STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505306	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Townsend	751 Kearney Street Port Townsend, WA 98368

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 - Some	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 screen residents for mental health conditions prior to admission for 2 of 5 sampled residents (Resident 12 and 47) residents reviewed for Preadmission Screening and Resident /review (PASRR). This failure placed residents at risk for unidentified mental health conditions, lack of appropriate mental health care and a decreased quality of life. Findings included . Resident 12 was admitted on [DATE]. Resident 12's Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 12 had a diagnosis of anxiety disorder. Resident 12's physician orders, dated 02/03/2026, showed Resident 12 had lorazepam (medication for anxiety) ordered every four hours as needed for anxiety related to anxiety disorder. Resident 12's Level 1 PASRR, dated 01/26/2026, showed Resident 12 was anticipated to be admitted to the facility on [DATE] and had no serious mental illness indicators and anxiety disorder was not documented. On 03/12/2026 at 1:13 PM, Staff C, Social Service Director (SSD), said they had reviewed Resident 12's PASRR Level 1 that was completed prior to admission and determined it was not correct due to Resident 12's diagnosis of an anxiety disorder. Staff C said they had been busy and had not completed a corrected PASRR until 03/11/2026. Resident 47 Resident 47 was admitted to the facility on [DATE], with no mental health diagnoses documented on diagnoses list. The admission MDS, dated [DATE], documented Resident 47 was cognitively intact and showed no mental health diagnoses or history. The PASRR Level I form, upon admission, documented Resident 47 had no mental health diagnoses or concerns, a Level II was not required. On 03/12/2026 at 11:19 AM, Staff B, Director of Nursing Services, reviewed Resident 47's diagnosis list and confirmed Resident 47 had no mental health diagnosis listed. Staff B then reviewed Resident 47's medication list that included an antidepressant and an antianxiety medication. Staff B reviewed the hospital discharge record and confirmed the hospital had a diagnosis of anxiety. Staff B said Resident 47 had been admitted to the facility on both medications, the diagnoses should have been caught and a new PASRR should have been completed and submitted to include the correct diagnoses. Reference WAC 388-97- -1915 (1)(2)(a-c)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505306	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Townsend	751 Kearney Street Port Townsend, WA 98368

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 psychotropic medications (any drug that affects the brain activities associated with mental processes and behavior) were regularly monitored for side effects and target behaviors and provided justification for use of the psychotropic medications and non-pharmaceutical interventions were used prior to utilizing psychotropic medications for 3 of 5 sampled residents (Resident 22, 47 & 12) reviewed for unnecessary medication. This failure placed residents at risk of unnecessary medication usage, increase in side effects without interventions, and a diminished quality of life.Findings included.Review of the facility policy titled, Psychotropic Medication Use, revised 03/01/2025, showed the facility staff should take a holistic approach to behavior management that involved a thorough assessment of underlying causes of behaviors and individualized person-centered non-drug and pharmaceutical interventions and psychotropic medications may be used to address behaviors only if non-drug approaches and interventions were attempted prior to their use. The policy showed all medications used should be monitored for harm and adverse consequences. Resident 22 Resident 22 was admitted to the facility on [DATE], with diagnoses that included depression (persistent feelings of sadness and loss of interest) and unspecified dementia, with other behavioral disturbances (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities). The admission Minimum Data Set (MDS, an assessment tool), dated 02/19/2026, documented Resident 22 was severely cognitively impaired. A physician's order dated 02/17/2026, documented Resident 22 was prescribed quetiapine (an antipsychotic) for unspecified dementia. A physician's order dated 02/17/2026, documented Resident 22 prescribed Trazadone (an antidepressant) for depression. Resident 22's electronic health record (EHR) showed no documentation of target behavior monitoring for the Trazadone. On 03/12/2026 at 10:55AM, Staff B, Director of Nursing Services (DNS) reviewed Resident 22's Electronic Health Record (EHR) and confirmed there was no target behavior monitoring in place or documented for Resident 22's antidepressant medication and said there should have been. Resident 47 Resident 47 was admitted to the facility on [DATE], with no mental health diagnoses documented on the diagnoses list. The admission MDS, dated [DATE], documented Resident 47 was cognitively intact and showed no mental health diagnoses or history. A physician's order, dated 02/12/2026, documented Resident 47 was prescribed escitalopram (an antidepressant) routinely for anxiety. A physician's order, dated 02/27/2026, documented Resident 47 was prescribed lorazepam (an (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505306	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Townsend	751 Kearney Street Port Townsend, WA 98368

