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	10/31/2024

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

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to provide information on formulating an advanced directive for 1 of 3 sampled residents (Resident 36) when reviewed for advanced directives. This failure placed residents at risk of not having an established decision maker, lacking input into care, and a diminished quality of life. Findings included . Review of the electronic health record showed Resident 36 admitted to the facility on [DATE]. Review of progress notes showed the social services department called Resident 36's representative on 09/19/2024 to schedule a care conference, which was held on 09/23/2024 (20 days after admitting to the facility). Review of the Social Service Assessment, dated 09/04/2024, showed the advanced directive area left blank. Review of the care plan, dated 09/03/2024, showed no information regarding Resident 36's advanced directive status. During an interview on 10/29/2024 at 1:46 PM, Staff P, Social Service Director, stated Resident 36 was provided information regarding formulating an advanced directive on 09/19/2024 (13 days after admitting to the facility) and this did not meet their expectation. During an interview on 10/29/2024 at 3:43 PM, Staff A, Administrator, stated residents should be asked about their advanced directive status within 48 hours of admission to the facility and provided information on formulating an advanced directive if they did not have one. Staff A stated Resident 36's delay in addressing an advanced directive did not meet expectation. Reference WAC 388-97-0280 (3)(c)(i-ii), -0300 (1)(b), (3)(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: 505526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024

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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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on interview and record review, the facility failed to properly notify the Office of State Long-Term Care Ombudsman (SLTCO, an advocacy group for residents in a nursing home) of discharges for 2 of 4 sampled residents (Residents 177 and 42) reviewed for hospitalization . These failures placed residents at risk for being inappropriately discharged , lack of access to an advocate who could inform them of their options and rights, and to ensure that the SLTCO was aware of facility practices and activities related to transfers and discharges. Findings included . Resident 177 Review of Resident 177's entry minimum data set (MDS, a required assessment tool), dated 09/22/2024, showed the resident was readmitted on [DATE] after a transfer out to a local medical center with diagnoses to include heart and kidney disease, diabetes, depression and anxiety. The MDS further showed that Resident 177 was able to make needs known. During an interview on 10/28/2024 at 10:19 AM, Resident 177 stated they had been transferred to a local medical center for treatment of shingles (a skin condition that occurs in people with a compromised or suppressed immune system) several weeks ago. Review of Resident 177's electronic health records (EHR) showed the resident was transferred out to a local medical center on 09/11/2024 for treatment and care of shingles however, the SLTCO had not been notified of the resident's transfer. During an interview on 10/29/2024 at 3:26 PM, Staff A, Administrator, stated they were unable to locate any documentation of notification to the SLTCO of Resident 177's transfer. Staff A stated it was their expectation that the SLTCO should have been notified of the resident's transfer. 38344 Resident 42 Review of Resident 42's EHR showed the resident readmitted to the facility on [DATE] with diagnoses to include anemia (lack of healthy red blood cells to carry oxygen throughout the body) and diabetes (a condition resulting in high blood sugar levels). The resident was able to make needs known. Review of the discharge MDS, dated [DATE], and the entry tracking record MDS, dated [DATE], showed that Resident 42 was transferred from the facility to the hospital on 09/12/2024 and readmitted to the facility on [DATE]. During an interview on 10/29/2024 at 3:24 PM, Staff A, Administrator, stated they were unable to locate documentation that the SLTCO was notified of Resident 42's transfer to the hospital on 09/12/2024 and there should have been. (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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Reference WAC 388-97-0120 (2)(a-d), -0140(1)(a)(b)(c)(i-iii)

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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 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on interview and record review, the facility failed to provide written bed hold notices at the time of transfer to the hospital for 4 of 4 sample residents (Residents 177, 27, 42, and 47) reviewed for hospitalization . This failure placed residents at risk for lacking knowledge regarding their right to hold their bed while in the hospital. Resident 177 Review of Resident 177's entry minimum data set (MDS), an assessment tool, dated 09/22/2024, showed the resident readmitted on [DATE] with diagnoses to include heart and kidney disease, diabetes, depression and anxiety. The MDS showed Resident 177 was able to make needs known. During an interview on 10/28/2024 at 10:19 AM, Resident 177 stated they had been transferred to a local medical center for treatment of shingles (a viral infection that causes a painful rash) several weeks ago; however, no bed hold was provided to them at that time. Review of the Resident 177's electronic health records (EHR) showed the resident was transferred out to a local medical center for treatment and care of shingles. Review showed no documentation that a bed hold notice was provided or discussed with the resident and/or resident's representative when the resident was admitted to the hospital. During an interview on 10/29/2024 at 1:15 PM, Staff D, Business Office Manager, stated the bed hold was to be offered to the resident upon any transfer out to a medical center by the licensed nurses and documentation was to be placed into the resident's EHR. During an interview on 10/29/2024 at 1:29 PM, Staff C, Licensed Practical Nurse/Unit Care Coordinator (LPN/UCC), stated the bed hold policy was to occur whenever the resident was transferred to a medical center. Staff C stated the bed hold offering should have been documented in the residents' EHR; however, they could not find documentation in Resident 177's EHR. During an interview on 10/29/2024 at 3:26 PM, Staff A, Administrator, stated they were unable to locate any documentation of a bed hold being offered to Resident 177. Staff A stated it was their