STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505272	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Mount Vernon	2120 East Division Street Mount Vernon, WA 98273

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43954 Based on interviews, and record review, the facility failed to ensure resident rights were being followed for 2 of 3 (Resident 1 and 2) residents when a scheduled appointment was canceled for Resident 1 without their knowledge, and the facility did not answer phone calls and Resident 2's guardian was unable to speak with staff or Resident 2. These failures placed residents at risk for unmet care needs, delays in communication or care, and decreased quality of life. Findings included . <RESIDENT 1> Resident 1 was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD- lung disease that causes breathing problems and restricted air flow), coronary artery disease (a condition affecting the heart that causes damage or disease in the heart's major blood vessels), and left foot pain. Review of Resident 1's admission progress note dated 05/23/2024 at 7:44 PM, showed Staff C, Licensed Practical Nurse (LPN) Admission Nurse, documented Resident 1 was alert and oriented and wished to be asked before any care decisions were made. Documentation showed Resident 1 was angry their follow up appointment scheduled for 5/24/2024 had been canceled without their knowledge or permission. Review of Resident 1's progress note dated 05/24/2024 at 12:28 PM, showed Staff B, Social Services Director (SSD), documented Resident 1 was upset about their appointment being rescheduled for the following week. In an interview on 08/01/2024 at 1:45 PM, Staff B stated Staff G, social services assistant is responsible to make, cancel or reschedule appointments for residents in the facility. Staff B stated they were unsure how the appointment was canceled as they were unable to find documentation. Staff B stated they remember telling the resident their appointment had been cancelled or rescheduled but was unsure where that information came from. In an interview on 08/01/2024 at 3:42 PM, Staff G stated they schedule, reschedule, or cancel appointments for new admissions and residents. Staff G stated they did not cancel or reschedule any appointments for Resident 1. Staff G stated there was no documentation from them in Resident 1's electronic medical record. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/02/2024 at 10:38 AM, Resident 1 stated staff at the facility canceled their appointment without their knowledge and it had not been rescheduled. In an interview on 08/06/2024 at 2:20 PM, Staff C, Admission LPN stated during the admission process, Staff G is responsible for managing appointments. Staff C stated they believe the appointment was canceled by the hospital and reviewed Resident 1's hospital order from admission and was unable to find any documentation related to their cancelled appointment. In an interview, and record review on 08/6/2024 at 2:42 PM, Staff D, LPN unit care coordinator stated they were able to print a record of resident appointments from a different computer program that showed Staff G had cancelled Resident 1's scheduled appointment on 05/23/2024 at 2:38 PM and the appointment had not been rescheduled. In an interview on 08/06/2024 at 4:02 PM, Staff A, interim Director of Nursing (DNS) stated it was their expectation resident appointments were discussed with residents and any documentation should be in the resident's electronic medical record (EMR). <RESIDENT 2> Resident 2 was admitted to the facility on [DATE] with diagnoses to include pneumothorax (air leaks into the space between the lung and chest wall), and cognitive communication deficit (difficulty with communication caused by a cognitive deficit). Review of Resident 2's EMR showed they had a healthcare Power of Attorney (POA) as their responsible party. In an interview on 07/26/2024 at 2:20 PM, CC1, Resident 2's POA stated they were contacted by Resident 2 on 07/13/2024. CC1 stated the resident seemed to be in distress with confusion and had left voicemails for the POA. CC1 stated on 07/26/2024 between 2:32PM to 5:00 PM, they called the facility 32 times with no answer, no directory and no way to leave a voicemail. CC1 was upset that they were unable to reach the facility or Resident 2. In an observation on 07/28/2024 at 10:09 AM, called the facility main number and there was no answer, no directory and no way to leave a voicemail. In an observation on 07/28/2024 at 8:43 PM, called the facility main number and there was no answer, no directory and no way to leave a voicemail. In an interview on 08/06/2024 at 1:55 PM, Staff E, RN care manager stated they provide phones in resident rooms and there is a direct number to the resident rooms, when asked if they provide the direct room number to families, Staff E stated they were unsure. In an interview on 08/06/2024 at 2:07 PM, Staff D, LPN unit care coordinator, stated they instruct resident families to call the main facility number and then they can be transferred to the resident's room. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/06/2024 at 3:40 PM, Staff H, receptionist stated they work Monday through Friday 8:00 AM to 4:30 PM. Staff H stated there is a weekend receptionist that works from 9:00 AM to 4:00 PM, Saturday & Sunday. Staff H stated that when there is not a receptionist, they switch the lines to 'night' mode which has the main phone ring at the nurse's station. Staff H stated they have had complaints related to phone calls not being answered, and the last complaint was within the last 1-2 weeks. Staff H stated that family members get frustrated when they are unable to get through to the facility or their loved ones. In an interview on 08/06/2024 at 4:02 PM, Staff A, interim DNS stated it is their expectation the facility phone calls be answered during day and after hours. Reference WAC: 388-97-0180 (1-4)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43954 Based on interview and record review, the facility failed to ensure that a thorough investigation was completed for 1 of 3 residents (Resident 3) reviewed for investigations. This failure placed residents at risk for new or continued abuse, possible harm, and a decreased quality of life. Findings included . Resident 3 admitted to the facility on [DATE] with diagnoses to include right hip fracture, history of falls, and atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow). Review of Resident 3's admission Minimum Data Set (MDS- assessment tool), dated 05/27/2024, showed the resident was cognitively intact. Review of Resident 3's progress note dated 6/27/2024 at 5:07 PM, showed Staff E, Registered Nurse (RN) Care Manager, documented that Resident 3 reported that a staff member had acted angry during repositioning the night before. Review of the facilities investigation showed there was no statement from Staff F, Nursing Aide Certified (NAC), related to the abuse allegation. In an interview on 8/1/2024 at 1:05 PM, Resident 3 stated they recalled the incident with Staff F. Resident 3 stated Staff F had come in to assist them during the night and had been angry when they were repositioning them. Resident 3 stated they reached their hand out to Staff F to ask them to slow down and was told Don't touch me. Resident 3 stated they did not say anything else as they were shocked and surprised. In an interview on 8/6/2024 at 1:55 PM, Staff E, RN care manager stated they initiate an investigation as soon as an allegation is brought to their attention. Staff E stated Staff F was suspended immediately while the investigation was in progress and that a statement should have been obtained from the suspended staff member. Staff E stated that they did not obtain a statement from Staff F and was unable to find a statement in the completed facility investigation. In an interview on 8/6/2024 at 2:07 PM, Staff D, Licensed Practical Nurse (LPN) unit care coordinator stated that they reported the incident to the state and initiated the investigation. Staff D stated they did not obtain a statement from Staff F related to the allegation. In an interview on 8/6/2024 at 4:02 PM, Staff A, RN, interim DNS stated it was their expectation that any staff involved in an allegation would be interviewed and asked to provide a statement. Staff A stated that the facility cannot rule out abuse or neglect without statements from staff in an allegation. Reference WAC: 388-97-0640 (6)(a)(b)