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	04/09/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interviews, and record reviews, the facility failed to conduct thorough investigations for 3 of 3 allegations of abuse and/or neglect for (Residents 117, 164, and 216), 3 of 4 falls (Residents 46, 115, and 218), and 1 of 1 medication error (Resident 24) whose investigations were reviewed for thorough investigations. The failure to conduct thorough investigations placed residents at risk for repeat incidents, injury, and for unmet care needs due to a lack of thorough investigations after incident occurred. These failures placed residents at risk for repeated incidents and injuries. Findings included . Review of the facility policy titled, Incident and Reportable Event Management, reviewed 09/25/2024 stated the facility would provide an environment free from accident hazards by identifying hazards and risk, evaluating and analyzing, implementing interventions, and monitoring the effectiveness and modification of interventions if necessary . to prevent recurrence the facility should evaluate what happened, who provided care, witnesses to event, why did it happen, and what mitigation efforts were done. Review of the facility policy titled, Abuse - protection of residents, reviewed 06/17/2024, stated the facility will ensure all residents are protected from harm during and after the investigation . the facility should notify all agencies as applicable. <ABUSE/NEGLECT> RESIDENT 216 Resident 216 admitted to the facility on [DATE] with diagnoses that included benign prostatic hyperplasia (BPH - enlargement of the prostate gland that can cause difficulty and frequent urination), history of stroke with right side weakness, and muscle weakness. Resident 216's Admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE] documented the resident had a mild cognition impairment, and required substantial to maximum assistance for toileting, transfers and personal hygiene. They had occasional incontinence (inability to control) of the bladder and bowel. In a review of Resident 216's admission nursing progress note on 03/10/2025 the nurse documented the resident was alert and oriented to person, place, time, and events. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a review of Resident 216's care plan documented a focus area dated 03/10/2025 for urinary incontinence with interventions to assist with toileting as needed, ensure urinal was within reach, perineal care (cleaning of genitals and anus) as needed. In a review of the facility investigation on 04/07/2025 (dated 04/02/2025) for the allegation of neglect that was reported to the facility for Resident 216 who reported they had been left lying in urine at night for over an hour. The investigation showed education was completed with staff on rounding timely, no education was provided in the investigation. The investigation included a question-and-answer sheet from twelve residents, two of which stated they did not feel the care needs had been met, and two residents reported they did not receive care in a timely manner. There was no [NAME] follow up included in the investigation, and the facility investigation stated residents were interviewed with no negative findings. The conclusion of the investigation was documented because they were not able to identify a staff member, therefore no abuse or neglect occurred. There was no documentation to support the facility had ruled out abuse and neglect, as the resident was alert and orientated and there was no interview included that they were interviewed, two other residents voiced concerns that were not addressed, there was no education with staff provided, and the investigation lacked a root cause analysis to rule out abuse and/or neglect. In an interview on 04/02/2025 at 3:17 PM, Resident 216 stated that at least two, to three times since their admission to the facility they have had nights where they have had to lay in their own urine for over an hour while they wait for someone to answer their call light. Resident 216's roommate (Resident 54) stated that they can get out of bed on their own and will go into the hallway to locate a staff member and it will feel like a ghost town, unable to find anyone to help. In an interview on 04/07/2025 at 2:01 PM, Staff D Nursing Assistant Certified (NAC) stated that Resident 216 required assistance with toileting, and that they were able to ask for assistance. In an interview on 04/08/2025 at 9:01 AM, Staff E NAC stated Resident 216 was alert and orientated and able to request help when needed. Staff E stated they had occasional incontinence and would need help to clean up at times. In an interview on 04/08/2025 at 9:51 AM, Staff F Licensed Practical Nurse (LPN) stated 216 residents were able to ask for assistance appropriately, had occasional incontinence, and required assistance for toileting and transfers. <ABUSE> Resident 117 admitted on [DATE] with diagnoses to include left hip fracture Parkinsonism, dementia and anxiety. Review of a progress note written by Staff H, LPN/Unit Care Coordinator (UCC) on 04/02/2025 at 4:14 PM, showed Resident 117 admitted