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	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Orchard	2031 Pottery Avenue Port Orchard, WA 98366

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to accurately assess Minimum Data Set (MDS) assessments for 2 of 24 sampled residents (Residents 12 & 39) reviewed. Failure to ensure accurate assessments regarding Preadmission Screening and Resident Review (PASRR) and oxygen requirements, placed residents at risk for unidentified and/or unmet care needs. Findings included . 1) Resident 12 was admitted to the facility on [DATE]. The Annual MDS, dated [DATE] and 03/10/2024, documented no that the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. A review of the Level II PASRR Initial Psychiatric Evaluation Summary and Notice of Determination, dated 12/28/2023, said Resident 12 was determined to require a Level II for depressive disorder. On 02/26/2025 at 1:54 PM, Staff H, Registered Nurse (RN) and MDS Coordinator, said Resident 12 was assessed to need a Level II PASRR and received specialized services on 12/28/2023. Staff H said Resident 12 should have been coded for a Level II on both annual MDSs, dated 03/10/2024 and 02/02/2025. On 02/27/2025 at 3:08 PM, Staff B, Director of Nursing, said her expectation was the MDSs be coded appropriately. 50945 2) Resident 39 was admitted to the facility on [DATE] and had diagnoses of acute and chronic respiratory failure and dependence on supplemental oxygen. The Admission MDS, dated [DATE], showed Resident 39 was cognitively intact, but did not code for oxygen usage. Review of Resident 39's orders showed an order, initiated 01/27/2025, for oxygen at two liters per minute continuously via nasal cannula. Review of Resident 39's oxygen saturation vitals, showed they had vitals taken with the resident on oxygen via nasal cannula, on 01/30/2025 and 01/31/2025. The other vitals showed Resident 39 was on room air when the vitals were taken. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 39's Medication Administration Record, showed licensed nursing staff had signed off, from 01/27/2025 to 01/31/2025, on Resident 39's order for two liters per minute of continuous oxygen. During an interview on 02/28/2025 at 9:10 AM, Staff G, Licensed Practical Nurse, said Resident 39 had been on oxygen since admit, believed they had tried titrating off the oxygen, but the resident got lung infiltrates (shown on imaging, can indicate infection of the lungs) and had been on oxygen since. During an interview on 02/28/2025 at 11:11 AM, Staff H, RN/MDS Coordinator, provided documentation of Resident 39's vitals, reported the capture period for the MDS was 01/25/2025 to 01/31/2025, and said oxygen therapy should have been coded. Reference WAC 388-97-1000 (1)(b)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure baseline care plans were developed and implemented within 48 hours of admission and included the minimum information necessary to properly care for 2 of 6 residents (Residents 131 and 331) reviewed for new admission. This failure placed residents at risk for unidentified and/or unmet care needs, and other negative health outcomes. Findings included . 1) Resident 131 admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), dated 02/22/2025, showed the resident's diagnoses included a venous stasis (open sore that occurs on the lower legs due to impaired blood flow caused by venous insufficiency), cellulitis (a bacterial infection affecting the deeper layers of the skin), and edema (swelling caused by too much fluid trapped in the body's tissue). Resident 131 also received diuretic and anticoagulant medication during the assessment period. Review of the 02/19/2025 hospital discharge summary and transfer orders showed Resident 131 admitted with: a) A non-healing ulcer to the top of the right foot, which required daily dressing changes. b) An order for coumadin therapy, a high-risk medication that decreases the clotting ability of the blood. c) An order for International Normalized Ratio (INR, a blood test used to test the clotting time of people taking coumadin) testing to ensure the INR remained in the therapeutic range of 2-3. Review of the baseline care plan showed it did not address Resident 131's right foot stasis ulcer or treatment with coumadin and need for INR testing. On 02/28/2025 at 1:54 PM, Staff B, Director of Nursing Services (DNS), said Resident 131's stasis ulcer and treatment with coumadin and associated INR testing should have been addressed on the baseline care plan. 50945 2) Resident 331 was admitted to the facility on [DATE], with a diagnosis of Type 2 Diabetes (problem with blood sugar regulation). Review of the Admission MDS, dated [DATE], showed Resident 331 was moderately cognitively impaired. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 331's care plans, on 02/24/2025, showed the facility had not developed a baseline care plan within 48 hours of their admission, to include the minimum healthcare information necessary to properly care for the resident, as there was no care plan for Resident 331's diagnosis of Type 2 Diabetes nor their insulin requirements (a high risk medication used to help regulate blood sugars, was ordered by a physician). Review of the Medication Administration Record showed Resident 331 had insulin ordered on 02/17/2025 and started receiving insulin on 02/18/2025. During an interview on 02/28/2025 at 1:52 PM, when asked if Resident 331's high risk insulin medication should be included on the care plan, Staff I, Resident Care Manager said, absolutely. When asked if it should have been added before today, Staff I said, yes. During an interview on 02/28/2025 at 12:46 PM, when asked what goes in a baseline care plan, Staff B, DNS, said they put as much as they can, starting with mobility, pain, and activities of daily living. Staff B said Resident 331's diabetes and insulin usage should be care planned, but thought they had 21 days to get a full comprehensive care plan. Reference WAC 388-97-1020 (3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to develop and implement individualized comprehensive care plans for 3 of 19 residents (Residents 1, 44, & 59) whose care plans were reviewed. This failure placed residents at risk for unmet care needs and other potential negative outcomes. Findings included . 