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	04/10/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to ensure sufficient qualified nursing staff were available to provide care and services as evidenced by information provided in Resident/Surveyor interviews for 11 residents (Resident 56, 4, 60, 40, 71, 2, 34, 7, 50, 36 & 97) interviewed, and 3 staff (Staff L, G & M) interviewed. The facility had insufficient staff to ensure residents received assistance with care in a timely manner without long wait times. These failures placed residents at risk for unmet care needs and a diminished quality of life. Findings included . Resident InterviewsOn 04/06/2026 at 11:25 AM, Resident 56 said wait times for care was up to an hour on the morning and afternoon shifts. Resident 56 said they need more Certified Nursing Assistants (CNAs) to help answer call lights. On 04/06/2026 at 11:39 AM, Resident 4 said they have had to wait for cares from 30 minutes to an hour. On 04/06/2026 at 11:47 AM, Resident 60 said the facility had long waits for care, usually over an hour. Resident 60 said they pressed their call light that morning and at that point they had been waiting 45 minutes for staff to respond to the call light. On 04/06/2026 at 12:18 PM, Resident 40 said on average they have had to wait 30 minutes for staff to respond. On 04/06/2026 at 12:27 PM, Resident 71 said on the night shift they have had to wait over an hour for assistant. On 04/06/2026 at 1:39 PM, Resident 2 said wait times on weekends and night shift were over an hour. On 04/06/2026 at 2:50 PM, Resident 34 said on Sunday they had to wait over 30 minutes for staff to come and clean and replace their leaking colostomy bag. Resident 34 said it was always a lengthy wait for staff to provide care. On 04/06/2026 at 3:35 PM, Resident 7 said staffing was frustrating, they have had to wait for 30 minutes or up to an hour for staff to provide care. Resident 7 said some staff would respond to the call light, tell them they would be back and they did not return for up to an hour. Resident 7 said when they have had to wait that long, by the time staff would respond to them, they were in so much pain. Resident 7 said they had a booklet where they would write down all the times staff would take over hour to respond to cares. On 04/07/2026 at 8:08 AM, Resident 50 said it usually took staff 45 minutes to respond to call lights. On 04/07/2026 at 9:10 AM, Resident 36 said the facility had long waiting times for staff to provide care. Resident 36 said on average they have had to wait anywhere between 30 minutes and an hour for staff to provide care. Resident 36 said they had gotten to the point where they would write down the times when they would press the call button and how long it took the staff to respond. Resident 36 said sometimes it had been over an hour for cares. On 04/07/2026 at 9:56 AM, Resident 97 said there were not enough staff on the weekends. Resident 97 said they told staff multiple times, they wanted to get up on Easter Sunday, because they had plans, but they ended up spending all day in bed, because there were not enough staff. Staff InterviewsOn 04/08/2026 at 3:31 PM, Staff L, Certified Nursing Assistant (CNA) said the facility has been short staffed weekly and the biggest concerns were not being able to give 4-5 showers plus provide routine care. Staff L said they normally covered B Hall but were covering C Hall today. On 04/09/2026 at 10:28 AM, Staff G, CNA, said the facility has a problem with staffing levels, it has not been manageable with only two aids, due to things like Hoyer transfers and the hardest task to do was making sure all the residents received showers. Staff G said the weekends were even harder because management was not available to help. On 04/09/2026 at 11:31 (continued on next page)

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

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	04/10/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	AM, Staff M, CNA, said sometimes they were by themselves working on the hall and it was unmanageable, if they was another aid on the hall they would split the hall, which helped but it was still difficult to complete all daily tasks, between routine care, transfers and showers. Staff M said it was nice to have a 3rd aid or a float aid to help. Staff M said they recently completed a double weekend shift (for the past two weekends) and the facility was short staffed then too. Staff M said the most difficulty tasks to complete were showers and getting the residents out of bed. Payroll Based Journal (PBJ-a Center for Medicaid and Medicare Services, a mandated system for long-term care facilities to electronically submit daily, auditable, and verifiable direct care staffing data) triggered excessively low weekend staffing for the 1st Quarter 2025 (October 1-Decmeber 31). Grievances A grievance filed on 10/22/2025 stated, RSD [resident] reports she waited longer than expected for call light to be answered. A grievance filed on 10/24/2025 stated, RSD [resident] reports he waited longer than expected for call light to be answered. A grievance filed on 11/05/2025 stated, RSD [resident] reports she waited longer than expected for call light to be answered. A grievance filed on 01/03/2026 stated, RSD [resident] reports he waited longer than expected for call light to be answered. A grievance filed on 01/13/2026 stated, Resident states that she was not provided W/A shower as she expected. A grievance filed on 01/16/2026 stated, RSD [resident] reports she waited longer than expected for call light to be answered. A grievance filed on 01/16/2026 stated, RSD [resident] reports he waited longer than expected for call light to be answered. Staffing RecordOn 04/06/2026 the Staff C, Assistant Director of Nursing Services, observed working A Hall medication cart, due to staff call out. On 04/07/2026, Staff N, Staffing Coordinator, worked 6AM-2PM A Hall medication cart, due to staff call out and Staff V, Infection Preventionist, worked 2PM-6PM medication cart, due to staff call out. On 04/08/2026, Staff U, Resident Care Manager, covered the North Hall medication cart, and Staff B, Director of Nursing Services (DNS), covered Resident Care Manager (RCM) concerns. On 04/09/2026 11:53 AM, Staff N, Staffing Coordinator, said they focus on census for staffing levels, each hall has 2 aids with a float aid and shower aid available to help when needed. Staff N said for example if the facility census was above 75 then each hall would have two and a float aide to help. When asked about emergencies and call outs, Staff N said they had a list of staff they would call for over time, PRN (as needed) staff and when required management staff (Assistant Director of Nursing, Director of Nursing or herself) would come in. When asked about weekend staffing, Staff N said they do double weekend staff (meaning staff working 6AM-10PM Saturday and Sundays) and again managers would come if needed. When asked about the PBJ report- triggered low weekend staffing, Staff N said they did not know what the PBJ report was. After PBJ was explained, Staff N said weekend staffing has been difficult due to call outs. ON 04/09/2026 at 12:38 PM, Staff B, DNS, said they follow the PPD Patients Per Day for staffing levels, meaning 2 aides per hall and floats available when needed. When asked how the facility handles call outs, Staff B said they would call other staff, use PRN staff, or ask current staff to work overtime. When asked about the low weekend staffing reported on the PBJ, Staff B said weekends have been difficult but did not elaborate on what that meant. When it was explained that the CNAs reported a difficult time completing daily tasks, including showers and getting residents out of bed, Staff B said they have an open-door policy and staff have come to them in the past about the staff shortages in the facility. Reference WAC 388-97 -1080 (1), 1090 (1)