from the hospital and required two-person max assistance with transfers and bed mobility . Bedfast most of the time. (Resident 117) exhibits anxiety and fear when turning/repositioning. Review of the care plan initiated on 04/02/2025 directed staff that Resident 117 required one person assist for bed mobility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/03/2025 at 8:26 AM, Resident 117 reported when staff turn them sometimes, they were a little rough, and they turned them too quick and all of the above. Resident 117 stated there was supposed to be two people to turn them but when there was only one , there was trouble. In an interview on 04/03/2025 at 8:33 AM, Staff B, Director of Nursing (DNS), was notified of Resident 117's report of rough handling. In an interview on 04/04/2025 at 10:42 AM, Staff H, LPN/UCC stated Resident 117 had anxiety with transfers. Staff H stated they had heard in the report from the hospital the resident was anxious and fearful of transfers. The first initial assessment was put on the baseline care plan and then they revise them as they get to know the resident. Staff H said they had not put that information on the care plan at first but could add it as it would be useful information for staff who were caring for the resident. Review of the abuse allegation investigation included two statements from staff. There were no statements from other staff who cared for them to assist with identifying when the allegation occurred. The investigation did not include the finding that the staff knowledge of the residents' fear and anxiety during positioning and transfers was not transferred to the care plan as a means to prevent this allegation. In an interview on 04/09/2025 at 8:30 AM, Staff C, Regional Director of Clinical Services (RDCS) stated the expectation was they get statements from the shift the incident occurred on and they could have obtained more staff statements. <FALLS> <RESIDENT 115> Resident 115 admitted on [DATE] after hospitalization following a motor vehicle accident that resulted in a sternal fracture, fractured ribs, bilateral radius and ulna fractures, right humerus fracture and third toe fracture. In an interview on 04/03/2025 at 9:54 AM, Collateral Contact 4 , brother of Resident 115 stated their family member fell out of bed five days after admission. CC 4 said that their brother had surgery at the beginning of March after they broke both arms and hands in an accident. CC 4 stated the facility sent their family member out to the local hospital after the fall but the hospital did not x-ray the arms after the fall. CC 4 said the hardware was torn up and facility staff did not realize his left hand was torn up. CC 4 stated then (Resident 115) went two weeks before their follow-up orthopedic visit. At the visit, they did x-rays to check the healing process and his left hand , wrist and arm were a mess and screws were backing out. This required surgery and it was long after the fall so they had to deal with scar tissue and healing in the wrong place. CC 4 stated they were dissatisfied with the care and Resident 115 would be transferring to another facility that day. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The fall investigation showed that on 03/14/2025 around 4:50 AM, an NAC called the nurse into the room, to find Resident 115 lying on their abdomen. The fall was unwitnessed, and the resident was unable to state what happened. Range of motion was checked prior to getting resident off the floor, on call Medical Doctor called and ordered to send resident to the emergency room as resident on Lovenox (blood thinner) injections. Resident returned to the facility with no new injuries. The NAC statement showed the resident received last toileting at 1:00 AM and had been checked on at 4:20 AM. Resident 115 was wearing nonskid socks on and the floor was dry. The fall scene investigation and nurse fall statement were not signed, making it unclear if the investigation was complete. RESIDENT 46 Review of an un-witnessed fall investigation on 03/10/2025 at 2:53 PM, documented the nurse was notified by the NAC that Resident 46 had fallen in the bathroom and was found sitting in front of the toilet with their legs crossed. Resident 46 stated they got up from the toilet and fell hitting their head on the toilet seat. On 03/21/2025 the resident complained of right foot pain and an x-ray was obtained that revealed a right phalanx (toe) fracture. The investigation included a fall statement that showed a front wheel walker was present at the fall, a detail not present in the summary. The handwritten, unsigned statement showed it was unknown by staff when the resident was last toileted. The attached fall scene investigation showed Resident 46 transferred to the bathroom after getting up from the toilet and fell over onto their walker and hit their head on the toilet seat. The NAC caring for the resident was the first at the scene and they were unaware of the last time being toileted. There was no statement from the involved NAC. The conflicting information was not addressed. Review of a note from the Collateral Contract 5, facility contracted Advanced Registered