

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

PRINTED: 01/26/2016  
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 01/20/2016
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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	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Life Care Center of Port Orchard on 12/30/15; 1/6/16, 1/7/16, 1/12/16, 1/19/16 and 1/20/16. The sample included two current residents and two discharged resident out of a census of 107.</p> <p>The following are complaints investigated as part of this survey: #3172192 #3173364 #3115365 #3118445 #3120969</p> <p>The survey was conducted by:  Karen Didrckson, RN, BSN</p> <p>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 98907 Lakewood, WA 98496</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>Loretta Mustafa</i> Residential Care Services Date: 1-26-16</p>	F 000	<p>RECEIVED FEB 10 2016 DSHS RCS Region 3</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 02/04/16
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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 157 SS=D	<p><b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b></p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Findings include:</p> <p>Based on interview and record review, the facility</p>	F 157	<p><b>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.</b></p> <p><b>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.</b></p>		

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F 157	<p>Continued From page 2</p> <p>failed to alert the physician when a resident was identified with a decreased level of consciousness, manifested by sleeping more and subsequently becoming unarousable, not eating or drinking, needing more assistance with bed mobility, for one of four residents (R#1) sampled for notification of change in resident conditions. This failure of the facility to notify the physician of a change in condition placed the resident at risk of not receiving medical intervention in a time consistent with the resident's changed needs. Refer to citation written for F 309.</p> <p>Review of the resident's Minimum Data Set (MDS), a nursing assessment tool, dated 12/1/15, revealed, Resident #1 was admitted to the facility from the hospital on [REDACTED] 15, and the resident's diagnoses included [REDACTED] (a [REDACTED] that occurs together with [REDACTED] from a build up of [REDACTED] toxin in the blood stream causing abnormal behavior and confusion, a condition requiring frequent monitoring of [REDACTED] levels by checking blood levels), [REDACTED] and [REDACTED].</p> <p>The resident's life expectancy was more than 6 months, and there was an active discharge plan for Resident #1 to return to the community.</p> <p>During a record review of the nursing progress notes, Resident #1 was alert and oriented to self and family on 11/24/15 to 11/27/15. In a nursing progress note, dated 11/28/15, the resident was lethargic and sleeping all evening shift and did not eat or drink anything. Resident #1 accepted eye drops, but quickly went back to sleep. The 11/28/15 note revealed the resident was usually independent with moving about in bed, but needed a one person assist, on that day. The</p>	F 157	<p><b>F-157: Notify of changes (injury/decline/room, etc)</b></p> <p><b>Individual Residents</b> Resident #1 no longer residents in the facility.</p> <p><b>Residents in similar situations</b> Residents were assessed to identify any potential change in baseline condition and physician notification was completed at that time. Any Resident identified with potential change was placed on alert status for ongoing nursing assessment.</p> <p><b>Measures to prevent reoccurrence</b> The DON or designee provided education to licensed nurses on expectations of physician notification with any change in baseline condition as well as Interact 4 program including, Stop and watch forms, SBAR and care pathways.</p>		