expectation a bed hold should have been offered to the resident and placed into their EHR. 40817 Resident 27 Review of the EHR showed Resident 27 admitted to the facility on [DATE] and discharged to the hospital on 10/21/2024. Review showed no bed hold had been provided to Resident 27 for this transfer. During an interview on 10/30/2024 at 10:28 AM, Staff Q, Medical Records Director, stated Resident 27 was not provided a bed hold for the transfer to the hospital on 10/21/2024. (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 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	38344 Resident 42 Review of the discharge MDS, dated [DATE], and the entry tracking record MDS, dated [DATE], showed Resident 42 was transferred from the facility to the hospital on 09/12/2024 and readmitted to the facility on [DATE]. Review of Resident 42's EHR showed no documentation that Resident 42 was offered a bed hold for the transfer/discharge on 09/12/2024. During an interview on 10/29/2024 at 11:12 AM, Resident 42 stated they did not recall ever being offered a bed hold when transferred to the hospital. During an interview on 10/29/2024 at 3:24 PM, Staff A, Administrator, stated they were unable to locate bed hold documentation for Resident 42's transfer to the hospital on 09/12/2024 and this did not meet expectations. 46148 Resident 47 Review of the EHR showed Resident 47 admitted to the facility on [DATE] with a diagnosis of infected surgical implant. Review showed the resident was transferred to the emergency roiagnom on [DATE] for exposed hardware and concern of hardware infection in the elbow. No documentation was found in the EHR that the facility staff had offered Resident 47 a bed hold. During an interview on 10/29/2024 at 12:13 PM, Staff O, Licensed Practical Nurse, stated they were unable to locate documentation that a bed hold was offered for the 06/14/2024 transfer to the hospital for Resident 47. During an interview on 10/29/2024 at 1:32 PM, Staff B, Director of Nursing Services, stated it was their expectation that staff offered a bed hold and documented it in the resident's EHR on transfers to the hospital. Reference WAC 388-97 -0120 (4)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview, and record review, the facility failed to ensure the minimum data set assessment (MDS), an assessment tool, accurately reflected resident status for 1 of 20 sampled residents (Resident 226) reviewed for accuracy of assessments. This failure placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 226 admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, lung disease that causes restricted airflow and breathing problems) and chronic (long lasting) respiratory failure with hypoxia (low levels of oxygen [O2] in the blood). Resident 226 was able to make needs known. Review of the admission MDS, dated [DATE], showed Resident 226 was not receiving O2 while a resident. Observation on 10/28/2024 at 9:40 AM showed Resident 226 laid in bed receiving O2 set to two liters per minute via nasal cannula (devise to deliver O2 through a tube into the nose). Observation and interview on 10/29/2024 at 10:48 AM showed Resident 226 receiving O2 set to two liters per minute via nasal cannula. Resident 226 stated that they had received O2 continuously at two liters through the nose via the tube since they had admitted to the facility. Review of Resident 226's EHR showed documented respiratory symptoms screening tools dated 10/17/2024, 10/18/2024, 10/19/2024, 10/21/2024, 10/22/2024, 10/24/2024, 10/25/2024, 10/26/2024, 10/27/2024, and 10/28/2024 which showed the resident received O2 via nasal cannula. During an interview on 10/29/2024 at 5:16 PM, Staff H, Licensed Practical Nurse/MDS Nurse, stated Resident 226's admission MDS, dated [DATE], was coded in error for oxygen therapy and needed to be modified. During an interview on 10/30/2024 at 3:02 PM, Staff B, Director of Nursing Services, stated Resident 226's MDS dated [DATE] was coded inaccurately and should have been coded yes for O2 therapy while a resident and needed to be modified. Reference WAC 388-97-1000 (1)(b)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on observation, interview, and record review, the facility failed to include all required services in the plan of care for 3 of 20 sampled residents (Residents 40, 42, and 226) when reviewed for comprehensive care plan. This failure placed residents at risk of not receiving required services, staff being unaware of how to assist residents, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 40 admitted to the facility on [DATE] with diagnoses of ankylosing spondylitis (a type of arthritis that affects the spine and other parts of the body) and pneumonia (a lung infection). Review of provider's orders showed Resident 40 had an order for a fluid restriction. Review of Resident 40's care plan, initiated 09/26/2024, showed no information related to a fluid restriction. During an interview on 10/30/2024 at 9:54 AM, Staff R, Licensed Practical Nurse/Resident Care Manager, stated residents on a fluid restriction should have a care focus area for it in the care plan. Staff R stated there was no information related to Resident 40's fluid restriction in their care plan and this did not meet expectation. During an interview on 10/30/2024 at 1:16 AM, Staff B, Director of Nursing Services, stated information about a fluid restriction should be in the plan of care. Staff B stated Resident 40's care plan had no information about a fluid restriction, and this did not meet expectation. 38344 Resident 42 Review of Resident 42's EHR showed the resident readmitted to the facility on [DATE] with diagnoses to include anemia (lack of healthy red blood cells to carry oxygen throughout the body), diabetes (a condition resulting in high blood sugar levels), hyperkalemia (a condition where there is too much potassium, a mineral/electrolyte that helps muscles and nerves function, in the blood), and chronic (persistent/long lasting) kidney disease. The resident was able to make needs known. During an interview and observation on 10/28/2024 at 1:02 PM, Resident 42 stated they were on fluid restriction and pointed to a dietary meal tray slip dated 10/28/2024 that showed Resident 42 was on a fluid restriction. Review of the provider order dated 09/21/2024 showed that Resident 42 was prescribed a diet that included a fluid restriction. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 42's current care plan on 10/30/2024 at 8:23 AM showed no care plan or interventions documented for fluid restrictions. During an interview on 10/31/2024 at 12:30 PM, Staff J, Registered Nurse (RN), stated Resident 42 was on fluid restrictions and it should have been care planned when Resident 42 had orders obtained for fluid restrictions. Resident 226 Review of Resident 226's EHR showed the resident admitted on [DATE] with diagnoses to include arthritis (inflammation of the joints), paroxysmal atrial fibrillation (an irregular heart rate that commonly causes poor blood flow), and chronic obstructive pulmonary disease (COPD, lung disease that causes restricted airflow and breathing problems). Resident 226 was able to make needs known. During an interview on 10/28/2024 at 12:06 PM, Resident 226 stated they had a wound on their bottom and their wounds were being looked at and treated routinely. Review of Resident 226's EHR showed a provider order dated 10/17/2024 to treat a deep tissue injury (DTI) to the right heel and an order dated 10/25/2024 for a treatment to the right buttock wound. It showed a care plan dated 10/16/2024 for at risk for break in skin integrity; however, there was no care plan for actual skin integrity impairment. During an interview on 10/31/2024 at 9:26 AM, Staff G, Registered Nurse/Unti Care Coordinator (RN/UCC), stated Resident 226 had a pressure ulcer/skin injury to the right buttock and a DTI to the heel. Staff G stated they did not see a care plan for actual skin integrity issues and there should have been. Reference WAC 388-97-1020(1), (2)(a)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to include resident's input and preferences in development of the care plan for 1 of 3 sampled residents (Resident 36) when reviewed for care conferences. This failure placed residents at risk of not having input into their plan of care, lack of needed care, and a diminished quality of life. Findings included . Review of the electronic health record showed Resident 36 admitted to the facility on [DATE]. Review of progress notes showed the social services department called Resident 36's representative on 09/19/2024 to schedule a care conference, which was held on 09/23/2024 (20 days after admitting to the facility). During an interview on 10/29/2024 at 1:46 PM, Staff P, Social Service Director, stated initial care conferences should be held within 72 hours of admitting to the facility. Staff P stated Resident 36 had an initial care conference on 09/23/2024, and this did not meet expectation. During an interview on 10/29/2024 at 3:43 PM, Staff A, Administrator, stated residents should have an initial care conference within 72 hours of admitting to the facility and Resident 36's care conference did not meet this expectation. Reference WAC 388-97-1020 (2)(f), (4)(b)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on interview and record review, the facility failed to consistently monitor and document bowel movements and implement the bowel program as needed for 3 of 4 sampled residents (Residents 177, 176 and 40) reviewed for care and services. These failures placed the residents at risk for worsening condition, discomfort, and a decreased quality of life. Findings included . Review of a policy document titled, Bowel Protocol, dated 09/16/2024, showed the facility should provide effective interventions for signs and symptoms of constipation that were consistent with current standards of practice. The nursing staff was to record, in the electronic health record (EHR), each time a resident had a bowel movement (BM). In addition, the facility, in coordination with the resident's provider, would implement standing orders to address a lack of a BM. Resident 177 Review of Resident 177's entry minimum data set (MDS), an assessment tool, dated 09/22/2024, showed the resident readmitted on [DATE] with diagnoses to include heart and kidney disease, diabetes, depression and anxiety. The MDS showed Resident 177 was able to make needs known and required assistance with personal care needs. During an interview on 10/28/2024 at 10:21 AM, Resident 177 stated constipation had been an issue for them since admission to the facility. Review of Resident 177s EHR showed several provider orders dated 09/22/2024 for the licensed nurse (LN) to administer, as necessary, medication used in the treatment of constipation to include: Bisacodyl 5 milligrams (mgs) delayed release (orally) as necessary daily, Bisacodyl 10 mg suppository to be administered (rectally) as needed for constipation if the oral Bisacodyl was ineffective. The provider ordered the LN to administer fleets mineral oil enema (rectally) if the Bisacodyl suppository was ineffective. Review of Resident 177's EHR task section showed 9 days (10/15/2024 to 10/23/2024) had elapsed without the LNs administering any provider orders for the treatment of constipation. Resident 176 Review of Resident 176's MDS, dated [DATE], showed the resident admitted on [DATE] with diagnoses to include heart disease and depression. The MDS showed Resident 176 was able to make needs known and required staff assistance with personal care needs. Review of Resident 176's focus care plan, dated 09/26/2024, showed the resident used antidepressant medication related to depression. The goal showed the resident would be free from discomfort or adverse reactions related to antidepressant therapy. Interventions included for the LN to observed for and report as necessary for adverse reactions to antidepressant therapy to include constipation and fecal (stool) impaction. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 176's EHR showed several provider orders, dated 09/26/2024, for the LN to administer, as necessary, medication used in the treatment of constipation to include: Bisacodyl 5 mgs delayed release (orally) as necessary daily, Bisacodyl 10 mg suppository to be administered (rectally) as needed for constipation if the oral Bisacodyl was ineffective. The provider ordered the LN to administer fleets mineral oil enema (rectally) if the Bisacodyl suppository was ineffective. Review of Resident 176's EHR task section showed multiple days (greater than 72 hours) from 10/10/2024 to 10/12/2024 and 10/14/2024 to 10/16/2024 had elapsed without the LNs administering any provider orders for the treatment of constipation. Resident 40 Review of Resident 40's EHR showed the resident admitted on [DATE] with diagnoses to include kidney disease, stroke with hemiplegia (paralysis or loss of function to a part of or all the body) and depression. The MDS showed Resident 40 was able to make needs known and required assistance with personal care needs. During an interview on 10/28/2024 at 12:05 PM, Resident 40 stated they had constipation for several days and the staff have not provided them any medication. Review of Resident 40's EHR showed several provider orders dated 10/18/2024 for the LN to administered (as necessary) medication used in the treatment of constipation to include: Bisacodyl 5 mgs delayed release (orally) as necessary daily, Bisacodyl 10 mg suppository to be administered (rectally) as needed for constipation if the oral Bisacodyl was ineffective. The provider ordered