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	04/10/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to provide food that was palatable, attractive, and served at an appetizing temperature for 4 of 4 sampled Halls (Halls A, B, North 1 and North 2) reviewed for food . This failure placed residents at risk of weight loss, depressed mood, and a diminished quality of life.Findings included .Test TrayObservation of a test food tray on 04/10/2026 at 12:43 PM, showed a test tray with a white plate on a heated base system and had an insulated cover. The heated base system and white plate were both room temperature to the touch. Observation showed the white plate consisted of baked fish, coleslaw, corn and an Oreo dessert. Taste testing of corn showed it was mushy and overcooked. Taste testing of the fish showed lack of seasoning and was room temperature. Staff S, Dietary Manager, took the temperature of the fish at 112 degrees Fahrenheit, the corn at 129.5 degrees Fahrenheit, the coleslaw at 48.2 degrees Fahrenheit and stated the Oreo dessert was out of temperature range as it was just made.Resident InterviewsResident 50During an interview on 04/07/2026 at 8:11 AM, Resident 50 stated the food does not really look good and I don't always get what I ordered on the menu.Resident 7During an interview on 04/06/2026 at 3:41 PM, Resident 7 stated they would not eat the food it tasted like dead ashes and looked bad. Resident 47During an interview on 04/06/2026 at 12:23 PM, Resident 47 stated the food was not hot when they receive it and sometimes it was unidentifiable.Resident 56During an interview on 04/06/2026 at 9:52 AM, Resident 56 stated the food was not good, they have the same thing repeatedly and they have their family purchase food.Resident 60During an interview on 04/06/2026 at 11:51 AM, Resident 60 stated the vegetables were mush, the food was never hot just warm.Resident 71During an interview on 04/06/2026 at 12:28 PM, Resident 71 stated the food was terrible.Resident Council MinutesReview of the Resident Council Meeting Minutes showed food complaints from members in October 2025, November 2025, December 2025, January 2026, February 2026 and March 2026.Grievance LogReview of the facility's Grievance Log from October 2025 through April 2026 showed six food grievances in October, four food grievances in November, five food grievances in December, four food grievances in January, six food grievances in February, and 11 food grievances in March.During an interview on 04/10/2026 at 1:21 PM, Staff S, Dietary Manager, stated they were aware of issues with food temperature and had been waiting over 2 months for new plate warmers. Staff S stated the food temperatures and lack of palatability did not meet their expectations.During an interview on 10/27/2026 at 9:14 AM, Staff A, Administrator, stated that the facility's lack of temperature and quality did not meet their expectations.Reference WAC 388-97-1100(1), (2)

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	04/10/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident's representative of a new medication order and a doctor's appointment for 1 of 2 residents (Resident 6) reviewed for notification of change. This failure placed the resident at risk for not having their representative involved in their health care decision making and a diminished quality of life. Findings included .Resident 6 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, an assessment tool, dated 03/06/2026, documented Resident 6 had a diagnosis of Non-Alzheimer's Dementia (a cognitive disorder caused by diseases other than Alzheimer's, often presenting with distinct symptoms like early personality shifts, movement issues, or rapid decline) and was moderately cognitively impaired.A review of the electronic health record (EHR) showed Resident 6 had a resident representative through a court appointed guardianship. On 04/06/2026 at 2:10 PM, Resident 6's representative said they were not notified of a new medication order for metformin and were never told about an appointment to see an eye doctor until they saw Resident 6 wearing new glasses.<New Medication Order>A review of Resident 6's April 2025 Medication Administration Record (MAR) showed a medication order for metformin, dated 04/12/2025, to be given daily in the morning and discontinued on 04/14/2025. The MAR documented metformin was given on 04/14/2025.A review of Resident 6's EHR did not show where their representative was notified of the new order. On 04/09/2026 at 10:47 AM, Staff U, Resident Care Manager C/S Hall, said Resident 6 had a new order for metformin and their representative was not called and notified. Staff U said Resident 6 received one dose of metformin on April 14th. Staff U said Resident 6's representative was notified after the first dose and should have been notified of the new order prior to receiving the medication. <Eye Appointment>A review of Resident 6's EHR showed a documented titled, Attending Physician Request for Services and/or Consultation dated 04/24/2025 for Eye Care and documentation that stated, History of Present Illness 1. Glasses Mailed Adj. that was signed by the provider on 02/05/2026.A review of Resident 6's EHR did not show where their representative was notified of the appointment.On 04/09/2026 at 10:47 AM, Staff U, Resident Care Manager C/S Hall, said there was a referral for Resident 6 to see the in-house eye doctor on April 24th, 2025, and was seen for glasses on February 5th, 2026. Staff U said they probably had an eye appointment sometime in between. Staff U said they know Resident 6's representative takes them to an eye doctor in the community. Staff U said they should have contacted Resident 6's representative for new appointments and they should have notified the representative of the eye appointment for new glasses.On 04/09/2026 at 12:07 PM, Staff B, Director of Nursing Services, said they did not find anything regarding the representative having been notified of the new medication order of metformin or the eye appointment in the EHR. Staff B said their expectation was for there to be communication with the resident's representative.Reference WAC 388-97-0320

