STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER: Life Care Center of Port Orchard		STREET ADDRESS, CITY, STATE, ZIP CODE: 2031 Pottery Avenue Port Orchard, WA 98366	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on interview and record review, the facility failed to provide care and services adequate to prevent hospitalization for 2 of 3 residents (Residents 1 & 2) reviewed for hospitalization . The facility failed to provide and monitor for adequate hydration, recognize and intervene when decline occurred, and failed to notify physician and family of abnormal laboratory results. This failure placed residents at risk for dehydration, hospitalization , and a diminished quality of life. Findings included . Review of the facility policy, Hydration and Nutrition, revised [DATE], showed that each resident would receive sufficient fluids to maintain acceptable parameters of nutritional and hydration status. Review of the facility policy, Laboratory Services, revised [DATE], showed that laboratory services would meet the needs of residents and results would be promptly reported to the provider to address potential concerns, diagnose, and treat. <Resident 1> Resident 1 was admitted to the facility on [DATE] for aftercare and therapy services following lumbar and pelvic fractures. The admission Minimum Data Set (MDS), an assessment tool, dated [DATE], showed the resident had severe cognitive impairment, was dependent on staff for activities of daily living (ADLs), and had an indwelling catheter. The care plan, initiated [DATE], showed the resident was nutritionally at-risk secondary to swallowing difficulty and interventions included easy to chew texture, nectar thick liquids, assistance with meals, and for staff to report loss of appetite or refusals to eat. Review of the initial provider note, dated [DATE], showed Resident 1 was clinically stable and the provider ordered a CBC (complete blood count) and a BMP (basic metabolic panel), and nursing was to support with adequate oral hydration. A Skilled Nursing note, dated [DATE] at 4:39 PM, showed the resident was alert and oriented with clear speech, was receiving assistance with meals in the assisted dining room, was encouraged to increase fluid intake, and had a foley catheter that was draining yellow urine. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A skilled nursing note, dated [DATE] at 2:28 PM, showed the resident was alert, able to make needs known, pleasant and cooperative with care, eating meals in the dining hall, and had a catheter in place which was draining dark amber urine and their lung sounds were clear. Review of the provider note, dated [DATE], showed the resident was stable, with no reported concerns and the provider was awaiting the previously ordered lab results. A skilled nursing note, dated [DATE] at 1:56 PM, showed the resident was eating in the assisted dining room, required supervision and assistance with meals and the resident was encouraged to increase their fluid intake. Review of the laboratory sample received by an outside lab provider on [DATE] at 12:10 AM showed the results were reported to the facility at 2:40 PM, showed Resident 1 had elevated WBC's (white blood cells- a potential indicator of infection) of 11.8 (normal range is 3XXX,d+[DATE].8) and elevated sodium level (a potential indication of dehydration) at 147 (normal range is ,d+[DATE]). The lab results were review by facility staff and noted by the provider on [DATE]. An alert note, dated [DATE] at 11:32 PM, showed the resident was observed with a swollen penis and reports of pain. The provider was contacted, and an order was obtained to remove the catheter. A skilled nursing note, dated [DATE] at 2:41 PM, showed the resident was found with decreased oxygen saturations [no initial oxygen level was documented in the note], increased respiratory rate, and shallow breathing. Oxygen was applied and oxygen saturations were in the high 80's [normal with oxygen is 100%]. Provider and Family Member (FM) 1 were notified and instructions to transport the resident to the emergency room (ER) were given. Emergency Medial Services arrived and assessed the resident to be stable and a decision with FM 2 was made to not transport the resident. Review of the provider note, dated [DATE], showed the nurse reported at 9:30 AM the resident had cyanosis (when your skin, lips or nails turn blue due to a lack of oxygen in your blood) and oxygen saturations in the low 60's. The provider assessed the resident found to be sitting in his wheelchair, with oxygen saturations in the 70's on room air and a wet cough was noted. The provider spoke to FM 2 and recommended transport to ER, they agreed. When EMT's arrived their assessment was resident's oxygen was in the 90's on room air and a 12 lead EKG (electrocardiogram- a non-invasive medical test that records the electrical activity of the heart) was normal, the EMT's called FM 2, who declined resident transport to the ER. The provider note included that lab results were not available for the resident and new orders were given including a chest x-ray, CBC and CMP (complete metabolic panel). A skilled nursing note, dated [DATE] at 2:44 PM, showed the resident was alert and oriented, able to make his needs known, compliant with care and medications, was using supplemental oxygen. The note showed resident preferred eating in his room and was documented as independent after set up . A skilled nursing note, dated [DATE] at 11:37 AM, showed resident with weak hand grasps bilaterally and with 1+ non pitting edema to BLE [bilateral lower extremities] (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