Nurse Practitioner (ARNP) on 03/31/2025 showed Resident 115 went out to a Seattle hospital on 03/28/2025 for a planned follow up from the surgical intervention to lower left arm. Resident 115 went to ortho follow up a few days prior and follow up imaging demonstrated catastrophic hardware failure and severe shortening of the distal radius. This was suspected as a result from a fall out of bed of 03/14/2025. The resident was admitted to (Seattle hospital) and underwent left radius and ulna hardware removal, revision surgery to the radius fracture and ulna resection. Resident 115 readmitted to the facility on [DATE] for skilled therapy and nursing services. There was no addendum to the 03/14/2025 fall investigation or new investigation when the facility became aware of Resident 115's substantial injuries and hardware misplacement, requiring subsequent surgery and hospitalization . RESIDENT 218 Resident 218 was admitted to the facility on [DATE] with diagnoses that included the history of falls with fracture to right femur (upper leg bone), Parkinson Disease (progressive, declining neurological disorder that primarily affects movement, and causes tremors), and depression. The Admission MDS dated [DATE] documented the residents had cognition impairment and required substantial to maximum assistance for transfers and bed mobility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a review of Resident 218's physician orders there was an order for a bolster mattress to define parameters of the bed, no specific instructions dated 03/23/2025. There was an order for a fall mat on the right side of the bed for safety, no instructions dated 04/01/2025. In a review of Resident 218's care plan focus dated 03/19/2025 that they were at risk for falls, with interventions to assist with activities of daily living, bed in a low position for safety, bolster mattress in place, call light within reach, complete a fall risk assessment, and fall mat to right side of the bed for safety. In a review of the fall investigation dated 03/22/2025, Resident 218 had been found with their upper portion of the body (including their head) on the ground and the lower portion of the body still on the bed. The resident was unable to state how they became positioned that way. The investigation included statements from a NAC that stated the residents had possibly hit their head. The investigation included a neurological flow sheet dated 03/29/2025 (date of the residents fall 7 days later), there was no neurological flow sheet for the fall on 03/22/2025. The investigation included a NAC statement that read the staff need more help during mealtimes to help prevent the recurrence of falls, this concern was not addressed in the investigation. In a review of the fall investigation dated 03/29/2025, Resident 218 had been found on the right side of the bed, resident reported they were asleep then woke up on the floor. The investigation statements stated the head of the bed was up, the resident probably tilted to the side and fell out of the bed. The investigation did not show if the residents had their call light within reach, or if the bed was low. The intervention to prevent recurrence was to place a fall mat on the right side of the bed. <MEDICATION ERROR> RESIDENT 24 Resident 24 admitted to the facility on [DATE] with diagnoses that included bipolar disorder (mental illness with extreme mood shifts), anxiety and post traumatic stress disorder (PTSD). Resident 24's Admission MDS assessment dated [DATE] documented the resident was cognitively intact and had pain medication for routine and as needed pain management, and that in the last five days had experienced pain. In a review of Resident 24's physician orders showed an order dated 01/03/2025 for hydrocodone-acetaminophen (APAP) 10milligrams (mg) - 325 mg (narcotic medication used to treat pain) give one tablet every six hours for moderate to sever pain, the order was discontinued on 02/10/2025. On 02/10/2025 the physician changed the pain medication to Hydrocodone-APAP 5/325mg (a less strong narcotic). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a review of facility investigation dated 03/17/2025, Staff B, DNS documented they were notified that Resident 24 had been given the hydrocodone-APAP 10/325mg instead of the hydrocodone-APAP 5/325mg. The investigation had a copy of the narcotic ledger (sign out page for nurses to log they administered a narcotic), showed the hydrocodone-APAP 10/325mg was administered 10 times by several nurses. The investigation summary determined the cause of error was that narcotic medications needed to be destroyed when they were discontinued. The investigation lacked thoroughness, to determine the error was the licensed nursing staff had administered narcotics to a resident 10 times, outside of the accepted professional standard for medication administration. The investigation had no education or disciplinary action for the nurses that did not follow professional standards. In an interview on 04/08/2025 at 2:44 PM, Staff H LPN/Resident Care Manager (RCM) stated that typically the investigations were started on the floor with the cart nurses, and