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F 157	<p>Continued From page 3</p> <p>physician was not notified of a change in condition.</p> <p>Further review of the nursing progress notes revealed on 11/29/15, Resident #1 was unable to keep eyes open and was "minimally able to follow instructions." The resident was assisted to drink a supplement drink with "multiple cues to drink and swallow." The resident refused to allow staff to remove soiled clothing. The physician was not notified of these changes in condition.</p> <p>On 11/30/15, the physician was notified, as Resident #1's somnolence was attributed to a pain medication error. At that time, the physician wrote an order for a [REDACTED] level to be taken. The order was not executed, as the physician thought he heard the nurse state the labs were already drawn.</p> <p>On [REDACTED] 15, in a nursing progress note written at 2:23 p.m., Resident #1 had a "definite decrease in level of consciousness," and did not respond to touch or verbal, but responded to pain stimuli. Resident #1 was writhing and contorting her face and body, and had episodes of somnolence and agitation. The resident had [REDACTED] [REDACTED] above normal range) and [REDACTED] (increased [REDACTED]. The physician was then called and the resident was sent out to the emergency room, and was diagnosed with hepatic encephalopathy.</p> <p>It was confirmed in the emergency room Resident #1 had a critical high [REDACTED] level of 63.0 umol/L (micromole/liter) (normal being 9.0 to 30.0 umol/L). On [REDACTED] 15 at 10:49, the hospital called the Director of Nursing Services (DNS) and alerted the facility of the</p>	F 157	<p><b><u>On-going Monitoring</u></b></p> <p>The DON or designee will review 24 hour reports, SBARS, stop and watches forms daily, during ground rounds for immediate interventions and assessment of residents with potential change in baseline condition. DON or designee will complete change of condition audits for Residents with condition changes weekly times 1 month and then monthly x 2 months. Trends will be presented to the monthly QAPI committee x3 months for identification of needed education and training opportunities.</p> <p><b><u>Individual to Ensure Compliance</u></b> Executive Director</p> <p><b><u>Date of Compliance</u></b> February 18, 2016</p>

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F 157	Continued From page 4 critical high [REDACTED] value. This was discovered 4 days after family and staff noted a change in Resident #1's level of consciousness.  During an interview at 2:14 p.m., Staff C stated, if there was a change in the level of consciousness in a resident, he/she would assess the patient, notify the physician and supervisor and place the resident on alert charting.  At 2:20 p.m., Staff D stated, if there was a change in the level of consciousness in a resident, he/she would immediately report to a nurse and turn the report into a supervisor.  The facility failed to assess, monitor and alert the physician of a change in Resident #1's level of consciousness, which lead to a critical elevation of [REDACTED] levels. The resident died in the hospital on [REDACTED] 15.	F 157			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Findings include:  Based on interview and record review, the facility failed to ensure care provided by the facility met nursing professional standards of quality, when nursing staff did not notify the physician for a significant change in condition, and when nursing	F 281	<b>F-281: Services provided meet professional standards</b>  <b><u>Individual Residents</u></b> Resident #1 no longer residents in the facility.		

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F 281	<p>Continued From page 5</p> <p>staff did not monitor a resident with an acute condition that required intensive monitoring, for 1 of 1 discharged resident (R#1). Failure to provide nursing care within professional standards of quality care, resulted in a delay of medical intervention for the resident, in a time consistent with the resident's needs, and the resident subsequently died in the hospital. Refer to citation written for F 309.</p> <p>According to the American Nurses Association, Scope and Standards of Practice, 2011, according to standards of care, a licensed nurse shall, in a complete, accurate and timely manner, report and document nursing assessments or observations, the care provided by the nurse for the client and the clients response to that care. Nurses assume a liability risk if they fail to monitor a patient or to recognize changes in a patient's condition.</p> <p>Review of the updated face sheet, physician notes, and diagnosis history sheet, revealed Resident #1 was admitted to the facility on [REDACTED] 15 with diagnoses to include [REDACTED] (temporary or permanent damage to [REDACTED] due to a lack of [REDACTED] dysfunction), [REDACTED] (a [REDACTED] that occurs together with [REDACTED] from a build up of [REDACTED] toxin in the blood stream causing abnormal behavior and confusion, a condition requiring frequent monitoring of [REDACTED] levels by checking blood levels), [REDACTED] and [REDACTED] [REDACTED] and weakness.</p> <p>Review of the resident's Minimum Data Set</p>	F 281	<p><b><u>Residents in similar situations</u></b> Residents were assessed to identify any potential change in baseline condition and physician notification was completed at that time. Any Resident identified with potential change was placed on alert status for ongoing nursing assessment.</p> <p><b><u>Measures to prevent reoccurrence</u></b> The DON or designee will provide education to licensed nurses on expectations of physician notification with any change in baseline condition as well as the Interact 4 program including stop and watch forms, SBAR and care pathways.</p>