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	04/10/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate, investigate, and resolve a grievance for 1 of 1 sampled resident (Resident 3) reviewed for personal property and grievances. This failure placed the residents at risk for emotional distress and a diminished quality of life.Findings included .Review of the electronic health record (EHR) showed Resident 3 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease (gradual loss of kidney function), hyperlipidemia (high cholesterol or fats in the blood) and diabetes (too much sugar in the blood). Resident 3 was able to make needs known. During an interview on 04/06/2026 at 3:31PM, Resident 3 stated they had recently moved to a new room in February 2026 but did not receive all their personal belongings. Resident 3 stated they reported they were missing approximately 3 pairs of pants and a few shirts to Staff P, Registered Nurse (RN). Resident 3 stated Staff P went back to the previous room to look for the clothing, but they were unable to locate the items.Review of the grievance logs for February 2026, March 2026 and April 2026 showed no grievances filed on behalf of Resident 3 related to the missing clothing.During an interview on 04/07/2026 at 12:21 PM, Staff P, RN, confirmed Resident 3 reported missing clothing after their room move. Staff P stated they looked for the clothing but were unsuccessful. Staff P stated they did not complete a grievance but instead obtained clothing from the donation bin for Resident 3.During an interview on 04/09/2026 at 12:53 PM, Staff A, Administrator, stated when residents reported missing items to staff the expectation was that staff would complete a grievance form and submit it to the social services department for follow up.Reference WAC 388-97-0460

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	04/10/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pharmacy recommended gradual dose reductions (GDR, a stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) of psychotropic medications (prescription drugs that alter chemical levels in the brain, affecting mood, perception, thoughts, and behavior) were carried out, or if declined, a clinical rationale that indicated why a GDR attempt was likely to impair function or cause psychiatric instability in the individual was documented by the provider in the residents record, for 1 of 5 residents (Resident 56) reviewed for unnecessary medications. This failure placed residents at risk of receiving unnecessary psychotropic medications, experiencing adverse side effects, decline in physical function, and a diminished quality of life. Findings included . Resident 56 was admitted to the facility on [DATE]. Review of the Annual Minimum Data Set, an assessment tool, showed the resident had moderate cognitive impairment, diagnoses of anxiety disorder (a group of mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry that interferes with daily life), depressive disorder (a common, serious mental health condition characterized by persistent sadness, loss of interest in activities, and low energy, lasting at least two weeks) and insomnia (a common sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or waking too early, resulting in poor sleep quality and daytime fatigue), and received antidepressant and antianxiety medications during the assessment period. Record review showed Resident 56 had the following psychotropic medication orders:a) A 11/02/2025 order for lorazepam (an antianxiety medication) twice a day for target behaviors of increased agitation, shortness of breath, increased heart rate related anxiety disorder.b) A 02/22/2025 order for citalopram (an antidepressant medication) 20 milligrams (mg) once a day for target behaviors of self-isolation and statements of sadness related to major depressive disorder. Review of the electronic health record (EHR) showed Resident 56 had received citalopram 20 mg daily for major depressive disorder since 10/08/2022. The current citalopram order date was 02/22/2025 because on 02/21/2025 an order was input to discontinue the citalopram. On 02/22/2025 an order was obtained to start citalopram 20 mg daily (same dose). Review of the February 2025 Medication Administration Record (MAR) showed that Resident 56 received citalopram 20 mg on both 02/21/2025 and 02/22/2025, no dose was missed. This scenario (discontinuing citalopram on one day and restarting it at the same dose the next day) also occurred on 11/20/2024 and 11/21/2024, and 12/04/2023 and 12/05/2023. Review of the pharmacist Consultation Report, dated 02/02/2026, showed Resident 56 had received citalopram 20 mg daily since 2022. The consultation documented Per IDT [psychotropic committee interdisciplinary team], [Resident 56] exhibits behaviors of anger and increased falls with GDR attempts, [Resident 56] may discharge soon, team recommends no changes, benefits outweigh risks. A GDR of citalopram from 20 mg daily to 10 mg daily was recommended. On 02/19/2026 the provider reviewed the consult and under Physician's Response selected the response The resident's target symptoms returned or worsened after the most recent GDR attempt within the facility and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder AS DOCUMENTED BELOW. A space was provided below on the document that had the following instruction Please provide CMS [Center for Medicaid and Medicare Services] REQUIRED patient-specific rationale describing why a GDR attempt is likely to impair function or cause psychiatric instability in this individual The space provided for the documentation was left blank. A 02/19/2026 IDT note documented reviewed pharmacy recommendation for GDR of medication Citalopram with team citing contraindication due to presence of maladaptive behaviors and potential for increase in TBS [target behaviors]. PCP [primary care physician] in agreement with IDT with no (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	04/10/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes to be made with Citalopram at this time. The IDT note did not indicate what Resident 56's maladaptive behaviors were or how, if at all, they were associated with the resident's citalopram use. Review of the EHR showed there had been no attempted GDR of Resident 56's citalopram since it was ordered on 10/08/2022, to treat the target behaviors of self-isolation and statements of sadness related to the resident's depression diagnosis. Anger and/or agitation, as referred to in the pharmacy consult, were identified target behaviors for the use of lorazepam, which had a successful GDR on 11/20/2024, when it was decreased from three times a day, to two times a day. No documentation of a failed GDR of a psychotropic medication was found in Resident 56's electronic health record. Nor was there a resident-specific clinical rationale documented by the provider, as required, that indicated why a GDR of the citalopram was likely to impair function or cause psychiatric instability for Resident 56.During an interview on 04/10/2026 at 12:37 PM, documentation of Resident 56's prior failed GDR that allegedly caused Resident 56 to experience increased anger and falls, and the providers documented resident-specific clinical rationale indicating why a GDR of the citalopram was likely to impair function or cause psychiatric instability for Resident 56 was requested. Staff B, Director of Nursing Services, said they needed to look through Resident 56's record and would provide any documentation that was found. No further documentation was provided.Reference WAC 388-97-0620 (1)(a)