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	antianxiety) as needed for anxiety. A progress note, dated 03/02/2026, documented Resident 47 told the facility they did not have depression, but sometimes had anxiety. On 03/12/2026 at 11:19 AM, Staff B, DNS, reviewed Resident 47's diagnosis list and confirmed Resident 47 had no mental health diagnosis listed. Staff B then reviewed Resident 47's medication list that included an antidepressant and an antianxiety medication. Staff B reviewed the hospital discharge record and confirmed the hospital had a diagnosis of anxiety. Staff B said Resident 47 had been admitted to the facility on both medications, the diagnoses should have been caught and listed under diagnosis that also included justification of use. Resident 12 Resident 12 was admitted on [DATE] with diagnoses including Alzheimer's (type of dementia) with behavior disturbances and anxiety disorder. The admission MDS, dated [DATE], showed Resident 12 was severely cognitively impaired, exhibited physical behaviors toward others that interfered with care, put others at significant risk for physical injury and was dependent on staff assistance with activities of daily living. NON-DRUG AND PHARMACEUTICAL INTERVENTIONS Resident 12's change in mood or behavior due to late onset Alzheimer's disease care plan, dated 02/03/2026, showed staff were to explain each task before beginning and during the task and if resident was resistant to care to not contradict resident, ensure safety and reapproach. Resident 12's physician orders, dated 02/03/2026, showed risperidone (psychoactive medication) one tablet every 24 hours as needed for agitation related to Alzheimer's disease with agitation. Resident 12's physician orders, dated 02/03/2026, showed to monitor and document number of episodes of agitation were present and documented behavioral interventions attempted and the outcome of the behavioral interventions. Resident 12's physician orders, dated 02/03/2026, showed to monitor and document number of episodes of anxiety were present and documented behavioral interventions attempted and the outcome of the behavioral interventions. Resident 12's physician orders, dated 02/05/2026, showed lorazepam (psychoactive medication used to treat anxiety) 0.25 ML [milliliters] every four hours as needed for anxiety. Resident 12's physician orders, dated 02/05/2026, showed haloperidol (psychoactive medication) 0.25 ML every four hours as needed for agitation related to Alzheimer's disease with agitation. Resident 12's potential to be physically aggressive during care r/t [related to] dementia care plan, revised 02/11/2026, showed staff were to analyze times of day, places, circumstances, triggers, and what de-escalated the resident's behavior and document it. The care plan showed when the resident became agitated: intervene before the agitation escalates, guide away from source of distress, engage calmly in conversation, if response is aggressive, staff are to walk calmly away and approach later. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505306	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Townsend	751 Kearney Street Port Townsend, WA 98368

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	Resident 12's progress notes, dated 02/13/2026 at 2:31 PM, showed Resident 12 was administered haloperidol prior to a shower d/t [due to] aggressiveness during showers. Resident 12's Treatment Administration Record (TAR), dated 02/01/2026 through 02/28/2026, showed no documentation on 02/13/2026 of episodes of agitation and/or behavioral interventions prior to the administration of haloperidol. Resident 12's progress notes dated 02/16/2026 at 3:20 AM, showed Resident 12 was administered lorazepam for agitation. Resident 12's Treatment Administration Record (TAR), dated 02/01/2026 through 02/28/2026, showed no documentation on 02/16/2026 of episodes of agitation and/or anxiety. The TAR showed no documentation of behavioral interventions prior to the administration of lorazepam. Resident 12's progress notes, dated 02/17/2026 at 7:08 PM, showed Resident 12 was administered lorazepam prior to HS [bedtime] care. Resident 