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F 281	<p>Continued From page 6</p> <p>(MDS), a nursing assessment tool, dated 12/1/15, revealed, the resident had short term memory problems and was moderately impaired with decision making, inattention, disorganized thinking, psychomotor retardation, and an altered level of consciousness, which was an acute change in mental status from the resident's baseline. Life expectancy was more than 6 months, and there was an active discharge plan for Resident #1 to return to the community.</p> <p>Complications of elevated [REDACTED] level can lead to agitation, confusion, decreased level of consciousness, hyperactive deep tendon reflexes, seizures, and coma per Sign's and Symptoms by Lippincott, Williams and Wilkens, dated 2005.</p> <p>During a record review of the nursing progress notes, Resident #1 was alert and oriented to self and family on 11/24/15 to 11/27/15. In a nursing progress note, dated 11/28/15, the resident was lethargic and sleeping all evening shifts and did not eat or drink anything. The 11/28/15 note revealed the resident was usually independent with moving about in bed, but needed a one person assist, on that day. Nurses did not notify the physician of a change in condition.</p> <p>Further review of the nursing progress notes revealed on 11/29/15, Resident #1 was unable to keep eyes open and was "minimally able to follow instructions." Nurses did not notify the physician of a change in condition.</p> <p>Nursing progress notes dated 11/30/15 revealed the resident was in a wheelchair " ...lethargic and unarousable" and medications were held as the resident did not have a swallow reflex. Two</p>	F 281	<p><b><u>On-going Monitoring</u></b> The DON or designee will review 24 hour reports, SBARS, stop and watches forms daily, during ground rounds for immediate interventions and assessment of residents with potential change in baseline condition. DON or designee will complete change of condition audits for Residents with condition changes weekly times 1 month and then monthly x 2 months Trends will be presented to the monthly QAPI committee x3 months for identification of needed education and training opportunities.</p> <p><b><u>Individual to Ensure Compliance</u></b> Executive Director</p> <p><b><u>Date of Compliance</u></b>  February 18, 2016</p>		

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F 281	<p>Continued From page 7</p> <p>██████████ patches were discovered on the residents' body. At this time, the physician ordered staff to remove both patches, and in an undated incident report, Staff A conducted an investigation. The physician concluded Resident #1's pain management "...should be decreased related to the drowsiness."</p> <p>On 11/30/15, a physician's order was written to check Resident #1's ██████████ level, but was crossed out as the physician heard a nurse state that labs were already taken. It was not confirmed between the nurse and the physician what labs were actually taken, per an undated incident report from the facility. An ██████████ level was not taken by the facility during Resident #1's stay, between ██████████ 15 and ██████████ 15.</p> <p>On 12/1/2015, in a nursing progress note written at 2:23 p.m., Resident #1 had a "definite decrease in level of consciousness," and did not respond to touch or verbal, but responded to pain stimuli. Resident #1 was writhing and contorting her face and body, and had episodes of somnolence and agitation. The resident had ██████████ (increased ██████████ above normal range) and ██████████ (increased ██████████). The physician was then called and the resident was sent out to the emergency room, and was diagnosed with ██████████.</p> <p>It was confirmed in the emergency room Resident #1 had a critical high ██████████ venous blood level of 63.0 umol/L (micromole/liter) (normal being 9.0 to 30.0 umol/L). On ██████████ 15 at 10:49, the hospital called the Director of Nursing Services (DNS) and alerted the facility of the critical high ██████████ value. This was discovered 4 days after family and staff noted a</p>	F 281		