1) Resident 1 admitted to the facility on [DATE]. Review of the 02/10/2025 Admission Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, and identified the following activities as Very Important: keeping up with the news, taking part in group activities, doing their favorite activity and going outside for fresh air when the weather was nice. They identified participation in religious activities as Somewhat Important. Review of the Activity Care Area Assessment (CAA), dated 02/20/2025, showed staff documented they would proceed to care plan the resident's activity preferences. An at risk for social isolation/activity care plan, initiated 02/20/2025, documented Resident 1 had identified activities of interests and preference. The interventions included: a) Provide resident with an updated schedule for activity choices. b) Assist with any spiritual needs as requested by resident. c) Assist with any activity materials. d) Provide one-on-one visits to encourage resident to be active in interests and to try new ones. The care plan did not identify the activities the resident self-reported as being very important to them (keeping up on the news, taking part in group activities, doing their favorite activity (not identified) and going outside for fresh air when the weather was nice. On 02/28/2025 at 9:54 AM, Staff N, Activities Director, said the activities that Resident 1 self-identified as Very Important to them should have been care planned. 50945 2) Resident 39 was admitted to the facility on [DATE] and had diagnoses of acute and chronic respiratory failure and dependence on supplemental oxygen. The Admission MDS, dated [DATE], showed Resident 39 was cognitively intact. During an observation on 02/23/2025 at 11:52 AM, Resident 39 was seen wearing a nasal cannula, with their oxygen administered at two liters per minute. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 39's orders showed they had an order, initiated on 01/27/2025, for oxygen at two liters per minute. During an interview on 02/28/2025 at 12:46 PM, Staff B, Director of Nursing Serviecs (DNS), said care plans should include oxygen, how to care for the resident, and how to meet their needs. Staff B said, yes, Resident 39's oxygen usage should have been care planned. 2) Resident 44 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE], showed Resident 44 was moderately cognitively impaired. During an observation on 02/23/2025 at 1:46 PM, Resident 44's bed was seen with bilateral upper mobility bars (side rails that assist with movement while in bed). Review of Resident 44's care plans, on 02/24/2025, showed they did not have a care plan for their mobility bars. During an interview on 02/27/2025 at 10:29 AM, Staff I, Resident Care Manager (RCM), said for a resident to use a mobility bar, it should be care panned. Staff I confirmed there was no care plan for Resident 44's mobility bars. During an interview on 02/28/2025 at 12:46 PM, Staff B, DNS, said Resident 44's mobility bars should have been care planned. 3) Resident 59 was admitted to the facility on [DATE] and had diagnoses of chronic venous insufficiency (a disease that damages leg veins, can cause blood to pool in legs), malnutrition, and unstageable pressure ulcer of the left heel. Review of the Admission MDS, dated [DATE], showed Resident 59 had severe cognitive impairment. Review of Resident 59's orders showed they were receiving skip prep (a topical barrier), initiated 01/28/2025, twice a day. Review of 59's Electronic Health Record (EHR) showed they had a scab on their left heel with blanchable redness, on 01/21/2025. On 01/28/2025, Resident 59's skin assessment showed the left heel had a scabbed area, no measurement or staging was done, and a new order for skin prep was obtained. On 02/21/2025, a diagnosis from a provider was added to Resident 59's EHR, of an unstageable pressure ulcer. Review of Resident 59's care plans, on 02/26/2025, showed Resident 59 was at risk for a pressure ulcer and impaired skin integrity, but did not have any care plans for their scab/pressure ulcer of their left heel nor interventions specific to it. During an interview on 02/27/2025 at 11:13 AM, when asked if there was specific information or interventions for Resident 59's pressure ulcer in the care plan, Staff C, RCM said there was not and there should have been. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/28/2025 at 12:46 PM, Staff B, DNS, said a care plan should have included wounds, diagnoses, and how to care for residents and meet their needs. When asked about Resident 59 having a diagnosis of an unstageable pressure ulcer, said this should have been care planned. Reference WAC 388-97-1020(1), (2)(a)(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** 37044 Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice for 4 of 19 sample residents (Residents 1, 21, 331 and 59) reviewed. The facility's failure to obtain, follow and clarify physicians' orders when indicated, and to only sign for tasks they completed or validated were complete, placed residents at risk for medication errors, delays in treatment, unmet care needs, and potential negative outcomes. Findings included . 1) Resident 21 had a 10/10/2024 order for Lisinopril (blood pressure medication) daily, hold for a systolic blood pressure (SBP) less than 100. Review of the January 2025 Medication Administration Record (MAR) showed on 01/26/2025 at 8:00 AM, Resident 21's SBP was 91 and the nurse administered the medication instead of holding it as ordered On 02/28/2025 at 9:53 AM, Staff C, Resident Care Manager (RCM), said the nurse administered Resident 21's lisinopril outside of the physician ordered parameters when the medication should have been held. Review of the electronic health record (EHR) showed an order for an A1C (a blood test that measures your average blood glucose over a three-month period) to be drawn on 02/07/2025, but the A1C was not present in Resident 21's record. Review of the February 2025 MAR showed a spot was provided on 02/07/2025, 02/08/2025 and 02/09/2025 for the nurse to initial that the A1C was obtained. The documentation showed the following: 02/07/2025= left blank 02/08/2025= the nurse document the chart code 9. The chart code key showed 9 meant the resident was sleeping. 