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	04/10/2026

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 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** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS), an assessment tool, accurately reflected the status for 2 of 18 sampled residents (Resident 28 & 5) reviewed for accuracy of assessments. This failure placed the residents at risk for unmet care needs and a diminished quality of life.Findings included .Resident 28 Resident 28 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 28 was moderately cognitively impaired and required substantial to dependent assistance with activities of daily living (ADLs). A review of the electronic health record (EHR) showed a document titled Hospice Certification and Plan of Care with a start of care date of 05/16/2025. The Quarterly MDS, dated [DATE], documented Resident 28 received Hospice Care and no was marked when asked Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? The Quarterly MDS, dated [DATE], documented Resident 28 received Hospice Care and no was marked when asked Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? On 04/09/2026 at 1:39 PM, Staff R, Registered Nurse (RN)/Minimum Data Set (MDS) Coordinator, said Resident 28 was receiving Hospice Services. Staff R reviewed the MDSs dated 02/20/2026 and 08/22/2025 and said they should have been marked yes for the question Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? Staff R said she would fix this right away. On 04/10/2026 7:46 AM, Staff B, Director of Nursing Services (DNS) said her expectation was for the MDS to be marked appropriately. Resident 5 Resident 5 was re-admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident was cognitively intact, had a diagnosis of end stage renal disease (permanent kidney failure, usually the final stage of chronic kidney disease (CKD), where kidneys function at less than 10-15% of normal capacity), required dialysis (a life-sustaining medical treatment that filters waste products, toxins, and excess fluid from the blood when the kidneys have failed) services, but did not admit with a central line (a long, flexible tube inserted into a large vein, usually in the chest, neck, or groin, that reaches near the heart) and did not have intravenous access (a medical technique where a small, flexible tube (catheter) is inserted into a vein to provide direct, rapid, and continuous delivery of medications, fluids, blood products, or nutrition into the bloodstream). Review of the 05/27/2025 Quarterly MDS, also assessed Resident 5 without intravenous access. Review of a nephrology progress note, dated 03/03/2025, documented Resident 5's dialysis access was via TDC [tunneled dialysis catheter, a long-term central vascular access device, usually placed in the neck into the internal jugular vein or subclavian vein and tunneled under the skin for patients needing chronic or urgent hemodialysis]. Record review showed from 03/03/2025 - 03/06/2025 there were no orders in place or direction to staff to assess and/or monitor Resident 5's TDC. A 03/07/2025 order (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	04/10/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	directed nurses to monitor the resident's dialysis catheter site for signs and symptoms of infection or bleeding every shift, and a 03/08/2025 order directed staff to assess Resident 5's right subclavian port upon return from dialysis. A dialysis care plan, initiated 03/04/2019, directed staff to assess Resident 5's subclavian access site. On 04/08/2026 at 2:24 PM, when asked if central line and/or intravenous access were coded on the 03/06/2025 admission MDS and 05/27/2025 Quarterly MDS, Staff R, MDS Coordinator, stated, No. Staff R then acknowledged the resident had a TDC and the MDS was inaccurate. Reference WAC 388-97-1000 (1)(b)

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	04/10/2026

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure Pre-admission Screening and Resident Review (PASRR) assessments were accurately completed for 1 of 5 residents (Resident 3) reviewed for PASRRs and unnecessary medications. This failure placed the residents at risk for inaccurate mental health diagnoses and a diminished quality of life.Findings included .Review of the electronic health record (EHR) showed Resident 3 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease (gradual loss of kidney function), hyperlipidemia (high cholesterol or fats in the blood) and diabetes (too much sugar in the blood). Resident 3 was able to make needs known. Review of Resident 3's PASRR, dated 12/15/2025, completed by the hospital prior to Resident 3's admission to the facility on [DATE], showed mood disorders indicated as a diagnosis on the form.Review of Resident 3's medical diagnosis list and providers orders showed no mental health diagnosis or behavioral health medication prescribed.During an interview on 04/09/2026 at 9:59 AM, Staff O, Social Services Director, stated the PASSR was incorrect and a new one should have been completed. During an interview on 04/09/2026 at 12:32 PM, Staff A, Administrator, stated the expectation was for staff to ensure PASRR's were correct upon admission and if not, a new one should have been completed to reflect accurate resident information.Reference WAC 388-97-1975

