STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505526	A. Building B. Wing	11/13/2025

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

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. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 3 residents (Resident 1) reviewed received care and treatment in accordance with professional standards of practice regarding placement of an indwelling urinary catheter (a flexible tube inserted into the bladder to drain urine). This failure placed residents at risk of unmet care needs, pain, and medical complications Findings included . The facility policy for Indwelling Urinary Catheter (Foley) Management, revised 06/27/2023 and reviewed 09/04/2025, documented the facility would ensure that, for residents admitted with a urinary catheter, staff would adhere to professional standards of practice protocols and infection prevention and control procedures for insertion, ongoing care and catheter removal. The policy referenced [NAME] on Procedural Guidance on Routine care for indwelling urinary catheter (Foley) care and management. According to Lippincott Nursing Procedures (8th ed.) (2019). Wolters Kluwer, after insertion of a urinary catheter, documentation should record the date and time of insertion, the size and type of catheter used, and the amount of sterile water used to inflate the balloon, and the characteristics of the urine obtained. Documentation should also include any complications, the date and time the practitioner was notified, the prescribed interventions, the patient's response to those interventions, and to record patient teaching and the patient's comprehension of the teaching. Resident 1 was admitted to the facility on [DATE] for skilled nursing and rehabilitation services after presenting to the hospital and being diagnosed with generalized weakness, adult failure to thrive, complicated urinary tract infection (UTI), hematuria (blood in the urine), and high blood sugars. Resident 1 also had a history of bladder cancer and admitted to the facility with a chronic (long-term use) indwelling urinary catheter, and was also on anticoagulant (blood-thinner) medication to treat a deep vein thrombosis, a blood clot in a deep vein that can cause swelling, pain and redness. Resident 1 was alert and oriented and able to participate in care and make his needs known. Review of nursing progress notes dated 12/23/2024 documented Resident 1 had bright red blood in their urinary catheter and collection bag, and new orders were received to hold the resident's anticoagulant (blood thinner) medication for four days. Review of nursing progress notes showed the color of Resident 1's urine had lightened to pink, and then cleared by 12/26/2024 and the anticoagulant medication was restarted. Between 12/28/2024 and 01/02/2025, Nursing documented [on 12/28/2024, 12/31/2024, 01/01/2025, and 01/02/2025] that Resident 1's urinary catheter was in place and draining clear yellow or amber urine, with no complaints of pain or other problems. On 01/01/2025 at 6:06 PM, an order was entered to change the resident's Foley (urinary) catheter. On 01/03/2025 at 12:06 PM, Nursing documented Resident 1's indwelling urinary catheter was changed, and that hematuria (blood in the urine) was noted after the catheter was changed. Nursing documented the provider was notified and new orders were received to hold the resident's anticoagulant medication and to irrigate (flush) the catheter up to three times a day as needed. A Communication with Physician, dated 01/04/2025 at 5:44 PM, documented Resident 1 had bleeding from their penis that had started during the catheter change on 01/03/2025. Nursing documented the catheter was removed and the bleeding continued, and another new catheter was inserted. Nursing documented that on 01/04/2025 Resident 1 reported continued bleeding from the penis and had a large amount of blood in their brief when they went to the restroom. A provider note, dated 01/06/2025, documented that nursing staff reported concern that the resident had some blood in their Foley catheter, and the catheter was replaced which slowed down the bleeding. The provider noted the resident's anticoagulant medication was briefly held and the resident continued to have bleeding around the urethral meatus (where the catheter entered the resident's body). The provider documented Resident 1 had hematuria most likely secondary to trauma from Foley catheter insertion being inserted incorrectly. The provider documented Resident 1's Foley catheter was replaced and the hematuria had resolved. Resident 1 continued to have bleeding from the urethral meatus, and new orders for continued monitoring and labs to be collected were given. On 01/08/2025, review of Resident 1's record showed the resident began experiencing low back pain and fever, and increased lethargy. On 01/09/2025, the provider noted Resident1 had left-sided flank pain and fever likely due to a UTI, and new orders written that included labs to be drawn, antibiotics and IV fluids to be started, and medication for pain management. On 01/09/2025, Nursing documented, via Communication with Physician, that Resident 1's oxygen saturation level was at 87% (normal 92% - 100%), and they were put on oxygen via nasal cannula (plastic tubing that delivers oxygen via the nasal passages), and the provider was notified. On 01/10/2025, the provider examined Resident 1 and noted they were diaphoretic (sweaty) and in