02/09/2025= left blank There was no documentation to support facility staff or their contracted laboratory service, made any further attempts to obtain Residents 21's A1C as ordered. A 02/26/2025 provider note documented A1C ordered 2/7/2025 - results not available. The provider reordered an A1C for 02/28/2025. On 02/28/2025 at 10:35 AM, Staff C, RCM, said the 02/07/2025 and 02/09/2025 nurses should have documented why the A1C was not obtained and the 02/08/2025 nurse or the contracted lab personnel should have continued to try and obtain the A1C and if not possible, notified the provider. When asked if there was any documentation to show that occurred, Staff C stated, no. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 21 had a 02/08/2025 order to administer two units of aspart insulin (fast acting) with meals, with instruction to hold for a blood glucose (BG) less than 150. Review of the January and February 2025 MARs showed facility nurses administered the aspart insulin six times in January and 11 times in February when Resident 21 had a documented BG of less than 150. On 02/28/2025 at 10:46 AM, Staff C, RCM, confirmed facility nurses administered Resident 21's aspart insulin six times in January and 11 times February outside of the physicians ordered parameters. 2) Resident 1 admitted to the facility on [DATE]. An order for daily weights was obtained on 02/08/2025 with instruction to notify the physician for a weight gain greater than three pounds in 24 hours, or greater than five pounds in a week. Review of the February 2025 MAR showed Resident 1's weights for 02/10/2025, 02/15/2025 and 02/17/2025 were not recorded or signed off as obtained. On 02/28/2025 at 11:58 AM, Staff C, RCM, indicated there should not be any blanks on the MAR and nurses should have ensured the weights were obtained and signed or signed and explained why they were unable to get the weight. When asked if there was documentation to show why the weights were not obtained as ordered, Staff C, RCM, stated, No. The February MAR showed that the nurse signed that Resident 1's weight was obtained on 02/11/2025 as ordered. Review of the EHR showed no weight was recorded for that date. On 02/28/2025 at 11:58 AM, Staff C, RCM, confirmed the nurse signed that Resident 1's weight was obtained on 02/11/2025. When asked if there was a weight documented in the EHR for 02/11/2025, Staff C, RCM, stated, No, not that I see. Staff C then acknowledged the nurse erroneously signed for a task they did not complete. 50945 3) Resident 331 was admitted to the facility on [DATE], with diagnoses of Type 2 Diabetes (problem with blood sugar regulation), hypertension (high blood pressure), and diagnoses of pain in the right shoulder. Review of the Admission MDS, dated [DATE], showed that Resident 331 was moderately cognitively impaired. Review of Resident 331's orders showed an insulin Lispro order (for diabetes management to lower blood sugar levels), for before meals and at bedtime. During an observation of Resident 331 on 02/25/2025 at 12:11 PM, Staff J, LPN, entered Resident 331's room to give the 11:30 AM insulin Lispro dose. Resident 331 was observed with only drinks in front of her, no meal. Staff J educated Resident 331 on the dose of insulin and the reason for it being due to the blood sugar check before lunch. Resident 331 was observed to be given their insulin dose after lunch, not before. (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 331's orders showed they had a hydralazine order, for lowering blood pressure, with a hold parameter of a systolic blood pressure (the upper number of the blood pressure read) of less than 110, and to notify the primary care physician. Review of the EHR showed that a dose of hydralazine was given on 02/21/2025, with a blood pressure of 97/60, for the midnight dose. Review of Resident 331's orders showed an order for a lidocaine patch (for localized pain relief), without a location for where to put the topical medication. Review of the MAR, from 02/19/2025 to 02/23/2025, showed the lidocaine medication had been given seven times, with locations of upper left front of arm, upper right front of arm, right front of shoulder, and right rear of shoulder. During an interview on 02/28/2025 at 1:52 PM, Staff I, RCM, confirmed the dose of hydralazine was given on 02/21/2025 and said it should not have been given. Staff I said that the lidocaine patch did not have a location on the order, and they would need to fix it to have a location of where it should go. 4) Resident 59 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease and chronic respiratory failure. The Admission MDS, dated [DATE], showed that Resident 59 had severe cognitive impairment, and was on continuous oxygen. Review of Resident 59's orders showed an order, initiated on 01/21/2025, for continuous oxygen at 3 liters (L) per minute, via nasal cannula, to keep oxygen saturations above 92%. During an observation on 02/23/2025 at 2:30 PM, Resident 59 had their oxygen rate at 4 L. During an observation on 02/24/2025 at 8:31 AM, Resident 59 had their oxygen rate at 3 L. During an observation on 02/25/2025 at 3:19 PM, Resident 59 had their oxygen rate at 4 L. During an observation on 02/26/2025 at 9:10 AM, Resident 59 had their oxygen rate at 4 L. During an observation on 02/28/2025 at 8:56 AM, Resident 59 had their oxygen rate at 3.5 L. Review of the EHR showed Resident 59 had progress notes that documented their oxygen at 4 L. A 02/17/2025 progress note, documented Resident 59 was maintaining their oxygen saturations at 95% with 4 L of oxygen. A 02/20/2025 progress note, showed Resident 59 was maintaining their oxygen at 93% with 4 L of oxygen. During an interview on 02/28/2025 at 9:00 AM, Staff