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	05/20/2025

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

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interview and record review the facility failed to protect the resident's right to be free from neglect when they failed to conduct a thorough assessment, communicate a change in condition timely to the physician and notify other nursing staff to respond correctly to a medical emergency for 1 of 1 resident (Resident 1) reviewed for abuse and neglect. Resident 1 experienced harm when they had a change in condition, several caregivers were aware of the change from the resident's baseline, which worsened when nursing staff failed to take timely action; the resident became unresponsive, required cardiopulmonary resuscitation (CPR), and an unexpected death occurred. These failures placed all residents at risk of unmet care needs and potential neglect. Findings Included . Review of the facility policy titled, Abuse Identification, reviewed [DATE] documented the facility would identify abuse, neglect, and exploitation of residents and misappropriation of resident property. This includes but is not limited to identifying and understanding the different types of abuse and possible indicators. The facility defined deprivation by staff of goods or services as abuse, which included failure to provide goods and services necessary to attain or maintain physical, mental, and psychosocial well-being. Staff had the knowledge and ability to provide care and services, but chose not to do it, or acknowledge the request for assistance from a resident(s), which result in care deficits to a resident(s). Resident 1 admitted to the facility on [DATE] with diagnoses to include congestive heart failure (condition in which the heart doesn't pump blood as well as it should) and cellulitis (bacterial skin infection) of the left and right lower limbs. According to the Admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], the resident was cognitively intact. Review of Resident 1's Electronic Medical Record (EMR) documented weights on [DATE] that showed they weighed 324.8 pounds (lbs.) and on [DATE] they weighed 343.5 pounds (lbs.), a weight gain of 18.7 lbs. in a 24-hour period. Further review showed no documentation the physician had been notified of the resident's significant weight increase. Review of Resident 1's Medication Administration Record (MAR) dated [DATE], showed a physician order dated [DATE] for daily weights before breakfast and staff were to report a three-pound weight gain in a day or five-pound weight gain in a week to the physician. The weight documented on [DATE] was 324.8 lbs., and on [DATE] the weight was 343.5 lbs. There were no documented weights for [DATE]. (continued on next page)

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.

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

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's MAR for [DATE], dated [DATE], showed a monitor for edema (swelling that occurs when fluid builds up in the body's tissues) and a documented 3 + (a moderate to severe degree of swelling). [DATE] MAR showed no refusals for Resident 1's Lasix (a medication to treat fluid retention). Review of Resident 1's progress notes dated [DATE] at 5:31 PM showed an entry by Staff B, Registered Nurse (RN), that the resident had developed difficulty breathing at 3:20 PM and was assessed (oxygen saturations at 96 percent-a measurement of how much oxygen the blood is carrying), resident's oxygen was increased to four liters (L) per minute (lpm-flow rate of oxygen administered to a patient) and provided a nebulizer treatment. The progress note showed Resident 1 stabilized for about an hour, then developed shortness of breath again and given an inhaler (a device that delivers medication directly to the lungs). At 5:30 PM Resident 1 condition was noted to deteriorate and the NAC's reported they had no pulse. Emergency services were contacted and Resident 1 passed away at 6:18 PM at which time the Director of Nursing Services (DNS) was notified and the provider. No other interventions and assessments were found to be completed with Resident 1. There was no documentation found in the EMR that the resident's physician or any other medical professional had been notified of the change in condition. Review of Resident 1's MARs dated [DATE], documented that the resident had an order for Ipratropium-Albuterol solution 3 milliliters (mL) inhaled orally via nebulizer two times daily AM and bedtime. The review showed that on [DATE], [DATE] and [DATE] at AM the resident refused this medication. Staff B documented in their progress note dated [DATE] at 5:31 PM that nebulizer was provided to the resident, however this is not reflected on the MAR. The [DATE] MAR also documented an order for continuous oxygen to be administered at two L per minute. There was no order or documentation the physician was notified with request to increase the resident's oxygen to four L as documented in Staff B's progress note on [DATE] at 5:31 PM. In an interview on [DATE] at 11:12 AM Staff A, Nursing Assistant Certified (NAC), stated Resident 1 was not acting themselves, presented with slurred speech, a swollen left arm, and was not able to track with their eyes. Staff A stated they notified their nurse, Staff B at around 9 AM and again around 12 PM. Staff A stated they knew something was Really wrong with Resident 1 and Staff B was not paying attention. Staff A stated Staff B had not checked on Resident 1 during their shift. Staff A stated they did not notify any other nursing staff of Resident 1's change of condition. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on [DATE] at 12:16 PM Staff B stated they were the assigned nurse to care for Resident 1 on [DATE] and had worked a double shift that day, 6:00 AM-10:00 PM. Staff B stated they recalled Resident 1 and their diagnoses of Chronic Obstructive Pulmonary Disease (COPD-a group of chronic lung diseases) and high blood pressure. Staff B stated they were notified at approximately 3:00 PM on [DATE] of Resident 1's change of condition by an NAC. Staff B stated they assessed Resident 1's lungs and they were clear, and they oxygen saturations were at 90%. Staff B stated Resident 1 used continuous oxygen therapy, had shortness of breath and provided breathing treatment by inhaler per physician orders. Staff B stated they directed the NAC to keep a close eye on Resident 1. Staff B stated they were called back to Resident 1's room between ,d+[DATE] PM and stated they had deteriorated and was pulseless. Staff B stated they checked Resident 1 for a pulse, found one, and provided them with an ordered nebulizer (physician ordered treatment which administers a fine mist of respiratory medication through a medical device to improve breathing) breathing treatment before exiting the room and calling 911. Staff B stated Resident 1 passed away in the facility after CPR was provided by the NAC's and emergency medical services (EMS). Staff B stated Resident 1 had refused medication for the last two shifts, which included Lasix and Albuterol. Staff B stated they had not called the physician during their shift regarding Resident 1 but had notified the Resident Care Manager and the Director of Nursing Services after they passed away. When asked about swelling in Resident 1's limb, Staff B stated Resident 1 had swelling in their left arm for a while. In an interview on [DATE] at 2:02 PM Staff C, NAC stated on [DATE] at the start of their shift at approximately 3:30 PM they attempted to get Resident 1's weight. Staff C stated Resident 1 looked terrible and was trying to say something, but they could not understand them. Staff C stated they had to demand that Staff B go to Resident 1's room to assess them. Staff C stated an inhaler was administered to Resident 1 by Staff B. Staff C stated when they checked on Resident 1 again at approximately 4:00 PM, their color and breathing pattern had changed. Staff C stated they had to demand Staff B contact 911 or they were going to. Staff C stated they initiated CPR with other NAC's. Staff C stated Staff B did not assist and did not provide direction to the NAC's present. Staff C stated Resident 1's vitals were taken by the NAC's and no pulse was found. Staff C stated after Resident 1 passed away they spoke with Staff G Director of Nursing Services (DNS), by telephone and expressed concerns about Staff B's lack of urgency, assessment, and assistance during Resident 1's change of condition. In an interview on [DATE] at 4:50 PM Staff G stated Resident 1 had respiratory failure and then got a respiratory illness. Staff G stated NACs assisted Resident 1 with all their activities of daily living. Staff G stated Resident 1 did not have a history of refusing care or treatments and their death was not expected. Staff G stated they were unaware of any weight changes for Resident 1, changes in weight were to be reported to the provider, and the provider should have been notified of their weight increase from , d+[DATE]-[DATE]. Staff G stated they completed an investigation related to Resident 1's death, under risk management, did not make a report to the state hotline, and the death had not been reported to the coroner's office. Staff G stated they had provided all the documents related to their investigation, however when asked about statements from staff they stated they would need to find those. When asked why the statements were not part of their investigation, Staff G stated they guessed they should have been. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the incident report dated [DATE] at 6:18 PM, documented CPR was started on Resident 1 by the facility licensed nurse in addition to defibrillator use. EMS services arrived and were unable to resuscitate Resident 1. The notes section of the incident report showed Resident 1 passed away unexpectedly in the facility potentially related to a respiratory illness and other comorbid conditions. There were no other documents, statements or interviews attached, referenced or included with the incident investigation report. The investigation did not document that the physician had been notified of Resident 1's unexpected death. Review of the written statement by Staff J, NAC, dated [DATE] with an event time of 5:40 PM documented they were serving dinner when they were notified Resident 1 was unresponsive and came to assist. Staff J, according to their statement, attempted to get Resident 1's vitals and could not get an oxygen reading, while Staff B returned to the room with a nebulizer treatment. Staff J indicated they were directed to start CPR by a nurse from another unit. Staff J wrote that Staff B was not in the room until EMS arrived. Review of the written statement by Staff K, NAC dated [DATE] at 5:40 PM showed they had asked the assistance of Staff C to obtain a weight for Resident 1 earlier in the day. Resident 1 was described as responsive but nonsensical in their speech. Staff K indicated later vital signs were taken of Resident 1 and there was no pulse and no oxygen. Staff K wrote that the other aides had to push Staff B to contact 911. In an interview on [DATE] at 12:45 PM Anonymous Staff E, LPN stated Staff C, NAC had come to them visibly upset over the passing of Resident 1. Staff E stated it was reported to them that Staff B had been told several times about Resident 1's deteriorating condition and they did not address it. Staff E stated they attempted to discuss the staff's concerns regarding Staff B with Staff G and they were told they needed to keep their mouth shut. In an interview on [DATE] at 1:00 PM Staff F, Administrator stated Resident 1 was a full code status. Staff F stated the facility staff had performed CPR and used the defibrillator on [DATE] and had no concerns. Staff F stated information had come to them about Resident 1 after they passed away. Staff F stated they did not complete an interview with Staff B and relied upon their progress note in Resident 1's EMR. Staff F stated they did not think Staff B notified the doctor, did not contact them, and lacked communication with the proper individuals regarding Resident 1's change of condition. Staff F stated they did not know why the NACs did not seek out another nurse after informing Staff B of Resident 1's change of condition and getting no response. Staff F stated Staff B had been terminated. Cross Reference F684 Refer to WAC [DATE](1)(3)(c)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interview and record review, the facility failed to identify and report to the State Hotline an unexpected death for 1 of 1 resident (Resident 1), reviewed for unexpected death in the facility. The failure to report an unexpected death prevented the facility from identifying the occurrence of abuse or neglect and placed other residents at risk for harm and decreased quality of life. Findings included . According to Nursing Home Guidelines (Purple Book), Sixth Edition, dated [DATE] - Reporting Guidelines to be followed for nursing homes on reporting requirements Appendix D, page 27 showed that unexpected deaths need to be: 1. Reported to the Department of Social Health Services (DSHS) State Hotline 2. Logged on the DSHS reporting log within five days 3. Reported to the Law Enforcement (notify the police or call 911) 4. Call or notification of the Coroner or Medical Examiner Resident 1 admitted to the facility on [DATE] with diagnoses to include congestive heart failure (condition in which the heart doesn't pump blood as well as it should) and cellulitis (bacterial skin infection) of the left and right lower limbs. According to the Admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], the resident was cognitively intact. Review of Resident 1's Electronic Medical Record (EMR) showed they passed away unexpectedly in the facility on [DATE]. Review of the facility incident reporting log dated [DATE] showed no logged entries related to Resident 1's death. In an interview on [DATE] at 11:12 AM Staff A, Nursing Assistant Certified (NAC), stated Resident 1 was not acting themselves, presented with slurred speech, a swollen left arm, and was not able to track with their eyes. Staff A stated they notified their nurse, Staff B at around 9:00 AM and again around 12:00 PM. Staff A stated they knew something was Really wrong with Resident 1 and Staff B was not paying attention. Staff A stated Staff B had not checked on Resident 1 during their shift. Staff A stated they did not notify any other nursing staff of Resident 1's change of condition or of Staff B's lack of assessing the resident. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 11:40 AM Anonymous Staff D, RN stated they had received a call from Staff B on [DATE] at approximately 6:19 PM. Staff D stated Staff B informed them that Resident 1 had passed away. Staff D stated they worked the next day and attempted to gather information about what had happened with Resident 1 and the information they obtained was inconsistent with the information Staff B provided to them. Staff D stated several NAC's expressed concerns and were visibly emotional about the passing of Resident 1. Staff D stated Resident 1 was not expected to pass away and was anticipated to return home. Staff D stated they had expressed to Staff E, Director of Nursing Services (DNS), several times about the lack of clinical judgement they observed in Staff B. Staff D stated they had thought about making a report to the state agency but hadn't yet. In an interview on [DATE] at 2:02 PM Staff C, NAC stated on [DATE] at the start of their shift at approximately 3:30 PM they attempted to get Resident 1's weight. Staff C stated Resident 1 looked terrible and was trying to say something, but they could not understand them. Staff C stated they had to demand that Staff B go to Resident 1's room to assess them. Staff C stated they had to demand Staff B contact 911 or they were going to. Staff C stated after Resident 1 passed away they spoke with Staff G Director of Nursing Services (DNS), by telephone and expressed concerns about Staff B's lack of urgency, assessment, and assistance during Resident 1's change of condition. Review of the written statement by Staff K, NAC dated [DATE] at 5:40 PM showed they had asked the assistance of Staff C to obtain a weight for Resident 1 earlier in the day. Resident 1 was described as responsive but nonsensical in their speech. Staff K indicated later vital signs were taken of Resident 1 and there was no pulse and no oxygen. Staff K wrote that the other aides had to push Staff B to contact 911. In an interview on [DATE] at 12:45 PM Anonymous Staff E, LPN stated Staff C, NAC had come to them visibly upset over the passing of Resident 1. Staff E stated it was reported to them that Staff B had been told several times about Resident 1's deteriorating condition and they did not address it. Staff E stated they attempted to discuss the staff's concerns regarding Staff B with Staff G and they were told they needed to keep their mouth shut. In an interview on [DATE] at 4:50 PM Staff G, stated they were kind of familiar with Resident 1 and their care. Staff G stated Resident 1 had respiratory failure and then got a respiratory illness. Staff G stated NACs assisted Resident 1 with all their activities of daily living. Staff G stated they did not know Resident 1's cause of death and they were notified after they had passed away. Staff G stated they completed an incident report, risk management, did not put the statements from staff with it, and had not known they needed to notify the state reporting agency. Staff G stated they had not reported the death the coroner's office or law enforcement. When asked if they had consulted the Purple Book for guidance, Staff G stated they had not. In an interview on [DATE] at 1:00 PM Staff F, Administrator stated Resident 1 was a full code status. Staff F stated the facility staff had performed CPR and used the defibrillator on [DATE] and had no concerns. Staff F stated they did not complete an interview with Staff B and no further investigation was completed. Staff F stated the coroner's office was not notified. Reference WAC [DATE](2)(b)(5)(a)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interview and record review, the facility failed to provide a thorough assessment to timely recognize a significant change in condition, take action to notify the medical provider as ordered, and to ensure required staff were certified in Cardiopulmonary Resuscitation (CPR) for 1 of 1 resident (Resident 1) reviewed for an unexpected death in the facility. Resident 1 experienced harm when they had a significant weight gain over a 24-hour period, swelling in their left arm, slurring of their speech, difficulty breathing and change in their mentation throughout the day of [DATE], until they were found unresponsive without a pulse when assessment and treatment were delayed for several hours that constituted an immediate jeopardy. An Immediate Jeopardy (IJ) was identified, and the facility was notified of the noncompliance on [DATE]. The IJ was determined to have begun on [DATE] when the facility failed to assess and timely act on a resident's significant change in condition. The IJ was removed on [DATE] when an on-site inspection validated the facility implemented their removal plan by terminating the staff that failed to assess, treat and timely notify the physician of Resident 1 regarding their significant change in condition. The facility audited the records of all residents for unidentified changes in condition, educated staff on what to do when a resident has a change in condition, and audited employee Cardiac Pulmonary