STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of South Hill	2508 7th St Southeast Puyallup, WA 98374

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46472

Based on interview and record review, the facility failed to implement their abuse prohibition policy for 2 of 6 residents (Residents 10 & 11) reviewed for abuse. The failure to properly identify a resident grievance as an alleged violation and report the alleged violation to the State Agency (SA) placed residents at risk for further exposure to potential abuse/neglect, unmet care needs, and diminished quality of life/quality of care.

Findings included .

<POLICY>

Review of the facility's Abuse-Reporting and Response - No Crime Suspected policy, reviewed 06/17/2024, showed all alleged or suspected violations involving mistreatment, abuse, neglect, and injuries of unknown origin would be reported immediately but no later than two hours after the allegation was made, to the appropriate authorities, including the SA (in accordance with State Laws). The reporter of the violation did not have to explicitly characterize the situation as abuse, neglect, mistreatment, or exploitation in order to trigger the facility to investigate. If the facility staff could reasonably conclude that the potential existed that a violation occurred, then they would consider the allegation to be a reportable event and would require action.

Review of the Washington State Department of Social & Health Services Nursing Home Guidelines -The Purple Book, dated October 2015 (guidelines to assist nursing homes with compliance of the State and Federal requirements for the prevention, identification, reporting, and investigating incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, exploitation, and misappropriation of nursing home residents) showed the methods of reporting included by telephone, fax, online, and by the Reporting Log (a log required to be maintained by facilities, readily accessible at all times to SA staff that included specific information outlined in The Purple Book). Immediate telephone reporting to the SA is required of all incidents of suspected or alleged abuse, neglect, abandonment, mistreatment, exploitation, or misappropriation of resident property had occurred as well as on the Reporting Log within five days.

<Resident 10>

(continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of South Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 2508 7th St Southeast Puyallup, WA 98374	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 08/28/2024 Admission Minimum Data Set (MDS-assessment tool) showed Resident 10 admitted to the facility on [DATE] and diagnoses included multiple fractures and anxiety disorder. Resident 10 had no problems with cognition and had occasional pain, with the worst pain in the previous five days rated 9/10. Review of the Pain Care Plan (CP), dated 08/19/2024, showed Resident 10's pain was related to multiple rib fractures. The CP directed staff to evaluate the effectiveness of pain interventions and provide pain medication as ordered. Review of a Concern & Comment Form, written by Resident 10's Collateral Contact (CC-10) on 08/20/2024 at 11:15 AM, showed Resident 10 was in pain and requested pain medication from Staff L, Registered Nurse (RN)-previous employee, at approximately 1:30 AM and Staff L did not provide the pain medication until approximately 5:30 AM. Resident 10 told CC-10 the pain kept them awake through the night and they had other concerns they wanted to report to Staff L but did not because they felt Staff L would not listen. The concern form follow-up showed Staff C, RN, interviewed Resident 10 on 08/27/2024 (seven days after the concern was written). Staff C documented Resident 10 received pain medication prior to the time that was reported by CC-10 but did not state what time. Actions taken to resolve the concern included customer service training and disciplinary action. Review of Resident 10's August 2024 Medication Administration Record (MAR) showed a physician order, dated 08/19/2024, for a narcotic pain medication to be given every four hours as needed for pain 6-10/10. The MAR showed Staff L administered the pain medication on 08/20/2024 at 4:29 AM for pain rated 9/10 (a delay of three hours after Resident 10 requested pain medication). Review of the facility's Reporting Log did not show the facility reported the alleged violation of delayed care and services for the treatment of pain. In an interview on 09/17/2024 at 10:35 AM, Staff B, Director of Nursing, stated the facility should have reported the alleged violation to the SA as soon as they were aware of the concern but did not. <Resident 11> Review of Resident 11's Concern & Comment Form, dated 08/24/2024, showed Resident 11 had concerns regarding Staff L's nightly pattern of poor customer service and three-hour delay in pain medication administration. In an interview on 09/12/2024 at 2:50 PM, Resident 11 stated Staff L took more than an hour to provide requested pain medication on multiple occasions prior to 08/24/2024. Resident 11 stated the longest wait time from the time they requested pain medication to the time they received pain medication was between three and four hours. Review of the facility's Reporting Log did not provide documentation to support the facility recognized and/or reported Resident 11's alleged violation of delayed care and services. In an interview on 09/17/2024 at 10:35 AM, Staff B stated the facility should have reported the alleged violation to the SA as soon as they were aware of the concern but did not. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of South Hill	2508 7th St Southeast Puyallup, WA 98374

