



**Nursing Home Survey Report**  
STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page <u>1</u> of <u>1</u> Pages
2. DATES OF DATA COLLECTION 7/1/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1418

3. NAME OF FACILITY Life Care Center of Port Orchard	4. TYPE OF SURVEY <input type="checkbox"/> Full <input checked="" type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify _____
6. STREET ADDRESS 2031 Pottery Ave	CITY STATE ZIP CODE Port Orchard WA 98366

**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.	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
<input type="checkbox"/> 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.  <input checked="" type="checkbox"/> The following deficiencies were determined to be corrected.	-1660 (3) ( c )	483.75 (g)(1)&(2)	499		<input type="checkbox"/>	6/24/16
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					<input type="checkbox"/>	

15. Surveyor's Signature(s)			
SIGNATURE	DATE	SIGNATURE	DATE
		<i>Cheryl Diederichsen RN BSN</i>	7/1/16
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: 06/14/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/31/2016																		
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF PORT ORCHARD			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Life Care Center in Port Orchard on 5/31/16. The sample included 9 closed records and 6 current residents out of a census of 101.</p> <p>The following are complaints investigated as part of this survey:</p> <table border="0"> <tr> <td>#3228220</td> <td>#3151342</td> <td>#3159296</td> </tr> <tr> <td>#3214498</td> <td>#3191724</td> <td>#3205191</td> </tr> <tr> <td>#3212479</td> <td>#3156291</td> <td>#3173147</td> </tr> <tr> <td>#3221299</td> <td>#3193911</td> <td>#3223438</td> </tr> <tr> <td>#3185032</td> <td>#3159828</td> <td></td> </tr> <tr> <td>#3185134</td> <td>#3206084</td> <td></td> </tr> </table> <p>The survey was conducted by:</p> <p>Karen Didrickson, RN, BSN Tammey Thompson, RN, BSN Kim Britcher, RN, BSN</p> <p>The surveyor is from:</p> <p>Department of Social and Health Services Aging and Long-Term Support Administration Division of Residential Care Services District 3, Unit B PO Box 98907 Lakewood, WA 98496</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>Loretta Maestas</i> Residential Care Services</p> <p>Date: 6.14.16</p>	#3228220	#3151342	#3159296	#3214498	#3191724	#3205191	#3212479	#3156291	#3173147	#3221299	#3193911	#3223438	#3185032	#3159828		#3185134	#3206084		F 000	<p>RECEIVED</p> <p>JUN 23 2016</p> <p>DSHS RCS Region 3</p>		
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#3185134	#3206084																						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Janece D. Bottemelle*  
TITLE: ED  
(X8) DATE: 6-20-16

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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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF PORT ORCHARD			STREET ADDRESS, CITY, STATE, ZIP CODE 2031 POTTERY AVENUE PORT ORCHARD, WA 98366		
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F 000	Continued From page 1	F 000	<u>Individual Residents</u> No individual resident were identified		
F 499 SS=D	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS  The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.  Professional staff must be licensed, certified, or registered in accordance with applicable State laws.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 3 sampled Nursing Assistant Certified (NAC), (Staff A), had an active Nursing assistant certification license while providing care to facility residents. This failure placed residents at risk of receiving care from potentially unqualified staff.  Findings include:  Review of NAC licenses and a staff roster Staff A, on 5/31/16, revealed the staff member was hired on 10/24/14 to work as a NAC, had an active Washington State NAC certification that was expired on 4/21/16.  Review of the staff time sheets, dated 4/21/16 to 5/26/16, revealed Staff A had worked for 6 days: 4/22/16, 4/24/16, 4/25/16, 4/26/16, 4/28/16 and 5/7/16 without the proper certification.  During an interview on 5/31/16, at 12:45 p.m., Staff B stated Staff A, did not have a current NAC	F 499	<u>Resident in Similar Situations</u> Staff member A has not been allowed to work until certification is active  An audit has been completed to assure all other NAC'S have active certification.  Education has been provided to NAC hiring managers regarding assuring active certification  Before providing patient care.  <u>Measures to Prevent Reoccurrence</u> SDC has initiated a new filing system which will be audited prior to the beginning of each month to assure NAC certification are active.  <u>Ongoing Monitoring</u> SDC will audit certification file to assure all NAC'S have active certification prior to each QAPI meeting X 3 months.  Neg trends will be reported to committee and the QAPI committee will set an action plan if necessary.  <u>Individual to Ensure Compliance</u> SDC and DON		

6-24-16

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F 499	Continued From page 2 certification and worked 6 days after the certification expired. Staff B added, the NAC was not coming back to work until the certification was up to date. Staff B stated the facility missed the NAC's expiration period, and was not in compliance.	F 499			



AGING AND LONG-TERM SUPPORT ADMINISTRATION  
**Nursing Home Survey Report**  
 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page 1 of 1 Pages  
 2. DATES OF DATA COLLECTION  
 5/26/16, 5/31/16 & 6/1/16  
 5. TIME OF SURVEY  Day  Night  
 Weekend  Holiday  
 7. LICENSE NUMBER  
 1418

3. NAME OF FACILITY  
 Life Care Center of Port Orchard  
 4. TYPE OF SURVEY  
 Full  Post  Complaint  Other: specify \_\_\_\_\_  
 6. STREET ADDRESS  
 2031 Pottery Ave  
 CITY: Port Orchard STATE: WA ZIP CODE: 98366

**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.**

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**15. Surveyor's Signature(s)**

SIGNATURE <i>Charen Dickrickson RN, BSU</i>	DATE 6/13/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

**16. Licensee or Agent**

SIGNATURE OF LICENSEE (OR AGENT) <i>Jamie Bottemiller</i>	TITLE <i>Executive Director</i>	DATE
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