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	07/31/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely initiate a grievance for 1 of 1 residents (Resident #2) reviewed for grievances. This failure placed residents at risk for delayed resolution affecting their quality of life.Findings Included.Review of the facility policy titled, Grievance Program (concern and Comment) revised 01/07/2025 showed residents had the right to voice grievances and the facility must ensure the prompt resolution of all grievances and there would be a recordkeeping system. The executive director or designee oversaw the compliance of the grievance process.Resident 2 admitted to the facility on [DATE] with diagnoses to include kidney failure (a condition in which the kidneys lose the ability to remove waste and balance fluids in the body) and dependence on renal dialysis (filtration of the blood to remove waste).In an interview on 07/29/2025 at 4:15 PM, Resident 2 stated they had been transported by foot in their wheelchair by a facility staff member for their dialysis appointment which was scheduled for very early in the morning. Resident 2 stated the facility did not provide any vehicle transport and they were pushed in their wheelchair for approximately 30 minutes to the dialysis center. Resident 2 stated they complained of being cold, could not recall what they were wearing, and complained to both dialysis staff and the facility staff.In an interview on 07/30/2025 at 11:39 AM Staff A, Administrator, stated Resident 2 had admitted to the facility with a dialysis time the next morning of 6:30 AM the next day. Staff A stated they did not want the resident to miss their dialysis due to the importance of the treatment and had a facility staff push Resident 2 in their wheelchair to the dialysis center. Staff A stated they were aware that Resident 2 was frustrated, complained of being cold, and were wanting to be discharged from the facility. Staff A stated Resident 2 was dressed in warm clothing and had a blanket during the walk to dialysis. Staff A stated they did not complete a grievance form for Resident 2's complaints.In an interview on 07/30/2025 at 11:51 AM Staff C, Nursing Assistant Certified, stated they were dropped off at the dialysis center on a Saturday to push Resident 2 back to the facility in their wheelchair. Staff C stated another staff had taken Resident 2 in the morning. Staff C stated Resident 2 complained they were cold on the trip in the morning. Staff C stated Resident 2 was dressed in sweatpants, jacket and had a blanket. Staff C stated they didn't tell anyone about Resident 2's complaints, however it was known the resident was not pleased with the mode of transportation to the dialysis center. Review of the grievance log for July 2025, showed no logged grievance for Resident 2's complaints of lack of vehicle transportation and being cold during the trip to dialysis. Reference WAC 388-97-0460

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 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** Based on observation, interview and record review the facility failed to conduct a thorough investigation of an injury of unknown source for 1 of 3 residents (Resident 3) to rule out abuse and neglect. This failed practice placed residents at risk for potential unrecognized abuse or neglect.Findings included .Resident 3 admitted to the facility on [DATE] with diagnoses to include morbid obesity and pressure ulcers to their buttocks and sacral region (at the base of the spine to the coccyx).In a review of the facility's policy titled, Abuse-Conducting an Investigation reviewed 05/07/2025 showed when an incident or suspected incident of resident abuse and/or neglect was reported the administrator/designee will investigate and collect evidence of the occurrence. The investigation included conducting observations, interviews, and record review. The administrator would review the incident report for completeness.Reviewed the facility incident reporting log for July 2025 and requested incident report logged on 07/23/2025 at 10:00 AM for Resident 3.In an interview on 07/30/2025 at 11:39 AM Staff A, Administrator stated they were still completing the incident report related to a skin impairment for Resident 4, which occurred seven days prior. When asked the reason why it was not complete, Staff A stated the assistant director of nursing had left without completing it.Review of an incident report dated 07/23/2025, documented Resident 3 had two new, stage three pressure ulcers (full thickness tissue loss exposing the fatty tissue), to their right thigh near their buttock. Resident 3 had a urinary catheter (a flexible tube inserted into the bladder to remove urine) placed on 07/18/2025 and then on 07/23/2025 pressure ulcers were discovered.On 07/23/2023 Resident 3 was found to be lying on their catheter tubing, without a securement device (used to keep a catheter tube in place). The incident report failed to rule out abuse and/or neglect and contain interviews with other residents, audits of residents who used catheters, interviews with staff members who placed the catheter and had contact with Resident 3 during the four days prior to discovering the pressure ulcers.In an interview on 07/30/2025 at 2:23 PM Staff B, Director of Nursing stated they did not complete the incident report, and it was delegated to the assistant director