs, and had medical conditions including mental health disorders, memory deficits, and a brain injury with resulting left-sided weakness. The MDS showed Resident 48 had functional limitation in ROM in one side of their upper and lower limbs. The MDS showed Resident 48 was not provided any RNP during the look back period. Review of Resident 48's revised 04/28/2025 Activities of Daily Living/mobility CP showed the resident had self-care performance deficit related to their left-sided weakness and contractures. A 12/18/2024 RNP CP intervention instructed the staff to apply a splint/brace on the resident's left hand and to provide AROM or PROM as tolerated. Review of the revised 06/16/2023 functional CP showed Resident 48 had limited physical mobility and contractures because of their brain injury. A 08/18/2025 RNP CP intervention instructed the staff to apply a splint/brace on Resident 48's right ankle and to provide AROM or PROM six times weekly for 15 minutes prevent further deformities. In an observation and interview on 05/27/2026 at 10:11 AM, Resident 48 was observed lying in bed and a left hand splint/brace was on; their fingers were curled up and stiff. Resident 48 was observed capable of minimally lifting their left arm up when prompted. Resident 48 was observed wearing non-skin socks and did not have a right ankle splint/brace in place. Observations on 06/02/2026 at 12:08 AM and 06/03/2026 at 9:16 AM showed Resident 48 did not have a right ankle splint/brace on. Review of Resident 48's RNP flow sheets from 04/01/2026 through 05/31/2026 showed the resident was provided five minutes of splint/brace assistance every time they were seen by the restorative staff instead of 15 minutes as care planned. There was no AROM or PROM documented as provided to Resident 48 by the restorative staff for two months. In an observation and interview on 06/03/2026 at 9:17 AM, Resident 48 was observed without a right ankle splint/brace on. Staff L (CNA) stated they did not see an ankle splint/brace inside Resident 48's room. In an interview on 06/03/2026 at 9:36 AM, Staff I (Restorative CNA) stated Resident 48's RNP involving the application of the R ankle splint/brace was no longer appropriate per the resident's preference, lack of participation, and refusals to have it on. Staff I stated the right ankle splint/brace RNP should be removed from Resident 48's CP. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 48's Restorative Program Evaluation log showed the last RNP evaluation done for the resident was completed on 01/31/2025, more than a year ago. In an interview on 06/03/2026 at 9:50 AM, Staff C reviewed Resident 48's RNPs, stated the interventions did not fit the program of the resident as listed in their CP, and the RNPs needed revision. Staff C stated the provision of RNP was important to maintain functional mobility and strength, to prevent decline, and to avoid the development of contractures from immobility. Staff C stated it was important to periodically evaluate the RNPs as required to ensure the residents continue to be benefit from them, and to decrease the restorative staff's workload when RNPs were no longer appropriate. Refer to F641- Accuracy of Assessments. REFERENCE: WAC 388-97-1060(3)(d)(j)(ix).		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure the menu set was followed, affecting 1 of 2 sample residents (Resident 21) reviewed for food concerns and 2 supplemental residents (Residents 72 & 54) observed during lunch service. This failure placed residents at risk for lack of food enjoyment, nutritional deficits from poor food intake, and a decreased quality of life. Findings included. <Facility Policy>The facility policy titled, Menus, Substitutions, and Alternatives, revised 05/20/2026, showed menus were planned in advance and were followed as written in order to meet the nutritional needs of residents in accordance with established national guidelines. The policy showed the menus must be followed.<2026 Spring/Summer Menu>Review of the facility's week 1 menu showed the set menu for breakfast on 06/01/2026 was biscuits with sausage gravy, the main dish for lunch was sliced ham with baked sweet potato wedges, and the alternate menu was Salisbury steak and gravy. In an observation and interview on 06/01/2026 at 9:32 AM during lunch preparation, Staff O (Cook) was observed preparing mashed potatoes. Staff O stated they were replacing the sweet potato menu option with the mashed potatoes to serve residents who had orders for a mechanically altered texture diet because they ran out of the sweet potato puree. Staff O stated they did not check the menu to ensure all food items listed were available for meal service. In an interview on 06/01/2026 at 9:41 AM, Staff N (Food Services Director) stated the kitchen staff did not notify them about being out of the sweet potato puree. Staff N stated the residents did not get timely communication regarding the menu change. Staff N stated it was important to stick with the planned menu in respect of residents' food choices and preferences. In an observation and interview on 06/01/2026 at 10:28 AM, Staff O was observed whisking (white) sausage gravy in a deep metal container. Staff O stated it will be served as the gravy together with the Salisbury steak. <Resident 21>In an observation and interview on 06/01/2026 at 12:48 PM, Resident 21 was observed in their bed and was assisted by a family member in eating their lunch. Resident 21's meal tray had ground Salisbury steak topped with sausage gravy; only a small bite was eaten out of it. Resident 21 stated they did not like the food because it did not taste good together. <Resident 72>In an observation and interview on 06/21/2026 at 12:31 PM, Resident 72 was observed eating a slice of ham in the dining room next to Staff S (Restorative Certified Nursing Assistant). Resident 72's meal tray had Salisbury steak with sausage gravy and was observed left untouched. Staff S stated they needed to request a piece of the sliced ham from the kitchen for Resident 72 because the resident did not like the food served. Resident 72 stated the Salisbury steak was their original choice when they placed their meal order last week, but the steak was served with the wrong gravy. <Resident 54>In an observation and interview on 06/01/2026 at 12:35 PM, Resident 54 was observed eating their lunch in the dining room next to Staff S. Resident 54's meal tray had double portions of the Salisbury steak topped with sausage gravy and was observed left untouched. Resident 54 stated they did not like the food served because the combination of the meat and the sauce used tasted bad. In an interview on 06/01/2026 at 1:07 PM, Staff O stated they used the sausage gravy for lunch meal service instead of preparing the (brown) gravy outlined in the menu because they had a lot left over from breakfast. Staff O stated they should have prepared the gravy that went with the Salisbury steak according to the planned menu, but they did not. In an interview on 06/01/2026 at 1:16 PM, Staff N stated the kitchen staff must follow the planned menus as required. REFERENCE: WAC 388-97-1160(1)(a)(b), -1120(3)(c)(4).		