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	09/11/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff were available to respond to call lights for 5 of 7 sampled residents (Residents 8, 9, 10, 13, and 4) and 1 of 2 family members (CC1- Resident 2's family member) reviewed for sufficient nurse staffing. This failure placed residents at risk for frustration, unmet care needs and a diminished quality of life. Findings included .<RESIDENT 8>In an interview and observation on 09/08/2025 at 10:10 AM, Resident 8 was observed in their room sitting in a wheelchair (w/c). When asked if there was enough staff here to meet their needs, Resident 8 stated it could take 30-40 minutes to have their call light responded too. Resident 8 stated they were aware their room was at the end of the hallway, but they had to wait a bit at times to get any help. When asked if there was a specific time when this occurred, they replied all the time.<RESIDENT 9>In an interview and observation on 09/08/2025 at 10:40 AM, Resident 9 was observed lying in bed watching television (TV). Resident 9 was asked if there was enough staff here to meet their needs, the resident stated, seems to be down staff. Resident 9 was not able to give a specific shift/time when this occurred. <RESIDENT 10>In an interview on 09/08/2025 at 11:16 AM, Resident 10 was lying in their bed watching TV. Resident 10 was asked if there was enough staff here to meet their needs, the resident stated No. Resident 10 stated there were times when they had to wait and wait. Resident 10 did not identify a specific shift or for how long they waited, just replied it is a long time. <RESIDENT 2>In an interview on 09/08/2025 at 2:00 PM, Collateral Contact 1 (CC1), Resident 2's family member, stated the facility was so short staffed. CC1 stated staff would place their loved one on the toilet and leave them there. CC1 stated they put the resident's call light on and eventually would have to go out into the hallway to ask for help. When asked if there was a specific time when this occurred, CC1 replied the short staffing happened all the time. CC1 stated it was worse around mealtimes and on the weekends.In an interview on 09/08/2025 at 11:43 AM, Staff Q, Nursing Assistant Certified (NAC), stated the facility was short staffed at times. Staff Q stated this occurred on all shifts.In an interview and observation on 09/08/2025 at 2:57 PM (the call light panel was viewed during the observation), Staff F, NAC, was asked if there was enough staff here to meet the resident's needs. Staff F stated there was not enough staff, and currently they were waiting on another NAC to transfer a resident who was a two person assist. Staff F stated there used to be seven NAC's working on this shift and now there were only five. Staff F stated this occurred about a week ago. In a continuous observation of the call lights conducted on 09/08/2025 starting at 2:57 PM to 3:34 PM. The call lights were observed illuminated, at the call light panel at the North nurse's station and the panel on the 200 hall. The following rooms call lights were observed on at 2:57 PM: 105, 102, 204, and 207:- room [ROOM NUMBER]'s call light was answered within 5 minutes.- At 3:12 PM, staff were observed to enter room [ROOM NUMBER], 15 minutes later. During this observation three unidentified NAC's and one unidentified Licensed Nurse (LN) were observed in the hallway entering other residents' rooms who did not have their call light on.- At 3:22 PM, Staff E, Licensed Practical Nurse (LPN), an unidentified LN were standing at the 200-hall medication cart. Resident 13 was observed sitting in their w/c and calling out (Resident 13 had difficult expressing themselves verbally) and their call light was on. An unidentified NAC joined the LNs at the medication cart. The unidentified LN and NAC then entered Resident 13's room at 3:23 PM, 26 minutes later.- At 3:24 PM, Resident 4 was observed in their room sitting in a w/c. When asked how the resident was doing today, Resident 4 stated they wanted to lie down and take a nap. The resident stated the staff had started to make their bed around lunch time and was waiting for the staff to return to finish making the bed and help them lie down for a nap. At 3:26 PM, Staff E entered the room to administer the resident's medications. As this surveyor left the room, it was conveyed to Staff E that Resident 4 wished to have their bed made and to take a nap. At 3:28 PM, Staff E came out of the room and stated this surveyor could continue talking to Resident 4. The resident's call light remained on. At 3:34 PM, Staff E was observed at the medication cart in the hallway. Staff E was informed the resident wished to have his bed made and to take a nap. Staff E stated they would take care of it. Resident 4's call light had been on for over 30 minutes.In an interview, date and time withheld to maintain staff member's anonymity, Anonymous Staff 1 (AS-1) was asked if there was enough staff here to meet the needs of the residents. AS-1 stated on some halls there were not enough staff to meet the residents' acuity needs. AS-1 identified quite a few of the residents residing on the 400 and part of the 300 halls require two people to assist with their needs. AS-1 stated, It is very hard to do a good job when you are caring for residents who

