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	11/21/2025

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate, investigate, and resolve a grievance for 1 of 2 sampled residents (Resident 142) when reviewed for grievances. This failure placed the residents at risk for lack of comfort and a diminished quality of life.Findings included .Review of the electronic health record (EHR) showed Resident 142 admitted to the facility on [DATE] with diagnoses that included congestive heart failure (condition that happens when your heart is unable to pump blood well enough to give your body a normal supply) and chronic kidney disease (condition where the kidneys are damaged and unable to filter blood). Resident 142 was able to make needs known. During an interview on 11/17/2025 at 3:05 PM, Resident 142 stated they did not have enough room in their bed to turnover comfortably. Resident 142 stated they had requested a larger bed upon admission however they did not get a response.Review of the EHR showed a progress noted dated 10/31/2025, the progress note stated Resident 142 had requested a bariatric bed and side rails. Further review showed no bed assessment or documentation related to the bed or side rail request.Review of the grievance log for October 2025 showed no grievances related to Resident 142.During an interview on 11/20/2025 at 2:09 PM, Staff N, Resident Care Manager/Licensed Practical Nurse, stated a grievance should have been initiated on behalf of Resident 142.During an interview on 11/21/2025 at 10:30 AM Staff B, Director of Nursing Services (DNS) stated the expectation was that staff would initiate a grievance for concerns expressed by residents.Reference WAC 388-97-0460

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement safety interventions to ensure safety from potential further abuse for 1 of 3 sampled residents (Resident 143) when reviewed for abuse. This failure placed the resident at risk for physical harm, mental anguish, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 143 admitted to the facility on [DATE] with diagnoses that included dementia (a group of thinking and social symptoms that interfere with daily functioning), anxiety (feeling of worried thoughts) and depression (feeling of sadness and/or loss of interest). Resident 143 was able to make needs known. During an interview on 11/18/2025 at 9:42 AM, Resident 143 stated they would like to share a room with their spouse who was also a resident in the facility (Resident 306). Resident 143 stated their Power of Attorney (POA) had also spoken to the facility about the concern; however, Resident 143 did not know the outcome. Observations on 11/18/2025 at 12:48 PM showed Resident 143 and Resident 306 in Resident 143's room eating lunch. Observation on 11/18/2025 at 1:30 PM showed Resident 143 and Resident 306 in the room prior to the door being closed. During an interview on 11/18/2025 at 1:39 PM, Staff F, Certified Nursing Assistant, stated they were unaware of any abuse allegations between Resident 143 and Resident 306. Review of the care plan, dated 11/13/2025, showed no focus, goal, or interventions related to allegations of abuse. Review of the November 2025 incident and grievance logs showed no documentation of an investigation related to the allegation of abuse. Observation on 11/19/2025 at 10:38 AM showed Resident 143 in their room with Resident 306 watching television. During an interview on 11/19/2025 at 10:43 AM, Staff O, Social Services Director, stated the social services department was informed by the admissions coordinator that Resident 143 made an allegation of physical abuse against Resident 306 prior to admission to the facility and it was reported to Adult Protective Services (APS). Staff O stated they did not have any details about the case and did not know the status of the case. Staff O stated if the residents were together in one room it should have been supervised to protect Resident 143. During an interview on 11/19/2025 at 2:15 PM, Staff P, Social Services Assistant, stated Resident 143's POA requested Resident 143 and 306 room together upon admission. Staff P informed the POA that due to the allegation of abuse the residents could not room together. Staff P stated they did not care plan safety interventions related to the allegation because they did not have confirmation the allegation was true. Staff P stated they