the LN to administer fleets mineral oil enema (rectally) if the Bisacodyl suppository was ineffective. Review of Resident 40's EHR task section showed greater than 72 hours had elapsed from (10/22/2024 to 10/24/2024) without LNs administering any provider orders for the treatment of constipation. Review of 40's focus care plan, dated 10/25/2024, showed the resident used antidepressant medication related to depression. The goal showed the resident would be free from discomfort or adverse reactions related to antidepressant therapy. Interventions included for the LN to observed for and report as necessary for adverse reactions to antidepressant therapy to include constipation, and fecal impaction. During an interview on 10/29/2024 at 1:58 PM, Staff C, Licensed Practical Nurse/Unit Care Coordinator, stated the LN should have administered the ordered (as necessary) constipation medication if there was greater than 72 hours since the resident had a BM. During an interview on 10/30/2024 at 11:14 AM, Staff B, Director of Nursing Services, stated it was their expectation LNs were to administer the providers orders as necessary for the resident's constipation. Reference WAC 388-97-1060(1)(2)(3)(b)(c)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on observation, interview, and record review, the facility failed to accurately monitor resident fluid intake and/or ensure dietary and supplement orders were obtained/transcribed according to standard of practice for 2 of 2 sampled residents (Residents 40 and 42) reviewed for nutrition. This failure placed residents at risk of fluid overload, swelling, discomfort, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 40 admitted to the facility on [DATE] with diagnoses of chronic heart failure (CHF), ankylosing spondylitis (a type of arthritis that affects the spine and other parts of the body), and pneumonia (a lung infection). Review of provider's orders showed Resident 40 had an order for a 2000 milliliters (ml) fluid restriction related to CHF. Review of the order showed for nursing to provide 480 ml fluid during day, evening, and night and for dietary to provide 200 ml day and 180 ml evening and night. Review of Resident 40's October 2024 medication administration record (MAR) showed fluid tracking for nursing day and evening shifts and did not have documentation of dietary provided liquids. Review showed no area to total Resident 40's fluid intake. During an interview on 10/30/2024 at 9:54 AM, Staff R, Licensed Practical Nurse/Resident Care Manager, stated Resident 40 was on a fluid restriction and it was tracked through the MAR and nursing was responsible for monitoring total fluid intake. Staff R stated Resident 40's MAR had only two spaces in the MAR to record fluid intake, dietary fluids were not being tracked, and nursing was not totaling or monitoring total fluid intake. Staff R stated Resident 40's monitoring of fluid restriction did not meet expectation. During an interview on 10/30/2024 at 1:16 PM, Staff B, Director of Nursing Services, stated Resident 40 did not have fluid monitoring for the evening shift, dietary fluids were not being monitored, and nursing was not totaling or monitoring total fluid intake. Staff B stated Resident 40's monitoring of fluid restriction did not meet expectation. 38344 Resident 42 Review of Resident 42's EHR showed the resident readmitted to the facility on [DATE] with diagnoses to include anemia (lack of healthy red blood cells to carry oxygen throughout the body), diabetes (a condition resulting in high blood sugar levels), hyperkalemia (a condition where there is too much potassium, a mineral/electrolyte that helps muscles and nerves function, in the blood), and chronic (persistent/long lasting) kidney disease. The resident was able to make needs known. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 10/28/2024 at 1:02 PM, Resident 42 stated they were on fluid restrictions and pointed to a dietary meal tray slip dated 10/28/2024 that showed Resident 42 was on a fluid restriction of 1200 ml thin liquids. During an interview on 10/30/2024 at 11:28 AM, Resident 42 stated they thought that they were to have 1.5 liters of fluids in 24 hours; however, staff did not keep track of their intake and never asked them how much fluid they had consumed. Review of the dietary provider order dated 09/21/2024 showed Resident 42 was prescribed a diet that included a fluid restriction of 1200 ml (this order did not specify fluids that would be provided by the kitchen for meals or how much fluids would be provided by nursing in between meals). Review of Resident 42's provider order dated 09/22/2024 showed, ProSource Sugar Free two time a day for wound care. (This order did not show the route or the amount of ml to be provided). Review of the provider order dated 10/25/2024 showed Resident 42 was prescribed fluid restrictions of 1500 ml per day (300 ml more than the dietary provider order). Dietary to provide; breakfast = 360 ml, lunch = 240 ml, dinner = 360 ml, and from Nursing: day shift = 180 ml, evening shift = 180 ml, night shift = 120 ml, and every shift document amount consumed. (This order did not show the rationale or related diagnosis for the fluid restriction). Review of Resident 24's 05/21/2024 initiated care plan showed no care plan or interventions documented for fluid restrictions. During an interview on 10/31/2024 at 11:24 AM, Staff K, Certified Assistant Nursing (CNA), stated Resident 42 was on fluid restrictions. Staff K stated they did not document how much fluid the residents on fluid restrictions drank but informed the nurse [licensed nurse] verbally or on a sticky note how much they drank for meals and throughout their shift. During an interview on 10/31/2024 at 12:30 PM, Staff J, Registered Nurse (RN), stated CNA documented how much fluids were consumed during meals in the computer system and would inform nursing [licensed nurses] what fluids were provided in between meals during their shift. Staff J stated that fluids provided in between meals were all documented in the MAR. Staff J stated Resident 42's order for ProSource Sugar Free did not show the route or amount to be provided, the October 2024 MAR did not have a spot to document amount consumed, and the order needed to be clarified with the provider. Staff J stated the dietary order dated 09/21/2024 showed Resident 42 was on a 1200 ml fluid restriction which conflicted with the provider order dated 10/25/2024 that showed a fluid restriction of 1500 ml and both orders needed to be clarified with the provider. Staff K stated all fluids should be totaled for a 24-hour period and documented in the MAR to ensure provider orders were followed; however, that did not happen for Resident 42. Staff J stated that Resident 42's care plan did not include fluid restrictions and should