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	02/12/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate intervention, update and consistently implement the care plan to prevent accidents/falls for 1 of 2 residents (Resident 1) reviewed for accidents. The facility failure to provide adequate supervision and implement appropriate interventions placed residents at risk for further falls, injury, and a diminished quality of life. Findings included . Review of a facility policy titled, Fall Management, revised date 03/11/2025, documented the facility to evaluate each resident's fall risk to develop and implement care plan interventions that create a safe and secure environment where falls and injuries are minimized. The facility falls interventions include adequate supervision, development of care plan interventions to minimize fall risk, consistent with the resident's needs, goals, care plan, current professional standards of practice, and evaluation of effectiveness of fall risk interventions. Resident 1 readmitted to the facility on [DATE] with diagnoses to include Epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures caused by abnormal electrical activity), Atresia of foramina of Magendie and Luschka (a rare congenital anomaly causing obstructive brain's ventricle outlets blocked), Muscle weakness, and difficulty in walking. According to the admission Minimum Data Set (MDS - an assessment tool) assessment, dated 12/22/2025, the resident had no cognitive impairment. Resident 1 required set-up assistance for toilet transfer (the ability to get on and off a toilet or commode) and required supervision and touching assistance for walking up to 50 feet using a walker.On 02/10/2026, a review of Resident 1's clinical record documented that the resident had nine falls during 12/17/2025 to 02/02/2026.Review of an incident investigation, dated 12/17/2025 at 12:00 AM, documented Resident 1 fell from using their bedside table as a walker to assist to self-transfer to the bedside commode (BSC). Review of the staff training record, under plan/intervention to prevent recurrence, documented a bedside table needed to always have one wheel locked. There was no other intervention documented. On 02/12/2026, Resident 1's current care plan was reviewed. There was no documentation to lock the bedside table all the time.On 02/12/2026, review of current nursing Kardex (a tool used to provide directions on how to care for a resident), there was no documentation directing staff to lock the bedside table all the time.Review of an incident investigation, dated 12/21/2025 at 10:30 AM, documented Resident 1 had an unwitnessed fall and stated they had fallen off the lobby bench onto the ground. The investigation documented that the resident required one person assist for transfer and walking and the resident walked without assistance. The investigation concluded that Resident 1 had walked with their walker to the front of the building and did not use their wheelchair, which resulted in a fall. There was no documentation on what interventions provided to prevent further fall.Review of an incident investigation dated 12/24/2025 at 10:45 AM, documented confusing information about whether the resident was using a front wheeled or four wheeled walkers, and whether the resident fell in the hallway or in the room, and whether the resident was found on the floor or (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their head with laceration and swollen on the right eye. The resident stated they had personal caregivers who usually stayed with the resident for about four to five hours daily from Monday to Friday, but not 24 hours.In an interview on 02/10/2026 at 12:12 PM, Staff D, Nurse Assistant Certified (NAC), stated Resident 1 was a fall risk, but they did not use their call light when using their BSC, and fell frequently when they transferred without assistance from staff. When asked if the resident needed more supervision, Staff D stated they always reminded Resident 1 to use their call light even though the resident knew they needed to use call light, but they did not.In an interview on 02/10/2026 at 12:50 PM, Staff E, Licensed Practical Nurse (LPN), stated Resident 1 had frequent falls due to impulsive behaviors, forgetfulness, and unsteady gait, did not use their call light, and self-transferred to the BSC. Staff E stated the resident needed to use their wheelchair instead of a walker. When asked if Resident 1 needed more supervision with their transfer, Staff E stated the resident had personal care givers who stayed with the resident. Asked if the personal care giver was with the resident for 24 hours, Staff E stated no.In an interview on 02/12/2026 at 10:57 AM, Staff F, LPN/Unit Care Coordinator, stated Resident 1 did not follow the therapists' recommendations, and the resident used a four wheeled walker which was not safe to use. Staff F stated they educated the resident and the family multiple times but there was no documentation about what risks were provided. Staff F stated Resident 1 was supposed to use call light and was constantly reminded to use the call light, but the resident did not listen and had fallen multiple times from self-transferring. When asked if Resident 1 needed more supervision, Staff F stated the personal care giver was there with the resident all the time. Asked if the personal care giver was with the resident 24 hours, Staff F said no. Staff F stated Resident 1 had so many falls and nothing else they could do about it.In an interview and record review on 02/12/2026 at 11:32 AM, Staff B, Director of Nursing Services, stated among Resident 1's nine falls from 12/17/2025 to 02/02/2026, there were multiple incidents related to the resident self-transferring to the BSC without supervision or assistance, and used the four wheeled walker with no supervision or assistance.In an observation and interview on 02/12/2026 at 11:46 AM with Staff B, observed Resident 1's four wheeled walker was at the foot of their bed, the BSC was placed behind their recliner next to the wall. Staff B stated Resident 1 was not supposed to use the four wheeled walker and the BSC was supposed to be closer to the recliner.An interview was conducted on 02/12/2026 at 11:47 AM with Staff B and Staff D, NAC. Staff D stated Resident 1's BSC was placed behind the resident's recliner next to the wall all the time.An interview was conducted on 02/12/2026 at 11:48 AM with Staff B and Staff G, Director of Rehab. Staff G stated Resident 1 was not safe to use their four wheeled walker. Staff G stated a care conference recently held with a collaborating agency staff member who stated the resident had the right to use the walker they preferred and they had the right to fall. Staff G stated they did not document the care conference.In an interview on 02/12/2026 at 11:55 AM, Staff B stated the facility provided education to Resident 1 and their family regarding the four wheeled walker was unsafe to use. Staff B was unable to find the documentation on what risks and benefits educated to the resident and their family.In an interview on 02/12/2026 at 1:36 PM, Staff B stated Resident 1's room setting needed to be rearranged to better access the resident's BSC and minimized turns to keep the resident safe. Staff B stated the BSC, which was next to the wall behind the recliner the resident slept in, needed to be moved to the other side of the room near the bed for better access for the resident to use. Staff B stated the resident used their walker to pivot and turn to get close to the BSC, and the walker needed to be placed next to their recliner instead of far away from the recliner at the foot of bed. Staff B stated they needed safety strips on the floor to remind the resident the path to get to the commode. In a joint interview on (continued on next page)

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