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	04/10/2026

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 ensure residents received the bowel care in accordance with provider orders for 2 of 7 residents (Resident 97 &1) reviewed for bowel management, and routine assessment and monitoring of edema (swelling caused by excess fluid trapped in the body's tissues) occurred for 1 of 2 residents (Resident 1) reviewed for edema management. These failures placed residents at risk for abdominal pain/discomfort, nausea, decreased appetite, delayed identification of fluid volume changes and other negative health outcomes.Findings included .<Bowel Management>Resident 1Resident 1 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 02/25/2026, showed the resident had moderate cognitive impairment and did not have constipation. On 04/06/2026 at 2:15 PM, Resident 1 reported constipation had been an ongoing problem. Record review showed Resident 1 had the following 11/22/2025 PRN bowel management orders:a) Milk of Magnesia (MOM) PRN (as needed), if no bowel movement (BM) for 72 hours, administer on day four. b) Bisacodyl suppository PRN, if no results from MOM, administer on day five. c) Fleet enema PRN, if no results from suppository, administer on day six. Review of Resident 1's bowel monitor for February and March 2026 showed the resident went the following periods without a BM: 02/12/2026 - 02/15/2026 (4 days). 02/04/2026 - 02/07/2026 (4 days). 03/07/2026 - 03/10/2026 (4 days). Review of the February and March 2026 Medication Administration Record (MAR) showed facility nurses failed to administer MOM on the fourth day without a BM (02/07/2026, 02/15/2026 and 03/10/2026) as ordered. On 04/09/2026 at 3:01 PM, when asked if on the above referenced occasions, facility nurses administered Resident 1's PRN bowel medication on the fourth day without a BM as ordered, Staff B, Director of Nursing Services (DNS), stated, No. Resident 97Resident 97 was admitted to the facility on [DATE]. Review of Resident 97's March 2026 bowel record showed the resident had no BM from 03/12/2026 - 03/16/2026 (5 days).Record review showed Resident 97 had the following 03/12/2026 as needed (PRN) bowel management orders:a) MOM PRN, if no BM for 72 hours, administer on day four.b) Bisacodyl suppository PRN, if no results from MOM, administer on day five. c) Fleet enema PRN, if no results from suppository, administer on day six. Review of the March 2026 MAR showed facility nurses failed to administer MOM on the fourth day without a BM (03/15/2026) as ordered.During an interview on 04/09/2026 at 3:01 PM, when asked if facility nurses administered Resident 97 PRN bowel medication on the fourth day without a BM as ordered, Staff B, DNS, stated, No. <Edema Monitoring>Resident 1Resident 1 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was moderately cognitively impaired, had a diagnosis of renal insufficiency and required diuretic medication during the assessment period. A renal insufficiency care plan, initiated 01/18/2026, directed staff to observe and report dependent edema, weight gain greater than two pounds in 24 hours, neck vein distension and /or shortness of breath. A hypertension (high blood pressure) care plan, initiated 01/18/2026, directed staff to notify the physician of edema. Record review showed a 12/09/2025 order directing nurses to apply ace wrap to left lower extremity PRN for edema and a 04/09/2026 order directing nurses to monitor Resident 1's edema every shift. The March 2026 MAR showed facility nurses signed every shift that they monitored Resident 1's edema as ordered, but no place was provided and nurses did not document whether there was edema or not, and if so, where and to what extent (e.g., 3+ pitting edema to the left lower extremity from foot to mid-shin).During an interview on 04/09/2026 at 3:04 PM, Staff U, Resident Care Manager, was asked to clarify what it meant when a nurse initialed off on the MAR that they monitored Resident 1's edema as ordered. Did it mean the resident had edema, if so, where and to what extent, or did it mean the resident did not have edema? Additionally, Staff U was asked how a nurse would know if Resident 1's edema was worse, better or the same, without knowing the location and extent of edema that was identified on previous assessments. Staff U explained that (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	04/10/2026

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	nurses should have documented the location of the edema and used the 0-4+ edema monitoring method to grade it. After reviewing the MAR and Resident 1's electronic health record Staff U acknowledged facility nurses had not documented the amount (0-4+), location, or whether edema was present and indicated the edema monitoring order was incorrectly input into the computer without direction to document or a place provided to record the presence/absence of edema, and if present, the location and extent assessed. Reference WAC 388-97-1060 (1)