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure staff used appropriate Personal Protective Equipment (PPE - disposable barriers such as gloves, eyewear, and gowns used to prevent exposure to infectious materials) for 3 of 3 residents (Residents 91, 53, & 56) reviewed for Transmission Based Precautions (TBP - used to prevent the spread of transmissible infections), staff used PPE in accordance with Enhanced Barrier Precautions (EBP - infection control measure used to reduce the spread of multidrug-resistant organisms) for 1 of 3 supplemental residents (Residents 84) reviewed for skin conditions, and perform hand hygiene during wound care for 1 of 3 residents (Resident 91) reviewed for wounds. These failures placed residents and staff at risk for exposure to and development of contagious, communicable infectious diseases.<Policy>According to the facility policy titled, Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, dated September 2024, the facility would ensure staff donned gown and gloves with resident's on TBP to prevent the spread of infections to other residents and staff. According to the facility policy titled, Hand Hygiene for Residents, Families, and Visitors, dated 07/08/2025, the facility would ensure staff performed hand hygiene during care provided to residents. <TBP> <Resident 91> According to a 05/30/2026 admission Minimum Data Set (MDS &ndash; an assessment tool) Resident 91 admitted to the facility on [DATE]. The MDS showed Resident 91 was on isolation precautions for an active infectious disease. The MDS showed Resident 91 had diagnoses of a multidrug resistant organism, a bone infection, and an amputation of their left great toe. Review of Resident 91's 05/28/2026 infection Care Plan (CP) showed they were on contact precautions for the duration of the infection. Observation on 05/27/2026 at 8:45 AM showed a contact precaution sign posted outside of Resident 91's room instructing staff to put on a gown and gloves before entering Resident 91's room. In an observation and interview on 05/27/2026 at 8:55 AM showed Staff Q (Housekeeping Assistant) enter Resident 91's room without putting on the appropriate PPE. Staff Q exited the room not wearing gloves or performing hand hygiene and carrying a bag filled with rolls of garbage bags. Staff Q stated they should follow contact precautions before entering but did not. In an interview on 06/02/2026 at 10:02 AM Staff E (Unit Care Coordinator) stated they expected staff to follow precaution signs posted outside of resident rooms. Staff E stated it was important to follow TBP to prevent the spread of infection. <Resident 53> According to the 03/09/2026 Quarterly MDS Resident 53 re-admitted to the facility on [DATE] with (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses including high blood pressure, a degenerative brain disease affecting memory, and kidney disease. The MDS showed Resident 53 was incontinent of bowels and was dependent on staff for assistance with toileting. Review of Resident 53's health records showed a hospitalization on 05/06/2026 returning to the facility on [DATE] admitting into room [ROOM NUMBER] with Resident 56. Resident 53's hospital discharge records showed a positive result for C-Diff (a highly contagious bowel infection) on 05/09/2026. Review of Resident 53's physician orders showed a 05/12/2026 orders for oral antibiotics to treat C-Diff and contact enteric precautions (precautions used to prevent the spread of infections of the bowels) to reduce the risk of spreading the infection to others. Review of Resident 53's 05/29/2026 loose stool care plan showed an intervention for contact enteric precautions, to place resident in a private room and if a private room was not available to place resident in a room with another resident with the same condition. In an observation on 06/02/2026 at 4:46 AM showed Resident 53 had a contact enteric precaution sign posted outside of room instructed staff to don gloves and gowns before entering room and to wash hands with soap and water before leaving room. In an observation on 06/02/2026 at 4:47 AM showed Staff X (CNA - Certified Nursing Assistant) and Staff Z (CNA) provided peri care to Resident 53 without wearing gowns, wearing gloves only. Staff Z left Resident 53's room and while wearing the same gloves entered a room across the hall to answer a call light. Staff Z then left the room across the hall, removed gloves and used hand sanitizer and returned to Resident 53's room without wearing gown or gloves. In an observation on 06/02/2026 at 4:48 AM showed Staff X left Resident 53's room with a bag of linens and went into a room across the hall with the same bag. In an interview on 06/02/2026 at 4:49 AM Staff Z stated they were supposed to wear gown and gloves every time they entered Resident 53's room and wash hands with soap and water before leaving but did not. In an interview on 06/02/2026 at 5:39 AM Staff X stated they should not have brought a bag of linens from Resident 53's room to another room due to the risk of cross-contamination. <Resident 56> According to the 04/24/2026 admission MDS Resident 56 admitted to the facility on [DATE] with diagnoses of Human Immunodeficiency Virus (HIV &ndash; a virus that attacks the immune system making the body vulnerable to infections), chronic wounds to the lower legs, and high blood pressure. Review of Resident 56's 04/29/2026 impaired immunity care plan showed an intervention to keep the environment clean and people with infections away. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review Resident 56's health records showed that they admitted into room [ROOM NUMBER] and received Resident 53 as a roommate on 05/12/2026. Review of a 05/28/2026 Order note showed that Resident 56 began having loose stools and a provider ordered for a stool sample to be collected to test for C-Diff. Review of Resident 56's Physician Orders showed a 05/28/2026 order for contact enteric precautions for loose/watery stools. In an interview on 05/27/2026 sat 3:06 PM Staff D (Infection Preventionist) stated when a resident with C-diff is admitted to the facility they should be admitted to a private room to prevent the spread of infection. Staff D could not say how or why Resident 53 and Resident 56 shared a room. Staff D stated the entire room would be considered contaminated when a resident with c-diff resides there, which is why staff should put on PPE (gowns and gloves) prior to entering the room. Staff D stated it was important for staff to read and follow the precaution signs outside the door of the rooms to ensure they do not potentially spread infections. In an interview on 06/03/2026 at 9:11 AM Staff B (Director of Nursing) stated it was their expectation that staff follow the signs outside the rooms for residents on transmission-based precautions. Staff B stated that the facility had to be careful when placing residents on transmission-based precautions with another resident as they had to be mindful of those who were immunocompromised. Staff B stated that residents with C-Diff should have a room by themselves. <EBP> <Resident 84> According to the 05/04/2026 5 Day Medicare MDS, Resident 84 admitted to the facility on [DATE] and had Medically complex conditions including cancer and seizure disorder. The MDS