A skilled nursing note, dated [DATE], at 2:32 PM, showed Resident 2 was alert but was not oriented and unable to make wants and needs known, non-compliant with medications and treatments during the shift. Oxygen was 98% on 2 liters. Hand grasps were weak bilaterally, 2+ non pitting edema to Bilateral lower extremities, resting in bed with eyes closed.

A skilled nursing, dated [DATE], at 2:33 PM, showed Resident 1 was unresponsive to verbal and physical stimuli, Vital signs were stable although oxygen saturation was 67% [critically low oxygen level - life threatening] with 5 liters continuous oxygen . family was notified and resident transported to ER.

Review of the Hospital admission record for [DATE] showed that Resident 1 was found to have received a significant fluid bolus enroute to and in the ER to correct dehydration with admitting diagnosis of shock, multi organ failure, acute renal failure, was positive for Influenza A (a highly contagious respiratory illness caused by influenza viruses that infects the nose, throat and lungs) and RSV (Respiratory Syncytial Virus - a common respiratory virus that primarily affects the lungs and respiratory tract), a UTI [urinary tract infection], and had elevate WBCs of 13.4 and a sodium level of 151 [frequently indicated dehydration]. Resident 2 expired on [DATE].

Review of the facility's infection control log for February 2025 showed the facility had identified cases of RSV on [DATE] and Influenza A on [DATE].

Review of Resident 1's February 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not show that fluid intake or urinary output was recorded.

Review of Resident 1's Task Record for Eating [DATE] through [DATE] showed the following:

Date Breakfast Lunch Dinner

,d+[DATE] ,d+[DATE]% ,d+[DATE]% ,d+[DATE]%

,d+[DATE] ,d+[DATE]% ,d+[DATE]% ,d+[DATE]%

,d+[DATE] ,d+[DATE]% ,d+[DATE]% ,d+[DATE]%

,d+[DATE] ,d+[DATE]% ,d+[DATE]% ,d+[DATE]%

,d+[DATE] no record no record ,d+[DATE]%

,d+[DATE] ,d+[DATE]% ,d+[DATE]% ,d+[DATE]%

,d+[DATE] ,d+[DATE]% Refused ,d+[DATE]%

,d+[DATE] ,d+[DATE]% ,d+[DATE]% ,d+[DATE]%

,d+[DATE] ,d+[DATE]% ,d+[DATE]% ,d+[DATE]%

,d+[DATE] no record

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:37 PM, Resident 1's FM1 said they visited the resident regularly and could see him getting weaker and weaker, he had previously been going to the dining room but then remained in his room, and staff fed him in bed and his last few days. FM1 said they could see he was not really responsive. FM1 said Resident 1 had a situation with his catheter, and the facility was supposed have done a urine test for infection and a chest x-ray but FM1 said they did not think that happened. FM1 said they moved Resident 1's room to keep a better eye on him, but it seemed his care completely disappeared. FM1 said staff knew about his concerns. On [DATE] at 1:18 PM, Resident 1's FM 2 said they received a call from EMTs on [DATE] reporting they arrived at the facility to transport Resident 1, but their assessment was he was medically stable at that time with improved oxygen levels, and she decided it was best not to transport the Resident to the ER based on that information. On [DATE] at 3:30 PM, Staff F, Nursing Assistant (NA), said Resident 1's changes in behavior, mood, appetite, or lethargy (abnormal sleepiness or inactivity) would cause concern and she would report those to the nurse. Staff F said they tried to monitor fluid intake for all residents, but it was only recorded for residents on fluid restriction. Staff F, said they did not recall Resident 1 having a decline, but he did not want to get up or eat at times and they would offer to feed him in his room. Staff F said they did not report concerns to LN staff other than he did not want to get up. They did not recall hearing concerns from family other than he was tired and not adjusting to the facility. On [DATE] at 3:55 PM, Staff E, Licensed Practical Nurse (LPN), said changes in vital signs or respiratory status would cause concern and they would report to the RCM (resident care manager), provider, and family. Staff E, said they didn't monitor fluid intake for all residents, only if they were on a fluid restriction or had a catheter or were receiving intravenous fluids. Staff E said documentation would be found in the nurses notes or flow sheet. Staff E said lab results were in the computer [electronic health record] or the RCMs would tell them what the results were. Staff E said the floor nurse was usually the one to notify the provider of lab results. Staff E said she could not recall anything specific regarding Resident 1's care and thought she only provided care for him once. Review of Resident 1's Progress notes from [DATE] to [DATE] show Staff E provided care to Resident 1on [DATE], [DATE], [DATE], and [DATE]. On [DATE] at 11:23 AM, Provider A, Nurse Practitioner, said, staff notify them of changes in condition usually by SBAR [situation-background-assessment-request often in written form left for provider], for non-urgent issues or a phone call for more urgent matters. Provider A said staff received lab results when staff placed them in her box to review or if she was called for abnormal or urgent labs results. Provider A said she ordered labs for Resident 1 and did not recall being informed of the results. Provider A said she recognized a decline in Resident 1 and requested he be sent to the ER and was not aware there were lab results in the resident record on that day. Provider A said the results may have changed her plan of care but most likely she would have requested they be repeated and the resident monitored. Provider A reviewed the signed copy of labs results and said she would have expected to receive them sooner. Provider A would have expected Resident 1 to be tested for respiratory viruses based on his symptoms and per facility's protocol. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:09 PM, Staff C, Infection Preventionist, Registered Nurse (RN), said in the beginning of the facility outbreak they were not testing all residents, just if they were symptomatic. When asked if a resident experienced shortness of breath, decreased oxygen levels and a cough, would she expect the resident to have been tested for influenza or RSV, Staff C said, not necessarily. Staff C said she was not aware of a decline in Resident 1. Staff C said she was not made aware Resident 1 was having signs or symptoms of influenza or RSV. Staff C noted there was a chest x ray and urine analysis ordered but was not able to locate the results. Regarding Resident 1's entry on the infection control log, Staff C said that was logged after his admission to the hospital and the facility was not yet in outbreak status at that time. Staff C said after the hospital notified them, they put a plan into place. At 12:21 PM, Staff D, LPN, RCM, said staff would notify the provider if a resident had experienced a change in condition such as increased weakness, altered mental status, falls with injuries, or shortness of breath and decreased oxygen levels. They would notify the provider by phone for acute changes or a written SBAR for non-urgent changes. When asked how they monitor resident fluid intake, Staff D said there was not a process. Staff D said they monitor food intake and if the residents were on a fluid restriction they would document on the MAR and the nurse documents intake in those instances. When asked how they monitor residents for dehydration, Staff D said they watch for signs and symptoms such as decreased output, lethargy, and skin tenting. Dehydration prevention included offering fluids and verbal cueing, and the kitchen supplied water pitchers. When asked if they monitor intake and output for resident with catheters, Staff D said