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refer to F-610 REFERENCE WAC 388-97-0640 (1)(2)(a)(b)(5)(a).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46472 Based on interview and record review, the facility failed to implement their abuse prohibition policies and procedures for 2 of 6 residents (Residents 10 & 11) reviewed for abuse. The failure to conduct a thorough investigation of an alleged violation and maintain documentation to show an alleged violation was thoroughly investigated that included immediate interventions implemented to prevent further potential abuse/neglect during (and after) the investigation placed residents at risk for further exposure to potential abuse/neglect, unmet care needs, and diminished quality of life/quality of care. Findings included . <POLICY> Review of the Washington State Department of Social & Health Services Nursing Home Guidelines -The Purple Book, dated October 2015 (guidelines to assist nursing homes with compliance of the State and Federal requirements for the prevention, identification, reporting, and investigating incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, exploitation, and misappropriation of nursing home residents) showed the facility must begin an immediate investigation of alleged violations in order to collect accurate data. The facility must conduct a thorough investigation and document the findings of the investigation. If the alleged perpetrator was a staff member, a thorough investigation included interviews of an expanded sample of residents the staff person was assigned to. Any findings during the expanded sample interviews of the extended investigation must be entered into the Reporting Log and be available within five days of the discovery of the incident. Evidence of the investigation must be readily available to State Agency (SA). <Resident 10> Review of a Concern & Comment Form, written by Resident 10's Collateral Contact (CC-10) on 08/20/2024 at 11:15 AM, showed Resident 10 was in pain and requested pain medication from Staff L, Registered Nurse (RN)-previous employee, at approximately 1:30 AM and Staff L did not provide the pain medication until approximately 5:30 AM (a delay of four hours). Review of the facility's Reporting Log did not show the facility reported the alleged violation of delayed care and services for the treatment of pain. In an interview on 09/17/2024 at 10:35 AM, Staff B, Director of Nursing, stated the facility should have conducted and documented a thorough investigation of the alleged violation but did not. <Resident 11> Review of Resident 11's Concern & Comment Form, dated 08/24/2024, showed Resident 11 had concerns regarding Staff L's nightly pattern of poor customer service and three-hour delay in pain medication administration. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of South Hill	2508 7th St Southeast Puyallup, WA 98374