showed Resident 84 had unstageable pressure ulcer and was dependent on staff to meet their daily needs. Observation on 05/27/2026 at 9:00 AM showed an EBP sign posted outside Resident 84's door. Observation on 05/27/2026 at 10:10 AM showed Staff J (Licensed Practical Nurse) entered Resident 84's room, had medications crushed and mixed with apple sauce in a cup in their hands and was not wearing gloves or gown. Staff J explained and tried to administer medications to Resident 84. Resident 84 spit some of the medications out and Staff J grabbed a tissue and cleaned Resident 84's mouth with no gloves on. Then Staff J tried to administer nasal spray to Resident 84 without gloves but Resident 84 turned their face away. In an interview on 05/27/2026 at 10:26 AM, Staff J stated they did not see the EBP sign posted outside Resident 84's room. Staff J stated they should follow the sign posted outside Resident 84's room. In an interview on 05/29/2026 at 9:00 AM, Staff D stated they expected staff to follow the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	instructions on EBP sign posted outside resident's room, but they did not. Staff D stated staff should follow EBP precautions to prevent the spread of infection. <Hand Hygiene> <Resident 91> Observation and interview on 06/01/2026 at 3:04 PM Staff R (Licensed Practical Nurse) provided wound care to Resident 91. Prior to wound care, Staff R donned 3 pairs of gloves. Staff R removed the old, soiled dressing from Resident 91's wound, removed the top layer of gloves, and prepared the new gauze to be applied to Resident 91's wounds. Staff R removed another layer of gloves and cleaned the wounds with normal saline and gauze. Staff R removed the third layer of gloves, did not perform hand hygiene and placed another pair of gloves on. Staff R applied gauze and skin prep to wounds, removed their gloves and did not perform hand hygiene. Staff R placed two layers of gloves on and wrapped the wounds with a gauze wrap. Staff R removed the top layer of gloves and secured the dressing with an ace bandage and changed their gloves without performing hand hygiene. Staff R discarded linens and garbage then removed gloves. Staff R stated they were expected to perform hand hygiene before putting gloves on. Staff R stated they layered the gloves, so they didn't have to perform hand hygiene between dirty and clean cares or between glove changes. In an interview on 06/02/2026 at 10:01 AM Staff E (Unit Care Coordinator) stated they expected staff to perform hand hygiene between dirty and clean cares and glove changes. Staff E stated staff were not supposed to layer gloves in place of hand hygiene. Staff E stated proper hand hygiene was important to prevent the spread of infections. Reference: WAC 388-97-1320 (1)(a)(c), (3).		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Advance Directives (AD) for 2 of 3 residents (Residents 48 & 9) reviewed were in place in the event residents became incapacitated to make medically related healthcare decisions. The facility failed to follow up on guardianship status (Resident 48) and failed to ensure the AD was accessible to staff as required (Resident 9). These failures placed residents at risk of losing their right to have their stated preferences and decisions honored regarding medical treatment and/or end-of-life care. Findings included . <Facility Policy>The facility policy titled, Area of Focus: AD, reviewed [DATE], showed the facility provided residents and their representatives the policy regarding AD and applicable State law upon admission to the facility, quarterly, and when a change in the resident's condition was noted. The policy showed the Social Services Director (SSD) or designee would assist residents with updating AD documents that needed revision. The policy showed the SSD or designee would ensure resident AD was present and documented in the medical records in accordance with state and federal requirements. <Resident 48>According the [DATE] Quarterly Minimum Data Set (MDS - an assessment tool), Resident 48 had medical conditions including memory deficits, disorganized thinking, mental health problems with behavioral disturbance, and a brain injury with resulting weakness to one side of their body. The MDS showed Resident 48 and their legal guardian participated in the assessment and goal setting process. The [DATE] AD Care Plan (CP) showed Resident 48 elected full code for their life-sustaining treatment. The CP showed Resident 48 was under the care and supervision of a duly appointed guardianship/conservator (a court-appointed individual or organization tasked with managing the financial affairs, daily life, or medical decisions of a person deemed unable to do so themselves). On [DATE] at 10:39 AM, review of Resident 48's medical records showed their legal guardianship letter expired on [DATE]. In a joint interview on [DATE] at 10:15 AM with Staff G (SSD) and Staff H (Social Services Assistant), Staff G stated an AD was important to have because it would help residents and their representatives remember what the resident's wishes and preferences were when needed, .[AD] would validate or speak for them [residents] when they can no longer do so themselves during healthcare decision-making. Staff H stated they ask residents and their representatives regarding their AD status (either with current delegation or the lack thereof) during their initial cognitive evaluation with the resident or during care conferences. Staff G validated Resident 48's guardianship records on file and stated they were expired. <Resident 9>According to the [DATE] Discharge MDS, Resident 9 sustained a fall with major injury while at the facility and was sent to the hospital. A [DATE] Entry MDS tracker showed Resident 9 readmitted back to the facility. The [DATE] Significant Change in Status MDS showed Resident 9 initially admitted to the facility on [DATE], was alert and oriented, had clear speech, and had medical conditions including heart and respiratory failure, unstable blood sugar levels and mental health problems. In an observation and interview on [DATE] at 11:26 AM, Resident 9 was observed lying in bed; they were breathing supplemental oxygen via a cannula to their nose and had a brace on their left leg. Resident 9 stated they had their AD in place and had elected their brother to be their Durable Power of Attorney for Healthcare (DPOA-HC). On [DATE] at 9:31 AM, review of Resident 9's medical records did not show any AD listed for the resident that was accessible to staff as required. In a joint interview on [DATE] at 10:15 AM with Staff G and Staff H, Staff H reviewed Resident 9's medical records and stated the resident's AD was not on file. Staff H stated that in the event Resident (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9 could no longer make medical decisions on their own, the facility could not honor the resident's brother as the DPOA-HC during an emergency if the facility did not have the AD paperwork on file. REFERENCE: WAC 388-97-0280 (3)(c)(i-ii).		