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	04/23/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to protect residents right to be free from physical abuse for 2 of 2 sampled residents (Residents 3 and 4) reviewed for resident-to-resident altercations. Resident 3 caused potential harm for Resident 4 when they kicked them for not responding to a question. This failure placed residents at risk for potential physical or mental abuse, feeling safe, experiencing fear, intimidation, and a decreased quality of life.Findings included.Review of the facility policy Abuse-Protection of Residents reviewed 04/01/2026 documented the facility will ensure that all residents are protected from physical and psychosocial harm during and after the investigation.Review of the Nursing Home Guidelines the purple book, dated October 2015, Appendix A, Definition Diagram-Abuse, documented Physical abuse means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, or prodding. <RESIDENT TO RESIDENT ALTERCATION>RESIDENT 3Resident 3 admitted to the facility on [DATE] with diagnoses to include depression and aphasia (a language disorder caused by brain damage that impairs a person's ability to communicate). Review of a quarterly Minimum Data Set (MDS - an assessment tool) assessment, dated 02/11/2026, documented the resident was cognitively intact. Resident 3 was independent with their wheelchair (w/c) mobility and 1-person assist for longer distances.Review of a progress note dated 04/09/2026 at 10:15 AM documented that Resident 3 had kicked another resident and that the resident continued to be confused.Review of Resident 3's electronic medical record (EMR) did not show alert charting for the resident to resident altercation.In an interview on 04/22/2026 at 3:04 PM, Staff C, Licensed Practical Nurse (LPN), stated they were told that Resident 3 had kicked at Resident 4. Staff C stated Resident 3 was able to self-propel in their wheelchair.In an interview and record review on 04/23/2026 at 10:52 AM, staff G, LPN, nurse manager reviewed Resident 3's EMR and acknowledged there was no alert charting for the incident.RESIDENT 4Resident 4 admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia with agitation, anxiety, and major depressive disorder. Review of a Significant Change MDS, dated [DATE], documented the resident had significant cognitive impairment. Resident 4 required assistance with wheelchair mobility.In an interview on 04/22/2026 at 2:35 PM, Resident 4 stated no when asked if they had an incident with another resident and stated no when asked if they had concerns with any residents in the facility.Review of Resident 4's EMR did not show alert charting prior to 04/11/2026.In an interview and record review on 04/23/2026 at 10:52 AM, staff G, LPN, nurse manager reviewed Resident 4's EMR and acknowledged there was no alert charting for the resident until 04/11/2026.RESIDENT TO RESIDENT INCIDENT INVESTIGATIONReview of a facility incident investigation dated 04/09/2026 documented a physical altercation was observed between Resident 3 and Resident 4. Resident 3 was in their w/c and had wheeled past resident 4 who was in their w/c at the South nurses station. Resident 3 stopped and commented fine just ignore me and kicked resident 4 in the left lower leg. Residents 3 and 4 were separated.The investigation documented Resident 3's behavior toward Resident 4 was a result of their continued confusion and delusions and they had been (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on alert for behaviors that had started the previous week but had not shown aggression to other residents. The investigator documented Resident 3's actions were ruled out as willful abuse.Abuse and neglect were ruled out related to Resident 3 having continued confusion and delusions.In a joint interview on 04/23/2026 at 12:32 PM, Staff A, administrator, and Staff B, Registered Nurse, Director of Nursing, were asked how physical abuse was ruled out regarding the resident-to-resident physical altercation between Resident 3 and Resident 4. Staff A stated abuse was ruled out because Resident 3 was frustrated, did not intend to cause physical harm and was having a change in condition, there was no psychosocial harm to Resident 4 and Resident 4 could not recall the incident. Staff B stated Resident 4 was placed on alert charting on 4/11/2026. Staff A stated alert charting was not in place for Resident 3. Both Staff A and Staff B stated alert charting should be initiated at the time of the incident. Reference WAC 388-97-0640(1)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to thoroughly investigate incidents for 1 of 1 sampled resident (Resident 1) reviewed for injury during handling resulting in bruising, and failed to investigate 2 of 2 sampled residents (Resident 1 and 2) reviewed for resident to resident altercations. This failure prevented the facility from identifying the potential causes of the occurrence and contributing factors, placed residents at risk for unidentified abuse or neglect, risk for injury, and unmet care needs. Findings included . According to the Washington State Reporting Guidelines for Nursing Homes (Purple Book), dated October 2015, A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It includes guidelines for prevention and protection, incident identification, investigation and reporting for nursing homes, the facility investigation should end with the identification of who was involved in the incident, and what, when, where, why, and how the incident happened including the probable or reasonable cause. Findings included.