K, Registered Nurse, said Resident 59 had an ordered rate for 3 L of oxygen, and the order was not titratable. When asked what steps staff should take when Resident 59 was put on 4 L, Staff K said they should check oxygen saturations on 4 L, turn the rate down to 3 L, and continue to monitor. Staff K said they should notify the provider and see if any changes were needed, such as a titration order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/28/2025 at 12:55 PM, Staff B, DNS, said their expectation when a resident had an order for 3 L and there were observations of oxygen being given at 4 L, was that staff would notify the physician and update the order. Refer to F760 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** 50945 Based on interview and record review, the facility failed to implement or document on the bowel protocol (how the facility intervenes to a resident with no bowel movement over a certain amount of time) for 2 of 3 sampled residents (Residents 59 & 1) reviewed for constipation. This failure placed residents at risk for unidentified care needs, discomfort, lack of monitoring, and a diminished quality of life. Findings included . Review of the facility policy titled, LCC [Life Care Center] Port Orchard Bowel Protocol, undated, showed the following order of medications to be given: 1. Milk of Magnesia (helps stimulate a bowel movement) to be given after 72 hours/on day four of no bowel movement 2. Bisacodyl (helps stimulate a bowel movement) to be given after no bowel movement on day five 3. Fleet Enema (helps stimulate a bowel movement) to be given after no bowel movement on day six 1) Resident 59 was admitted to the facility on [DATE] with a diagnosis of constipation. The Admission Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 59 had severe cognitive impairment. Review of Resident 59's orders showed three medications ordered for no bowel movement: 1. Milk of Magnesia (for day four of no bowel movement) 2. Bisacodyl (for day five of no bowel movement) 3. Fleet Enema (for day six of no bowel movement) Review of Resident 59's bowel record, from 01/28/2025 to 02/25/2025, showed that they did not have a bowel movement recorded from 02/05/2025 to 02/11/2025 (seven days). Review of the Electronic Health Record (EHR) showed no documentation of interventions for bowel protocol/orders from 02/05/2025 to 02/11/2025. During an interview on 02/27/2025 at 4:40 PM, Staff C, Resident Care Manager (RCM), confirmed that Resident 59 did not have a bowel movement from 02/05/2025 to 02/11/2025. Staff C said staff should have documented that Resident 59 had refused the bowel protocol and have documented that they did a bowel assessment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/28/2025 at 12:55 PM, Staff B, Director of Nursing Services, said their expectations was for staff to follow bowel protocol and do bowel assessments if there was a refusal, and they had requested staff write a progress note or document the refusal on the Medication Administration Record (MAR). 37044 2) Resident 1 admitted to the facility on [DATE]. Review of the Admission MDS, dated [DATE], showed the resident was cognitively intact and was assessed to be constipated during the assessment period. On 02/24/2025 at 9:54 AM, Resident 1 complained of constipation due to not getting up and moving around enough. Resident 1 had the following as needed bowel management orders dated 02/07/2025: 1. Milk of Magnesia (If no bowel movement for three days, administer on day four.) 2. Bisacodyl (for day five of no bowel movement) 3. Fleet Enema (for day six of no bowel movement) Review of the bowel record showed Resident 1 had no documented bowel movements from 02/07/2025 - 02/10/2025 (four days). The February 2025 MAR showed facility nurses did not offer/administer Resident 1 any as needed bowel medications. On 02/28/2025 at 10:36 AM, Staff C, RCM, said facility nurses failed to administer Resident 1's as needed Milk of Magnesia on 02/10/2025 (the fourth day without a bowel movement) as ordered. Reference WAC 388-97-1060(1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on observation, interview and record review, the facility failed to appropriately monitor pressure ulcers in a manner consistent with professional standards of practice for 2 of 5 sampled residents (Residents 59 and 44) reviewed for pressure ulcers. This failure placed residents at risk of worsening conditions, unnecessary treatment, pain, and a diminished quality of life. Findings included . Review of the facility's policy titled, Documentation & Assessment of Wounds, dated with a review date of 07/09/2024, showed the Overall Wound Impression is documented based on the clinical impression of the overall wound bed, peri wound, and wound healing outcome as expected wound decline/worsening may not be acknowledged by just and increase in wound measurement [.]. 1) Resident 59 was admitted to the facility on [DATE] and had diagnoses of chronic venous insufficiency (a disease that damages leg veins, can cause blood to pool in legs), malnutrition, and unstageable pressure ulcer of the left heel. Review of the Admission MDS, dated [DATE], showed Resident 59 had severe cognitive impairment. Review of the Electronic Health Record (EHR) showed Resident 59's skin assessments were as follows: - On 01/21/2025, on the Admission Assessment, it was documented that Resident 59 had a left heel 1x1 scab inside a 2x2 red non-blanchable area. - On 01/21/2025, a braden scale (assessment that determines risk of a pressure ulcer) was done that selected that the resident had an existing pressure ulcer. Under the section that asked for location of blanchable redness, it said sacrum//left heel around scab. This assessment tool did not provide measurements or staging. - On 01/28/2025, it was documented Resident 59 had left heel 2 scabbed area, new order for skin prep - no measurement or staging were done (Such as: Stage I, Stage II, Stage III, Stage IV, deep tissue injury, unstageable) - On 02/04/2025, it was documented Resident 59 had left heel 2 scabbed area, new order for skin prep - no measurement or