Washington State Department of Social & Health Services
ADSA Aging & Disability Services Administration

AGING AND DISABILITY SERVICES ADMINISTRATION

Nursing Home Survey Report

STATE AND CORRESPONDING FEDERAL REQUIREMENTS

2. DATES OF DATA COLLECTION
1/13/16

3. NAME OF FACILITY
Life Care Center of Port Orchard

4. TYPE OF SURVEY
☐ Full ☒ Post ☐ Complaint ☐ Other: specify _____

5. TIME OF SURVEY ☒ Day ☐ Night ☐ Weekend ☐ Holiday

6. STREET ADDRESS	CITY	STATE	ZIP CODE	7. LICENSE NUMBER
2031 Pottery Avenue	**Port Orchard**	**Wa**	**98366**	**1418**

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8.

☐ The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: _____.

**Licensee must complete column 14.

☒ The following deficiencies were determined to be corrected.

9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
-0960(1)	15(g)(1)	250		☐	
-1920, -1940 & -1960	20(m)	285		☐	
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15. SURVEYOR'S SIGNATURE(S)

SIGNATURE	DATE	SIGNATURE	DATE
Karen Dickickson	1/13/16	Loretta Maestos	1-14-16
SIGNATURE	DATE	SIGNATURE	DATE

16. LICENSEE OR AGENT

SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505210		C 12/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF PORT ORCHARD	2031 POTTERY AVENUE PORT ORCHARD, WA 98366

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at LCC Port Orchard 11/23/15 and 12/8/15. The sample included 3 residents out of a census of 108. The sample included 3 current residents. The following are complaints investigated as part of this survey: #3146807 #3144371 The survey was conducted by: Marilyn Edwards, RN, MN Lori Madison, RN, ADN The surveyor is from: Department of Social and Health Services Aging and Long-Term Support Administration Division of Residential Care Services District 3, Unit B PO Box 45819, MS: N27-24 Olympia, WA 98504-5819 Telephone: (253) 983-3800 Fax: (253) 589-7240 Loretta Morsted 12.18.15 Residential Care Services Date	F 000	RECEIVED JAN 04 2016 DSHS Region 3	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/29/15

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.

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F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement discharge planning to assist a resident with arranging for an appropriate community setting, for 1 of 1 resident (Resident #1) with discharge needs. This failure resulted in the resident being discharged from the facility against medical advice (AMA) without housing accommodations, to ensure the resident was safe with access to care and services in place when discharged. Findings include: Resident #1's medical record revealed the resident was admitted to the facility on [redacted]15 from a hospital. The resident's discharge diagnoses included [redacted] Resident #1 required supervision with ambulation in the facility.	F 250	**This plan of correction is submitted as required under Federal and state regulations and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.** **Please accept this Plan of Correction as our credible allegation of compliance. Our compliance will be achieved by the date identified on the plan of correction.**	

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F 250	Continued From page 2 In interview on 11/23/15 at 3:40 p.m., Staff C stated Resident #1 was "very dissatisfied here and did not want to be here." In interview on 11/23/15 at 5:05 p.m. Staff A and Staff B explained when Resident #1 signed the AMA paperwork. he didn't indicate he was going to the hospital, "...he just wanted to leave. The facility discharge plan wasn't for him to go to the streets - we were working very hard to find him appropriate placement." Review of Resident #1's medical record did not reveal a discharge plan had been initiated. In interview on 12/15/15 at 10:00 a.m. Staff A stated that due to changes in Social Service staff, discharge planning was not done for Resident #1. According to Staff A, Resident #1 had been saying he wanted to leave the facility since July 2015, and the facility staff were aware. Lack of discharge planning for a resident known to be dissatisfied at the facility, placed the resident at risk to leave AMA without discharge plans in place. Without appropriate living conditions identified, the resident was at risk of living on the streets.	F 250	**F 250** 1. Resident #1 no longer resides in the facility 2. Residents reviewed for discharge planning. Per assessment, no current residents at risk. 3. Director of Social Services and Social Services Assistant educated on discharge planning and documentation. 4. DSS, SSA and/or designee to turn in each week x2 months an audit of discharge planning notes indicating residents progress. Results of the audit will be reviewed in QAPI monthly for 2 months.	
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.	F 285	5. The Executive Director will ensure ongoing compliance. 6. Date of compliance is December 31, 2015.	

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F 285	Continued From page 3 A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by:	F 285	**F 285** 1. Resident #2 no longer resides in the facility 2. Residents admitting to the facility have the potential to be impacted. No current residents impacted. 3. Admissions Coordinator, Director of Social Services and Executive Director have been in-services on the policy regarding PASRR requirements. PASRRs will be reviewed by DSS or designee on the next business day. 4. DSS, SSA and/or designee to turn in on each week x2 months an audit of new admission charts verified for accuracy of new admission PASRRs. Results of the audit will be reviewed in QAPI monthly for 2 months. 5. The Executive Director will ensure ongoing compliance. 6. Date of compliance is December 31, 2015.	

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F 285	Continued From page 4 Base on interview and record review, the facility failed to ensure preadmission screening and resident review (PASRR) was provided at the time of admission to the facility, for 1 of 1 (Resident #2) sampled for admission with a [redacted] This failure place the resident at risk of not receiving the specialized care and services needed in the most appropriated setting. Findings include: Resident #2 admitted to the facility on [redacted]15 at 5:15 A.M. from the hospital Emergency Department, with diagnoses including [redacted] The resident required supervision for activities of daily care (ADL). On admission the resident arrived to the facility without a Level I PASRR completed. Per 483.20(m)(1) a nursing facility must not admit any new resident with [redacted] without a PASRR. Review of Resident #2's medical record revealed Level I PASRR was not completed until [redacted]15 by Staff C, following two communications with a [redacted] Case Manager . In interview on 11/23/15 at 3:40 p.m., Staff C explained that the PASRR was not completed because the resident admitted to the facility on the weekend and that was not the usual process. In interview on 11/23/15 at 4:40 p.m., with Staff D said the weekend managers of the day rotated	F 285		

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F 285	Continued From page 5 and they were all aware of what was required for admission and were provided with a packet outlining the admission checklist.	F 285		

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Nursing Home Survey Report

STATE AND CORRESPONDING FEDERAL REQUIREMENTS

2. DATES OF DATA COLLECTION
11/23/15, 12/8/15,12/15/15

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Life Care Center of Port Orchard

4. TYPE OF SURVEY
☐ Full ☐ Post ☒ Complaint ☐ Other: specify ____

5. TIME OF SURVEY ☒ Day ☐ Night ☐ Weekend ☐ Holiday

6. STREET ADDRESS
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CITY **Port Orchard** STATE **Wa** ZIP CODE **98366**

7. LICENSE NUMBER
1418

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15. SURVEYOR'S SIGNATURE(S)

SIGNATURE	DATE	SIGNATURE	DATE
Loretta Maestas	12.18.15	Edwards	12/18/15
SIGNATURE	DATE	SIGNATURE	DATE

16. LICENSEE OR AGENT

SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE
	Administrator	12/29/15

DSHS 10-207 (REV. 04/2009)