<INJURY DURING HANDLING INVESTIGATION>RESIDENT 1Resident 1 admitted to the facility on [DATE] with diagnoses including dementia, depression, cirrhosis of the liver (long term inflammation of the liver), and need for assistance with personal care. According to the Significant Change Minimum Data Set (MDS-an assessment tool) assessment dated [DATE], the resident had moderate cognitive impairment. Resident 1 required 2-person assistance with toileting, dressing, and bed mobility. Review of the facilities State Incident Reporting log, dated April 2026 showed documentation of an incident for Resident 1 of injury during handling with bruising on 04/09/2026 at unknown time. Review of a document titled Skin Integrity update, dated 04/09/2026 at 7:08 PM documented the resident had bruising to the right side of their groin and above vaginal area. The document did not show the color, size, or how many bruises were identified. Review of a document titled Witness Interview/Statement Form, dated 04/09/2026 at 6AM, Staff C, Licensed Practical Nurse (LPN), documented Resident 1 had two bruises above the vaginal area and 1 bruise in the right side of the groin. Review of a document titled Witness Interview/Statement Form, dated 04/09/2026 at 8:40 AM, Staff D, Registered Nurse (RN), nurse manager documented Resident 1 had three red/purple marks to their pubic bone skin area. Review of an email dated 04/09/2026 at 12:40 PM, Staff A documented Resident 1 was found to have a bruise to their pelvic bone. Review of a statement dated 04/14/2026, Staff E, Acute Care Nurse Practitioner, documented they were notified of bruising found in Resident 1's vaginal area on 04/10/2026. Staff E documented that staff reported mild bruising was noted to the external vaginal labia during care. Staff E documented they inspected the area and concluded this had occurred with the prior shift's peri care. Review of an email dated 04/09/2026 at 12:40 PM, Staff A, Administrator, documented Resident 1 was found to have a bruise to their pelvic bone, Staff E looked at the resident and felt that it was from pressing down to hard while wiping the area during care. Review of Resident 1's physician orders did not show monitoring of bruising to the resident's pelvic bone area. Review of Resident 1's Treatment Administration Record April 2026 did not show documentation of monitoring of bruising to the resident's pelvic bone area. Review of Resident 1's care plan focus for activities of daily living (ADL) showed an intervention initiated on 04/14/2026, documented;-During peri care, please ensure to be gentle with Resident 1's skin. She has very fragile skin due to her current Hospice status. She is expected to decline in all aspects of care, care staff to provide the gentlest care possible. Review of Resident 1's progress notes did not show documentation of bruising to the resident's pelvic bone area after April 12th, 2026. In an interview on 04/22/2026 at 2:58 PM, Staff F, Certified Nursing Assistant, stated the Kardex (a tool used to provide directions on how to care for a resident) gives information about how to provide care for a resident. In an interview on 04/22/2026 at 3:04 PM, Staff C, Licensed Practical Nurse, (LPN), stated when a skin issue is identified the resident is placed on alert charting for three days. Staff C stated the nurse manager would update the care plan for skin issues. Staff C stated they did (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not think the bruising to Resident 1's pelvic area was being monitored on the TAR. In an interview and record review on 04/23/2026 at 10:30 AM, Staff G, LPN, Nurse Manager, stated if a skin issue is identified the provider would be notified and an order would be put in to monitor every shift on the TAR until resolved. Staff G reviewed Resident 1's physician orders and TAR and acknowledged there was not a physician order to monitor bruising the resident's pelvic area and the bruising was not being monitored on the TAR. Staff G reviewed Resident 1's care plan and stated the bruising to the resident's pelvic area was not on the care plan. INJURY DURING HANDLING INCIDENT INVESTIGATION Review of a facility investigation dated 04/09/2026 documented Resident 1 was found to have bruising to their pelvic bone area that occurred during peri-care. The investigation did not show statements from staff prior to the identification of the bruising and did not show observations of peri-care performed by staff who provided incontinent care for the resident prior to identification of the bruising to rule out abuse or neglect. The investigation documented the bruising to Resident 1's pelvic area occurred during peri-care and no concerns of abuse. Abuse and neglect were ruled out related to bruising to Resident 1's pelvic area occurred from staff wiping to hard when providing peri-care. In a joint interview and record review on 04/23/2026 at 12:32 PM, with Staff A, and Staff B, RN, Director of Nursing, Staff A stated they interviewed one nursing assistant from the evening shift prior to identification of the bruising to Resident 1's pelvic area but did not document the interview. Staff A stated they did not get statements from staff who provided care for Resident 1 prior to the identification of the bruising. Staff