of nursing to complete. Staff B stated they did not conduct interviews and did not participate in the completion of the incident report.In an interview on 07/31/2025 at 4:12 PM Staff A, Administrator, stated it was their responsibility to ensure the incident report was completed timely, accurately and thorough and they did not get all the pieces. Staff A stated there was a nurse manager over the weekend that could have helped with the completion; however, they were not utilized.Reference WAC 388-97-0640 (6)(a-b)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, and record reviews, the facility failed to assess/monitor the position of a catheter tubing (a flexible tube inserted into the bladder to remove urine and attached to a drainage bag) during catheter care and bed mobility/positioning to prevent the occurrence of an avoidable pressure ulcer (PU) and provide ordered treatment for the PU for 1 of 3 residents (Resident 3) reviewed for PU's. Resident 3 experienced harm when they developed an avoidable Stage III PU (full-thickness skin loss of skin, which is when fat is visible in the ulcer and granulation tissue which is new connective tissues and microscopic blood vessels, and rolled wound edges are often present. Slough, nonviable tissue, and/or eschar, dead or devitalized tissue, may be visible. Undermining -destruction of tissue or ulceration extending under the skin edges and tunneling - a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound) which caused pain and discomfort.Findings included .The National Pressure Ulcer Advisory Panel (NPUAP) April 2016, showed a PU/Pressure Injury (PU/PI) definition and stages as:-A PU is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear (a combination of downward pressure and friction).-Medical device related PU/PIs were a result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.- Moisture Associated Skin Damage (MASD) was superficial skin damage caused by sustained exposure to moisture such as incontinence, wound exudate, or perspiration. Resident 3 admitted to the facility on [DATE] with diagnoses to morbid obesity and PU's to their buttocks and sacral region (at the base of the spine to the coccyx).Review of an in-service training dated 06/19/2025 showed Nursing Assistants (NA's) were educated on urinary catheter care and directed the staff to assess the securing device daily and change it when clinically indicated.Review of Resident 3's progress note, dated 07/18/2025 at 2:00 PM, showed a urinary catheter was placed by the Assistant Director of Nursing Services and the floor nurse. Resident 3 expressed pain in their groin and genital area.Review of Resident 3's wound care assessment provided by an outside wound healing company, dated 07/23/2025, showed a newly developed facility acquired 5.0 centimeter(cm) by 7.0 cm by 0.3 cm stage III PU. The documentation showed this was caused by a medical device (Foley). The resident had MSAD in multiple locations . due to incontinence and sweat. The treatment recommendations were to apply a wound gel and foam dressing every day and as needed.Review of Resident 3's progress note, dated 07/23/2025, showed the resident's catheter tubing was found under their right thigh, with no securement device, along with a stage III PU where the tubing was found.Review of Resident 3's current care plan had a focus problem of a Foley device related stage III PU on the right buttock. Interventions included: treatment as ordered by the physician and weekly skin checks (initiated on 11/29/2024), pressure redistribution mattress (initiated on 07/25/2025), and to ensure catheter securement device was in place and the Foley catheter was properly hung on the bed (initiated on 07/29/2025).Review of Resident 3's July 2025 Treatment Administration Record showed wound care to stage III right posterior thigh every day. The nurse was instructed to clean the wound, apply wound gel and a foam dressing. Wound care was to be completed every 24 hours and as needed.In an interview and observation on 07/31/2025 at 12:12 PM, Resident 3 was observed lying on their back with the head of the bed in the upright position. There was a catheter bag attached to the right-hand side of the bed. When asked by the surveyors if they had any skin breakdown, the resident stated they had skin breakdown all over their body. Resident 3 stated they recently had their indwelling catheter replaced and the staff had placed the tubing under their leg rather than over their leg. The resident was asked if the indwelling catheter tubing was now being secured. Resident 3 proceeded to remove their sheet and expose their right leg and part of their left thigh. The catheter tubing was observed to be secured in a removable device on their upper right thigh. The resident showed an open area on the right middle upper inner thigh between a skin fold. The wound was approximately five inches long, open, wound bed was pink, and the surrounding skin was intact. The resident showed the upper inner part of both thighs. There was a brief in place, the skin was red, irritated appearing, an open wound was observed on the right inner thigh located close to the bottom of, the skin was moist, and there was no evidence of an application of a cream/ointment (that was MASD related, not r/t to the PU). This area was hard to visualize completely without assistance from staff. The resident stated the area between