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	11/18/2025

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 - Minimal harm or potential for 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. (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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the needed assessments and monitoring for 1 of 1 resident (Resident 1) reviewed for post-surgical care and hospitalization, who experienced increased pain to their right foot for six days, licensed nurses did not assess the residents skin to their right foot for 11 days after surgery. Resident 1 experienced a blood clot that restricted the blood flow to their right foot, required surgical intervention and developed several pressure injuries to their right foot due to the lack of assessment and monitoring. This failure resulted in neglect to Resident 1, who experienced unmet care needs, and avoidable skin issues. Findings included. Review of the facility policy titled, Abuse - Identification of Types, reviewed 05/06/2025 documented that neglect was a failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.neglect includes when the facility's lack for resident care results in physical harm, or pain.neglect may be the result of one or more failures. Review of the facility policy titled, Comprehensive Care Plan and revisions, reviewed 08/29/2025 documented when changes occur the facility shall update the plan of care to reflect changes to care delivery, this can include additional interventions, updating goals and interventions. Review of the facility policy titled, Changes in Resident Condition or Status, reviewed 08/29/2025 documents the facility will notify the primary provider of changes in the resident's condition. Resident 1 readmitted to the facility on [DATE] after an elective total right knee arthroplasty (replacement of the joint) (TKA) with diagnoses including atrial fibrillation (irregular heart rhythm), and peripheral vascular disease (condition that can affect blood flow to limbs). The 5-Day Minimum Data Set (MDS - an assessment tool) dated 10/28/2025 documented the resident had intact cognition, no refusal of care and was dependent on staff to assist with dressing, wearing footwear, and bed mobility. The MDS assessment documentation showed Resident 1 was at risk for pressure ulcer/pressure injury (PU/PI - injury to skin and underlying tissue resulting from prolonged pressure) and had no PU/PI to their right leg or foot on readmission. Review of Resident 1's readmission physician orders post-surgical knee replacement surgery there were no orders for licensed staff to assess the resident's right leg, including assessment of the skin, checking for pulse, ability to move, and sensation in an affected limb after their surgery. The physician order for Resident 1 to where compression stockings were not complete, it did not indicate, length of time, when to remove, how long to remove, monitoring of effectiveness, or whether the resident had refused. Review of Resident 1's skin assessments 10/23/2025 - 11/02/2025 had no documentation that a licensed nurse or provider had visualized the resident's actual right leg and foot without wearing a compression stocking. There was no assessment that showed Resident 1's right foot was assessed. Review of Resident 1's care plan from 10/23/2025 - 11/2/2025 had no information related to their right knee replacement surgery. The care plan lacked any goals of care for the right leg, interventions for staff, assessment and monitoring of the resident's right leg. Review of Resident 1's progress notes dated between 10/23/2025 - 11/02/2025, documentation showed no timely documentation that the resident had refused to allow facility staff to remove the compression stocking to the right leg. Further review of Resident 1's progress notes showed the following Late Entry notes by licensed staff:- Progress note Late Entry, dated 11/05/2025, regarding the resident's refusal to remove compression stocking for skin assessment, entered retro date of 10/23/2025, - Progress note Late Entry, dated 11/05/2025, regarding the resident's refusal to remove compression stocking, entered retro date of 10/29/2025, - Progress note Late Entry, dated 11/05/2025, regarding the deep purple area to the resident's right top foot, and black heel, entered retro date of 11/02/2025.On 11/03/2025 at 11:31 AM, the resident was transferred to the local community hospital. Review of Resident 1's hospital (local community) records dated 11/03/2025, the resident was transferred to another hospital (trauma - higher level of care) on the evening of 11/03/2025. Review of the facility investigation dated 11/03/2025, for Resident 1, included six witness statements by licensed nurses and Nursing Assistant Certified (NAC) that wrote the resident had refused to allow the staff to remove the compression stocking to the right leg. The investigation lacked evidence that staff had communicated any refusal of care to the physician, and there was no documentation in the resident's medical record that they had refused care until 11/05/2025, two days after the resident was admitted to the hospital. Review of Resident 1's trauma hospital medical records dated 11/04/2025 at 2:00 AM, documented the resident had two unstageable [obscured full-thickness skin and tissue loss, full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed

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F 0684 Level of Harm - Actual harm 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** Based on interview and record review, the facility failed to establish an appropriate plan of care, consistently provide the required assessments monitoring, and care interventions following a total knee replacement surgery for 3 of 4 residents (Residents 1, 2, and 3) reviewed for post-surgical care and hospitalization. Resident 1 experienced harm when they verbalized increased pain to the right foot that was unassessed for six days, developed a blood clot to their right foot that caused lack of blood flow to the foot that required transfer to the hospital where a surgical intervention was performed to remove the clot and the potential for right foot amputation (removal of limb). This failure placed all post-surgical residents at risk for unmet care needs, injury, and a diminished quality of life. Findings include.Review of the facility policy titled, Comprehensive Care Plan and revisions, dated 08/29/2025 documents the facility will ensure the timeliness of each resident's person-centered care plan is reviewed and revised When changes occur, the facility shall review and update the plan of care to reflect changes to care delivery, this can include additional interventions, updating goals and interventions. Review of the facility policy titled, Changes in Resident Condition or Status, dated 08/29/2025 documents the facility will notify the primary provider of changes in the resident's condition. <RESIDENT 1> Resident 1 readmitted to the facility on [DATE] after an elective total right knee arthroplasty (replacement of the joint) (TKA) with diagnoses including atrial fibrillation (irregular heart rhythm), and peripheral vascular disease (condition that can affect blood flow to limbs). The 5-Day Minimum Data Set (MDS – an assessment tool) dated 10/28/2025 documented the resident had intact cognition, no refusal of care and was dependent on staff to assist with dressing, wearing footwear, and bed mobility. Review of Resident 1's readmission physician orders related to their knee surgery, documented the following:- Dressing to right knee to remain in place until follow up with provider, if soiled can change pad. Compression stockings to hold pad in place. Two times a day for dressing change dated 10/24/2025, - Congestive heart failure (CHF) monitor for edema every shift dated 05/29/2025,- Eliquis (blood thinning medication) oral tablet, given by mouth two times a day for anticoagulant (prevention of clots). Review of Resident 1's care plan from 10/23/2025 – 11/02/2025 did not show documentation of the resident's recent surgery, no focus area of care related to post-surgical care of the right leg, no goals of care for the right leg, and did not show interventions for staff related to the resident's post-surgical care, assessment and monitoring of the resident's right leg. Review of Resident 1's medical record documented the readmission skin assessment was completed on 10/23/2025, by Staff D Licensed Practical Nurse (LPN) / Resident Care Managers (RCM)the license nurse, did not remove the compression stocking on the right leg to visualize the skin. Further review from 10/23/2025 – 11/02/2025, showed no documentation that any licensed staff visualized the resident's right leg with the compression stocking removed, and that no licensed staff had attempted to remove the compression stocking to the resident's right leg for a skin assessment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the facility investigation dated 11/02/2025 at 1:45 PM, documented the licensed nurse (Staff E, Registered Nurse – RN) was called to Resident 1's room. The licensed nurse reported that the Nursing Assistant Certified (NAC) had removed the resident's compression stocking to the right leg and found the top of the right foot to be deep dark purple, non-blanchable (indicating potential compromised blood flow to the area) and that the heel was black and hard. The investigation documented that the resident was sent to the local community hospital on [DATE] at 9:00 AM. Review of local community hospital records dated 11/03/2025, documented Resident 1 had severe narrowing and some occlusion to the arteries to their right lower leg. The resident was transferred to a trauma hospital. Review of the trauma hospital records dated 11/03/2025, documented Resident 1 had experienced worsening pain over the last week and half, imaging at local community hospital showed the residents had ischemia (inadequate blood supply) and occlusion to the right foot/ankle. The documentation reflected that the resident would need an angiogram (medical procedure using X-ray imaging and a contrast dye to visualize blood vessels and diagnose the blockage) and a percutaneous thrombectomy (surgical procedure to remove blood clots using a catheter guided