Resuscitation (CPR) certifications to ensure there were an adequate number of staff working each shift with active CPR certifications. Findings Included . Review of the facility policy titled, Changes in Resident's Conditions or Status undated, documented the facility would utilize the Lippincott procedure-change in status, communication and long-term care. Review of the Lippincott procedures titled, Change in status, identifying and communicating, long-term care, revised [DATE], documented the health care team members were responsible for communicating a resident's change in condition from their baseline. A nursing assistant who noticed a change should immediately report them to a nurse and the nurse must communicate a resident's change in status, including assessment findings, to the practitioner. At a minimum, assessment should include: reviewing the resident's medical record, asking how the resident feels and what symptoms the resident has, obtaining vital signs, observing the resident's overall condition, including function and cognition, exploring the resident's complaints. Resident 1 was admitted to the facility on [DATE] with diagnoses to include congestive heart failure (CHF-condition in which the heart doesn't pump blood as well as it should) and cellulitis (bacterial skin infection) of the left and right lower limbs. Review of Resident 1's Minimum Data Set (MDS-an assessment tool) dated [DATE] showed they were administered the Brief Interview for Mental Status (BIMS-tool to screen for cognitive impairment) with a score of 13 out of 15 which indicated intact cognition. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident 1's electronic medical record (EMR) documented the resident had passed away unexpectedly in the facility on [DATE]. Review of the care conference record dated [DATE], Resident 1 was planning to return home after rehabilitation services at the facility. Review of Resident 1's care plan dated [DATE] showed they were at risk for rehospitalization due to their history of CHF with an intervention for staff to provide timely communication to the physician regarding any change of condition. The care plan also showed Resident 1 may experience weight fluctuations with interventions to include observation and report, as needed, dependent edema of legs and feet, weight gain unrelated to intake, disorientation, cool skin, and weakness and daily weight monitoring before breakfast. Review of Resident 1's EMR documented weights on [DATE] that showed they weighed 324.8 pounds (lbs.) and on [DATE] they weighed 343.5 lbs., a weight gain of 18.7 lbs. in a 24-hour period. Review of Resident 1's Medication Administration Record (MAR) dated [DATE], documented a physician order dated [DATE] to weigh the resident every day shift before breakfast and report a three lb. weight gain in a day or five lb. weight gain in a week to the physician. The weight documented on [DATE] was 324.8 lbs., and on [DATE] the resident's weight was 343.5 lbs. There was no documented weight for [DATE]. Resident 1's EMR showed no documentation of the physician being notified of Resident 1's significant weight gain. Review of Resident 1's MAR for [DATE], dated [DATE], showed a monitor for edema (swelling that occurs when fluid builds up in the body's tissues) and a documented 3+ (a moderate to severe degree of swelling). [DATE] MAR showed no refusals for Resident 1's Lasix (a medication to treat fluid retention). Review of Resident 1's EMR documented the last vitals for the resident were taken [DATE] at 8:49 AM. Review of Resident 1's progress notes dated [DATE] at 5:31 PM documented an entry by Staff B, Registered Nurse (RN), stating the resident had developed difficulty breathing at 3:20 PM and was assessed (oxygen saturations at 96 percent-a measurement of how much oxygen the blood is carrying), resident's oxygen was increased to four liters per minute(lpm-flow rate of oxygen administered to a patient) and provided a nebulizer treatment. The progress note showed Resident 1 stabilized for about an hour, then developed shortness of breath again and was given an inhaler (a device that delivers medication directly to the lungs). At 5:30 PM Resident 1's condition was noted to deteriorate and the NAC's reported they had no pulse. Emergency services were contacted and Resident 1 passed away at 6:18 PM at which time the Director of Nursing Services (DNS) was notified and the provider. Review of Resident 1's physician orders for [DATE], showed there was no order in the residents record to titrate (increase) the oxygen up to four liters a minute. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident 1's MARs dated [DATE], documented that the resident had an order for Ipratropium-Albuterol solution 3 milliliters (mL) inhaled orally via nebulizer two times daily AM and bedtime. The review showed that on [DATE], [DATE] and [DATE] at AM the resident refused this medication. Staff B documented in their progress note dated [DATE] at 5:31 PM that nebulizer was provided to the resident, however this is not reflected on the MAR. The [DATE] MAR also documented an order for continuous oxygen to be administered at two L per minute. There was no order or documentation the physician was notified with request to increase the resident's oxygen to four L as documented in Staff B's progress note on [DATE] at 5:31 PM. In an interview on [DATE] at 11:12 AM Anonymous Staff A, Nursing Assistant Certified (NAC), stated that on [DATE] they were the assigned NAC for Resident 1 and the resident was not acting themselves. The resident had slurred speech, a swollen left arm, and was not able to track with their eyes. Staff A stated they notified their nurse, Staff B, Registered Nurse (RN) at around 9:00 AM and again around 12:00 PM. Staff A stated they knew something was Really wrong with Resident 1 and they felt that Staff B was not paying attention. Staff A stated Staff B had not checked on Resident 1 during their shift. Staff A stated they did not notify any other nursing staff of Resident 1's change of condition. In an interview on [DATE] at 12:16 PM Staff B stated they were the assigned nurse to care for Resident 1 on [DATE] and had worked a double shift that day, 6:00 AM-10:00 PM. Staff B stated they recalled Resident 1 and their diagnoses of Chronic Obstructive Pulmonary Disease (COPD-a group of chronic lung diseases) and high blood pressure. Staff B stated they were notified at approximately 3:00 PM on [DATE] of Resident 1's change of condition by an NAC. Staff B stated they assessed Resident 1's lungs and they were clear, and the oxygen saturations were at 90%. Staff B stated Resident 1 used continuous oxygen therapy, had shortness of breath and provided breathing treatment by inhaler per physician orders. Staff B stated they directed the NAC to keep a close eye on Resident 1. Staff B stated they were called back to Resident 1's room between 4:,d+[DATE]:00 PM and stated the resident had deteriorated and was pulseless. Staff B stated they checked Resident 1 for a pulse, found one, and provided them with an ordered nebulizer (physician ordered treatment which administers a fine mist of respiratory medication through a medical device to improve breathing) breathing treatment before exiting the room and calling 911. Staff B stated Resident 1 passed away in the facility after CPR was provided by the NAC's and emergency medical services (EMS). Staff B stated Resident 1 had refused medication for the last two shifts, which included Lasix and Albuterol. Staff B stated they had not called the physician during their shift regarding Resident 1 but had notified the Resident Care Manager and the Director of Nursing Services after they passed away. Staff B stated they did not perform CPR on Resident 1 and stated there were NAC's in the room to initiate it. When asked about Resident 1's swollen left arm, they stated Resident 1 their left arm was not new, and they had that for a while. In an interview on [DATE] at 2:00 PM Staff F, Administrator, stated Staff B did not have a current Cardiopulmonary Resuscitation certification. (continued on next page)

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	05/20/2025

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

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 11:40 AM Anonymous Staff D, RN stated they had received a call from Staff B on [DATE] at approximately 6:19 PM. Staff D stated Staff B informed them that Resident 1 had passed away. Staff D stated Staff B was difficult to understand because they were scattered. Staff D stated Staff B reported Resident 1 had been having breathing problems and they had given them a nebulizer. Staff D stated Staff B then hung up. Staff D stated they worked the next day and attempted to gather information about what had happened with Resident 1 and the information they obtained was inconsistent with the information Staff B provided to them. Staff D stated several NAC's expressed concerns and were visibly emotional about the passing of Resident 1. Staff D stated Resident 1 was not expected to pass away and was anticipated to return home. Staff D stated they had expressed to Staff E, Director of Nursing Services (DNS), several times about the lack of clinical judgement they observed in Staff B. Staff D stated they were unaware of the weight gain Resident 1 had from ,d+[DATE]-[DATE] and stated the physician should have been notified after reweighing them. In an interview on [DATE] at 1:14 PM Staff H, NAC stated they worked with another NAC on [DATE] and took care of Resident 1. Staff H stated they assisted with a brief change on [DATE] at approximately 12:00 PM. Staff H stated Resident 1 was incoherent, was not making sense and this was unusual for them. Staff H stated the other NAC stated they were going to notify the nurse of Resident 1's change in condition. Staff H