12's TAR, dated 02/01/2026 through 02/28/2026, showed no documentation on 02/17/2026 of episodes of anxiety and/or behavioral interventions prior to the administration of lorazepam. Resident 12's progress notes, dated 02/18/2026 at 7:25 PM, showed Resident 12 was administered lorazepam prior to personal care. Resident 12's TAR, dated 02/01/2026 through 02/28/2026, showed no documentation on 02/18/2026 of episodes of anxiety and/or behavioral interventions prior to the administration of lorazepam. Resident 12's progress notes, dated 02/20/2026 at 2:58 AM, showed Resident 12 was aggressive during care, scratching staff, staff was encouraged to use two people to assist and to let the LN [licensed nurse] know to medicate resident with PRN [as needed] lorazepam prior to care. Resident 12's progress notes, dated 02/20/2026 at 7:16 AM, showed Resident 12 was administered risperidone because they were agitated and needed care done, attempting to help relax resident so they would allow care at this time. Resident 12's Resident 12's TAR, dated 02/01/2026 through 02/28/2026, showed no documentation on 02/20/2026 of episodes of agitation and/or behavioral interventions attempted prior to risperidone being administered. Resident 12's progress notes, dated 02/23/2026 at 7:18 PM, showed Resident 12 was administered lorazepam prior to personal care. Resident 12's Resident 12's TAR, dated 02/01/2026 through 02/28/2026, showed no documentation on 02/23/2026 of episodes of anxiety and no behavioral interventions were documented attempted prior to lorazepam being administered. Resident 12's progress notes, dated 03/08/2026 at 8:11 AM, showed Resident 12 was administered lorazepam for anxiety. Resident 12's Resident 12's TAR, dated 03/01/2026 through 03/31/2026, showed no documentation (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505306	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Townsend	751 Kearney Street Port Townsend, WA 98368

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	on 03/08/2026 of episodes of anxiety and no behavioral interventions were documented attempted prior to lorazepam being administered. Resident 12's physician orders, dated 03/11/2026, showed a new order for an additional dose of risperidone 0.25 MG every day in the morning for dementia with agitation. On 03/11/2026 at 3:51 PM, Staff H, Licensed Practical Nurse, said they administered lorazepam to Resident 12 in anticipation of care and/or a bath. Staff H said they did not want Resident 12 to become anxious. Staff H said they did not administer the medication to sedate Resident 12 but to relax them and enable them to receive care. On 03/12/2026 at 1:13 PM, Staff C, Social Service Director, said they complete the behavior section of the MDS and the behavior care plan. Staff C said there seemed to be a pattern to Resident 12's physical aggressiveness. Staff C said it seemed to occur when showering/bathing and/or later in the day. Staff C said they had seen most of the behaviors in the evening, but they had not made changes to the behavioral interventions in the care plan. Staff C said when Resident 12 became aggressive the staff should stop and walk away and come back later and try other tactics. Staff C said they did not know if those interventions were working but they had not heard otherwise. Staff C said they were not involved in any medication changes for Resident 12 and did not know why Resident 12's risperidone medication had been increased, I was wondering that too, I figured hospice but wasn't sure, I was not brought into the discussion. On 03/12/2026 at 10:17 AM, Resident 12 was observed during care. Staff F, Certified Nursing Assistant (CNA) and Staff G, CNA were completing the care. Staff F and G changed Resident 12's brief and changed their clothes. During the care Resident 12 patted Staff G's chest, Staff F gave Resident 12 a stuffed animal to hold. Resident 12 hit Staff G with the animal. Staff F and G continued to provide the care, they did not pause and/or step back when Resident 12 hit them with the stuffed animal. Resident 12 was placed in the manual lift and placed in the wheelchair. Staff G leaned over Resident 12 to put their shoes on. Resident 12 walked the animal across Staff G's back and then patted Staff G's face. Staff G continued to put the resident's shoes on. Resident 12 smiled when Staff G was done. On 03/12/2026 at 1:42 PM, Staff B, DNS, said if Resident 12 was exhibiting agitation, anxiety and/or physical behavioral symptoms, they expected the licensed nurses to ask the nursing assistants if they had attempted the behavioral interventions and if the interventions were ineffective, they would administer the medication. Staff B reviewed Resident 12's progress notes and TARs and said it appeared the staff had not been doing that. Staff B said Resident 12's risperidone was increased on 03/11/2026 