through blood vessels). The vascular surgeon documented that even if they were able to reestablish arterial flow to the foot, the resident would be at risk for continued wound complications and potential amputation. In a phone interview on 11/05/2025 at 3:58 PM, Collateral Contact (CC) 1, Resident 1's power of attorney (POA) stated they were concerned about Resident 1's care at facility, and that the staff had not been removing the compression stocking to Resident 1's right leg and now they were in the hospital. In a follow up phone interview on 11/06/2025 at 3:50 PM, CC1 stated they were usually in the facility at least every other day visiting and never observed or overheard the facility staff request to remove the compression stocking on their right leg. In a phone interview on 11/06/2025 at 3:50 PM, Resident 1 stated they were still admitted to the trauma hospital, and that they had a surgical procedure the day before to try and reestablish blood flow to their right foot. Resident 1 stated I tried to tell them to take that stocking off, they just looked at me like I was a crazy lady. Resident 1 stated they do not recall ever refusing to let the staff remove the compression stocking, and said, for a while there I was in so much pain and that the pain was all they could focus on. Resident 1 stated they did not recall any staff every asking to remove the compression stocking. In an interview on 11/12/2025 at 9:10 AM, Staff I, RN stated they did not work with Resident 1 after they readmitted following their right knee replacement surgery. Staff I stated they were asked to observe the resident's foot by Staff E, RN on 11/02/2025. Staff I stated the right foot was dark red/purple on the top of the foot, and their heel was completely black and real hard. Staff I stated that Staff E looked at me and then looked at the resident and stated to the resident we might have to send you to the hospital, and the resident agreed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In a phone interview on 11/12/2025 at 10:24 AM, Staff E, RN stated that facility staff utilize the care plan, and orders to guide the care that was delivered to each resident. Staff E stated that most of the updates and revisions to the care plan are done by the nurse managers, however they could if needed. Staff E stated all documentation was required to be in the resident's medical record by end of the shift, or before you leave the facility for the day. Staff E stated it was the facility process for the licensed nurses to complete weekly skin checks on all the residents. Staff E stated that if a resident was wearing compression stockings, they are supposed to remove them to look at the skin. They stated if they refuse the electronic medical record system will send a notification to the nurse managers and they will follow up with the resident, they stated if a resident refused a medication, then they contact the provider but would not contact the provider if they were refusing a skin assessment. Staff E stated that they remembered Resident 1 had a recent knee replacement and was having increased pain. Staff E stated they asked the resident if they could remove the compression stocking to assess the pain in their right foot, but that the resident refused. Staff E stated they did not communicate that to the provider and stated it was more about pain management for them. Staff E confirmed they never looked at the resident's right foot until the NAC removed the stocking on 11/02/2025 around 1:45 PM. They stated the whole top of the resident's right foot was deep purple, redness down the sides and their heel was black and hard. Staff E stated they contacted the provider to get an order for a doppler (to check for blood flow) or to send Resident 1 out to the hospital. Staff E stated the on-call provider refused to let them get a STAT (immediately) doppler or send the resident to the hospital, so they notified the on-call nurse manager, and were instructed to monitor the resident. Staff E confirmed they did not contact the doctor at any time between 10/23/2025 – 11/02/2025 (prior to discover of right foot) that the resident had been refusing to let them remove the compression stocking to assess the residents increased pain to their right foot, and that they never documented the refusal in the residents' medical record. In an interview on 11/12/2025 at 1:54 PM, Staff G, NAC, stated if a resident was refusing care, they would notify the nurse. Staff G stated they were in Resident 1's room, and the POA was in the room as well, and they removed the compression stocking to Resident 1's right leg. Staff G stated the foot was black, so I went to go get the nurse. In an interview on 11/12/2025 at 2:15 PM, Staff H, NAC, stated that they will ask residents if they would like to have their compression stockings removed at nighttime, or they remove them at night. Staff H stated some residents prefer to keep them on. Staff H stated if a resident was refusing care they would retry and then let the nurse know. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In a phone interview on 11/13/2025 at 7:51 AM, Staff F, LPN stated that the nurse managers usually would be the ones to update the care plans. They are expected to have all their documentation completed prior to leaving the facility at the end of their shift. Staff F stated they were not sure who was selected for skin checks, just that they are notified in the electronic medical record which residents on their shift need a skin check. Staff F stated they are to report to the Director of Nursing Services (DNS) and provider if a resident was refusing to let them look at their skin, and they would document in the medical record. Staff F stated they cared for Resident 1 while they were at the facility. Staff F stated they remembered the resident was having a lot of pain in the right foot, and that they were wearing compression stockings. Staff F stated the report from the day shift nurses, was that the family of Resident 1 did not want staff to remove the compression stockings. Staff F stated that they never tried to remove the compression stockings, they looked at the resident's right leg with the stocking on, and it appeared very tight. Staff F stated the orders for the compression stockings were unclear, and they never reached out to the provider to clarify the orders. Staff F stated they thought the day shift nurses were dealing with the situation, and they were focused on the pain they were having in the right foot and just wanted to make the resident comfortable. In an interview on 11/18/2025 at 12:49 PM, Staff D, LPN/Resident Care Manager (RCM) stated they had just started all the licensed nurses should be able to update the care plan, anyone who is aware of a change or revision should be responsible. Staff D stated the staff should be removing any compression device that is on a resident to assess the area of the skin at least daily if not each shift. Staff D stated they remembered Resident 1, and that they were having a lot of issues with managing their pain in the right leg, they added they recalled the pain regimen was changed a lot. Staff D stated the resident had a recent total knee replacement on the right leg, and they should have been monitored as they were at risk for blood clots. Staff D confirmed they never removed the compression stocking to the right leg, never visualized the right foot that had the increased pain, never documented that the resident had refused and never notified the provider that the resident had been refusing to remove the compression stocking to the right foot. In an interview on 11/18/2025 at 1:57 PM, Staff B, RN/Outgoing DNS/Incoming RCM stated all the department managers are responsible for ensuring the residents plan of care was updated appropriately. Staff B stated skin checks are completed on all residents weekly, and if there was a concern the staff were to report to the provider, get new orders and place a referral to our contracted outside wound provider, and place the resident on monitoring. Staff B stated the standard order for compression stockings would be on in the morning and off at night, unless there was a specific order to follow. Staff B stated if the orders are not clear they should be contacting the provider to ensure we have a clear order to follow and get it updated. Staff B stated they were familiar with Resident 1 and stated they were aware the resident had been refusing to allow staff to remove the compression stockings. Staff B stated they were not sure if any licensed staff ever contacted the provider about the clarification of the compression stockings or that they were refusing to allow them to be removed. Staff B stated they knew the resident was on a blood thinner and was at risk for blood clots. Staff B confirmed that the plan of care for post-knee replacement surgery was never incorporated into Resident 1's care plan, that there was no assessment or monitoring for blood clots, no documentation of the refusals, and that no one had contacted the provider. In joint interview on 11/18/2025 at 2:31 PM, Staff A, Administrator, Staff C, Incoming DNS/RN, Staff A and Staff C were asked if there was any notification, documentation, care planning, monitoring or assessment of Resident 1's right leg, or right foot after their surgery. Staff A & Staff C both stated there was not.No further information was provided by Staff A, and Staff C. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<CARE PLAN> <RESIDENT 2> Resident 2 was admitted on [DATE] with diagnoses to include left knee replacement surgery. Resident 2 had physician orders to include ted hose (compression socks) on everyday shift and staff were to monitor for edema every shift with a start date of 10/28/2025. Resident 2's care plan did not show care interventions for the ted hose or edema monitor. <RESIDENT 3> Resident 3 was admitted on [DATE] with diagnoses to include right hip fracture. Resident 3 had physician orders to include ted hose on every morning with a start date on 10/13/2025. Resident 3's care plan did not include care interventions for the ted hose. In an interview on 11/18/2025, at 12:48 PM, Staff D, LPN/RCM, stated that residents who have ted hose orders should be in the care plan. Refer to WAC 388-97-1060(1-3)