A stated the provider felt the bruising was due to care. Staff B stated demonstration/return demonstration for peri-care should be completed to ensure staff are aware of how to provide incontinent care correctly and stated there was no documentation that observations of care were completed. Staff B stated they completed verbal competencies for reporting skin issues; the verbal competencies were not documented. Staff A stated hands on education was not completed. Staff B stated residents with identified skin issues would be put on alert charting for monitoring until resolved. Staff B acknowledged there was no documentation of bruising in Resident 1's charting after 04/12/2026. Staff A stated if bruising is identified the resident is placed on alert charting, the care plan is updated, and an intervention is initiated that day. Staff A stated they did not complete demonstration/return demonstration for care and after ruling out sexual abuse and establishing the bruising was care related they did not further investigate. <RESIDENT TO RESIDENT VERBAL ALTERCATIONS>RESIDENT 1Review of a progress note dated 04/06/2026 at 12:46 AM, documented Resident 1 was verbally fighting with her roommate (Resident 2) and calling them names. Nurse had to go in and asked both ladies to be respectful with each other and if they are not getting along they should stop talking to each other, so they don't end up offending each other. No reports of further escalation of their verbal fight was reported. Review of a progress note dated 04/21/2026 at 4:40 PM, Staff C documented Resident 1 was calling their roommate names and staff asked the resident to be nice to their roommate and not to cuss at them. Staff G, Staff A, and Staff B were notified. Review of a progress note dated 04/22/2026 at 10:15 AM documented Resident 1 was changing rooms per request from Hospice. Review of Resident 1's progress notes did not show alert charting for resident to resident altercations. Review of Resident 1's care plan showed no interventions for verbal altercations toward other residents. In an interview and observation on 04/22/2026, Resident 1 was observed lying in bed and denied concerns with other residents. RESIDENT 2Resident 2 re-admitted to the facility on [DATE] with diagnoses including anxiety, cognitive communication deficit, and need for assistance with personal care. According to the Quarterly MDS dated [DATE], the resident was cognitively intact. Resident 2 was dependent on staff for transfers. Review of a progress not dated 04/19/2026 at 3:13 AM, documented Resident 2 was answering back to their roommates insults when the nurse came in and this evening and was doing rounds. AM nurse and this nurse tried to remind both ladies to be respectful of each other but her roommate was just ignoring us. Resident was more compliant with our request. Review of Resident 2's progress notes did not show alert charting for the resident to resident altercations. Review of (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2's care plan did not show interventions for resident to resident altercations. In an interview on 04/23/2026 at 9:56 AM, Resident 2 stated Resident 1 would call them names, called them stupid and stated they were not a woman. The resident stated Resident 1 was manic and would verbalize things but was not physically aggressive toward them. Resident 2 stated staff were aware of Resident 1's behaviors and did not do anything to stop them. In an interview on 04/23/2026 at 10:32 AM, Staff H, CNA, stated Resident 2 did not voice concerns about Resident 1 to them. Staff H stated if they there was a resident to resident altercation they would separate the residents and report the incident. In an interview on 04/22/2026 at 3:04 PM, Staff C stated Resident 1 has had altercations with Resident 2. Staff C stated on 04/21/2026, Resident 1 was calling Resident 2 a fat cow, and they talked with both residents, re-directed Resident 1 and reported the incident to Staff A and Staff B. Staff C stated Resident 2 heard Resident 1. Staff C stated when Resident 1 yelled at Resident 2 they tried to deescalate the situation. Staff C stated Resident 1 was moved to another room on 04/22/2026. In an interview and record review on 04/22/2026 at 10:52 AM, Staff G stated residents yelling and calling names at another resident would be considered a resident to resident altercation. Staff G stated if a resident to resident altercation occurred residents would be separated, an investigation would be initiated, and the residents would be placed on alert charting. Staff G reviewed progress notes for Resident 1 dated 04/06/2026 and 04/21/2026 and Resident 2 dated 04/19/2026 and stated the documentation would be considered resident to resident altercations, investigations were not completed, the residents were not placed on alert charting and there were no interventions initiated until Resident 1 was moved to another room on 04/22/2026. In an interview and record review on 04/23/2026 at 12:32 PM with Staff A and Staff B, Staff A reviewed progress notes for Resident 1 dated 04/06/2026 and 04/22/2026 and Resident 2 dated 04/19/2026 and acknowledged these were resident to resident verbal altercations and no investigations were completed. Staff B reviewed Resident 1 and Resident 2's medical records and stated there were no interventions initiated prior to Resident 1's room move on 04/22/2026. Reference WAC 388-97-0640(6)(a)