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F 281	<p>Continued From page 8 change in Resident #1's level of consciousness.</p> <p>During an interview on 12/30/15 at 4:51 p.m., Collateral Contact (CC) #1 stated, comments were made to the facility regarding Resident #1's decreasing level of consciousness on 11/27/15 on evening shift, 11/28/15 on eve shift, and an [REDACTED] level (due to Resident 1's decreased LOC) was demanded by CC#1 on 11/29/15.</p> <p>During an interview on 1/6/16 at 2 p.m., Staff B stated, the [REDACTED] patch was discovered on 11/30/15, with the written date of [REDACTED] 15, which was the day before Resident #1 was admitted to the facility.</p> <p>During an interview at 2:14 p.m., Staff C stated, if there was a change in the level of consciousness in a resident, he/she would assess the patient, notify the physician and supervisor and place the resident on alert charting.</p> <p>At 2:20 p.m., Staff D stated, if there was a change in the level of consciousness in a resident, he/she would immediately report to a nurse and turn the report into a supervisor.</p> <p>During an interview on 1/12/16, Staff F did not recall the [REDACTED] patch medication error, and stated the nurse told him/her the labs were already drawn. Staff F explained, the elevated [REDACTED] levels were typically not an accurate reflection of symptoms of [REDACTED] toxicity, and he/she ordered an increase in [REDACTED] on 11/30/15. [REDACTED] is used specifically to lower [REDACTED] blood levels though bowel movements.)</p> <p>On 1/20/15 at 8:30 a.m., Staff A reported the facility did not have a specific pathway for nursing</p>	F 281		

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F 281	<p>Continued From page 9</p> <p>staff to review for residents with a history of [REDACTED] "We use books or consult the physician." Staff A also added in February, there will be an in-service by the physician to educate staff regarding [REDACTED]</p> <p>The facility did not provide a care plan (pathway) related to [REDACTED] for Resident #1 and did not identify signs and symptoms staff should consistently continue to assess, monitor and document. The facility failed to assess, monitor and alert the physician of a change in Resident #1's level of consciousness, which lead to a critical elevation of [REDACTED] levels. The resident died in the hospital on [REDACTED] 15.</p>	F 281		
F 309 SS=G	<p><b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Findings include:</p> <p>Based on interview and record review, the facility failed to monitor a resident with a significant change in condition, in a time consistent with the resident's changed needs, for one of four</p>	F 309	<p><b>F-309: Provide Care/Services for Highest Well Being</b></p> <p><u>Individual Residents</u> Resident #1 no longer residents in the facility.</p> <p><u>Residents in similar situations</u> Residents were assessed to identify any potential change in baseline condition and physician notification was completed at that time. Any Resident identified with potential change was placed on alert status for ongoing assessment.</p>	

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F 309	<p>Continued From page 10</p> <p>residents (R#1) sampled for monitoring of health conditions. This failure resulted in the resident's continuing decline and subsequent death related to a delay in providing medical interventions.</p> <p>According to the updated face sheet, physician notes, and diagnosis history sheet, Resident #1 was admitted to the facility on [REDACTED] 15 with diagnoses to include [REDACTED], (temporary or permanent damage to the [REDACTED] due to a lack of [REDACTED], [REDACTED] (a [REDACTED] that occurs together with [REDACTED] from a build up of [REDACTED] toxin in the blood stream causing abnormal behavior and confusion, a condition requiring frequent monitoring of [REDACTED] levels by checking blood levels), [REDACTED] and [REDACTED] and weakness.</p> <p>Review of the resident's Minimum Data Set (MDS), a nursing assessment tool, dated 12/1/15, revealed, the resident had short term memory problems and was moderately impaired with decision making, inattention, disorganized thinking, psychomotor retardation and an altered level of consciousness, which was an acute change in mental status from the resident's baseline. Life expectancy was more than 6 months, and there was an active discharge plan for Resident #1 to return to the community.</p> <p>During a record review of Resident #1's care plan, it did not identify specific interventions for staff to follow, or what signs and symptoms to monitor related to Resident#1's [REDACTED] a condition when the [REDACTED] could no longer</p>	F 309	<p><b><u>Measures to prevent reoccurrence</u></b></p> <p>The DON or designee provided education to licensed nurses on expectations of physician notification with any change in baseline condition, as well as the Interact 4 program, including stop and watch forms, SBAR and care pathways.</p> <p><b><u>On-going Monitoring</u></b></p> <p>The DON or designee will review 24 hour reports, SBARS, stop and watches forms daily, during ground rounds for immediate interventions and assessment of residents with potential change in baseline condition. DON or designee will complete change of condition audits for Residents with condition changes weekly times 1 month and then monthly x 2 months Trends will be presented to the monthly QAPI committee x 3 months for identification of needed education and training opportunities.</p> <p><b><u>Individual to Ensure Compliance</u></b> Executive Director</p> <p><b><u>Date of Compliance</u></b> February 18, 2016</p>