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	04/10/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to monitor and accurately document fluids consumed to ensure fluid restrictions (a diet which limits the amount of daily fluid intake) was implemented per provider's orders for 2 of 4 residents (Resident 48 and 96) reviewed for nutrition. These failures placed the residents at risk for medical complications and a diminished quality of life.Findings included .Review of the electronic health record (EHR) showed Resident 48 admitted to the facility on [DATE] with diagnoses that included heart failure, diabetes (too much sugar in the blood) and muscle weakness. Resident 48 was able to make needs known. Observation on 04/06/2026 at 11:20 AM, showed Resident 48 with a water pitcher and a straw stuck in it on the overbed table for easy access to consume fluids. During an interview on 04/07/2026 at 11:53 AM, Resident 48 stated they were upset that their water pitcher had been taken by Staff Q, Certified Nursing Assistant (CNA) and they did not understand why. Resident 48 stated Staff Q, CNA had provided and filled the water pitcher since admission, and they did not understand what changed. Review of Resident 48's providers orders showed a 03/20/2026 order to monitor fluid intake and document amount. An additional order, dated 03/20/206, showed Fluid Restriction Total 2000 milliliters (MLS) per day; Nursing to provide 240 MLS for day and evening shift. 80 MLS for night shift, 480 MLS for breakfast and dinner and 480 MLS for lunch related to CHF [congestive heart failure]. During an interview on 04/07/2026 at 11:56 AM, Staff Q, CNA stated they were instructed to take Resident 48's water pitcher due to a fluid restriction. Staff Q stated they were aware Resident 48 was on a fluid restriction and did not recall providing or filling Resident 48's water pitcher in the past. During an interview on 04/07/2026 at 11:59 AM, Staff R, Registered Nurse/ MDS Coordinator (RN/MDS), stated during medication administration they noticed Resident 48 had a water pitcher on the overbed table and instructed Staff Q, CNA to take the water pitcher and provide a cup of water. Staff R stated they were not aware if Staff Q explained to Resident 48 why the water pitcher was taken. Review of the Resident 48's meal tray card did not show a fluid restriction. During an interview on 04/07/2026 at 3:00 PM, Staff S, Dietary Manager, reviewed a Diet Order and Communication form dated 04/04/2026 completed by nursing. Staff S stated the order did not reflect that Resident 48 was on a fluid restriction. Staff S stated communication between nursing and dietary had been an ongoing concern. During an interview on 04/09/2026 at 12:01 PM, Staff B, Director of Nursing Services, stated that residents on fluid restrictions should not have a water pitcher at the bedside. After reviewing Resident 48's April 2026 Medication Administration Record (MAR), Staff B stated the MAR had inaccurate totals and that did not meet expectations. Staff B stated Resident 48's diet slip should have accurately reflected the fluid restriction and the lack of communication between nursing and dietary did not meet expectations. (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	04/10/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 96 Resident 96 was admitted to the facility on [DATE] with an order for a 1500 milliliter (ml) per day free water restriction (medical strategy to limit the intake of low-sodium, low-protein, or hypotonic fluids to manage conditions like hyponatremia, heart failure and kidney disease) for hyponatremia (low sodium levels). On 04/07/2026 at 9:37 AM, Resident 96 was not in their room. A water pitcher was on the overbed table containing 750ml of a clear liquid. On 04/07/2026 at 12:37 PM, a male visitor was observed entering Resident 96's room and pulled a bottle of arrowhead water from his jacket and handed it to Resident 96 who was sitting in a wheelchair at bedside. A pitcher containing 600 ml of clear fluid was on the overbed table in front of Resident 96. On 04/09/2026 at 2:08 PM, Resident 96 was observed sitting up in a wheelchair at bedside. An overbed table was positioned in front of the resident with a pitcher containing a clear fluid sitting on top of it. Review of the March 2026 MAR showed nurses were directed to document the amount of free fluid provided by nursing each shift. Each shift was allotted up to 500 ml of free fluid. A space was provided to record the resident's free water intake each shift, but there was no direction to staff to calculate, or place provided to record Resident 96's total 24-hour intake of free water. When Resident 96's 24-hour free water intake for the seven-day period of 04/01/2026 - 04/07/2026 were totaled, it showed the resident exceeded the free water restriction on three of seven days, as follows: 04/01/2026- total free water intake= 2750 ml. 04/05/2026- total free water intake= 1600 ml. 04/06/2026- total free water intake= 1750 ml. Review of the EHR showed there was no documentation that staff had calculated Resident 96's 24-hour free fluid intake totals, identified they frequently exceeded the restriction, performed patient education or notified the provider. On 04/09/2026 at 3:36 PM, Staff B, DNS, explained for residents with orders for fluid restrictions staff would record the resident's fluid intake each shift and then calculate the total 24-hour intake total. If a resident was non-adherent with the restriction (exceeding) patient education would be performed and the provider notified. When asked if staff had calculated Resident 96's 24-hour free water intake totals, identified they exceeded the restriction on three of seven days (04/01/2026, 04/05/2026 and 04/06/2026), and whether there was documentation of patient education and/or provider notification Staff B said no, and explained that the fluid restriction order had been input into the computer system incorrectly, without direction to nurses to calculate the resident's 24-hour free fluid intake total. Reference WAC 388-97 -1060 (3)(i)

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	04/10/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure respiratory services were provided according to professional standards of practice for 1 of 2 sampled residents (Residents 2) reviewed for respiratory care. Failure to have a provider's order for oxygen placed residents at risk for discomfort, unmet needs and a diminished quality of life.Findings included.Review of the electronic health record (EHR) showed Resident 2 admitted to the facility on [DATE] with diagnoses that included chronic kidney disease (gradual loss of kidney function), hyperlipidemia (high cholesterol or fats in the blood) and diabetes (too much sugar in the blood). Resident 2 was able to make needs known. Observations on 04/06/206 at 9:36 AM, 04/07/2026 at 10:48 AM and 04/08/2026 at 8:40 AM showed an oxygen concentrator on set to 2 liters per minute near Resident 2's bed. Resident 2 was not observed wearing a nasal cannula during the observations.Review of Resident 2's Care Plan initiated 03/19/2026, showed an intervention for oxygen via nasal cannula at 2 liters per minute as needed for shortness of breath.Review of the EHR showed no active provider's order for oxygen.During an observation and interview on 04/08/2026 at 8:42 AM, Staff C, Assistant Director of Nursing Services, asked Resident 2 when they used the oxygen. Resident 2 stated they only used oxygen at night. Staff C checked the EHR and stated there was no active order on file for oxygen but should have been.During an interview on 04/09/2026 at 11:38 AM, Staff B, Director of Nursing Services, stated the oxygen order was discontinued however since Resident 2 was still using oxygen a new order should have been obtained.Reference WAC 388-97-1060(3)(j)(iv)-(vi)