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a system in which resident's records were complete, accurate, accessible and systematically organized for 3 of 6 sampled residents (Residents 4, 12 and 9) reviewed. This failure included inaccurate readmission and nursing assessment/documentation, and a hospice referral follow- up. These failures placed residents at risk for unmet needs, and inaccurate medical records. Findings included .<RESIDENT 4>Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's physician order, dated 08/27/205, showed to obtain the resident's weight every day shift for two days.Review of Resident 4's August 2025 Medication Administration Record (MAR), showed the Licensed Nurse (LN) initialed on the MAR the resident's weight was obtained on 08/29/2025 and 08/30/2025. There was no weight documented on the MAR.Review of Resident 4's weights showed the resident was weighed on 08/27/2025 and 08/29/2025. There were no weights documented on 08/29/2025 and 08/30/2025.Review of Resident 4's at risk for weight fluctuation care plan, created on 09/08/2025, showed the resident was underweight and pursuing a hospice referral. An intervention included weighing the resident weekly for four weeks.Review of Resident 4's Advanced Registered Nurse Practitioner order, dated 09/04/2025, showed a referral for hospice services.Review of a Social Service Assistant (SSA) progress note, dated 09/04/2025, showed Staff H, SSA, talked to Resident 4 and their family member. The resident requested to be on hospice services.Review of Resident 4's medical record showed no additional progress notes indicating hospice services had been initiated.In an interview on 09/10/2025 at 2:34 PM, Staff E was asked Resident 4 had been referred to hospice services. Staff E stated the resident had gone back and forth on wanting hospice services. Staff E stated they had several conversations with the resident and currently did not want hospice services. Staff E stated this had not been documented. <RESIDENT 12>Resident 12 admitted to the facility on [DATE]. Review of Resident 12's care plan, dated 07/26/2025, showed the resident required cares in pairs. An intervention, dated 09/01/2025, was added to the care plan directing staff the resident wished for no male caregivers or nurses. Review of a facility investigation dated 09/02/2025, Resident 12 reported to staff that they felt Staff O, Registered Nurse (RN), administered something in the middle of the night. Resident 12 felt Staff O drugged them and they were fearful.In an interview and observation on 09/08/2025 at 1:40 PM, Resident 12 was lying in bed, and their family member was at their bedside. Resident 12 was asked about an incident with Staff O and if they had seen Staff O since the concern was made. The resident responded no they had not seen Staff O. Review of a progress note dated 09/04/2025, Staff O documented they assessed Resident 12.In an interview on 09/10/2025 at 3:02 PM, Staff B, RN/Director of Nursing Services, was asked about Staff O documenting an assessment in Resident 12's chart when the resident was to have no male caregivers or nurses. Staff B stated Staff O did not go into the room to assess the resident. When asked how Staff O documented they assessed the resident, Staff B stated Staff O had not and educated the staff member regarding this inaccurate documentation. <RESIDENT 9>Resident 9 readmitted to the facility on [DATE] after a short hospitalization. Review of Resident 9's Admission/readmission Collection Tool, effective date 09/01/2025, showed the residents admission assessment was not completed. For example, the residents were not assessed regarding their sensory, mood, behavior, oral/nutrition status, chewing/swallowing status, cardiovascular status, respiratory status, bowel and bladder status, the activities of daily living abilities, and other areas. In an interview on 09/11/2025 at 9:42 AM, Staff B viewed Resident 12's admission/readmission collection tool and acknowledge the assessment had not been completed timely and was missing information. This is a repeat citation from survey dated 03/12/2025, and 05/24/2024.Reference WAC: 388-97-1720 (1)(a)(i)(ii)