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain comfortable sound levels in the environment for 1 of 4 units (100 hall). This failure placed residents at risk for diminished quality of life. Findings included. <Policy> According to the facility's 04/01/2026 Resident Belongings and Home Like Environment policy, the facility would provide a comfortable and homelike environment. The policy provided did not address comfortable sound levels in the facility. <100 Hall> In an interview on 05/27/2026 at 11:09 AM, Resident 27, who resided in room [ROOM NUMBER], stated the television down the hall was too loud at night. Resident 27 stated they had reported it to staff, but it was not resolved. In an observation at the nurse's station on 06/02/2026 at 4:40 AM, loud televisions could be heard from rooms [ROOM NUMBERS] at the end of the hallway. Upon entering the rooms, it was observed that the residents were asleep with the televisions on and the volume turned up. In an interview on 06/02/2026 at 9:09 AM, Staff B (Director of Nursing) stated staff should encourage residents to lower television volume at 10:00 PM to ensure comfortable sound levels for others at night, and to provide headphones for residents that would prefer louder sounds at night to not impede the sleep of others. Staff B stated that this did not occur but should have. REFERENCE: WAC 388-97-0880(4)(b)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to comprehensively assess and monitor the needs of physical restraints for 1 of 3 residents (Resident 12) reviewed for physical restraints. This failure placed residents at risk for harm and diminished quality of life. Findings included.<Facility Policy>According to the facilities policy titled, Physical Restraint Use, dated 09/03/2025, the intent was for each resident to attain and maintain their highest practicable well-being in an environment that prohibited the use of physical restraints for discipline or convenience and prohibited the use of physical restraints to unnecessarily inhibit a resident's freedom of movement. The policy showed when alternatives to restraint use were not effective, the facility should evaluate the least restrictive restraint to promote safety for the residents and should have documentation including physician orders, informed consent, care plans, and reevaluation in resident's records.<Resident 12>Resident 12 readmitted to the facility on [DATE]. According to the 05/04/2026 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 12 was cognitively severely impaired, unclear speech, and had diagnoses of stroke with weakness on one side of their body. The MDS showed Resident 12 was dependent on staff with transfers from bed to wheelchair. The MDS showed Resident 12 was not currently using any form of physical restraints.Observations on 05/27/2026 at 9:33 AM and 05/28/2026 at 8:25 AM showed Resident 12 was lying in their bed. Resident 12's bed was against the wall (right side of the resident), was in lowest position, and floor mat on left side of their bed. Additionally, two folded pillows were tucked under the left side of the mattress causing a large barrier bump. Resident 12 was attempting to move in bed but could not move because of the large bump in the mattress due to pillows underneath the mattress. Observation on 05/29/2026 at 7:30 AM showed Resident 12 was sleeping in their bed. Resident 12's bed was against the wall, in a lowest position with floor mat on left side of the bed, and three folded pillows were tucked under the mattress to restrict the resident from getting out of their bed.In an interview on 05/29/2026 at 7:50 AM, Staff W (Certified Nursing Assistant) Stated they did not work with Resident 12. Staff W stated night shift staff might have tucked the pillows under the mattress to prevent the resident rolling out of bed. Review of Resident 12's record included physician orders, evaluations, and care plans, showed no evidence that the facility had assessed the resident's condition that would warrant use of restraints for the purpose of convenience. In an interview on 05/29/2026 at 8:10 AM, Staff B (Director of Nursing) stated putting pillows under the resident's mattress to prevent resident from moving in bed or from getting out of the bed was not acceptable and could be considered restraints.Reference: WAC 388-97-0620 1(a)(b)2(d).		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a discharge summary that included a recap of the residents stay and reconciliation of all medications for 1 of 3 residents (Residents 4) reviewed for discharge process and offer a bed hold for 1 of 2 residents (Resident 86) reviewed for hospitalizations. Failure to properly prepare residents for discharge placed residents at risk of rehospitalization, negative health outcomes, and a break in continuity of care. Failure to offer/provide a bed hold to the resident/resident representative placed residents at risk for not having an opportunity to make informed decisions about their transfer/discharge rights. Findings included .<Policy>According to the facility policy titled, Against Medical Advice (AMA) Discharges, dated 08/29/2025, the facility would conduct a safe AMA discharge for residents requesting to discharge earlier than outlined in their Care Plan (CP). The policy showed the facility would complete the required documentation and provide written discharge instructions as with any discharge. According to the facility's undated NW Bed Notification policy the facility would provide the resident or their representative with a copy of the bed hold form upon transfer to the hospital or within 24 hours in the case of an emergency. The policy stated the facility would document multiple attempts to reach resident representatives in cases where they were unsuccessful.<Resident 4> According to the 05/22/2026 Discharge Return Not Anticipated Minimum Data Set (MDS) Resident 4 admitted to the facility on [DATE]. The MDS showed Resident 4 had diagnoses of a bone infection, heart failure, and unstable blood sugar dependent on insulin. Review of Resident 4's health records showed a 05/22/2026 progress note Resident 4 wished to discharge AMA. Resident 4's health records showed no discharge summary or medications were offered or provided to ensure a safe discharge. In an interview on 06/01/2026 at 2:03 PM Staff B (Director of Nursing) stated they expected staff to offer and provide Life-sustaining medications, if they had them available, to residents who discharged AMA. Staff B stated they expected staff to provide a recap of the residents' stay. Staff B stated the facility provider would not write scripts or call in prescriptions for residents discharged AMA to ensure a safe discharge. Staff B reviewed Resident 4's health records and stated staff did not offer/provide a recap of their stay or send them with Life-sustaining medications but should have. <Resident 86> According to the Discharge Return Not Anticipated MDS Resident 86 admitted to the facility on [DATE] with diagnoses of respiratory failure, kidney disease, and low blood pressure. Review of Resident 86's health record showed a 04/13/2026 progress note stated the resident was transferred to the hospital due to a health emergency and the facility was not able to contact their representative. There were no notes regarding offering or attempting to offer a bed hold for Resident 86's unplanned discharge. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/03/2026 at 9:05 AM Staff B stated it was expected of staff to offer a bed hold for Resident 86 at the time of discharge, or to have offered to Resident 86's representative. Staff B reviewed Resident 86's health record and stated that did not happen but should have. Reference: WAC 388-97-0080 (5), -0120(3)(a), (4).		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS - an assessment tool) of 1 of 20 residents (Resident 21) were completed accurately to reflect the resident's condition and health status. The facility failed to identify Resident 21's appropriate diet and Restorative Nursing Program (RNP) exercises. This failure placed Resident 21 and other residents at risk for unmet care needs and a decreased quality of life. Findings included . <Facility Policy>The facility policy titled, Certification of Accuracy of the MDS, reviewed 08/29/2025, showed the MDS assessment must accurately reflect the resident's status. The policy showed a registered nurse must conduct and coordinate each assessment with the appropriate participation of health professionals. The policy showed appropriate health professionals would correctly identify and document assessed needs necessary for care planning to maintain and/or improve the resident's medical status and functional abilities. <Resident 21>According to the 05/14/2026 Quarterly MDS, Resident 21 was alert, capable of verbalizing their needs, and had medical conditions including heart failure, a chronic, progressive neurological disorder affecting their movement, and was on a mechanically altered and therapeutic diet. The MDS showed Resident 21 had functional limitations in Range of Motion (ROM) in both their upper and lower limbs and was provided active ROM exercises during the look back period. In an observation and interview on 05/27/2026 at 8:41 AM, Resident 21 was lying in bed and was observed to have very minimal ability to move independently. A left-hand splint was observed applied on Resident 21's hand/wrist. At 1:24 PM, Resident 21 stated they did not like eating mashed-up foods and wished the kitchen staff would serve them more regular food items. The revised 05/19/2026 nutrition Care Plan (CP) showed Resident 21 was at risk for malnutrition and listed a 02/12/2026 CP intervention showing the resident's current diet order: Mechanically Altered, thin liquids, diet condiments. The CP did not show Resident 21 was on a therapeutic diet. The revised 03/13/2026 functional CP showed Resident 21 had limited physical mobility, weakness, and contractures. A 02/26/2026 RNP CP intervention showed Resident 21 was on passive ROM exercises to prevent further deformities. Review of Resident 21's 02/12/2026 nutrition assessment showed the resident was on a regular diet. The items Therapeutic or Fortified Foods were not checked off by the Registered Dietician (RD) as applicable to Resident 21 during their evaluation. In a joint interview on 06/02/2026 at 8:54 AM with Staffs AA and BB (Registered Nurse MDS Coordinators), Staff AA stated it was important for the MDS assessment to be accurate because it was the basis of a resident's CP. Staff AA reviewed Resident 21's MDS and stated they coded therapeutic diet because of the diet condiments ordered for the resident. Staff AA reviewed Resident 21's medical records and stated the resident was not capable of actively participating with RNP exercises because of the resident's functional mobility deficits. Staff AA stated Resident 21 was provided with passive ROM exercises (as opposed to active ROM exercises) and that the RNP was inaccurately coded in the MDS. In an interview on 06/02/2026 at 11:37 AM, Staff CC (RD) stated Resident 21 was not on a therapeutic diet. Refer to F688- Increase/Prevent Decrease in Range of Motion/Mobility. REFERENCE: WAC 388-97-1000(1)(a)(b)(4)(a).		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct care conferences for residents and their representatives and the applicable Interdisciplinary Team (IDT) members for 2 of 3 sample residents (Residents 5 & 41) reviewed for care planning. These failures placed residents at risk for inconsistent and/or inadequate care and treatment, a diminished quality of care, unmet care needs, and other negative health outcomes. Findings included. <Facility Policy> Review of a 08/29/2025 Comprehensive Care Plans and Conferences policy showed the facility would ensure the timeliness of each resident's person-centered, comprehensive CP, ensure the CP was reviewed and revised by an IDT, and that each resident and their representative, if applicable, was involved in developing the care plan and making decisions about their care. Care plans were to be revised based on changing resident needs. The facility had the responsibility to assist residents to engage in the care planning process including care planning conferences, and to encourage their representatives to attend. <Resident 5> According to the 03/06/2026 Quarterly Minimum Data Set (MDS &ndash; an assessment tool), Resident 5 admitted to the facility on [DATE]. The MDS showed Resident 5 had no memory impairment. The MDS showed Resident 5 had diagnoses of adult failure to thrive and schizophrenia. The assessment showed Resident 5 did not exhibit any behaviors during the assessment period. Review of Resident 5's health records showed the last care conference offered and provided was 12/01/2025. Resident 5's health records showed no quarterly care conference was offered and provided since 12/01/2025. In an interview on 05/28/2026 at 9:22 AM Resident 5 stated they understood the facility would only offer a care conference annually. Resident 5 stated they would appreciate a care conference every few months to keep them up to date with their care and to be able to ask questions of the appropriate departments regarding their care when needed. In an interview on 06/02/2026 at 10:40 AM Staff G (Social Services Director) stated they expected care conferences to be offered and provided within four days of admission to the facility, quarterly, and as needed. Staff G reviewed Resident 5's records and stated they last had a care conference in December 2025 but had not had one offered since. Staff G stated care conferences were important to give the residents the opportunity to talk with their whole IDT and address specific concerns related to the different departments. Staff G stated they do not provide a copy of the resident care plan to the residents at each care conference but should. <Resident 41> Review of an admission Record, dated 06/02/2026, showed Resident 41 admitted to the facility on [DATE] and was their own Responsible Party. Resident 41 had two family members listed as emergency contacts, and one family member listed as Other. Review of a 04/02/2026 admission MDS showed Resident 41 had medically complex conditions and (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was able to understand and to be understood. Review of a progress note, dated 04/07/2026, showed Staff H (Social Services Assistant) attempted to contact two of Resident 41's family members to schedule a care conference but was unsuccessful. In an interview on 05/27/2026 at 12:17 PM, Resident 41 stated the facility told them they were going to have a care conference, but they never did. In an interview on 06/03/2026 at 8:52 AM, Staff G stated the facility process was to hold a care conference within 72 hours (three days) after a resident admitted to the facility. Staff G reviewed Resident 41's record and stated they were unsuccessful with attempts to contact family members on 04/07/2026, five days after admission, and no further attempts were documented. Staff G stated Resident 41 did not have a care conference with the IDT but should have. REFERENCE: WAC 388-97-1020 (2)(e)(5)(b).		