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	04/10/2026

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete Certified Nursing Assistant's (CNA) annual performance reviews as required for 3 of 5 sampled nursing assistants (Staff H, I, & J) reviewed for performance reviews. This failure placed residents at risk of receiving care from inadequately trained and/or under-qualified care staff, and a diminished quality of life. Findings included .Staff H, CNA, was hired on 04/09/2025. Record reviewed on 04/09/2026, showed no annual performance review had been completed. Staff I, CNA, was hired on 04/25/2024. Record reviewed on 04/09/2026, showed an annual performance review was completed on 09/17/2025 (5 months past annual review date). Staff J, CNA was hired on 06/20/2024. Record reviewed on 04/09/2026, showed an annual performance review was completed on 09/17/2025 (3 months past annual review date). On 04/09/2026 at 12:38 PM, Staff B, Director of Nursing Services, said annual performance reviews needed to be completed and pointed to a binder (indicating CNA annual performance reviews that needed to be completed). When shown the listed staff above without or past due annual performance reviews, Staff B said the annual performances were completed within the year. It was explained that the regulation reads from hire date to hire anniversary and not calendar year, Staff B said the annual performance reviews should have been completed within timeframe. Reference WAC 388-97 -1680 (1), (2)(a-c)

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	04/10/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were dated when opened for 2 of 3 medication carts (A hall cart & North hall cart) reviewed for medication storage. Additionally, the facility failed to ensure medications were secured for 1 of 1 resident (Resident 28) observed with medications at bedside. These failures placed residents at risk for medication discrepancies and an impaired quality of life.Findings included. <North Hall Medication Cart>An audit of the North Hall medication cart on 04/10/2026 at 9:26 AM showed the following:a) Resident 104's latanoprost eye drops were opened and undated. Review of the package insert showed the medication should be discarded six weeks after opening.b) Resident 104's fluticasone propionate was opened and undated. Review of the package insert showed the medication should be discarded 90 days after opening.c) Resident 103's latanoprost eye drops were opened and undated. Review of the package insert showed the medication should be discarded six weeks after opening.d) Resident 14's Spiriva Respimat was opened and undated. Review of the package insert showed the medication should be discarded 90 days after opening. On 04/10/2026 at 9:38 AM, when asked if the above referenced medications should have been dated when opened, Staff U, Resident Care Manager (RCM), said the nurse who opened the eye drops and/or inhalers should have recorded the date opened, but failed to do so. <A Hall Medication Cart>An audit of the A Hall medication cart on 04/10/2026 at 9:52 AM showed the following:a) Resident 47's Wixela inhaler was opened and undated. Review of the package insert showed the medication should be discarded 30 days after opening. On 04/10/2026 at 9:56 AM, Staff U, RCM, said Resident 47's Wixela inhaler should have been dated when opened, but was not. <Medications at Bedside>Resident 28 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, an assessment tool, dated 02/20/2026, documented Resident 28 was moderately cognitively impaired and required substantial to dependent assistance with activities of daily living (ADLs). A review of Resident 28's electronic health record showed orders for:1) Apply calmoseptine to the coccyx (a small triangular bone at the base of the spinal column) blanchable redness (a red area of skin that turns white or paler when pressed) every 24 hours as needed after each incontinent (the inability to voluntarily control bladder or bowel movements, leading to involuntary leakage) episode dated 03/11/2026 2) Apply calmoseptine to the coccyx blanchable redness every shift dated 03/11/2026 On 04/06/2026 at 11:13 PM, creams observed on the bedside table of Resident 28 in 2 different medicine cups, one cream pink and one cream white, with Resident 28's last name written on the medicine cups. On 04/07/2026 at 8:28 AM, observations of a white and pink cream located on Resident 28's bedside table in 2 medicine cups labeled with the first letter of Resident 28's last name. On 04/08/2026 at 8:27 AM, Resident 28 had 2 medicine cups with a pink and white cream, on the bedside table with Resident 28's name written on the outside of the medicine cups. (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	04/10/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/08/2026 at 11:05 AM, 2 medicine cups with a white and a pink cream inside were observed on the table of Resident 28. On 04/08/2026 at 11:11 AM Staff P, Licensed Practical Nurse went into Resident 28's room and said they observed 2 medicine cups with cream in them by Resident 28's bed. Staff P was observed throwing the medicine cups with a pink cream and a white cream in the garbage. Staff P said they believed the white cream was a zink paste and the pink cream was calmoseptine. Staff P said some nurses may ask the nurse aides to apply the cream to the resident's skin when they are proving care and Staff P believed this was not permissible. Staff P said the creams in the medicine cups should not be left at the bedside. On 04/08/2026 at 11:22 AM, Staff B, Director of Nursing Services, said the 2 medicine cups with creams in them should not have been left in the resident's room. Staff B said it was the facility's policy for nurse aides to let the nurse know when they are providing resident care so the nurse can go in and apply the creams to the resident's skin. Reference: WAC 388-97 -1300 (2), -2340, -1300(1)(b)(ii), (c)(ii-v)-1300 (2)