stated they did not notify anyone of Resident 1's change in presentation. In an interview on [DATE] at 1:25 PM Staff I, Licensed Practical Nurse (LPN) stated they were not familiar with Resident 1's care. Staff I stated they were notified on [DATE] by an NAC that Staff B, RN needed help with Resident 1 who had no pulse. Staff I stated they went to the nurse's station and Staff B was on the phone with 911. Staff I stated they did not assess Resident 1 and their only involvement was when Staff B handed them the phone with 911 still on. Staff I stated if a resident had no pulse and was a full code, CPR should start immediately. On [DATE] at 11:38 AM a staff list of CPR certifications was requested and there were 86 nursing staff without certifications. Staff B and I did not have current CPR certifications, and there was no documentation as to when they had prior certification or when their certifications expired. Review of facility LPN and RN job descriptions, undated, showed LPN's and RN's must have a CPR certification upon hire and remain current during employment. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 2:02 PM Staff C, NAC stated on [DATE] at the start of their shift at approximately 3:30 PM they attempted to get Resident 1's weight. Staff C stated Resident 1 looked terrible and was trying to say something, but they could not understand them. Staff C stated they decided to hold off on getting the resident's weight and notified the nurse. Staff C described Resident 1 as not looking well and being pale in color. Staff C stated when they notified Staff B of the resident's changes Staff B stated Resident 1 just needed their inhaler. Staff C stated they had to ask Staff B to come into Resident 1's room and assess them and Staff B did not take their concerns as urgent or serious. Staff C stated they checked on Resident 1 again at approximately 4:00 PM and they were not speaking anymore, their breathing was very slow, and their skin was waxy and yellow in color. Staff C stated they directed the NAC with them to get Staff B and Staff B returned with nebulizer treatment. Staff C stated they told Staff B something was wrong, but they proceeded with placing a nebulizer mask on the resident. Staff C described Resident 1 as having their eyes rolled back in their head, their tongue was sticking out of their mouth, and they did not appear to be breathing when Staff B placed the nebulizer mask on them. Staff C stated they told Staff B to call 911multiple times and finally told them if they did not call for EMS, they would. Staff C stated when Staff B returned to the room, another aide had asked Staff B if they should start CPR and Staff B did not respond and left the room again. Staff C stated Resident 1 was not expected to pass away, they were planning on returning home. Staff C stated they were interviewed by Staff G on the evening of [DATE] over the telephone regarding this incident. Review of the Fire Department EMS patient care record for Resident 1, dated [DATE] at 5:47 PM showed the staff present stated they had completed seven rounds of CPR and Resident 1 had been seen 40 minutes prior and had complained of shortness of breath. Resident 1 was documented to be unresponsive, pulseless, was cool to touch and pale in color, and their lower extremities revealed cellulitis (serious bacterial infection) and pitting edema (a type of swelling where a pit remains after applying pressure indicating fluid buildup in the tissues). In an interview on [DATE] at 4:50 PM Staff G stated Resident 1 had respiratory failure and then got a respiratory illness. Staff G stated NACs assisted Resident 1 with all their activities of daily living. Staff G stated they did not know Resident 1's cause of death and they were notified after they had passed away. Staff G stated Resident 1 did not have a history of refusing care or treatments and their death was not expected. Staff G stated they were unaware of any weight changes for Resident 1, changes in weight were to be reported to the provider, and the provider should have been notified of the resident's weight increase from ,d+[DATE]-[DATE]. In an interview on [DATE] at 1:00 PM Staff F, Administrator stated Resident 1 was a full code status. Staff F stated the facility staff had performed CPR and used the defibrillator on [DATE] and had no concerns. Staff F stated information had come to them about Resident 1 after they passed away. Staff F stated they did not complete an interview with Staff B and relied upon their progress note in Resident 1's EMR. Staff F stated they did not think Staff B notified the doctor, did not contact them, and lacked communication with the proper individuals regarding Resident 1's change of condition. Staff F stated they did not know why the NACs did not seek out another nurse after informing Staff B of Resident 1's change of condition and getting no response. Cross reference F600 Reference WAC [DATE](1)