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure physician's orders were followed for 1 of 2 residents (Resident 8) reviewed for bowel care and 2 of 5 residents (Residents 83 & 12) reviewed for Unnecessary Medications. The failure to follow orders for oxygen administration, bowel protocols, and parameters for blood pressure (BP) medications placed residents at risk for medication errors, unmet care needs, and other negative health outcomes. Findings included. <Facility Policy> According to a Bowel Protocol policy, reviewed 09/15/2025, the facility would provide effective interventions for signs and symptoms of constipation that were consistent with current standards of practice. Nursing staff would record each time a resident had a bowel movement (BM), and implement physician orders to address the lack of a BM. <Bowel Protocol> <Resident 8> According to the 04/04/2026 admission Minimum Data Set (MDS &ndash; An assessment tool) Resident 8 admitted to the facility on [DATE] with diagnoses of high blood pressure, stroke, and muscle weakness. The MDS showed that Resident 8 was incontinent of bowel and dependent on staff for assistance with toileting. Review of Resident 8's physician orders showed the following 02/27/2026 orders: An oral liquid laxative every 24 hours as needed for constipation A laxative suppository every 24 hours as needed for constipation if no results from the liquid laxative A different oral liquid laxative every 12 hours as needed for constipation Review of Resident 8's May 2026 task documentation showed no bowel movements from 05/14/2026 through 05/18/2026 a total of four days. Review of Resident 8's May 2026 Medication Administration Record (MAR) showed no laxatives were given for constipation. In an interview on 06/03/2026 at 8:46 AM Staff B (Director of Nursing) stated Resident 8 was monitored every shift for bowel movements and if they did not have one for three days an as needed laxative should be given. Staff B stated staff should have given a laxative to Resident 8 but did not. <Resident 83> According to the 05/04/2026 admission MDS Resident 83 had medically complex conditions including high blood pressure and constipation, was incontinent of bowel and bladder, and required substantial/maximal assistance with toileting hygiene. Resident 83 had cognitive impairments, was sometimes understood, and sometimes understood others. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 83's May 2026 MAR showed the following 04/28/2026 physician order's: Two oral laxative tablets every 12 hours as needed for constipation A liquid oral laxative every 12 hours as needed for constipation A different liquid oral laxative to be given if no BM for 48 hours A laxative suppository (administered rectally) to be given if no BM for three days STEP 1. An enema if no BM after suppository. STEP 3 bowel protocol &ndash; if suppository or enema were not effective, nurses were to assess the resident, document in progress notes and notify MD for instructions. Review of Resident 83's task documentation, 04/30/2026 through 06/03/2026, showed the following: No BM for six days, from 04/30/2026 through 05/05/2026, then a BM on 05/06/2026. No BM for four days, from 05/10/2026 through 05/13/2026, then a BM on 05/14/2026. No BM for five days, from 05/22/2026 through 05/26/2026, then a BM on 05/27/2026. No BM for six days, from 05/28/2026 through 06/02/2026, then a BM on 06/03/2026. Review of Resident 83's May 2026 and June MARs showed the following: A laxative suppository was given on 05/05/2026 after no BM for five days. A laxative suppository was given on 05/26/2026 after no BM for four days. An additional laxative suppository was given on 05/27/2026 after no results from the first suppository, instead of an enema per physician orders. A liquid laxative was given on 06/02/2026 after no BM for five days. No other medications to address the lack of a BM were given from 05/01/2026 through 06/02/2026. Review of a 5/30/2026 progress note showed Resident 83 refused a laxative after staff offered three times during that shift. No other documentation was found to show refusals of medications to treat constipation. In an interview on 06/02/2026 at 8:28 AM, Staff C (Assistant Director of Nursing) stated when a resident did not have a BM for three days, a clinical alert was generated that was visible to nurses. Nurses were to offer the laxatives in sequence, according to the resident's physician orders. Staff C stated nurses should check the clinical alerts every shift. Staff C stated they reviewed the BM list (a (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	listing of residents with no BM for three days) every day and informed nurses when they needed to start the bowel protocol. Staff C reviewed Resident 83's BM task documentation and MARs and stated each time Resident 83 did not have a BM for three days, nurses should have started the bowel protocol on day three, but they did not. <BP Medication Parameters> <Resident 83> Review of Resident 83's May 2026 MAR showed a 05/15/2026 physician orders for a BP medication to be given once daily, with instructions to hold (do not give) the medication for a systolic BP (SBP &ndash; the top number in a BP reading) less than 110. The medication was given on 05/23/2026 with an SBP of 103, and on 05/27/2026 with an SBP of 101. In an interview on 06/02/2026 at 8:28 AM, Staff C stated that nurses were to check Resident 83's BP results prior to giving the BP medication to ensure it met the ordered parameters. Staff C stated the BP medication should have been held on 05/23/2026 and 05/27/2026, but it was not. <Resident 12> According to the 05/04/2026 Quarterly MDS Resident 12 had diagnoses of stroke with weakness on left side of their body and received hospice care. The assessment showed Resident 12 was dependent on staff for daily activities including personal hygiene and transfers. Review of the May 2026 MAR showed Resident 12 had a 11/03/2025 physician orders to have oxygen at 2 liters per minute continuously per nasal canula. Observations on 05/26/2026 at 10:21 AM, on 05/27/2026 at 8:37 AM and at 12:43 PM showed Resident 12 was lying in their bed in their room and had no oxygen on. Other observations on 06/01/2026 at 9:14 AM and 11:32 AM showed Resident 12 was up in their wheelchair in hallway and had no oxygen on. In an interview on 06/01/2026 at 12:18 PM, Staff E (Unit Care Coordinator) stated their expectation was for staff to follow the physician orders. Staff E reviewed Resident 12's record and stated staff should clarify the order with provider and follow as ordered, but they did not. REFERENCE:WAC 388-97-1620(2)(b)(i)(ii)(6)(b)(i).		

