STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505188	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Federal Way	1045 South 308th Street Federal Way, WA 98003

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident’s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement a system to ensure Physician's Orders for Life Saving Treatments (POLSTs) were implemented for 2 of 22 sample residents (Residents 32 & 16) and one supplemental resident (Resident 60), related to lifesaving treatment orders. The failure to follow the POLST instructions for Cardiopulmonary Resuscitation (CPR) (Resident 32) or ensure the POLST was readily available (Residents 16 & 60) placed residents at risk for receiving unwanted CPR, avoidable trauma, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's [DATE] CPR policy, when a resident admitted to the facility, staff would verify if the resident had any Advanced Directives (legal documents that provide instructions for medical care when a resident cannot communicate their own wishes) and if not, verify if the resident did not wish to receive CPR. The policy showed if the resident did not want CPR, a physician's order would be obtained (this information would be documented on a POLST form). According to the facility's [DATE] Advanced Directives and Advanced Care Planning policy, all residents would receive lifesaving treatment unless they had Do Not Resuscitate (DNR) documentation in place, in which case the DNR directive would be honored. The policy showed a physician's order would be obtained reflecting the DNR status. The policy showed the Director of Nursing (DON) would establish a system to inform all direct care staff of residents' DNR status. <Resident 32> According to the [DATE] Significant Change Minimum Data Set (MDS - an assessment tool) Resident 32 had diagnoses including cancer, multiple heart conditions, high blood pressure, stage-3 kidney disease, diabetes mellitus (a condition making blood sugar regulation more difficult), high cholesterol, and Chronic Obstructive Pulmonary Disease (lung disease). The MDS showed Resident 32 experienced shortness of breath when lying down. (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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on [DATE] at 1:49 PM showed a staff member announced a Code Blue (medical emergency) for room [ROOM NUMBER] (Resident 32's room). At that time at the 100-200 Unit nurse station Staff I (Infection Preventionist) was observed calling out from the nurse station toward room [ROOM NUMBER] to attempt resuscitation. At 01:50 PM a voice carried from room [ROOM NUMBER] stating it is bed 3. At that point Staff I yelled Gosh you guys, no CPR for bed 3 - selective treatment for BED 3! You have got to say which bed! At 1:58 PM the paramedics arrived at the facility and took over treatment. In an interview on [DATE] at 1:48 PM Staff I stated they heard the housekeeper make the Code Blue alert for Resident 32. Staff I stated they heard the housekeeper say it was for room [ROOM NUMBER], bed 1. Staff I stated they looked at the POLST book (a binder held at the nurse station which was to include the POLST forms of every resident for the 100 and 200 units) and called out 207, bed 1 - full code, selective treatment. Staff I stated shortly thereafter they overhead Code Blue 207-3 at which point Staff I provided the correct information for Resident 32. Staff I stated by that point CPR was already initiated which meant it was necessary to continue until the paramedics took over treatment. In an interview on [DATE] at 8:46 AM with Staff B (Interim Director of Nursing) and Staff C (Regional Director of Clinical Services) Staff B explained Resident 32 was found unresponsive by a facility volunteer who alerted Staff K (Licensed Practical Nurse) who immediately went to Staff I's office for help. Staff B stated Staff I reviewed the POLST and said full code which was not correct for Resident 32. Staff B confirmed three other nurses went to room [ROOM NUMBER] and started CPR and continued until the paramedics arrived. Staff B stated staff should have properly identified the resident and referred to the correct POLST but did not. Staff C stated the facility identified the root cause of the miscommunication was the fact the POLST book was organized by room, rather than by resident name. <Resident 16> According to the [DATE] admission MDS Resident 16 had intact memory. The MDS showed Resident 16 had diagnoses including anemia and a right femur (thigh bone) fracture. Review of the POLST book on [DATE] at 10:03 AM showed no POLST available for Resident 16. There was also no POLST in Resident 16's chart. In an interview at that time Staff C confirmed there was no POLST in the book and stated it may be in Resident 16's chart or with the medical records department. In an interview on [DATE] at 10:05 AM Staff L confirmed they did not have a POLST for Resident 16's POLST. In an interview on [DATE] at 11:22 AM Staff B stated they were unable to find Resident 16's POLST and it was necessary for Resident 16 to complete a new POLST form. Staff B confirmed the POLST book was the first place nurses would look for a POLST. <Resident 60> Review of the POLST book on [DATE] at 11:18 AM showed there was no POLST for Resident 60 in the POLST book. In an interview at that time Staff B took note that the POLST was not in the POLST book. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	REFERENCE: WAC 388-97-1060 (1). .