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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 and record review, the facility failed to ensure assessments were completed to evaluate the need for pressure offloading preventative measures post-surgery, assess and monitor skin integrity, and to consistently implement interventions to prevent development of an avoidable pressure ulcer/pressure injury (PU/PI - injury to skin and underlying tissue resulting from prolonged pressure) for 1 of 1 sampled resident (Resident 1), reviewed for pressure ulcers. Resident 1 experienced harm when they developed an unstageable PI [a full thickness wound where the depth of damage cannot be determined because the base is covered by slough (yellow, tan, or grayish tissue) or eschar (brown or black leathery tissue)] to their right heel, an unstageable PI to their right bottom foot, and a Deep tissue pressure injury (DTPI) to the right foot on the lateral side. These failures placed residents at risk of pain, infection, medical complications, and a decreased quality of life. Findings include. Review of the facility policy titled, Skin Integrity & Pressure Ulcer/Injury Prevention, reviewed 06/11/2025 documents that this policy follows the professional standards of the National Pressure Injury Advisory Panel (NPUAP).a comprehensive skin assessment/inspection should be completed on re-admission to the facility, then weekly, quarterly and as needed.measures to maintain and improve residents skin will be implemented into the plan of care.implement measure to prevent against adverse effects of external forces such as pressure, friction and shearing. The National Pressure Injury Advisory Panel (NPUAP) Pressure Injury (Ulcer) definition and stages included:- A pressure injury (PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present itself as intact skin or an open ulcer and may be painful. The injury occurred because of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and sheer may also be affected by microclimate, nutrition, perfusion, co-morbidities, and condition of soft tissue.- An DTPI, is a localized area of purple or maroon discolored intact skin or a blood-filled blister due to underlying soft tissue damage from pressure or shear. The area may be painful, firm, mushy, boggy, warmer, or cooler than surrounding tissues, - An unstageable PI is an obscured full-thickness skin and tissue loss, full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it was obscured by slough or eschar (non-viable tissue covering the wound bed) (the eschar was dry, adherent, and intact without redness). NPUAP (2017), Educational and Clinical Resources and PI Prevention Points, advises to inspect the skin at least daily for signs of pressure injury, assess pressure points, reposition all individuals at risk for pressure injury based on support surfaces and individual preference. Resident 1 readmitted to the facility on [DATE] after an elective total right knee arthroplasty (replacement of the joint) (TKA) with diagnoses including atrial fibrillation (irregular heart rhythm), and peripheral vascular disease (condition that can affect blood flow to limbs). The 5-Day Minimum Data Set (MDS - an assessment tool) dated 10/28/2025 documented the resident had intact cognition, no refusal of care and was dependent on staff to assist with bed mobility. The MDS assessment documentation showed Resident 1 was at risk for PU/PI and had no PU/PI to their right leg or foot on readmission. Review of Resident 1's readmission skin assessment completed on 10/23/2025, documented no wounds to the resident's right foot, compression stockings on legs, and edema to lower extremities. Review of Resident 1's medical record reflected a document titled, Skin Integrity Update, dated 10/28/2025, there was no documentation related to any open wounds or redness to the resident's right leg/foot. Review of Resident 1's progress notes from 10/23/2025 - 11/02/2025, showed there was no documentation that any licensed staff visualized the resident's right leg with the compression stocking removed, and that no licensed staff had remove the compression stocking to the resident's right leg for a skin assessment. Review of the facility investigation dated 11/02/2025 at 1:45 PM, the licensed nurse documented that they found several new PIs:- Top of the right foot was reddish/purplish color and measured 8.5 centimeters (cm) by 3.5cm, - Right inner foot was reddish/purplish color that measured 4cm x 1cm, - Right lateral foot reddish/purplish color that measured 2.5cm x 1.5cm, - Scab on top of foot that measured 0.5cm x 0.5cm, - Right heel with black eschar that measured approximately 8.5cm x 3.5cm. Review of Resident 1's progress note dated 11/03/2025, they were transferred to the local community hospital on [DATE]. Review of Resident 1's hospital (local community) records dated 11/03/2025, the resident was transferred to another hospital (trauma - higher level of care) on the evening of 11/03/2025. Review of Resident 1's trauma hospital medical records dated 11/04/2025 at 2:00 AM, documented the following wounds on admission: - PI to the right heel