have been included in the care plan when fluid restriction orders were obtained. Staff J stated Resident 42's fluid restrictions monitoring, and documentation did not meet expectations. Reference WAC 388-97-1060 (3)(h)(i)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview, and record review, the facility failed to ensure enteral nutrition (the delivery of nutrients through a feeding tube directly into the stomach or small intestine) was administered in accordance with provider's orders and professional standards of practice for 1 of 2 sampled residents (Resident 72) reviewed for enteral nutrition. The facility failed to have a system in place which ensured the amount of enteral formula (liquid food products) a resident received was reconciled with the amount they were ordered to receive. This failure placed the residents at risk for inadequate nutrition, dehydration, and other adverse outcomes. Findings included . Review of Resident 72's admission minimum data set (MDS), an assessment tool, dated 10/15/2024, showed the resident admitted on [DATE] with diagnoses to include stroke, kidney disease, aphasia (a language disorder that affects a person's ability to understand and express language), and muscle weakness. Resident 72's electronic health record (EHR) showed the resident had dysphagia (swallowing difficulty), required an enteral feeding tube for nutrition, and was dependent on facility staff for all activities of daily living. Review of a focused care plan, revised on 10/22/2024, showed Resident 72 required (enteral) tube feeding related to dysphagia. The goal for Resident 72 was to remain free of side effects or complications related to the tube (enteral) feed (TF). Interventions included the registered dietician (RD) to evaluate quarterly and when necessary and make recommendations for changes to the resident's tube feed as needed. An additional care plan focus showed the resident was at risk for weight fluctuations related to current health status with tube feed and risk for malnutrition. Review of a provider order, dated 10/14/2024, showed an order for the licensed nurse (LN) to infuse enteral feeding every shift, Nepro at 50 milliliters (ml) for 24 hours via pump for a total of 1200 ml. The LN's were instructed to flush with 250 ml of purified water every four hours. Review of Resident 72's medication administration record (MAR), dated October 2024, showed the LNs had been documenting (initialed) the resident's tube feed every shift as being infused along with the water flushes; however, no totals were being recorded or documented within the resident's EHR. Observation and interview on 10/30/2024 at 9:55 AM showed Staff E, Licensed Practical Nurse (LPN), provided care and treatment to Resident 72's sacral pressure wound (lower back and buttocks) area. The resident was initially positioned flat on their back and then turned onto their right side for the LN to provide the needed wound care. The resident's tube feed was off temporarily during the wound care (approximately 10-15 minutes). Staff E stated the TF was turned off during the wound care because the resident was positioned onto their back and was required to prevent aspiration (breathing in liquid) of the TF. Interview at 10:59 AM, Staff E was asked where the TF total was being documented in the EHR. Staff E stated they did not see where they were to document in the resident's MAR, but it should have been totaled every shift and documented. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 72's EHR showed a decline in their weights for the past several weeks as follows: 10/14/2024 - 165 pounds (lbs.), 10/25/2024 - 160 lbs. and 10/31/2024 - 158.2 lbs. During an interview on 10/30/2024 at 11:01 AM, Staff C, LPN/Unit Care Coordinator (UCC), stated it was their expectation Resident 72's enteral tube feed was to be totaled up every shift and documented in the MAR by the LNs to ensure the resident received their enteral tube feeds as ordered. Review of a document titled, Nutrition: Assessment /Nutritional Data Collection, dated 10/20/2024, for Resident 72 showed a registered dietitian (RD) had recommended a change to the resident's initial TF order to increase the TF to 60 ml per hour for 20 hours to equal 1200 ml total to infuse and to turn on the TF at 2:00 PM and off at 10:00 AM. During an interview on 10/30/2024 at 12:22 PM, Staff F, RD, stated they did not want Resident 72 to be on continuous TF for 24 hours, so they recommended to the UCC on 10/20/2024 to change the resident's TF order as indicated during their last evaluation on 10/20/2024. The TF recommendation was sent via email to the facility staff to change. Staff F stated the LN were to document the TF total every shift to ensure that the resident received their required nutritional intake. During an interview on 10/30/2024 at 12:55 PM, Staff B, Director of Nursing Services, stated it was their expectation that the RD's recommendation was to occur within 72 hours and that the LNs were to total up the resident's TF every shift. Reference WAC 388-97-1060 (3)(f)

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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** 38344 Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 2 sampled residents (Residents 226) reviewed for respiratory care. Failure to transcribe/obtain and follow physician orders for oxygen (O2) therapy, care plan, ensure O2 tubing was regularly changed and maintained, placed the resident at risk for unmet needs and potential negative outcomes. Findings included . Resident 226 admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, lung disease that causes restricted airflow and breathing problems), and chronic (long lasting/ongoing) respiratory failure with hypoxia (low levels of O2 in the blood). Resident 226 was able to make needs known. Observation on 10/28/2024 at 9:40 AM showed Resident 226 laid in bed receiving O2 set to two liters (L) per minute via nasal canula (devise to deliver O2 through a tube into the nose) and the tubing was not dated. Observation and interview on 10/29/2024 at 10:48 AM showed Resident 226 received O2 set to two L per minute via nasal canula. Resident 226 stated they had received O2 continuously at two liters through the nose via the tube since they had admitted to the facility. Review of Resident 226's hospital discharge orders dated 10/16/2024 showed, Continue taking these medications, and the list included Oxygen 2 liter daily. Review of the admission collection tool, dated 10/16/2024, Devices and Treatments (care profile) showed Resident 226 had O2 at 2 L/minute by nasal canula/mask and was a Chronic (treatment). Review of Resident 226's electronic health record (EHR) showed no orders for O2 therapy or to change and maintain oxygen tubing; however, documented respiratory symptoms screening tools dated 10/17/2024, 10/18/2024, 10/19/2024, 10/21/2024, 10/22/2024, 10/24/2024, 10/25/2024, 10/26/2024, 10/27/2024, and 10/28/2024 showed the resident received O2 via nasal canula. Review of Resident 226's 05/21/2024 initiated care plan showed no care plan or interventions documented for O2 therapy. During an interview on 10/29/2024 at 5:16 PM, Staff G, Registered Nurse/Unit Care Coordinator, stated Resident 226 was observed receiving O2 at two L per minute via nasal canula and the tubing and humidifier were not dated and should have been. Staff G stated Resident 226 had no orders for O2 therapy and O2 therapy had not been cared planned and should have been. During an interview on 10/30/2024 at 3:02 PM, Staff B, Director of Nursing Services, stated Resident 226's orders for O2 therapy should have been initiated and care planned upon admission. Staff B stated this did not meet expectations. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-1060 (3)(j)(vi)