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Reporting Log did not provide documentation to support the facility recognized and/or reported Resident 11's alleged violation of delayed care and services. In an interview on 09/17/2024 at 10:35 AM, Staff B stated the facility should have conducted and documented a thorough investigation of the alleged violation but did not. Refer to F-609. REFERENCE WAC 388-97-0640 (1)(2)(a)(b)(6)(a)(b)(c).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 Based on interview and record review, the facility failed to ensure services provided met professional standards of practice for 1 of 3 residents (Resident 3) reviewed for medication administration. The failure to follow, obtain, and/or clarify physician orders, only sign for medications administered placed, and accurately document medication timing requests placed residents at risk for medication errors, delay in treatment, and adverse outcomes. Findings included . <Resident 3> Review of the Admission Minimum Data Set (MDS-assessment tool) dated 05/08/2024, showed Resident 3 was admitted to the facility on [DATE], had no cognitive problems, and diagnoses included surgical aftercare following an orthopedic surgery and diabetes. Resident 3 received both scheduled and as needed pain medication. Resident 3 had frequent pain that reached an 8/10 during the five-day observation period. Review of the Pain Care Plan (CP), dated 05/03/2024, directed staff to administer pain medications as they were ordered. <05/03/2024> In an interview on 09/11/2024 at 10:17 AM, Resident 3 stated on the day of their admission (05/03/2024) they did not receive their ordered bedtime medications which included medication for a chronic pain condition. Resident 3 stated while waiting for their medications they fell asleep but woke up the next morning in more pain than normal. Resident 3 stated when they asked the staff why they did not get their medication at bedtime the staff told them it had to do with the time the orders were entered into the computer system. Review of the May 2024 Medication Administration Record (MAR) for 05/03/2024 showed ten medications that were entered into the electronic MAR before 5:30 PM and were scheduled to be administered at bedtime (between 8:00 PM and 10:00 PM). Of the ten medications, six were documented as administered by the nurse and three were documented as 10-see progress notes. Resident 3 also had orders for an as needed narcotic pain medication, entered in the electronic MAR at 4:39 PM, and was not administered on 05/03/2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/16/2024 at 3:28 PM, Staff M, Registered Nurse (RN), stated pharmacy deliveries typically arrived late at night or early in the morning so for new admissions to receive their ordered medications they would have to obtain them from the Omnicell (an emergency kit of commonly ordered medications). When they removed them from the Omnicell, they were required to enter the name of the resident and have valid orders. Staff M stated if the medication ordered was not in the Omnicell then they would call the pharmacy to have the ordered doses satellited (sent from a local pharmacy) or they would call the physician to notify them the medication is not available and obtain further orders to hold the medication or give an alternative medication. Staff M stated they always used the same process during their medication administration and did not document the medications as administered until after they delivered them to the patient. Staff M could not remember specifically back to 05/03/2024 if there were problems with obtaining Resident 3's medications and if the medications that were initialed as administered were stocked in the Omnicell because they were commonly ordered medications. Staff M stated they would document problems encountered in their progress notes. Review of Resident 3's progress notes for 05/03/2024 did not provide any information regarding medication concerns, inability to obtain the commonly ordered medications, or that the resident did not take their medications. Review of Resident 3's Omnicell transactions report for May 2024 showed no medications were removed from the Omnicell for 05/03/2024. Review of the Pharmacy Proof of Delivery report for Resident 3 showed their medications were delivered to the facility on [DATE] at 2:59 AM. In an interview on 09/16/2024 at 2:38 PM, Staff B, Director of Nursing, stated they reviewed the Omnicell for other resident transactions for 05/03/2024 and Staff M had removed medications for other residents but not for Resident 3. Staff B stated Staff M should have removed the medications for Resident 3 but did not. <05/12/2024> In an interview on 09/11/2024 at 10:17 AM, Resident 3 stated they were scheduled for a planned discharge home on 05/12/2024 but due to an abnormal lab result their discharge was put on hold and the physician ordered a medication to reverse the abnormality. Resident 3 stated they reviewed the reversal medications common adverse interactions with other medications on-line and decided they would follow the on-line recommendation to hold their routine medications for six hours after they took the reversal medication. Resident 3 stated they told the nurse they would take their routine medication at 11:00 PM. Resident 3 stated they left against medical advice at almost midnight on 05/12/2024 because the nurse would not give them their medication that was supposed to be on hold for six hours and they did not want to go another night without their medication like they did on 05/03/2024. Review of Resident 3's May 2024 MAR for 05/12/2024 showed their morning and afternoon medications were refused. The MAR showed, on 05/12/2024 at 8:23 AM, Physician Order