because they were speaking with the Hospice nurse and they said Resident 12 had grabbed them during care. Staff B said the staff had not reviewed the behavior care plan interventions for effectiveness and/or analyzed what interventions were effective and/or reassessed what other approaches would work. Staff B said they had wondered if Resident 12 was in pain during care but was unaware if the staff had assessed for pain. Staff B reviewed Resident 12's Medication Administration Record and said Resident 12 had not been given any medication for pain. Staff B said they had not done enough to assess and/or analyze Resident 12's behavior and what non-pharmacological interventions would be effective prior to increasing their psychoactive medication. SIDE EFFECT MONITORING (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505306	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Townsend	751 Kearney Street Port Townsend, WA 98368

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	On 03/09/2026 at 1:40 PM, Resident 12 was observed sitting in their wheelchair. Resident 12 was thrusting their jaw forward repetitively. On 03/10/2026 at 2:56 PM, Resident 12 was observed puckering their mouth, smacking their lips and rolling their tongue in their mouth, around their lips and outside of their mouth. Resident 12's antipsychotic medication care plan, dated 02/13/2026, showed Resident 12 was administered antipsychotic medications and was to be observed for side effects and adverse reactions to include tardive dyskinesia (a neurological syndrome characterized by involuntary, repetitive body movements-such as lip-smacking, tongue thrusting, puckering and jaw swinging, finger tapping or wiggling and/or rocking). Resident 12's physician orders, dated 02/03/2026, showed the antipsychotic medication was haloperidol and risperidone and staff were to monitor Resident 12 for side effects to include tardive dyskinesia every shift and if present document a plus symbol and write a progress note. Resident 12's TAR, dated 02/01/2026 through 02/28/2026, showed no documentation of side effects including tardive dyskinesia, from the antipsychotic medication. Resident 12's Abnormal Involuntary Movement Scale Assessment (AIMS) (tool used to screen for and monitor the severity of tardive dyskinesia), dated 02/05/2026, showed no observations of movements in the lips and perioral area (puckering, pouting and smacking) the jaw and/or the tongue. During an observation on 03/10/2026 at 3:00 PM, with Staff B, DNS, Resident 12 was observed thrusting their jaws outward, puckering their lips and rolling their tongue in their mouth and lips. Staff B observed Resident 12 and said they saw the jaw thrusting and tongue movements. Staff B said they would review the AIMS test. Resident 12's AIMS assessment, dated 03/11/2026, showed moderate observations of the lips and perioral area and jaw and mild movement of the tongue. Resident 12's TAR, dated 03/01/2026 through 03/31/2026, showed no documentation of side effects, including tardive dyskinesia, from the antipsychotic medication including tardive dyskinesia. On 03/12/2026 at 1:10 PM, Staff E, Licensed Practical Nurse, said they had cared for Resident 12 many times since admission. Staff E said they were monitoring Resident 12 for side effects from their antipsychotic medications. Staff E said that Resident 12 exhibited signs of tardive dyskinesia with their mouth and tongue. Staff E said they did not document their observations on Resident 12's TAR and/or progress notes because this was Resident 12's baseline and Resident 12 had the movements since admission to the facility. On 03/12/2026 at 1:42 PM, Staff B, DNS, said the staff had completed Resident 12's initial AIMS test incorrectly and they had corrected it. Staff B said the nursing staff should have documented Resident 12 was observed with side effects due to their oral facial movements and notified the medical provider of their observations. Staff B said it did not matter that Resident 12 had the movements since admission to the facility. Reference WAC 388-97-1060(3)(k)(i), 0620(1)(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505306	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Townsend	751 Kearney Street Port Townsend, WA 98368