then the RCMs ensure all the documentation such as orders, care plans, etc. was included. Staff H stated for all investigations related to abuse and neglect that are completed by the Administrator and for all other investigations the Director of Nursing Services (DNS) will complete. Staff H was not aware of the investigation for Resident 216 and was not a part of the investigation. Staff H stated they did not know Resident 218 well and were not aware of their fall history. Staff H was not aware of the medication error for Resident 24. In an interview on 04/08/2025 at 3:21 PM, Staff C, RDCS stated their expectations for all investigations were to ensure that they are complete and thorough.Staff Cstated the investigation into Resident 216 had been completed by the DNS, who were not available. Staff C were asked if there was a follow-up to the negative responses in the investigation made by other residents, they stated they were not aware and would follow up. Staff C was asked to review the investigation and Staff C stated the investigation was not clear or thorough and did lack evidence to show whether neglect had occurred. Staff C was unaware of the incomplete fall investigations for Resident 218. Staff C was unaware of the medication error for Resident 24, and stated their expectation was there should have been education and disciplinary action for all the licensed nurses that administered the wrong narcotic. 36787 <PRESSURE ULCER> RESIDENT 46 Resident 46 admitted to the facility on [DATE] after a prolonged hospitalization with multiple diagnoses to include diabetes, liver disease, cardiac disease, kidney disease, pulmonary disease, stroke with left sided hemiplegia and hemiparesis (weakness and paralysis),osteoarthritis, protein calorie malnutrition and chronic pain from fibromyalgia. Review of Resident 46's admission nursing evaluation on 01/29/2025 showed they had no pressure ulcers (PU's), or open areas were identified on the admit assessment. In an interview on 04/03/2025 at 8:45 AM, Resident 46 was sitting on the side of their bed with flip flops on, and a dressing was observed on their left heel. The resident stated the wound occurred after they fell in the bathroom where they had waited an hour for help, and no one came. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the pressure ulcer/injury incident report dated 03/20/2025 at 8:35 PM, showed Resident 46 developed an intact blister to their left heel measuring 1.2 centimeter (CM) by 1.2 cm. The incident report noted the resident had reported they had a blister to their left heel but did not include an resident interview about when or how the blister occurred. The incident investigation did not include the resident's medical diagnosis or risk factors. There were no statements from nursing staff who care for Resident 46 other than the nurse who initiated the investigation. There was no documentation that the residents footwear or air mattress settings were inspected. The report did not include the bed settings. The investigation lacked a root cause analysis. 37890 <DELAY IN PAIN MEDICATION> RESIDENT 164 Resident 164 admitted [DATE] with diagnoses which included aftercare for a total hip arthroscopy following a complicated hospital stay. Resident 164 discharged against medical advice on 03/19/2025. Review of a grievance form left by the resident on 03/19/2025 stated my pain medication seemed to be a problem for them to let me have every time I was put off for 15-30 minutes and by the time I received it I hurt so bad it wasn't enough to help. The grievance form was escalated to a reportable allegation on 03/19/2025. Review of Resident 164's hospital discharge orders to the facility dated 03/16/2025 documented an order for Oxycodone (an opioid pain medication) 2.5-5mg by mouth every three hours as needed. Review of Resident 164's electronic medical record orders showed the order for oxycodone had been incorrectly transcribed as: Oxycodone 2.5mg by mouth every three hours as needed (prn) for pain 7-10 (numeric pain scale) (omitting the 5mg availability). Review of the facility's investigation of the allegation showed there was a delay in oxycodone from the pharmacy related to an allergy alert that required clarification. Resident 164's medical record showed an allergy to Hydrocodone (also an opioid pain medication). The record showed no evidence of notification to the provider regarding a delay in receiving medication or to request any alternate orders. The investigation failed to identify the transcripton error from the admission orders which would have allowed the resident 5mg of oxycodone instead of only 2.5mg every three hours for pain. Review of the state incident reporting log on 04/03/2025 showed the reported allegation from Resident 164 was not logged within five days as required. In an interview on 04/09/2025 at 10:57 AM, Staff A, Administrator, stated they had received the resident's grievance form and was told there had been a question about a possible allergy when they admitted . Staff A stated they questioned why the medication was not available but did not get a response back and stated they were not aware there had been