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

PRINTED: 01/29/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505210</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF PORT ORCHARD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2031 POTTERY AVENUE PORT ORCHARD, WA 98366</b>
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F 309	<p>Continued From page 11 breakdown toxins to the body when the [REDACTED] was diseased.</p> <p>During a record review of the nursing progress notes, Resident #1 was alert and oriented to self and family on 11/24/15 to 11/27/15. In a nursing progress note, dated 11/28/15, the resident was lethargic and sleeping all evening shifts and did not eat or drink anything. Resident #1 accepted eye drops, but quickly went back to sleep. The 11/28/15 note revealed the resident was usually independent with moving about in bed, but needed a one person assist, on that day. The physician was not notified of a change in condition.</p> <p>Further review of the nursing progress notes revealed on 11/29/15, Resident #1 was unable to keep eyes open and was "minimally able to follow instructions." The resident was assisted to drink a supplement drink with "multiple cues to drink and swallow" and drank 60 cc's (cubic centimeters-a measurement for fluid amount). The resident refused to allow staff to remove soiled clothing. The physician was not notified of these changes in condition.</p> <p>Nursing progress notes dated 11/30/15 revealed the resident was in a wheelchair " ...lethargic and unarousable" and medications were held as the resident did not have a swallow reflex. Two [REDACTED] patches were discovered on the residents' body. At this time, the physician ordered staff to remove both patches, and in an undated incident report, Staff A conducted an investigation. The physician concluded Resident #1's pain management " ...should be decreased related to the drowsiness."</p>	F 309		
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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF PORT ORCHARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2031 POTTERY AVENUE PORT ORCHARD, WA 98366</b>		
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F 309	<p>Continued From page 12</p> <p>On 11/30/15, a physician's order was written to take [REDACTED] level, but was crossed out as he/she heard a nurse state that labs were already taken. It was not confirmed between the nurse and the physician what labs were actually taken, per an undated incident report from the facility. An ammonia level was not taken by the facility during Resident #1's stay.</p> <p>On 12/1/2015, in a nursing progress note written at 2:23 p.m., Resident #1 had a "definite decrease in level of consciousness," and did not respond to touch or verbal, but responded to pain stimuli. Resident #1 was writhing and contorting her face and body, and had episodes of somnolence and agitation. The resident had [REDACTED] (above normal range) and [REDACTED] (increased [REDACTED]). The physician was then called and the resident was sent out to the emergency room, and was diagnosed with [REDACTED].</p> <p>It was confirmed in the emergency room Resident #1 had a critical high ammonia venous blood level of 63.0 umol/L (micromole/liter) (normal being 9.0 to 30.0 umol/L). On [REDACTED] 15 at 10:49, the hospital called the Director of Nursing Services (DNS) and alerted the facility of the critical high [REDACTED] value. This was discovered 4 days after family and staff noted a change in Resident #1's level of consciousness.</p> <p>During an interview on 12/30/15 at 4:51 p.m., Collateral Contact (CC) #1 stated, comments were made to the facility regarding Resident #1's decreasing level of consciousness on 11/27/15 on evening shift, 11/28/15 on eve shift, and an [REDACTED] level (due to Resident 1's decreased LOC) was demanded by CC#1 on 11/29/15.</p>	F 309			