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F 0684 Level of Harm - Minimal harm or potential for 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** Based on observation, interview, and record review the facility failed to ensure residents' skin was assessed, documented, monitored, and treated as required for 2 of 5 residents (Residents 5 & 11) reviewed for non-pressure skin issues. These failures placed all residents at risk for delay in treatment, worsening of condition, and decreased quality of life. Findings included.<Policy>According to the facility policy titled, Area of Focus: Basic Skin Management, dated 12/03/2024, the facility would ensure all residents had a weekly head to toe skin assessment documenting a thorough description of all skin alterations at the time of the assessment.<Resident 5> According to the 03/06/2026 Quarterly Minimum Data Set (MDS &ndash; an assessment tool) Resident 5 had no memory impairment. The MDS showed Resident 5 was at risk for skin injuries and required staff assistance with all Activities of Daily Living (ADL). The assessment showed Resident 5 had diagnoses of general muscle weakness and adult failure to thrive. Review of a 01/10/2025 ADL self-care performance deficit Care Plan (CP) staff would ensure Resident 5 had weekly skin assessments completed every Saturday. The CP showed nurses would assess Resident 5 for any skin alterations. Review of a weekly skin assessment on 05/23/2026 showed no skin alteration to Resident 5's right forearm. Observation and interview on 05/28/2026 at 9:31 AM Resident 5 had a six-centimeter-long x four-centimeter-wide dark purple bruise to their right forearm. Resident 5 stated staff were not monitoring and did not come in to look at it. Review of a weekly skin assessment on 05/30/2026 showed no documentation of Resident 5's skin alteration to their right forearm. In an interview on 06/01/2026 at 2:03 PM Staff B (Director of Nursing) stated they expected staff to do weekly skin assessments documenting a description with measurements, color, breaks in skin, and any swelling. Staff B reviewed Resident 5's weekly skin assessment and stated staff did not assess and document the dark purple bruise to Resident 5's right forearm but should have. Staff B stated it was important to assess and document all skin alterations to be able to monitor for worsening or improvement. In an interview on 06/02/2026 at 8:24 AM Staff E (Unit Care Coordinator) stated staff should have documented Resident 5's dark purple bruise to their right forearm but did not. Staff E stated it was important to assess for worsening and/or improvement. <Resident 11> According to the 04/14/2026 Quarterly MDS Resident 11 re-admitted to the facility on [DATE] with diagnoses of wounds to the lower legs, heart failure, and kidney disease. The MDS showed Resident (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11 had non-pressure related wounds to the lower extremities. Review of Resident 11's 06/05/2025 chronic ulcer CP showed interventions to perform weekly skin checks. Review of Resident 11's physician orders showed a 03/27/2026 active wound care order for wounds to right leg and 04/16/2026 active wound care order for wounds to the left leg. Review of Resident 11's health record showed a 05/08/2026 progress note that stated the wounds had resolved. There were no further wound assessments seen and wound care orders were still in place. In an interview on 05/28/2026 at 9:01 AM Resident 11 stated they had chronic wounds to their lower legs. In an observation on 05/29/2026 at 10:19 AM showed Staff U (Licensed Practical Nurse) provided wound care for Resident 11 with wounds to both legs present. In an interview on 05/29/2026 at 10:40 AM Staff U stated Resident 11 had chronic wounds to both legs since admission. In an interview on 06/01/2026 at 1:11 PM Staff F (Unit Care Coordinator) stated wounds should be evaluated weekly for signs of healing and/or infection and to assess if interventions/treatments are effective. Staff F stated they were unaware that Resident 11's wounds had returned and should have been notified. Staff F reviewed Resident 11's health record and stated the wounds should have been seen in the weekly skin assessments but were not. Reference: WAC 388-97-1060(1).		