an error in transcribing the pain orders. Staff A stated the allegation had not been logged within five days. This is a repeat deficiency from SOD 08/06/2024 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97-0640(6)(a)(b)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on interview and record review the facility failed to ensure pain management was provided in accordance with the resident's physician's orders for one of three residents (Resident 164) reviewed for pain management. Failure to ensure prompt delivery and administer medications per the provider orders resulted in Resident 164's dissatisfaction with their care contributing to discharge against medical advice from the facility and placed residents at risk for diminished quality of life. Findings included . Resident 164 admitted [DATE] with diagnoses which included aftercare for a total hip arthroscopy following a complicated hospital stay. Resident 164 discharged against medical advice on 03/19/2025. Review of a grievance form left by the resident on 03/19/2025 stated my pain medication seemed to be a problem for them to let me have every time I was put off for 15-30 minutes and by the time I received it I hurt so bad it wasn't enough to help. The grievance form was escalated to a reportable allegation on 03/19/2025. Review of Resident 164's hospital discharge orders to the facility dated 03/16/2025 documented an order for Oxycodone (an opioid pain medication) 2.5-5mg by mouth every three hours as needed. Review of Resident 164's electronic medical record orders showed the order for oxycodone had been incorrectly transcribed as: Oxycodone 2.5mg by mouth every three hours as needed (prn) for pain 7-10 (numeric pain scale) (omitting the 5mg availability). Review of Resident 164's pain assessment and resident centered pain goals dated 03/16/2025 showed the resident's acceptable level of pain was 6 out of 10. Review of Resident 164's pain monitor showed on 03/16/2025 their pain level was documented at level 7 on both day and evening shift with no corresponding administration of prn oxycodone. The resident did receive prn Tylenol (non-opioid over the counter pain medication which was also available as needed for lesser level pain. On 03/17/2025 at 1:44 PM Resident 164 received a dose of 2.5mg oxycodone for pain level 7 with no follow-up documentation of effectiveness. On 03/18/2025 at 9:31 AM Resident 164 received a dose of 2.5mg oxycodone for pain level 8 with no follow-up documentation of effectiveness. On 03/18/2025 at 2:30 PM Resident 164 received a dose of 2.5mg oxycodone for pain level 7 with no follow-up documentation of effectiveness. On 03/18/2025 at 9:52 AM Resident 164 received a dose of 2.5mg oxycodone for pain level 7 with no follow-up documentation of effectiveness. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation of the allegation showed there was a delay in oxycodone from the pharmacy related to an allergy alert that required clarification. Resident 164's medical record showed an allergy to Hydrocodone (also an opioid pain medication). The record showed no evidence of notification to the provider regarding a delay in receiving medication or to request any alternate orders. The investigation failed to identify the transcription error from the admission orders which would have allowed the resident 5mg of oxycodone instead of only 2.5mg every three hours for pain. In an interview on 04/09/2025 at 10:57 AM, Staff A, Administrator, stated they had received the resident's grievance form and was told there had been a question about a possible allergy when they admitted . Staff A stated they questioned why the medication was not available but did not get a response back and stated they were not aware there had been an error in transcribing the pain orders. Reference WAC 388-97-1060 (1)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 37890 Based on interview and record review, the facility failed to document a facility-wide assessment to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies. Findings included . Review of the facility assessment provided by the facility dated 07/30/2024, included the names of the prior facility Administrator and Director of Nursing Services. The facility assessment only included a Part I template and failed to include the following required elements: - The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; - The staff competencies that are necessary to provide the level and types of care needed for the resident population; - The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; The facility's resources, including but not limited to, all buildings and/or other physical structures and vehicles; - Equipment (medical and non- medical); - Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; - All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; - Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and - Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. In an interview on 04/02/2025 at 1:40 PM, Staff A, Administrator, stated the facility assessment provided was the most current and they were unable to provide any further information. No associated WAC reference.