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 38344 Based on observation, interview, and record review, the facility failed to ensure the nursing staff posting was posted daily and/or reflected the actual nursing staff hours worked during 4 of 4 days of the survey period. This failed practice prevented residents, family members and visitors from knowing the facility's actual number of available nursing staff. Findings included . Observations on 10/28/2024 at 3:40 PM, 10/30/2024 at 8:49 AM, and 10/31/2024 at 8:31 AM showed nursing staff postings with no actual nursing staff hours posted (the actual hours worked were left blank on the form). Observation on 10/29/2024 at 8:49 AM showed the nursing staff posting was dated 10/28/2024 (previous day's date) and did not show actual nursing staff hours posted. During an interview on 10/31/2024 at 10:19 AM, Staff N, Staffing Coordinator, stated upon arriving to the facility they would remove the previous day's nursing staff posting form and put out the new nursing staff posting; however, on 10/29/2024 they had removed the posting to update the form and the previous date was left behind in its place until they were able to post the new/revised 10/29/2024 form. Staff N stated if there were no call offs for the day, they may not update the form to reflect actual hours worked until the next morning instead of each shift. Staff N showed nursing staff postings for 10/28/2024 through 10/31/2024 and the actual hours worked were not completed for all three shifts on 10/30/2024 and for the night shift on 10/31/2024. Staff N stated this did not meet expectations, and actual hours worked should have been posted each shift. During an interview on 10/31/2024 at 11:03 AM, Staff A, Administrator, stated the expectation was that the nurse staff postings be updated at the beginning of every shift to include actual worked hours. Staff A stated on 10/29/2024 Staff N should have updated the nursing staff posting electronically and then replaced the posted nurse staff posting with the revised 10/29/2024 nurse staff posting. No Associated WAC.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on interview and record review, the facility failed to implement non-pharmacological interventions (NPI, methods to reduce pain without medication) prior to providing pain medications for 5 of 5 sampled residents (Residents 6, 24, 32, 41 and 226) reviewed for unnecessary medications. This failure placed the residents at risk of receiving unnecessary pain medications and a decreased quality of life. Findings included . Resident 6 Review of the electronic health record (EHR) showed Resident 6 admitted to the facility on [DATE] with a diagnosis of fracture of the left forearm. Review of the EHR showed the resident had a provider order for oxycodone tablet (a narcotic pain medication) every four hours as needed for severe pain which was provided daily from 10/01/2024 through 10/28/2024. Included was a separate provider order to attempt NPI prior to administering the narcotic pain medication. Review of the medication administration record (MAR) from 10/01/2024 through 10/28/2024 showed all day shift administrations marked as NA for NPI and 12 night shift administrations marked as NA. Resident 24 Review of the EHR showed Resident 24 admitted to the facility on [DATE] with a diagnosis of left lower leg amputation. Review of the EHR showed the resident had a provider order for oxycodone every four hours as needed for severe pain with a start date of 09/24/2024. Included was a separate provider order to attempt NPI prior to administering the narcotic pain medication. Review of the MAR from 10/01/2024 through 10/28/2024 showed the resident received oxycodone daily and 15 of the day shift administrations and 19 night shift administrations were marked as NA. During an interview on 10/29/2024 at 1:02 PM, Staff O, Licensed Practical Nurse, stated the nursing staff should have documented NPI that was attempted prior to narcotic pain medications each shift and they should not mark NA (not applicable). 40817 Resident 32 Review of the EHR showed Resident 32 admitted to the facility on [DATE] with a diagnosis of respiratory failure (lung failure). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 32's provider's orders showed an order for acetaminophen (an over-the-counter pain medication), dated 10/03/2024, as needed for pain and an order for staff to provide NPI prior to use. Review of Resident 32's October 2024 MAR showed the resident was provided acetaminophen without NPI on 10/05/2024. 34567 Resident 41 Review of the EHR showed Resident 41 admitted to the facility on [DATE] with a diagnosis of osteomyelitis (infection of the bone) of the right ankle and foot. The resident had a provider's order for oxycodone tablet every 12 hours as needed for pain levels 6 to 10. Included was a separate provider order to attempt NPI prior to administering the narcotic pain medication. Review of the MAR for October 2024 showed the LNs had not documented any NPI for 18 oxycodone administrations for Resident 41. Review of a focus care plan, dated 10/04/2024, showed Resident 41 expressed pain/discomfort related to muscle weakness and wound. The interventions included for the licensed nurse (LN) to evaluate the effectiveness of pain interventions and administered the pain medications as ordered. During an interview on 10/29/2024 at 2:31 PM, Staff C, Licensed Practical Nurse/Unit Care Coordinator (LPN/UCC), stated the NPI documentation was wrong in the MAR for Resident 41 and the LNs were to provide NPI whenever they administered narcotics and document in the residents' EHR. 38344 Resident 226 Resident 226 admitted to the facility on [DATE] with diagnoses that included arthritis (swelling and tenderness of joints) and spinal stenosis (narrowing of the spinal canal in