followed up earlier that day with APS to obtain the status of the investigation. During an interview on 11/25/2025 at 4:15 PM, Collateral Contact Q stated the APS case related to Resident 143 was currently open and abuse had not been ruled out as additional interviews needed to be conducted. During a group interview on 11/20/2025 at 9:46 AM, Staff A, Administrator, Staff R, Regional Director, and Staff S, Assistant Administrator, stated the facility took precautions by not allowing Residents 143 and 306 to room together. Staff S stated they made nursing staff aware of the allegation yesterday (11/19/2025). Staff S stated the facility should have care planned, interviewed, and had a safety plan for Resident 143 to not be alone with Resident 306. Reference WAC 388-97-0640(1)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review the facility failed to develop care plans for 1 of 19 sampled residents (Resident 126) when reviewed for comprehensive care plans. Failure to care plan Resident 126's bowel functions and half a side rail equipment placed the Residents at risk of avoidable injuries, loss of functions and diminished quality of life. Findings included. Resident 126 was admitted to the facility on [DATE] with diagnoses to include malnutrition, diabetes (high blood sugar), anemia (low red blood cells) and depression. Review of the admission minimum data set (MDS) an assessment tool, dated 10/25/2025, showed Resident 126 was able to communicate needs. During an observation and interview on 11/18/2025 at 9:50 AM, Resident 126 stated they had a fall trying to go to the bathroom, and they use the half side rails in bed for mobility. Resident 126 was sitting next to their bed and was pointing towards the rails on the bed. Resident 126 stated they had diarrhea (multiple loose stools) all previous day and night. Review of Resident 126 care plan dated 10/24/2025 showed no instructions about bed rails or bowel functions. During an interview on 11/20/2025 at 1:58 PM, Staff D, Resident Care Manager, stated Resident 126's care plan did not address half side rails and bowel functions, and should have. During an interview on 11/21/2025 at 10:26 AM, Staff B, Director of Nursing Services, Stated Resident 126's care planning did not meet expectations. Reference WAC 399-97-1020(1),(2)(a)(b)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide ordered bowel medications for constipation per provider's orders for 2 of 5 sampled residents (Residents 136 and 124) when reviewed for quality of care. This failure placed the residents at risk for decreased comfort and a diminished quality of life. Findings included.Resident 136Review of the electronic health record (EHR) showed Resident 136 admitted to the facility on [DATE] with a diagnosis of recent spinal surgery. The resident was able to make needs known. Review of the bowel management documentation showed Resident 136 did not have a bowel movement (BM) from 11/07/2025 through 11/12/2025. Review of the medication administration record (MAR) for November 2025 showed no as needed bowel medications were offered to Resident 136. Resident 124Review of the EHR showed Resident 124 admitted to the facility on [DATE] with a diagnosis of dementia. The resident was unable to make needs known. Review of the bowel management documentation showed Resident 124 did not have a BM from 10/30/2025 through 11/03/2025. Review of October and November 2025 MAR showed Resident 124 did not receive an as needed bowel medication until 11/03/2025 (day 5). During an interview on 11/20/2025 at 10:03 AM, Staff C, Licensed Practical Nurse (LPN), stated if a resident went three days without a BM they were notified on the computer, and staff should give ordered bowel medications to those residents on the morning of day four with no BM. During an interview on 11/20/2025 at 10:19 AM, Staff D, Registered Nurse/Resident Care Manager (RN/RCM), stated the facility had a bowel protocol and after three days residents should receive bowel medication and then follow up to make sure it works. Staff D stated if a resident refused, it should be documented. During an interview on 11/20/2025 at 10:22 AM, Staff B, Director of Nursing Services, stated it was their expectation staff follow the bowel protocol and that Residents 124 and 136 should have received bowel medications after three consecutive days with no BM. Reference WAC 388-97-1060(1)-(3).