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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 observation, interview, and record review, the facility failed to ensure effective pain management was provided to residents, consistent with professional standards of practice, for 2 of 3 sampled residents (Residents 21 & 38) reviewed for pain management. The failure to offer non-pharmacological interventions to residents experiencing pain, investigate causes of pain, and notify the physician for appropriate pain management placed residents at risk for untreated pain, unnecessary discomfort, and a decreased quality of life. Findings included .<Facility Policy>According to the facility's 12/02/2025 Pain Management policy, the facility would ensure pain management was provided to residents who needed it, consistent with professional standards of practice and the resident's comprehensive assessment and care plan. <Resident 21> According to the 05/14/2026 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 21 was alert, capable of verbalizing their needs, and had medical conditions including muscle pain and spinal cord degeneration with back pain. The MDS showed Resident 21 had severe pain which affected their sleep and day-to-day activities during the assessment period. Review of the revised 03/13/2026 pain Care Plan (CP) showed Resident 21 had pain/discomfort on their back, muscle rigidity, and chronic pain. A 02/09/2026 CP intervention instructed staff to evaluate the effectiveness of Resident 21's pain management. A 03/13/2026 CP intervention directed staff to notify the physicians if interventions were unsuccessful or if Resident 21's current complaint was a significant change from the resident's past experience of pain. In an observation and interview on 05/27/2026 at 1:36 PM, Resident 21 was observed with facial grimacing and their body appeared tense while lying in bed. Resident 21 stated they had a lot of pain issues including muscle spasms and rated their current pain 9/10 (using a pain scale where zero (0) was without pain and 10 as having severe pain). Resident 21 stated their pain was not managed effectively. Review of the May 2026 Medication Administration Record (MAR) showed Resident 21 had PRN (as needed) pain medication for a pain rating of 1-4/10. The MAR did not show Resident 21 had PRN pain medication available to them for a pain rating of 5/10 or higher. On 05/03/2026, Resident 21's pain rating was documented as 7/10 and the nurse administered the PRN medication available which was not intended for the resident's pain rating based on the parameters outlined as ordered. In an interview on 06/02/2026 at 10:54 AM, Staff B (Director of Nursing) stated pain management was important because adequate pain control ensured resident's had quality of life. Staff B stated they expected the nursing staff to follow pain medication parameters and to administer them as ordered. Staff B reviewed Resident 21's May 2026 MAR and stated the nurse should not have administered the PRN pain medication available for a pain rating of 1-4/10 to Resident 21 since the resident reported a higher pain level. Staff B stated the nurse should have notified the physician, informed them of Resident 21's pain rating of 7/10, and obtained an order for what pain medication to administer, but (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they did not. <Resident 38> According to the 04/09/2026 Quarterly MDS, Resident 38 admitted to the facility on [DATE] with diagnoses of heart failure, hypertension, and stroke. The MDS showed Resident 38 had occasional moderate pain during the assessment period. Review of Resident 38's 01/08/2026 pain CP showed interventions to respond immediately to complaints of pain and to evaluate the effectiveness of pain medications. Review of Resident 38's physician orders showed a 01/19/2026 order for a non-narcotic pain medication to be given three times a day for mild to moderate pain, and a 05/01/2026 order for a muscle relaxer to be given three times a day for neuropathic pain. Review of Resident 38's health records showed pain levels at 10/10 on 05/10/2026 at 2:20 PM and at 8:40 PM. There were no notes in Resident 38's health record to indicate physician notification, pain assessment, or any interventions provided to address the resident's 10/10 pain. Resident 38's health records showed a zero out of 10 pain level at 10:02 PM on 05/10/2026. In an interview on 05/28/2026 at 8:26 AM, Resident 38 stated they did not feel the facility was managing their pain well. In an interview on 06/01/2026 at 1:20 PM, Staff F (Unit Care Coordinator) stated Resident 38's pain on 05/10/2026 should have been assessed and the physician notified, but these did not occur. In an interview on 06/02/2026 at 6:56 AM, Staff D (Infection Preventionist) stated they were the assigned nurse who documented the 10/10 pain for Resident 30 on 05/10/2026. Staff D stated they should have notified the physician as there was no as needed pain medication available to administer, but they did not. REFERENCE: WAC 388-97-1060(i), -1620(2)(b)(i)(ii).		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure expired medications were discarded timely for 1 of 2 medication storage rooms (North Medication Room) and to ensure medications were labeled appropriately in 1 of 4 medication carts (200 Hall Medication Cart) reviewed for medication storage. This failure placed residents at risk for receiving incorrect or expired medications, ineffective treatment, and diminished quality of life. <North Medication Room> Observation on 05/29/2026 at 8:00 AM in the North Medication room showed the following: Three inhalers (portable handheld devices that deliver medication via a fine mist, spray, or powder to be inhaled orally) that were opened with no open date. Two boxes containing vials of nebulizer medication (liquid medicine that is converted into a fine, breathable mist by a machine called a nebulizer) with expiration dates of 07/10/2025 and 10/29/2025. Vaccines stored in the refrigerator with expiration dates of 02/12/2025, 05/02/2025, 07/31/2025, and 10/23/2025. Review of a 2024 Medication Storage Guidance provided by Omnicare pharmacy showed the inhalers were to be discarded three months after opening. In an interview on 05/29/2026 at 8:15 AM, Staff D (Infection Preventionist) stated the inhalers should have been dated when opened but they were not. Staff D reviewed the found items and stated the medications were expired and should have been discarded or returned to the pharmacy, but they were not. <200 Hall Medication Cart> Observation and interview on 05/29/2026 at 10:51 AM showed a medicine cup containing five oral medications, including tablets and capsules of varying shapes and colors, was stored in the top drawer of the 200 Hall Medication Cart. The medication cup had no labeling to indicate what the medications were or which resident they were for. Staff U (Licensed Practical Nurse) stated they were not aware the medication cup with medications was in the drawer and did not know which resident they were for. Staff U stated the medications should have been discarded but were not. REFERENCE: WAC 388-97-1300(2).		

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 06/03/2026
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)		
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review the facility failed to implement an Antibiotic Stewardship Program to promote appropriate use of antibiotics and reduce the risk of unnecessary antibiotic use for 1 of 5 residents (Resident 91) reviewed for unnecessary medications and 1 of 1 supplemental residents (Resident 53). This failure placed residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of antibiotics. Findings included. <Policy>According to the facility's 06/02/2025 Infection Prevention and Control Program (IPCP) and Plan policy, the facility would conduct antibiotic surveillance to review the appropriateness of antibiotics in the facility to prevent unnecessary antibiotic use.<Resident 91>Review of Resident 91's health records showed they were receiving an intravenous antibiotic starting on 05/27/2026 with no stop date.<Resident 53>Review of Resident 53's health records showed they received an oral antibiotic from 05/12/2026 through 05/19/2026. Review of the facility's May 2026 Line Listing showed Resident 53 and Resident 91 were not listed as having an infection or receiving antibiotics. In an interview on 06/02/2026 at 11:57 AM Staff D (Infection Preventionist) stated they reviewed all antibiotic orders for appropriateness using McGeer's criteria (a tool used to determine antibiotic appropriateness) and included the review on the Line Listing for tracking and trending of infections. Staff D stated that it was important to review antibiotics to prevent unnecessary antibiotics and/or antibiotic resistance. Staff D reviewed the Line Listing and stated neither Resident 91 nor Resident 53 were listed but should have been. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii).		