they should be monitoring output, and it should be recorded. Staff D said they would expect a resident with shortness of breath, decreased oxygen levels and a cough to be tested for the flu, and RSV once the facility was aware they were in outbreak status. Regarding Resident 1, she recalled his family visited frequently and he ate in assisted dining unless he did not want to go, he was transported to the ER for unresponsiveness after previous decline in condition [on [DATE]] when EMTs were called but resident was not transported from the facility. Staff D said the resident had labs drawn on [DATE] and would have expected the provider to have been made aware on [DATE]. Staff D said staff usually print the labs out and place them in the provider box. Staff D said the labs showed the resident had elevated white blood cells and an elevated sodium level. When asked when the record showed those results were reviewed by facility staff, Staff D said, 8 days later. At 1:07PM, Resident 1's FM2 said, if they would have known Resident 1 had abnormal lab results on the 6th that potentially indicated infection and/or dehydration they would have absolutely told the EMTs to transport Resident 1 to the hospital on the [DATE]. <Resident 2> Resident 2 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed the resident had moderate cognitive impairment, and required substantial to maximum assistance from staff for ADLs. The care plan initiated on [DATE] identified the resident was at risk nutritionally secondary to variable intake, among other factors, with interventions including regular texture diet and thin fluids, and staff were to provide assistance with meals as needed. Review of Resident 2's progress notes from [DATE] to [DATE] showed no skilled nursing assessment documentation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Alert Note, dated [DATE] at 11:09 PM, showed Resident 2's family was concerned about increased lethargy and requested pain meds be held. Resident was placed on alert to monitor. Review of the Alert Note, dated [DATE] at 1:30 PM, showed the resident was found to be lethargic with elevated blood pressure and pulse. The Provider and family were notified, and the Resident was transported to the ER. Review of the Inpatient Hospital History and Physical Report, dated [DATE], showed an admitting diagnosis for Resident 2 included hypernatremia (high sodium level) and hypomagnesium (low magnesium level) and noted it was more likely related to poor oral intake. Resident was administered intravenous fluids. The resident remained hospitalized until [DATE] and then returned to the facility. Review of Resident 2's task record for eating from [DATE] to [DATE] showed the following: Date Breakfast Lunch Dinner ,d+[DATE] ,d+[DATE]% ,d+[DATE]% ,d+[DATE]% ,d+[DATE] ,d+[DATE]% ,d+[DATE]% ,d+[DATE]% ,d+[DATE] ,d+[DATE]% ,d+[DATE]% ,d+[DATE]% ,d+[DATE] no record no record ,d+[DATE]% ,d+[DATE] ,d+[DATE]% ,d+[DATE]% ,d+[DATE]% ,d+[DATE] ,d+[DATE]% ,d+[DATE]% ,d+[DATE]% ,d+[DATE] ,d+[DATE]% ,d+[DATE]% ,d+[DATE]% ,d+[DATE] no record ,d+[DATE]% ,d+[DATE]% ,d+[DATE] no record no record ,d+[DATE]% On [DATE] at 5:46 PM, Resident 2's FM1 said they were concerned about the decline the resident had following admission to the facility, she initially required a sit to stand (mechanical lift in which the resident participates and bears weight) for transfers and was talking and then she needed a Hoyer lift (mechanical lift in which the resident does not bear weight) and wasn't drinking water. They were putting her tray in front of her, but she didn't eat it. She went to the hospital with dehydration and an acute kidney injury. On [DATE] at 3:28 PM, Staff F said she was familiar with Resident 2 and recalled prior to her going to the hospital she just seemed drowsier and required more frequent checks. On [DATE] at 3:55 PM, Staff E said she recalled the resident's name but could not recall anything else regarding the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:23 PM, Staff D said the day before hospital transport Resident 2's [family member] reported lethargy and requested pain medication be held. The resident was transported to the hospital the next day for decreased level of consciousness. At 2:07 PM, Staff B, RN, Director of Nursing Services said there was a structured process for identifying and addressing a resident's change in condition: the NA would report changes to the LN (licensed nurse) and the LN would assess and report to the RCM, or Herself or Provider. Staff B said they do not monitor fluid Intake for all residents, only if they were on a fluid restriction or if a resident was identified at risk for dehydration. If a resident had a catheter they would monitor output. Regarding Resident 1 Staff B said she was not aware of a change in condition but recalled the resident was alert on the Thursday before he went to the hospital, he was transported due to non-responsiveness. Staff B did not know if Resident 1 was tested for influenza, stating they only had one case of RSV as of that Friday and did not recall if they had an influenza outbreak at that time. Staff B said Resident1 had labs drawn on [DATE] and they were reviewed by staff on [DATE]. Staff B said the lab results showed elevated WBCs, and an elevated sodium level which could have been a sign of mild dehydration. Staff B said the floor nurse usually reviewed labs and reported them to the provider but said there was not a system in the electronic charting that alerted staff that lab results were ready. Regarding Resident 2, Staff B said she was not aware of a decline in condition prior to them being sent to the hospital. Staff B said Resident 2's hydration status was not monitored prior to them going to the hospital. At 3:23 PM, Staff B said they would have expected staff to inform family and provider of test results for Resident 1 by [DATE]. Staff B was unable to provide documentation that fluid intake was being monitored for Resident 1 or Resident 2 prior to hospitalization . Reference WAC [DATE](1)