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate and follow-up on a preadmission screening and resident review (PASRR, a mental health screening tool) level 2 evaluation for residents diagnosed with a significant mental illness for 2 of 5 residents (3 and 4) reviewed for PASRR. This failure placed the residents at risk for unmet care needs and a decreased quality of life.Findings included .Resident 3Resident 3 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 12/05/2025, showed Resident 3 was cognitively intact and needed set up assistance with oral hygiene and partial/moderate assist to dependent with dressing and showering.Resident 3's PASRR, dated 07/03/2025, showed serious mental illness indicators were checked for psychotic disorder (severe mental illnesses characterized by a loss of touch with reality) depressive disorder (mental health condition characterized by persistent low mood, loss of interest, and low energy), delusion disorder (false beliefs) and neurocognitive disorder with Lewy bodies(a progressive disease associated with abnormal deposits of alpha-synuclein protein, causing cognitive decline, hallucinations, movement issues (parkinsonism), and fluctuating alertness). Level 2 evaluation referral was checked.A review of Resident 3's electronic health record (EHR) showed no level 2 evaluation. A review of Resident 3's EHR showed a progress note, dated 07/03/2025 at 12:03 PM by Staff D, Social Services Director (SSD, previous SSD), documented a request for Level II PASRR review was emailed to Acentra Health on the Resident.On 03/11/2026 at 12:02 PM, Staff C, Social Service Director, said they had been with facility since October 2025, and was still getting up to speed. Staff C said she was trying to figure out if they had received a Level 2 evaluation for Resident 3 and sent an email to the state and asked them to send an invalidation letter. Staff C said there had not been documentation or follow up with the state before this day.On 03/13/2026 at 8:32 AM, Staff A, Administrator, said there has not been follow-up on the PASRR sent until they were audited and brought up by the survey team this week. Resident 4Resident 4 was admitted to the facility on [DATE]. The Annual MDS, dated [DATE], showed the resident was cognitively intact and needed setup to supervision assistance with hygiene and dressing and partial to moderate assistance with bathing.Resident 4's PASRR, dated 04/30/2025, showed serious mental illness indicators checked were for major depressive disorder (a serious, common mood disorder characterized by persistent sadness, low energy, and loss of interest in activities) and anxiety disorder (persistent, excessive fear or worry that interferes with daily life). Level 2 evaluation referral was checked.A review of Resident 4's EHR showed no level 2 evaluation.On 03/11/2026 12:02 PM Staff C, SSD, said they had not received an invalidation from 04/30/2025. Staff C said she sent the state an email today and Resident 4 was in the queue for an evaluation.On 03/13/2026 at 8:32 AM Staff A, Administrator, said there was follow-up in July 2025 for Resident 4 but no follow-up since and should have been to make sure Resident 4 was still on the list for a level 2 evaluation. Staff A said their new Social Services Director was now contacting the state and following up on all the PASRRs sent.Reference WAC 388-97-1915(4)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505306	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Townsend	751 Kearney Street Port Townsend, WA 98368

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary services for a dependent resident for 1 of 2 sampled residents (3) reviewed for activities of daily living (ADL). This failure placed the resident at risk for a decline in health status and a diminished quality of life. Findings included.Resident 3 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 12/05/2025, showed Resident 3 was cognitively intact and needed set up or clean-up assistance with eating.On 03/09/2026 at 1:37 PM, Resident 3 said sometimes they could not reach their call light. Resident 3 was asked what they do when they cannot reach their call light and Resident 3 said, I have to wait.On 03/09/2026 at 1:51 PM, Resident 3 said they needed the staff to help them drink. Resident 3 was asked what they did when they needed a drink, Resident 3 said sometimes I must wait. Resident 3 said, they tell me I am dehydrated and I do want to drink more.On 03/11/2026 at 8:02 AM, Resident 3 was observed in bed and appeared asleep with their eyes closed. Resident 3's call light was hanging down the side of the bed from the bed rail and appeared out of reach. Their water container with a straw was placed at the far edge of the bedside table and appeared out of reach. On 03/11/2026 at 8:07 AM, Resident 3 awoke and was asked if they could reach their call light? Resident 3 said no. Staff J, Certified Nursing Assistant (CNA) came into the room and Resident 3 asked the CNA for a sip of water, Staff J reached for the water container and helped Resident 3 drink from the straw of the water container. Staff E, Licensed Practical Nurse came into the room to give Resident 3 their medications. Staff E was asked where Resident 3's call light was placed? Staff E lifted the call light that was dangling down the side of the bed and placed it in Resident 3's lap. Staff E was asked where Resident 3's call light should be? And Staff E said, where [Resident 3] can