the lower part of the back that could result in pain, numbness, or weakness). Resident 226 was able to make needs known. Review of Resident 226's October 2024 MAR from 10/16/2024 through 10/28/2024 showed orders dated 10/16/2024 to include acetaminophen every four hours as needed for pain. The MAR showed this was provided to Resident 226 without NPI on 10/17/2024 and 10/28/2024. The MAR showed hydrocodone-acetaminophen (use to treat severe pain) every eight hours as needed for pain that was provided 20 times without NPI documented. THe MAR showed an order for staff to provide NPI prior to as needed pain medication use per shift; however, it showed no specific time NPI provided. During an interview on 10/29/2024 at 2:08 PM, Staff G, Registered Nurse/UCC, stated Resident 226's order to attempt to provide NPI prior to giving as needed pain medication was per shift and did not pertain to the specific dose or time an as needed pain medication was provided, and this did not meet expectations. Staff G stated Resident 226's as needed pain medication orders needed to have supplemental documentation added to the orders to include NPI and interventions. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/30/2024 at 2:52 PM, Staff B, Director of Nursing Services, stated the expectation was NPI should be offered and provided prior to administering as needed pain medication and it should be documented in the MAR. Reference WAC 388-97 -1060 (3)(k)(i)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on interview and record review, the facility failed to timely initiate monitoring of adverse side effects and target behaviors for 3 of 6 sampled residents (Residents 24, 276 and 226) when reviewed for unnecessary psychotropic (affecting the mind) medications. These failures placed the residents at risk for unidentified mental health needs and a decreased quality of life. Findings included . Resident 24 Review of the electronic health record (EHR) showed Resident 24 admitted to the facility on [DATE] with a diagnosis of depression. Review of the EHR showed a provider order dated 09/23/2024 for nortriptyline (an antidepressant medication) at bedtime for depression. Review of Resident 24's medication administration record (MAR) from 09/23/2024 through 10/28/2024, showed Resident 24 was provided nortriptyline per provider orders; however, the order to monitor targeted behaviors related to the use of an antidepressant was not initiated until 10/28/2024. Resident 276 Review of the EHR showed Resident 276 admitted to the facility on [DATE] with a diagnosis of depression. Review showed provider orders for the following psychotropic medications: amitriptyline (an antidepressant) daily for depression, start date 10/20/2024, trazadone (an antidepressant) daily at bedtime for depression, start date 10/21/2024, and sertraline (an antidepressant) daily for depression, start date 10/20/2024. Review of Resident 276's MAR from 10/20/2024 through 10/28/2024 showed Resident 276 was provided the above antidepressants per provider orders; however, the order to monitor targeted behaviors related to the use of an antidepressant was not initiated until 10/28/2024. During an interview on 09/29/2024, Staff O, Licensed Practical Nurse (LPN), stated they did not know why there was no behavior monitoring in place until 10/28/2024 but there should have been. During an interview on 10/30/2024 at 2:25 PM, Staff B, Director of Nursing Services (DNS), stated resident's on a psychotropic medications, such as an antidepressant, should have targeted behavior monitoring in place on the day they start the medication. 38344 Resident 226 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 226 admitted to the facility on [DATE] with a diagnosis of depression and was able to make needs known. Review of Resident 226's EHR showed a provider order dated 10/16/2024 for duloxetine (an antidepressant medication) one time a day for depression. It showed an order dated 10/17/2024 to monitor for target behaviors related to a diagnosis of depression, listed several behaviors, and listed interventions to utilize/offer. It showed an order dated 10/24/2024 to monitor for side effects for use of duloxetine every shift. Review of Resident 226's October 2024 MAR from 10/16/2024 through 10/28/2024 showed Resident 226 was provided duloxetine per provider orders; however, the order to monitor for side effects for use of duloxetine was not initiated until 10/24/2024 (eight days after being provided the medication). An order dated 10/17/2024 to monitor for target behaviors with listed interventions showed documentation of nurses' initials for day and night shift; however, there was no documentation for evening shift, or to show if behaviors were or were not exhibited, or if interventions were offered. During an interview on 10/29/2024 at 1:51 PM, Staff G, Registered Nurse/Unit Care Coordinator (RN/UCC), stated Resident 226's order to monitor side effects related to use of antidepressant medication was started eight days after being provided the medication and should have been initiated upon admission. Staff G stated Resident 226's order to monitor target behaviors was entered into the system inaccurately and should have included supplemental documentation to show if the resident had behaviors and what interventions were provided if needed. During an interview on 10/30/2024 at 2:25 PM, Staff B, Director of Nursing Services, stated Resident 226's monitoring for adverse side effects for antidepressant medication use was initiated too late. Staff B stated Resident 226's October 2024 MAR did not show a space to document a code to show if Resident 226 had behaviors or if interventions were provided. The documentation should have been in the MAR but there was an error when they put the order in for codes for behaviors and interventions and this did not meet expectations. Reference WAC 388-97-1060 (3)(k)(i)