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F 309	<p>Continued From page 13</p> <p>During an interview on 1/6/16 at 2 p.m., Staff B thought leaving a [REDACTED] patch on the resident longer than 72 hours caused the resident's decrease in level of consciousness. Staff B said the [REDACTED] patch was dated [REDACTED] 15, and was discovered on 11/30/15, the day before Resident #1 was admitted to the facility.</p> <p>During an interview at 2:14 p.m., Staff C stated, if there was a change in the level of consciousness in a resident, he/she would assess the patient, notify the physician and supervisor and place the resident on alert charting. At 2:20 p.m., Staff D stated, if there was a change in the level of consciousness in a resident, he/she would immediately report to a nurse and turn the report into a supervisor.</p> <p>During an interview on 1/12/16 at 11:53 a.m., Staff F did not recall the [REDACTED] patch medication error, and stated the nurse told him/her the labs were already drawn. Staff F explained, the elevated [REDACTED] levels were typically not an accurate reflection of symptoms of [REDACTED] toxicity, and he/she ordered an increase in [REDACTED] on 11/30/15. [REDACTED] is used specifically to lower [REDACTED] blood levels though bowel movements.)</p> <p>On 1/20/15 at 8:30 a.m., Staff A reported the facility did not have a specific pathway for nursing staff to review for residents with a history of [REDACTED]. The facility did not have a care plan specific for providing care and service to residents with [REDACTED]. "We use books or consult the physician."</p> <p>The facility did not provide a care plan related to</p>	F 309		

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F 309	Continued From page 14 [REDACTED] for Resident #1 and did not identify signs and symptoms staff should consistently continue to assess, monitor and document. The facility failed to assess, monitor and alert the physician of a change in Resident #1's level of consciousness, which lead to a critical elevation of [REDACTED] levels. The resident died in the hospital on [REDACTED] 15.	F 309			



AGING AND DISABILITY SERVICES ADMINISTRATION  
**Nursing Home Survey Report**  
 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page 1 of 1 Pages

2. DATES OF DATA COLLECTION  
 12/30/15, 1/6/16, 1/7/16, 1/13/16, &  
 1/19/16, 1/20/16

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 Avenue

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.**

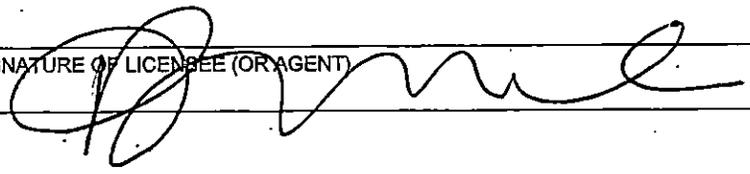
8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
<input checked="" type="checkbox"/> The requirements of the following WAC's 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: <u>1/20/16</u>  **Licensee must complete column 14.  <input type="checkbox"/> The following deficiencies were determined to be corrected.	-1060 (1)	483.25	309		<input type="checkbox"/>	
	-620(2)(b)(i)(ii), (6)(b)(i)	483.20 (k)(3)(i)	281		<input type="checkbox"/>	
	-320 (1)(a)-(d), 2(a)(b), 3	483.10(b)(11)	157		<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	

15. SURVEYOR'S SIGNATURE(S)

SIGNATURE <i>Loetta Maestas</i>	DATE 1-21-16	SIGNATURE <i>Karen Indrickson</i>	DATE 1/20/16
SIGNATURE <i>[Signature]</i>	DATE 02/04/16	SIGNATURE	DATE

16. LICENSEE OR AGENT

SIGNATURE OF LICENSEE (OR AGENT)

A handwritten signature in black ink, appearing to be 'D. M. L.', written over the signature line.

TITLE

Executive Director

DATE

02/04/14