touch it.On 03/11/2026 at 10:04 AM, Resident 3 said they waited when they needed the call light and sometimes, they needed a drink of water. Resident 3 was asked what they did when they needed a drink of water? And Resident 3 said, sometimes I wait until the morning.On 03/11/2026 at 3:16 PM, Staff B, Director of Nursing Services, said she would expect the staff to make sure Resident 3's call light and water was in reach before they left the room. Staff B said staff should say to Resident 3 Is there anything else you need before I leave? Staff B said she would add to Resident 3's care plan: Ensure before you leave [Resident 3] has water and their call light within reach. Reference WAC 388-97-1060(2)(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505306	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Townsend	751 Kearney Street Port Townsend, WA 98368

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 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** Based on interview and record review, the facility failed to prevent facility acquired pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure) from developing for 1 of 3 sampled residents (Resident 6) reviewed for pressure ulcers. This failure placed residents at risk for developing pressure ulcers, worsening pressure ulcers, increased pain, and a diminished quality of life.Findings included .Resident 6Resident 6 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, as assessment tool) dated 01/07/2026, documented Resident 6 was severely cognitively impaired, had communication deficits, was at risk for developing pressure ulcers and had two Stage 2 pressure ulcers. The skin integrity care plan, initiated on 07/10/2025, documented Resident 6 had an air overlay mattress (a medical device designed to prevent and treat pressure ulcers by redistributing pressure across the body. It typically consists of air-filled cells that inflate and deflate in a cyclical pattern, providing alternating pressure to reduce the risk of pressure injuries). A Nursing Wound Observation Tool, dated 07/10/2025, documented Resident 6 had one Stage 2 pressure ulcer on the left ischium (is a paired bone forming the lower and back part of the hip bone). The pressure ulcer was documented to be dry and intact with flaky skin, appears to be healing. The admission MDS, dated [DATE], documented Resident 6 had admitted to the facility with two Stage 2 pressure ulcers.A Nursing Wound Observation Tool, dated 07/23/2025, documented Resident 6 had one Stage 2 pressure ulcer on the right ischium. The pressure was documented to be healed. The Quarterly MDS, dated [DATE], documented Resident 6 had no pressure ulcers at the time of the assessment.A progress note, dated 12/01/2025, documented two new Stage 1 pressures ulcers, to the central coccyx (tailbone) and left coccyx with recommendations for air mattress and barrier cream. A Nursing Wound Observation Tool, dated 12/01/2025, documented Resident 6 had a Stage 1 develop at the central coccyx measuring 3 centimeters (cm) by 1.7cm. The treatment plan included barrier cream to coccyx every shift and air mattress to maintain skin integrity.A Nursing Wound Observation Tool, dated 12/01/2025, documented Resident 6 had a Stage 1 develop at the left coccyx bony prominence measuring 1.5cm by 1.5cm. The treatment plan included barrier cream to coccyx every shift and air mattress to maintain skin integrity.The skin integrity care plan, revised on 12/01/2025, documented bridge and reposition as allowed and for the registered dietitian to review. Progress notes, dated 12/04/2025, documented the area's (both areas on the coccyx) had opened, now staging as two new Stage 2 pressure ulcers. A Nursing Wound Observation Tool, dated 12/04/2025, documented Resident 6's Stage 1 pressure ulcer had developed into a Stage 2 at the central coccyx measuring 2cm by 1cm. The treatment plan included Cleanse with normal saline, pat dry, apply skin prep and cover with 4x4 silicone dressing every three days and PRN [as needed] soilage or dislodgement.A Nursing Wound Observation Tool, dated 12/04/2025, documented Resident 6's Stage 1 pressure ulcer had developed into a Stage 2 at the left coccyx bony prominence measuring .5cm by .3cm by .1 cm. The treatment plan included Cleanse with normal saline, pat dry, apply skin prep and cover with 4x4 silicone dressing every three days and PRN soilage or dislodgement.A Nutrition Dietary note, dated 12/06/2025, documented Resident 6 was reviewed by the Resident At Risk (RAR) Interdisciplinary Team Meeting (IDT) on 12/04/2025. Juven (a therapeutic nutrition powder with key ingredients to help support wound healing) was order once daily for 14 days. A physician's order, dated 12/08/2025, documented Resident 6 was ordered an air mattress to maintain skin integrity.A Nutrition Dietary Note, dated 01/11/2026, documented Resident 6 was receiving 118 milliliters house nourishments (supplement drink) three times daily for weight gain and skin healing of coccyx. No other pressure ulcer interventions implemented at that time. On 03/12/2026 at 11:05 AM, Staff B, Director of Nursing Services, said Resident 6 had admitted with two Stage 2 pressure ulcers that healed shortly after the resident arrived. Staff B said on 12/01/2025, Resident 6 was identified to have two Stage 1 pressure ulcers and developed into two Stage 2's by (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505306	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Townsend	751 Kearney Street Port Townsend, WA 98368