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 10/31/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of South Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 2508 7th St Southeast Puyallup, WA 98374	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on observation, interview, and record review the facility failed to implement an infection control program that included the application of enhanced barrier precautions (EBP) for 2 of 3 sampled residents (Residents 5 and 226) when reviewed for EBP. Also, the facility failed to track all infectious organisms for 2 of 3 months (August and September 2024) when reviewed for infection control. These failures placed residents at risk of communicable diseases, avoidable side effects, and a diminished quality of life. Findings included . <EBP> Review of the facility policy titled Enhanced Barrier Precautions, dated 06/03/2024, showed the facility should use EBP for residents who had chronic wounds, such as pressure wounds, or indwelling devices, such as urinary catheters. It further showed that EBP included posting a sign outside the resident's door instructing staff on the use of a gown and gloves for all high contact resident care activities. Resident 5 Review of Resident 5's electronic health record (EHR) showed Resident 5 readmitted to the facility on [DATE] with a pressure injury to their bottom. Further review showed the resident's pressure injury resolved on 07/12/2024 but continued to have a chronic wound to their left ankle which was still present on 10/28/2024. Observation on 10/29/2024 showed Resident 5 did not have an EBP sign on the door. During an interview on 10/29/2024 at 11:23 AM, Staff L, Certified Nursing Assistant, stated Resident 5 had not been requiring EBP. During an interview on 10/31/2024 at 9:57 AM, Staff M, Infection Preventionist (IP), stated it was their expectation that residents who had significant chronic wounds, such as Resident 5, would have EBP in place. Resident 226 Review of the EHR showed Resident 226 admitted to the facility on [DATE] with a diagnosis of obstructive and reflux uropathy (difficulty urinating) and required an indwelling urinary catheter (a tube inserted into the bladder to drain urine). Observation and interview on 10/28/2024 at 12:03 PM showed Resident 226 in their room. There was no EBP sign on the door and Resident 226 stated they had admitted to the facility with an indwelling urinary catheter. Resident 226 stated staff did not wear gowns when providing direct care. (continued on next page)

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	10/31/2024

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/29/2024 at 4:54 PM, Staff M, IP, stated Resident 226 had a indwelling urinary catheter and should have had EBP sign and a PPE isolation cart with appropriate supplies by the doorway, and it should have been care planed. During an interview on 10/30/2024 at 11:20 AM, Staff A, Administrator, stated it was their expectation that residents with chronic wounds and indwelling urinary catheters be placed on EBP and Resident 5 and Resident 226 should have had EBP in place. <Tracking> Review of the facility policy titled Infection prevention and Control Program, revised 01/25/2023, showed the program includes early detection, management of a potentially infectious, symptomatic resident that requires laboratory testing and/or the implementation of appropriate TBP/PPE (the plan may include tracking this information in an infectious disease log). August 2024 Review of the infection control log, map and monthly summary for August 2024 included no identified organisms and listed no multidrug resistant organism (MDRO, infections resistant to multiple antibiotics) for tracking. September 2024 Review of the infection control log, map and monthly summary for September 2024 showed no identified organisms and listed no MDRO for tracking. Review of Resident 177's EHR showed the resident was identified to have disseminated shingles (a viral infection that is highly contagious) on 09/11/2024 and was sent to the emergency room for evaluation. The September 2024 infection control log did not include this infection. Review of Resident 278's EHR showed the resident admitted on [DATE] with diagnosis of urinary tract infect (UTI) and was receiving cephalexin (an antibiotic) every eight hours for UTI. The September 2024 infection control log did not include this infection. During an interview on 10/30/2024 at 10:36 AM, Staff M, IP, stated it was their practice to track all infections on the infection control log, update the map daily, and complete a summary every month which included a section for tracking MDROs. During an interview on 10/29/2024 at 11:47 AM, Staff B, Director of Nursing Services, stated it was their expectation that the IP review lab results for new admissions and current residents who are receiving antibiotics for the infectious organisms, if applicable, and include each on the infection control logs for tracking. Reference WAC 388-97 -1320 (2)(a)(c)

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	505526	A. Building B. Wing	10/31/2024

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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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on interview and record review, the facility failed to implement an effective Antibiotic Stewardship Program to promote appropriate use of antibiotics, reduce the risk of unnecessary antibiotic use and decrease the development of adverse side effects and antibiotic resistance for 1 of 2 sampled residents (Resident 26) reviewed for antibiotic stewardship. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of antibiotics. Findings included . Review of the facility policy titled Antibiotic Stewardship, revised 05/16/2024, showed the facility would implement antibiotic time-out at 72 hours after antibiotic initiation or first dose in the facility. Each resident should be reassessed for consideration of antibiotic need by reviewing lab results, response to therapy and resident condition. It further showed the facility would design and use a system to identify residents with multidrug resistant organisms (MDRO, infections resistant to multiple antibiotics) by reviewing microbiology culture results. Resident 26 Review of the electronic health record (EHR) showed Resident 26 admitted to the facility on [DATE] with diagnoses of sepsis (a serious condition in which the body responds improperly to an infection), obstructive uropathy (difficulty urinating), and a urinary tract infection (UTI). There was no diagnosis of pneumonia included in the resident's diagnosis list. Review of Resident 26's provider's orders showed an order for cefdinir (a broad-spectrum antibiotic) twice a day for five days for a UTI with a start date of 10/10/2024 which was completed on 10/15/2024. Review of an outside provider's note dated 10/10/2024, provided to the facility by Resident 26's family member on 10/24/2024, showed the resident had a culture result positive for pseudomonas (a MDRO) and should have been changed to ciprofloxacin (an antibiotic) as pseudomonas was resistive to the cefdinir. During an interview on 10/29/2024 at 11:37 AM, Staff M, Infection Preventionist, stated they did not review the lab/culture results for all UTIs and they trusted the provider's judgment on whether the resident was on the appropriate antibiotic treatment. Staff M stated they believed it was a typical UTI. During an interview on 10/31/2024 at 11:13 AM, Staff B, Director of Nursing Services, stated it was their expectation that the infection preventionist review infections and associated laboratory culture results for antibiotic stewardship. No Associated WAC