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor and implement residents' fluid restrictions for 1 of 2 sampled residents (Resident 132) when reviewed for nutrition. This failure placed residents at risk of fluid overload, discomfort, and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 132 admitted to the facility on [DATE] with diagnoses to include end stage renal disease (the kidneys can no longer filter waste and excess fluid from the blood), muscle weakness, and diabetes (too much sugar in the blood). Resident 132 was able to make needs known. During an interview and observation on 11/17/2025 at 12:48 PM, Resident 132 stated they had a fluid restriction, was not sure how much, and facility staff did not monitor their fluid intake. Observation showed Resident 132 had a measured cup with 500 millimeters (ml) of fluid and an empty coffee mug on their overbed table. Review of provider's orders showed an order, dated 11/04/2025, for a fluid restriction of 2000 ml a day with dietary proving 360 ml at breakfast, 360 ml at lunch, and 360 ml at dinner and nursing providing 460 ml during the day and 460 ml at night. During an interview on 11/20/2025 at 2:11 PM, Staff E, Certified Nursing Assistant (CNA), stated they knew if a resident was on a fluid restriction by getting advice from nurses and they did not know Resident 132 was on a fluid restriction. During an interview on 11/20/2025 at 2:14 PM, Staff F, CNA, stated they knew a resident was on a fluid restriction by asking a nurse or looking at the care directive and knew how much fluid a resident with a fluid restriction could consume by asking a nurse or looking at the red tag on the resident's door. Staff F stated they were unaware Resident 132 was on a fluid restriction. During an interview on 11/20/2025 at 2:18 PM, Staff G, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated nurses monitor fluid restrictions and there were no signs/indicators to indicate a resident was on a fluid restriction. Staff G stated CNA should access a resident's care plan to determine if a resident was on a fluid restriction. Staff G stated residents on fluid restrictions should not have extra liquids available in the room and they were unaware Resident 132 kept sparkling water in their room. Observation on 11/20/2025 at 2:22 PM showed Resident 132 in their room with a metered cup with 500 ml of water and four plastic bottles of sparkling water on a shelf. During an interview on 11/21/2025 at 10:55 PM, Staff B, Director of Nursing Services, stated fluid restrictions were included in the care plan and there should be a sign indicating to staff residents were on a fluid restriction. Staff B stated staff should access a resident's care plan to know which residents had a fluid restriction. Staff B stated fluids at bedside should be limited. Staff B stated CNA being unaware of Resident 132's fluid restriction and sparkling water near bedside did not meet expectations. Reference WAC 388-97-1060(3)(i)

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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** 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 (Resident 121) reviewed for respiratory care. Failure to follow provider's orders for oxygen (O2) therapy placed the resident at risk for unmet needs and potential negative outcomes. Findings included . Review of the electronic health record (EHR) showed Resident 121 admitted to the facility on [DATE] with diagnoses that included congestive heart failure (condition that happens when your heart is unable to pump blood well enough to give your body a normal supply) and a fractured vertebra (broken bone in the spine). Resident 121 was able to make needs known. Review of Resident 121's care plan, dated 11/13/2025, showed no intervention for oxygen therapy. Observation on 11/17/2025 at 10:40 AM showed Resident 121 received O2 set to 6 liters (L) per minute via a nasal canula (device to deliver O2 through a tube into the nose). Review of a provider's order, dated 11/13/2025, showed oxygen at 2 L per minute via nasal cannula as needed. An additional provider's order, dated 11/13/2025, showed oxygen saturation (amount of O2 in the blood) rates every shift and may titrate (increase O2) to keep above ninety percent. During an interview and observation on 10/21/2025 at 9:07 AM, Staff H, Registered Nurse (RN), observed Resident 121's O2 and stated it was set at 6 L, but should have been at 3 L per minute per the provider's order. Staff H stated nursing staff adjust Resident 121's O2 after taking their oxygen saturation. During an interview on 11/20/2025 at 2:01 PM, Staff N, Resident Care Manager/Licensed Practical Nurse, stated the oxygen should have been care planned and the provider contacted for parameters of the order. During an interview on 11/21/2025 at 10:26 AM, Staff B, Director of Nursing Services, stated the oxygen orders should have been care planned and the providers order clarified. Reference WAC 388-97-1060(3)(i)(vi)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure proper storage of medications in 1 of 6 halls (700 hall) when reviewed for medication storage. This failure placed residents at risk for medication errors, ineffective treatment, and diminished quality of life. Findings included .Observation on 11/17/2025 at 11:12 AM showed room [ROOM NUMBER] with a medicine cup on the bedside table with three pills. Resident 92 stated one of the pills was an antibiotic but did not know what the others were. During an interview on 11/17/2025 at 11:31 AM, Staff H, Registered Nurse, stated they would leave medications with the resident when they were refusing. During an interview on 11/17/2025 at 11:16 AM, Staff D, Resident Care Manager, stated the medications should not been left at bedside. During an interview on 11/21/2025 at 8:04 AM, Staff J, Licensed Practical Nurse, stated the process for medication administration was when a resident refused, the nurse was to dispose of the medication and reapproach later. During an interview on 11/21/2025 at 11:29 AM, Staff B, Director of Nursing Services, stated the medications left at bedside were not acceptable practice. Reference WAC 399-97-1300(2)