STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505210	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Orchard	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 - 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 interview and record review, the facility failed to obtain labs as ordered, review and report to provider abnormal labs timely, and failed to fully implement neurological assessments for 1 of 4 residents (Resident 1) reviewed for Quality of Care. This failure places all residents at risk of unmet care needs, decreased quality of life, and other potential health complications. Findings included. LabsReview of the facility policy titled, Laboratory Services, dated 09/23/2025, showed the facility would, ensure that laboratory services met the needs of residents, that results were reported promptly to the ordering provider to address potential concerns, and the facility would notify the provider of laboratory results that fall outside of clinical reference ranges and document the provider notification and any changes in treatment in the medical record.Resident 1 was admitted to the facility on [DATE] with a diagnosis including SIADH, (syndrome of inappropriate antidiuretic hormone- a condition where the body produces too much antidiuretic hormone leading to water retention and low blood sodium levels, and electrolyte imbalances), was cognitively impaired and required moderate assistance from staff for completion of activities of daily living.Review of the physician's order dated 03/30/3036 showed Resident 1 was receiving a daily medication to treat hyperkalemia (too much potassium). Review of the medication manufacturer guidelines showed the medication binds to potassium to prevent absorption, and potassium levels should be monitored to ensure they stayed within the recommended range of 3.5 to 5.0. Adverse side effects also included edema (fluid retention) due to increased sodium in the medication. Review of the physician's order dated 04/01/2026, showed the facility was to obtain a BMP (basal metabolic panel- blood test) every Friday for three weeks; scheduled on 04/03/2026, 04/10/2026, and 04/16/2026. Review of Resident 1's electronic health record (EHR) showed lab results for 04/03/2026. Review of the Provider note dated 04/09/2026 showed Resident 1 was noted to have 2+ bilateral feet and ankle edema (swelling). There were no lab results for the scheduled 04/10/2026 lab order.Review of the Provider note dated 04/14/2026 showed Resident 1 had Lower extremity edema and a BMP was ordered.Review of the provider note dated 4/16/2026 showed a BMP was ordered on 4/14 and there were no results yet. Resident 1 continued to have 3+ bilateral pedal (both feet) edema. Review of Resident 1's EHR showed the lab results for the 04/16/2026 draw was received on 04/17/2026 at 2:21am, with multiple abnormal results, including a potassium level of 3.3 and Carbon dioxide level of 39 (normal 20-32, elevated levels can indicate serious health issues, respiratory failure and acidosis) There was no documentation the provider was notified and no provider acknowledgement of the low potassium level or other abnormal values. The lab results were electronically reviewed by the provider on 04/21/2026 at 1:52pm.Review of the Alert Note dated 4/21/2026 at 4:12pm by Staff D showed the resident had experienced a change in condition, the family was notified and requested the resident be treated in the facility, the provider was notified and orders were received for a chest x-ray. Review of the SBAR note dated 04/22/2026 showed facility staff contacted the provider to report the change in condition and received orders. The documentation also included that Resident 1's family member was aware and preferred to have resident treated in the facility. Review of the provider note dated 04/22/206 showed the resident had a change in condition, stat labs, x-rays, intravenous fluids and intravenous (continued on next page)

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 - Few	antibiotics were ordered. Review of the lab results received on 4/22/2026 showed worsening abnormal values including Resident 1's potassium level was now 3.0, the carbon dioxide value was now 43, additionally the sodium level was elevated at 151 (normal range 135-146).On 5/5/2026 Resident 1's family member said they were concerned when the resident began having swelling in her legs, they said they told nursing staff and they told him that was normal, then a few days before the resident was transported to the hospital the resident had a change in condition and was not really responding. Resident 1's family member said they felt the facility was not doing anything to help the resident and finally called 911 himself, to have the resident transported. On 06/02/2026 at 3:32pm, Staff D, Licensed Practical Nurse (LPN), said that when labs are ordered, they fill out a slip and place the order in the online portal for the lab service provider. When results come in, they are placed in the provider box. If there were abnormalities, they would call the provider or let them know if they were in the facilities. On 06/02/2026 at 3:59pm Staff C, LPN, Resident Care Manager (RCM), said labs results are printed off and placed in the provider box. If there were abnormal results they would be called to the provider. On 06/02/2026 at 4:14pm Staff B, Registered Nurse, Director of Nursing, said lab results show up on her dashboard, and she or an RCM will print them up and place them in the provider box and load them into the resident record. The provider is there daily to review, abnormal labs would be placed in the box, and the provider would be called if the labs were critical. On 06/02/2026 at 5:13pm Staff B said they were unable to locate any lab results for Resident 1 for 04/10/2026, or any documentation the provider was informed or noted the abnormal labs received on 04/17/2026 for Resident 1. Neuro Assessments Review of the facility policy titled, Neurological Checks, dated 08/09/2026, showed Neurological assessments would be initiated when a resident had a fall and or head injury and would be completed and documented in the electronic health record (EHR). Review of the facility fall incident report dated 04/20/2026 at 4:15pm showed Resident 1 was found on the floor on their left side and reported pain to their left forehead. Neurological assessments were initiated. Review of Resident 1's Neurological assessments showed that 13 of 21 scheduled assessments were completed; the first 4 every 15 minutes were completed, only 2 of 4 were completed for every 30 minutes, 4 of 4 for every 2 hours were completed, 3 of 4 were completed for every 4 hours, 0 of 4 were completed for every 8 hours, and 0 of 1 were completed for 24 hours after last 8 hours assessment.On 06/02/2026 at 3:32pm Staff D, LPN said Neuro assessments are completed every 15 minutes time 4, then every 30 minutes times 4, then every 2 hours times 4, then every 4 hours times 4, then every 8 hours times 4, then 24 hours after last 8-hour assessment. Staff D said they may not be completed if the resident was eating or in physical therapy. On 06/02/2026 at 3:59pm Staff C, LPN RCM, said Neuro assessments should be completed every 15minutes, 30 minutes, 2,4,8 hours in sets of 4. Staff C said they may not be completed if the resident was sleeping or the staff were not aware they were supposed to do it. Staff C said they would expect documentation if the neuro assessment was not completed.On 06/02/2026 at 4:14pm Staff B, RN DNS, said neuro assessments should be completed every 15 minutes times 4, then every 30 minutes times 4, then every 2 hours times 4, then every 4 hours times 4, then every 8 hours times 4, then 24 hours after last 8-hour assessment. Staff B said they may not be completed if the resident refused or was not in the building. Staff B said they would expect documentation if they were not completed as indicated. Reference WAC 388-97-1060