for the Named reversal medication now and another dose in four hours. The first dose was administered at 9:41 AM. The second dose, due at 1:41 PM, was not administered until 4:25 PM (two and a half hours late). The MAR did not show orders to hold the routine medications for six hours after the last dose of the reversal medication was administered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Life Care Center of South Hill		STREET ADDRESS, CITY, STATE, ZIP CODE: 2508 7th St Southeast Puyallup, WA 98374	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Nurse Progress Note, dated 05/12/2024 at 9:05 PM, showed the Physician was consulted about Resident 3's medications and the Physician said that all the medications were ok to administer with the Named reversal medication. Resident 3 was given their first dose at 9:30 AM and before their morning medications were administered. When the nurse went to administer the morning medications Resident 3 refuse to take them citing what was recommended on the Named on-line website. At 5:00 PM, the nurse asked Resident 3 about their 6:00 PM medications and Resident 3 repeated the guidance from the Named on-line website. The nurse told Resident 3 the 6:00 PM medications could not be given hours later, and they would not even show up on the electronic MAR for the night nurse to give. The note did not provide documentation to show the Physician was notified Resident 3 wanted to hold their medication for the six-hour window, that they did not get their medications for the day, or request orders for a later medication administration time for 05/12/2024. Review of a Nurse Progress Note, dated 05/13/2024 at 12:57 AM, showed Resident 3 requested their evening medications and the writer advised Resident 3 that those medications were not available on their electronic MAR to administer, and that the day nurse should have requested a one-time order to administer the medications later. The documentation did not show the Physician was consulted or notified regarding Resident 3's request to take the evening medications. In an interview on 09/11/2024 at 3:44 PM, Staff I, Licensed Practical Nurse (LPN)-Resident Care Manager, stated their expectation was that if the resident wanted to hold the medication, they could request a hold order from the Physician so the medication would be available to administer in the electronic MAR at the time they requested. Staff I stated it was not appropriate to document the medication was refused if they were willing to take it at a different time, which should be documented in the progress notes. Staff I stated the Physician should have been notified of the Resident's refusal to take the medication at the schedule time but was willing to take the medication later. Staff I stated they were not aware that was done. REFERENCE WAC 388-97-1060 (3)(k), -1080 (9)(10)(b)(c)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 46472 Based on interview and record review, the facility failed to implement the personalized discharge plan for a smooth transition to the community for 1 of 3 residents (Resident 2) reviewed for discharge planning. This failure placed residents at risk for delayed discharge, unmet care needs after discharge and a diminished quality of life. Findings included . <POLICY> Review of the facility's Discharge Plan policy, reviewed 09/05/2024, showed the facility would develop and implement an effective discharge planning process for post-discharge care and reduction in factors that led to preventable readmissions. <Resident 2> Review of the Admission Minimum Data Set (MDS-assessment tool), dated 04/05/2024, showed Resident 2 had no cognitive problems and diagnoses included a fracture of the pelvis. Resident 2 planned to discharge back to the community, had an active discharge plan, and no referrals were made to Local Contact Agencies (LCA). Review of the Discharge Care Plan, dated 04/02/2024, showed Resident 2's tentative plan was to move in with a family member. An intervention, dated 04/04/2024, showed Social Services would make community service referrals as needed which included Home Health services, Primary Care Provider (PCP) follow-up appointments, and order durable medical equipment needed for discharge. Review of a Psychosocial Progress Note, dated 04/24/2024 at 11:40 AM, showed Resident 2 did not have a PCP. Social Service staff sent a referral to the Named Home Health Agency (HHA-1) for home health therapy and a GAP provider (a provider affiliated with HHA-1 who will see the resident for the first appointment and assist with obtaining a PCP). Review of a State Agency (SA) referral, received 08/20/2024, showed Resident 2 was discharged home in May 2024 without home health services. In an interview on 09/12/2024 at 8:21 AM, a Collateral Contact for the HHA-1 stated they had no record of Resident 2 and had never received a referral for therapy or GAP services. In an interview on 09/12/2024 at 5:15 PM, Staff F, Social Services Director, stated they called all the HHA's they referred to and none of them received a referral for Resident 2. Staff F stated somehow Resident 2 fell through the cracks. Staff F stated they had a process for how they implemented discharges but recalled that back in May they were also down a full-time staff member. Staff F stated they now have hired new staff and would re-look at their process. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/16/2024 at 2:40 PM, Staff B, Director of Nursing, stated the referral for Home Health and PCP service was not received by HHA-1 and it was highly probable that Resident 2 did not have timely PCP follow-up care in addition to no home health therapy services and should have. This did not meet their expectation. REFERENCE WAC 388-97-0080