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	04/10/2026

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure dental services were provided for 1 of 3 Medicaid residents (Resident 1) reviewed for dental services. The facility's failure to follow up on dental referrals and to assist with appointment scheduling and transportation arrangements that resulted in Resident 1 not receiving the dental services they were assessed to require (tooth extraction(s) and new upper and lower dentures). These failures placed residents at risk for unmet dental needs including difficulty chewing, oral pain, decreased self-image and diminished quality of life.Findings included .Resident 1 was admitted to the facility on [DATE]. Review of the 10/06/2025 admission Minimum Data Set, an assessment tool, showed the resident was cognitively intact and had mouth or facial pain, discomfort or difficulty with chewing. On 04/06/2026 at 2:10 PM, Resident 1 reported they had chipped and cracked teeth on the bottom that needed work and stated, I pulled one out last week. Resident 1 went on to state, I don't have upper teeth see . I had spaghetti, how am I supposed to eat that? A resident has the potential for oral/dental health problems r/t [related to] natural carious and broken teeth, pain and difficulty with chewing care plan, initiated 10/14/2025, directed staff to coordinate arrangements for dental care and transportation as needed and/or as ordered. Record review showed a provider order, dated 11/22/2025, for the resident to receive dental services as needed. Review of a dental consult, dated 11/10/2025, showed a referral for Resident 1 to get x-rays, and evaluated for extraction of tooth 18. Resident 1 was then to be referred for new dentures. The dentist hand wrote on the consult that (Resident 1) would like tooth extraction and new dentures made. Review of the electronic health record showed no documentation that staff followed up to Resident 1's dental referral for tooth extraction and/or new dentures. On 04/10/2026 at 12:37 PM, when asked if the facility had documentation to show Resident 1's referral for x-rays, evaluation and tooth extraction and/or referral for new dentures had been followed up on Staff B, Director of Nursing Services, stated, No. Reference WAC 388-97-1060 (1), (3)(j)(vii)

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	04/10/2026

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview and record review the facility failed to ensure food preferences related to portion sizes were honored for 7 of 19 sampled residents (Residents 87, 77, 63, 61, 57, 37 and 4) reviewed for resident rights. This failure placed the residents at risk for dissatisfaction and diminished quality of life.Findings included.Review of the Diet spreadsheet showed the 04/10/2026 breakfast menu consisted of cheese scrambled eggs, bacon, buttered toast and choice of cereal. The entree was to be served with a #10 scoop for residents who received a regular diet.Observation on 04/10/2026 at 7:30 AM, showed Resident 61 preferred small portions and a small serving of starch. Staff T, Cook, used the size #12 scoop to plate a regular portion size and regular portion size of starch.Observation on 04/10/2026 at 7:32 AM, showed Resident 77 preferred small portions. Staff T used the size #12 scoop to plate a regular portion sizeObservation on 04/10/2026 at 7:41 AM, showed Resident 57 preferred small portions. Staff T used the size #12 scoop to plate a regular portion size.Observation on 04/10/2026 at 7:42 AM, showed Resident 37 preferred a small serving starch. Staff T used the size #12 scoop to plate a regular portion size of starchObservation on 04/10/2026 at 7:43 AM, Resident 87 preferred small portions. Staff T used the size #12 scoop to plate a regular portion size. Observation on 04/10/2026 at 7:53 AM, Resident 63 preferred a small serving of starch. Staff T used the size #12 scoop to plate a regular portion size of starch.Observation on 04/10/2026 at 7:55 AM, showed Resident 4 preferred a small serving of starch. Staff T used the size #12 scoop to plate a regular portion size of starch.During an interview on 04/10/2026 at 9:27 AM, Staff T stated they were unable to locate the #10 scoop for the breakfast entree and instead used the #12. Staff T stated for residents who preferred small portions of small starch they should have been using a smaller scoop.During an interview on 04/10/2026 at 9:30 AM, Staff S, Dietary Manager, stated they expected staff to follow the diet spreadsheet and use the correct scoop sizes when serving meals. Staff S stated when residents requested smaller portion sizes or a smaller amount of starch the expectation was for staff to provide half the regular serving size as requested.Reference WAC 388-97-1100(1).

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	04/10/2026

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to implement a system to ensure Certified Nursing Assistants (CNAs) received the required training for continued competency of no less than 12 hours per year for 2 of 5 sampled staff (Staff I & K) reviewed for training. The failure to implement a system to provide mandatory training placed residents at risk for abuse, neglect, emotional distress, physical injury and a diminished quality of life. Findings included .Staff I, CNA, was hired on 04/25/2024. Record reviewed on 04/09/2026, documented Staff I had 3.75 hours of training annually (from 04/25/2024-04/25/2025). Staff K, CNA, was hired on 07/15/2024. Record reviewed on 04/09/2026, documented Staff K had 11.25 hours of training annually (from 07/15/2024-07/15/2025). On 04/09/2026 at 12:38 PM, when shown the staff that did not meet the required annual 12-hour training minimum, Staff B, Director of Nursing Services, said the training hours should have been completed. Reference WAC 388-97-1680 (2)(a-c)