staging were done. - On 02/11/2025, it was documented Resident 59 had left heel 2 scabbed area, new order for skin prep- no measurement or staging done. - On 02/19/2025, there was no note of skin issue to the heels, only that heels floated. - On 02/21/2025, a provider progress note showed, She is complaining of pain to left heel and she is found to have a pressure ulcer and RN and DON [Director of Nursing Services] notified. A diagnosis was added to Resident 59's EHR, of an unstageable pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 02/21/2025, no skin assessment of the left heel by nursing was documented. Review of Resident 59's orders showed an order for skin prep (a topical skin protection), initiated 01/28/2025 to be applied twice a day. On 02/21/2025, an additional order was placed for skin prep application and off-loading of the heel with monitoring for every shift. During an interview and observation on 02/27/2025 at 10:41 AM, when asked what was involved in a skin assessment, Staff O, Registered Nurse, said they looked at all of the resident's kin to assess for breakdown. For Resident 59, after looking in the EHR, Staff O said for Resident 59 they had responded about a different skin issue, and that the document they were looking at said the heels were floated, Probably redness to heels, I saw something before. During observation of Resident 59's left heel with Staff O, Resident 59 was observed with the scab on their left heel, flakey skin to the right side of the foot that was peeling off, and there was generalized redness to the heel. During an interview on 02/27/2025 at 11:13 AM, Staff C, Resident Care Manager (RCM), when asked what their expectation was for documentation related to pressure ulcers, said they expected staff to document weekly, if there were signs or symptoms of infection, and if there was any changes in status. Staff C said if the wound care team was following the pressure ulcer, then weekly measurements were done. For Resident 59, Staff C said they were not being followed by the wound care team and there were not weekly measurements or staging. Regarding the 02/21/2025 provider note, Staff C said their expectation was for the licensed nurse to have put risk management in the EHR, to have written a progress note, to have filled out a braden scale, to have filled out a pain assessment, to have done a pain assessment, and to have notified family. During an interview on 02/28/2025 at 12:55 PM, Staff B, Director of Nursing Services (DNS), said for pressure ulcers, measurements were usually done in the wound observation tool, not all nurses knew how to stage a wound, and if the wound care team was not following the pressure ulcer, then it might not have been measured. When asked about Resident 59, Staff B said on admission the scabbed skin had come off and the heel was blanching, but this was not documented. Regarding the 02/21/2025 provider note, Staff B said the nurse who was notified by the provider should have notified risk management. Staff B said they did not have documentation of weekly measurements or wound assessment to include wound bed tissue type, any drainage, or response to treatment, for Resident 59 and that they should have had. 2) Resident 44 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE], showed Resident 44 was moderately cognitively impaired and at risk for a pressure ulcer. Review of the EHR showed Resident 44 acquired a pressure ulcer on 02/07/2025 on their left ear from their nasal cannula straps (from oxygen administration). Review of Resident 44's orders showed an order for skin prep three times a day until resolved, initiated on 02/07/2025. Review of Resident 44's skin assessments/wound observations showed: On 02/07/2025: Stage 2 acquired pressure ulcer with measurements of 0.5 x0.5 x0.1 cm (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/10/2025: No wound listed On 02/19/2025: No wound listed Review of a progress note from 02/13/2024, showed pressure area noted on top of resident's left ear from oxygen tubing. New order to apply skin prep to area BID [twice a day] until resolved. Placed new order to ensure padding is around oxygen tubing Q [every] shift for protection. Will continue to monitor. Review of Resident 44's orders showed an additional skin prep order was added on 02/13/2025, but the previous skin prep was never discontinued. Review of Resident 44's Medication Administration Record showed that Resident 44 had skin prep signed off five times a day, with documentation on multiple occasions within an hour of the previous administration. For example, on 02/20/2025 at 9:36 PM and 10 PM (24 minutes apart), and 02/22/2025 at 9:43 PM and 10:00 PM (17 minutes apart). Although the order was for their left ear, staff on multiple occasions signed off administration of skin prep on both ears. Review of a progress note from 02/20/2024 showed Resident 44 did not have oxygen or a nasal cannula on. Observation on 02/23/2025 at 1:47 PM, showed Resident 44 was not on oxygen and was not using a nasal cannula. During an interview on 02/25/2025 at 12:24 PM, Resident 44 said they had not had skin prep for a couple days and was able to correctly identify where staff had been putting skin prep on them. During an observation on 02/25/2025 at 12:28 PM, Staff J, Licensed Practical Nurse (LPN), entered Resident 44's room to apply skin prep. Resident 44 stated, There's nothing on my ear. Staff J said they could see a little bit of pinkness, and the pressure ulcer was mostly resolved. Staff J said they remembered seeing the pressure ulcer the previous week. During an interview on 02/27/2025 at 9:19 AM, Staff G, LPN, when asked what was included in a weekly skin assessment, said, head to toe, top to bottom, all of the resident's skin. When asked about one of the skin assessments they had filled out, Staff G said the pressure ulcer should have been on their documented assessment and was not. Staff G said they remembered seeing the pressure ulcer on Resident 44 on 02/24/2025. During an interview on 02/27/2025 at 10:22 AM, Staff I, RCM, when asked about the additional order for skin prep, said their understanding was that Resident 44's pressure ulcer was improving/resolving, that they only needed skin prep twice a day, and that the old order should have been discontinued. Staff I said their expectation for skin assessments was that they should have mentioned the pressure ulcer until resolved, and then still monitored for three weeks after resolution. Staff I confirmed the skin prep orders listed the left ear for location, and said the administration record should not show bilateral ears as being charted. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/28/2025 at 12:55 PM, Staff B, DNS, when asked if residents not followed by wound care were still getting measurements of their wounds, said that for residents not followed by wound team, if nursing did not obtain a measurement, then yes it would not have been done. When asked about Resident 44, Staff B said it did not meet expectations that they did not mention the pressure ulcer, and if staff did not see it then they should have documented it was resolved. When asked about the two separate skin prep orders, said it did not meet expectations. Reference F656 Reference WAC 388-97-1060 (3)(b)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure 1 of 3 residents (Resident 21) reviewed for insulin administration were free of significant medication errors. The failure to administer insulin in accordance with physician orders, and to hold insulin when blood glucose (BG) levels were below the ordered parameters for administration, placed residents at risk for hypoglycemia, seizures, coma and death. Findings included . Resident 21 admitted to the facility on [DATE]. Review of 11/21/2025 Annual Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, had a diagnosis of diabetes (a condition where the body cannot use insulin correctly and glucose builds up in the blood), and required insulin injections on seven of seven days during the assessment period. Review of the electronic health record showed Resident 21 had the following insulin orders: a) A 02/08/2025 order for Aspart insulin (fast acting), with meals. Hold for a BG less than 150. b) A 11/14/2024 order for Aspart insulin sliding scale coverage three times a day. c) A 02/07/2025 order for Lantus insulin (long acting), 11 units every morning and 18 units every evening. Hold if BG is less than 100. Review of the January and February 2025 Medication Administration Records showed on the following date(s)/time(s), facility nurses failed to hold Resident 21's insulin for BGs levels below than the physician ordered parameters for administration. January 2025 a) Aspart insulin with meals, hold for BG less than 150. 01/01/2025 8:00 AM, BG= 110; insulin administered. 01/01/2025 12:00 PM, BG= 131; insulin administered. 01/12/2025 5:00 PM, BG= 134; insulin administered. 01/26/2025 8:00 AM, BG= 136; insulin administered. 01/27/2025 8:00 AM, BG= 131; insulin administered. 01/29/2025 8:00 AM, BG= 122; insulin administered. b) Lantus insulin, hold for BG less than 100. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/21/2025 8:00 AM, BG=77; insulin administered. February 2025 a) Aspart insulin with meals, hold for BG less than 150. 02/01/2025 5:00 PM, BG= 147; insulin administered. 02/02/2025 8:00 AM, BG= 147; insulin administered. 02/08/2025 8:00 AM, BG= 90; insulin administered. 02/08/2025 12:00 PM, BG=148; insulin administered. 02/12/2025 5:00 PM, BG=124; insulin administered. 02/14/2025 8:00 AM, BG=136; insulin administered. 02/16/2025 8:00 AM, BG= 79; insulin administered. 02/18/2025 8:00 AM, BG=138; insulin administered. 02/19/2025 8:00 AM, BG=92; insulin administered. 02/20/2025 5:00 PM, BG=147; insulin administered. 02/21/2025 12:00 PM, BG=147; insulin administered. b) Lantus insulin, hold for BG less than 100. 02/08/2025 8:00 AM, BG=90; insulin administered. 02/19/2025 8:00 AM, BG=92; insulin administered. On 02/28/2025 at 10:46 AM, Staff C, Resident Care Manager, confirmed on the 20 occasions referenced above, facility nurses administered Resident 21's insulin, rather than holding it as ordered. Reference WAC 388-97-1060 (3)(k)(iii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on observations, interview and record review, the facility failed to enforce Enhanced Barrier Precautions (EBP) for 1 of 8 sampled residents (Resident 331) reviewed for infection control practices, to prevent residents' urinary catheter/foley (tube that goes into the bladder to drain urine) tubing or bags from touching the ground for 2 of 2 residents (Resident 331 &39) reviewed for urinary catheters, to ensure contact precautions were understood and followed outside of resident rooms for 2 of 2 sampled residents (Resident 39 & 131) reviewed, and to ensure staff complied with current infection control guidelines and standards of practice regarding proper hand hygiene/gloving practices for 1 of 1 sampled resident (Resident 22) reviewed for wound care. This failure placed residents at risk of infection, the spread of multidrug resistant organisms (MDROs), worsening of wounds, and a diminished quality of life. Findings included . <Enhanced Barrier Precautions> Review of the facility policy, titled, Enhanced Barrier Precautions, dated with a review date of 06/03/2024, defined EBP as refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The policy defined high contact care activities as include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, medical device care or use, and wound care. Resident 331 was admitted to the facility on [DATE]. Resident 331 had a urinary catheter/foley and was on EBP. During an observation on 02/25/2025 at 12:11 PM, Staff J, Licensed Practical Nurse (LPN), entered Resident 331's room to give them their insulin dose. Staff J cleaned Resident 331's abdomen and injected them with insulin, without wearing a gown. During an interview on 02/25/2025 at 1:12 PM, Staff J, LPN, said Resident 331's room was under EBP for a urinary catheter/foley. During an observation on 02/28/2025 at 11:52 AM, Staff L, Certified Nursing Assistant (CNA), was observed to assist Resident 331 with moving, from sitting on the side of the bed to moving to their wheelchair. Staff L was not wearing a gown, put a gait belt on the resident, moved the resident's foley bag, touched the gait belt again, and then helped Resident 331 to stand and pivot to the wheelchair. During an interview on 02/28/2025 at 12:29 PM, Staff L, CNA, said for EBP rooms they should wear gown and gloves for any patient contact, and that they had forgotten to wear a gown for assisting Resident 331. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/28/2025 at 2:20 PM, Staff F, Infection Preventionist/Assistant Director of Nursing (IP/ADON), said EBP precautions were to be used for residents with urinary foleys, and staff should wear gown and gloves when providing care to residents. When informed of staff not using gowns in Resident 331's room, Staff F said their expectation was for staff to have worn gowns when they were touching residents on EBP. <Foley Bag Touching Ground> Review of the Centers for Disease Control and Prevention's (CDC) document titled, Guideline for Prevention of Catheter-Associated Urinary Tract Infections, dated 06/06/2009, strongly recommended healthcare facilities do not rest the bag [foley bag] on the floor. 1) Resident 331 was admitted to the facility on [DATE] and had a urinary catheter/foley. During an observation on 02/23/2025 at 12:53 PM, Resident 331 was seen in their wheelchair with their foley bag touching the ground. During observations on 02/26/2025 at 9:04 AM and 12:51 PM, Resident 331 was seen in their wheelchair with their foley tubing touching the ground. During an observation on 02/28/2025 at 11:46 AM, Resident 331 was seen sitting on the edge of the bed, with their foley bag in a dignity cover, touching the ground. During an observation on 02/28/2025 at 11:52 AM, Staff L, CNA, moved Resident 331 from the bed to their wheelchair, and moved the foley bag. The foley bag was in a dignity cover and was observed to touch the ground. Staff L left the room. During an observation and interview on 02/28/2025 at 11:57 AM, Staff G, LPN, confirmed the foley bag was touching the ground and said it should not have been touching the ground. During an interview on 02/28/2025 at 2:20 PM, when told of observations of Resident 331's foley bag touching the floor ,Staff F, IP/ADON said they would expect the foley bags to not touch the ground. 2) Resident 39 was admitted to the facility on [DATE] and had a urinary catheter. During an observation on 02/23/2025 at 11:29 AM, Resident 39 was seen in their wheelchair with their foley bag touching the ground. During an observation on 02/25/2025 at 12:38 PM, Resident 39 was seen in their wheelchair with their foley bag touching ground. During an observation on 02/26/2025 at 8:54 AM, Resident 39 was seen in their wheelchair with their foley bag in a dignity bag and touching ground. During an observation on 02/26/2025 at 9:00 AM, Resident 39 was seen in their wheelchair being moved through the hallway with their foley bag in a dignity bag touching the ground, dragging on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/2025 at 12:29 PM, Staff G, LPN, said residents with foley bags in a dignity bag should still not have it touch the ground when outside of room, for infection control purposes. When asked about the foley bag or tubing touching the ground, said no it should not. When asked about if any of those parts should touch the ground when a resident in a wheelchair was being moved through the hall, said no. During an interview on 02/28/2025 at 2:20 PM, when told of the observation of Resident 39 seen in the hallway with their catheter bag dragging on the floor, Staff F, IP/ADON said their expectation was that the foley bag would be secured without touching the ground. <Contact Precautions> Review of the CDC document titled, Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, reviewed on 02/27/2025, had a section defining EBP as [.] infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at risk for MDRO acquisition (e.g., residents with wounds or indwelling medical devices, and contact precautions as [.] require the use of gown and gloves on every entry into a resident's room, regardless of the level of care being provided to the resident. It also explained that for contact precautions, Residents on Contact Precautions are recommended to be restricted to their rooms except for medically necessary care, including restriction from participation in group activities. Contact Precautions are generally intended to be time limited and, when implemented, should include a plan for discontinuation or de-escalation. The document also explained that contact precautions were recommended if the resident had acute diarrhea, draining wounds, or other sites of secretions or excretions, and that they were unable to be covered or contained. 1) Resident 39 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS -an assessment tool), dated 01/27/2025, showed that Resident 39 was cognitively intact. Review of a provider note on 01/28/2025 showed Resident 39 had initial urine and blood culture positive for Extended-spectrum beta-lactamases (ESBL, an MDRO) and E.coli (bacteria). The note mentioned the second blood culture remained negative. Review of the EHR showed a negative urine culture, collected on 02/08/2025. Review of a progress note from 02/08/2025, showed the resident was on contact isolation for ESBL to the urine and also on EBP. Review of the EHR, on 02/23/2025, showed Resident 39 was not on antibiotics for infection of the urine. Resident 39 was on antibiotics for pulmonary infiltrates (shown on imaging, can indicate infection of the lungs). During an observation on 02/23/2025 at 11:18 AM, Resident 39 had signage outside of their room for both EBP and contact precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/2025 at 12:18 PM, when asked if Resident 39 had any restrictions outside of the room for being on contact precautions, Staff M, CNA said no, they were allowed to come out of the room. Staff M said contact was only hands on. When questioned on the difference between EBP and contact, Staff M said contact was when you were