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/04/2025. Staff B said an air mattress was ordered on 12/01/2025. When asked about inventions that were in place prior to the development of the 12/01/2025 pressures ulcers, Staff B said Resident 6 had been working with therapy prior to that, but the resident stopped getting out of bed, and the facility gave the resident nutritional supplements to help wound healing. When asked specifically what interventions were in place prior, to prevent the development of the 12/01/2025 pressure ulcers, Staff B said none. Reference WAC 388-97-1060 (3)(b), -1060 (3)(j)(viii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505306	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Townsend	751 Kearney Street Port Townsend, WA 98368

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 interview and record review, the facility failed to reassess current nutritional interventions and implement new nutritional interventions for 1 of 1 sampled residents (Resident 6) reviewed to weight loss. This failure placed residents at risk for continued weight loss, malnutrition, medical complications and a diminished quality of life. Findings included .Resident 6 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, as assessment tool) dated 01/07/2026, documented Resident 6 was severely cognitively impaired, had communication deficits, had a 5 % weight loss and was not on a prescribed weight loss regimen.Resident 6's diet order, dated 07/09/2025, was regular diet, regular texture, thin consistency, finger foods/sandwiches when available. The electronic health record (EHR) documented no change in diet type to include nutritionally enhanced meals (NEM), fortified foods or calorie dense meals.On 10/11/2025, Resident 6 weighed 108 pounds (lbs.) On 03/07/2026, Resident 6 weighed 90.8 lbs, resulting in a 15.93% weight loss in 5 months.The EHR documented no food preference evaluations had been completed for Resident 6. The Amounts Eaten task documented Resident 6 usually only ate 0-25% of all their meals (reviewed for the last 30 days). The Snacks task documented Resident 6 only received 10 snacks in the last 30 days, in which 76-100% of them were consumed. A physician's order dated 07/11/2025-10/20/2025, documented Resident 6 was to receive 2Cal Med Pass Supplements, 120 milliliters (ml) three times a day for nutritional support. A physician's order dated 10/20/2025-11/20/2025, documented Resident 6 was to receive 2Cal Med Pass Supplements, 120 ml three times a day for nutritional support.A physician's order dated 11/21/2025-11/21/2025, documented Resident 6 was to receive House Shake, 120 ml, three times a day for nutritional support. A physician's order dated 11/22/2025-11/22/2025, documented Resident 6 was to receive Frozen Nutritional Supplement, 120 ml with meals for at risk of malnutrition. A physician's order dated 11/22/2025-12/19/2025, documented Resident 6 was to receive House Shake, 118ml, three times a day for nutritional support. A physician's order dated 12/19/2025-02/15/2026, documented Resident 6 was to receive House Supplements, 118ml three times a day and finger food when available for at risk of malnutritional.A physician's order dated 02/15/2026-Current, documented Resident 6 was to receive House Supplements, 90-120 ml three times a day for at risk of malnutrition.Resident 6's continued to lose weight during the previous five months. The nutritional supports, started on 07/09/2025 had not been reevaluated, changed or increased to support increase in nutrition.A Mini Nutritional Assessment, dated 10/02/2025, documented Resident 6 had no decrease in food intake, lost 2.2-6.6 lbs. in the previous three months and the resident's BMI was less than 19 and was at risk of malnutrition. No follow up was documented nor recommendations made. Resident 6's nutritional care plan, revised on 12/01/2025, by Staff B, Director of Nursing Services, documented at risk for unavoidable fluctuations/loss r/t [related to] continued decline in health status. Interventions included encouraging resident to go to the dining hall, ensuring no pocketing of food, oral care after meals, supervision for meals, and diet as ordered. The care plan showed no documentation of food preferences or that alternate interventions were attempted for weight gain such as Nutritional Enhanced Meals, diet change or an increase in nutritional supplements. A Mini Nutritional Assessment, dated 01/06/2026, documented Resident 6 had a severe decrease in food intake, a weight loss greater than 6.6 lbs. in three months, BMI less than 19 and documented Resident 6 was malnourished. No follow up was documented nor recommendations made.A Nutrition Dietary note, dated 02/25/2026, documented Resident 6's BMI was 14.5, indicating malnutrition, the resident received 90-120ml nourishments three times a day to help promote weight maintenance. Resident 6 had comfort focus for care and did not like staff to encourage her too much to eat or drink. Interdisciplinary team would continue with regular, regular, thin liquids diet and offer finger foods. No recommendations were made to address continued weight loss. Review of the March 2026 Medication (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505306	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Townsend	751 Kearney Street Port Townsend, WA 98368

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	Administration Record documented Resident 6, on average, consumed 90-110 ml of the House Shake three times a day, with two refusals and one unavailable to give.On 03/12/2026 at 11:00 AM, when asked about Resident 6's weight loss, Staff K, Registered Nurse, said they had not seen any weight loss but, they only work one day a week and they usually work on the other hall. Staff K said they knew the resident often refused to get out of bed or exercise. Staff K said the resident sometimes had a good appetite and other times not and she did get three house supplement drinks a day. Staff K said Resident 6 received snacks to boost calories and required one-to0one level assistant with eating. Staff K was not able to provide any further details about Resident 6's weight loss.On 03/12/2026 at 11:05 AM, Staff B, DNS, said Resident 6's weight loss had been progressive, the resident admitted to the facility malnourished and was on comfort care now. Staff B said the facility was trying to help obtain a guardian for Resident 6, so the resident could be placed on hospice care. When asked what interventions were currently implemented for Resident 6, Staff B said Resident 6 was on House supplement three times a daily and reviewed at the Resident at Risk (RAR) meeting weekly. When asked about the care plan statement, unavoidable weight fluctuation/loss r/t continued decline in health status, Staff B said before Resident 6 would sit in a wheelchair, but not anymore, they admitted on liquid morphine and has refused to work with us and had now been identified as malnutrition. Staff B reviewed Resident ?s weight chart confirmed Resident 6 had a 15.93% weight loss in 5 months. When asked about food preference, Staff B reviewed the EHR and confirmed the food preference evaluations had been documented. Staff B said they know Resident 6 likes sweets, chips and ice cream. When asked what interventions were in place to prevent weight loss, Staff B said I don't know. When asked what interventions had been put into place since the identified weight loss, Staff B said she was on a house supplement (the same House supplement since admit, before the weight loss started). On 03/12/2026 at 12:09 AM, Staff L, Registered Dietitian, said Resident 6 did not like staff to encourage them to eat, but had received House Supplement drinks three times a day. Staff L was asked to review the food preference evaluations and confirmed no food preference evaluations had been completed. Staff L said one of the dietary aids used to be a Certified Nursing Assistant and knew what Resident 6 liked as far as foods, but it was not documented. Staff L said Resident 6 liked soup in a mug, sandwiches, and they would usually have soup and sandwiches for dinner and cookies. Staff B said the finger foods gave the resident a sense of independence when eating. Staff L was asked to review Resident 6's weight for the previous five months. Staff L confirmed Resident 6 had lost 15.93% of their weight in five months, putting them under the severe weight loss category. Staff L confirmed Resident 6 had a variety of orders for nutritional support since admit, but it was never increased, always remained between 90-120ml three times a day and no other intervention had been recommended. When asked what other nutritional interventions had been in place prior to the weight loss, Staff B said they had been trying to get a guardian for Resident 6 because the facility believed Resident 6 needed to be on hospice care. When asked what additional interventions had been implemented in the meantime for the resident's 16% weight loss, Staff L was unable to answer the question. Reference WAC 388-97-1060 (3)(h)