touching or hands on, and EBP was more hands off. During an interview on 02/27/2025 at 12:29 PM, when asked what precautions there were for Resident 39 for going outside of their room, Staff G, LPN said Resident 39 could go outside of their room. During an interview on 02/28/2025 at 2:20 PM, when asked if the facility had time limits on contact precautions, Staff F, IP/ADON said usually it was done through the duration of the antibiotics, but for Resident 39 they had an MDRO, and there was no stop date for precautions because they had a catheter and intravenous line. Staff F added that Resident 39 had cellulitis that sometimes would weep, a urinary catheter/foley, and was being treated for pneumonia/cough. When asked what contact precautions were implemented outside of residents' room, Staff F, IP/ADON said, it depends. Staff F said if it could safely be contained, such as in a brief, then hand hygiene should be completed on the way out. Staff F said it depended on what the precaution was for related to the contact precautions, if they could safely leave the room. If they were contagious, then therapy should occur in the room. During an interview on 02/28/2025 at 4:52 PM, Staff B, DNS, when asked what precautions they expect staff to implement outside of a resident's room while on contact precautions, said it depended on the concern, if a resident had c-difficile then if the resident wore a brief it would be contained and they could leave the room after washing hands with soap and water. For wounds, Staff B said if covered, then the resident could leave the room. 37044 2) Resident 131 admitted to the facility on [DATE]. Review of the Admission MDS, dated [DATE], showed the resident's diagnoses included cellulitis (a bacterial infection affecting the deeper layers of the skin), and venous stasis ulcer (open sore that occurs on the lower legs due to impaired blood flow caused by venous insufficiency) and required antibiotic medication. During an observation on 02/23/2025 at 12:22 PM, an EBP sign was posted outside of Resident 131's door. Staff Q, LPN, explained it was due to the resident having a stasis ulcer to the right foot. During an observation on 02/24/2025 at 11:27 AM, an EBP sign was still posted outside of Resident 131's door. During an observation on 02/25/2025 at 11:14 AM, Resident 131 was noted to have both an EBP and contact precaution sign posted outside their door. On 02/25/2025 at 11:27 AM, Staff F, IP/ADON, explained a contact precaution sign was added because a record review showed Resident 131 had history of Methicillin-resistant Staphylococcus aureus (MRSA, an MDRO) wound infections. During an observation on 02/27/2025 at 10:41 AM, Resident 131 was self-propelling in a wheelchair up and down the hallway using their lower extremities (LEs) navigating around other residents. Resident 131 was wearing shorts exposing their LE edema wraps. (continued on next page)

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	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Orchard	2031 Pottery Avenue Port Orchard, WA 98366

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/2025 at 12:27 PM, when asked how staff knew what precaution (EBP or contact) should be followed when entering Resident 131's room, Staff P, RN, stated, They don't, they keep coming and asking me. Staff P then explained everybody needed to gown and glove prior to entering the resident's room regardless of their reason for entering to prevent staff/visitors from getting bacteria on their clothing and potentially carrying it to another resident. When asked to clarify why everyone had to gown and glove to enter Resident 131's room, but once the resident exited their room the precautions were no longer required, Staff P stated, it's confusing and indicated they had approached management with the same question and were told it was because the wound was covered. Staff P then said, wait that is EBP not contact precautions . before reiterating that it was confusing. 50392 <Wound Care> According to CDC recommendations, hand hygiene should be performed immediately before touching a patient, after touching a patient or patient's surroundings, after contact with blood, body fluids, or contaminated surfaces, and before moving from a soiled body site to a clean body site on the same patient. Review of the facility policy titled, Wound Care Resource Manual, reviewed 05/24/2024, documented that a resident with pressure ulcers would receive necessary treatment and services consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Resident 22 admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], documented Resident 22 had one stage 4 pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin). Resident 22 had physicians' orders for wound care every day shift and as needed. During an observation of wound care on 02/26/2025 at 1:55 PM, Staff E, LPN/ Resident Care Manager (RCM), was observed performing hand hygiene and putting on gloves. Staff E then assisted Resident 22 with both gloved hands onto their side (contaminating gloves) and proceeded to provide wound care. Once wound care was completed, Staff E with same gloves that were used for wound care (contaminated gloves) reapplied Resident 22's brief tab, assisted them to their backside position by touching their body, and adjusted Resident 22's clothing. On 02/26/2025 at 2:24 PM, Staff E, LPN/RCM, when discussing above observations said staff should have changed gloves and performed hand hygiene after assisting the resident to their side and prior to performing wound care, Staff E said, I knew I should have done it. When asked if hand hygiene and glove change should have been done after wound care, Staff E nodded in agreement. On 02/28/2025 at 1:08 PM, Staff F, IP/ADON, when made aware of the wound care observations for Resident 22, Staff F said she would expect, when ready to perform wound care, staff would only touch the wound and after wound care was completed then gloves would be changed and hand hygiene would be performed before additional care was provided. Reference WAC 388-97-1320 (1)(c),-1320 (2)(b)