

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of Mount Vernon		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview and record review the facility failed to provide a dignified and homelike experience and promote the rights of 1 of 1 resident reviewed for dignity (266), 2 of 3 (Residents 12 and 44) reviewed for urinary catheter use, 1 of 1 (Residents 4 and 11) dining observations and concerns voiced in resident council meeting (Residents 8, 11, 18, 24, 54, 214 and 265) residents reviewed for dignity when staff failed to interact with residents in a dignified manner, and failed to cover urinary bags, These failures placed residents at risk for feelings of emotional distress, frustration, humiliation, embarrassment, diminished self-worth and or quality of life, and a potential decline in nutritional status.</p> <p>Findings included .</p> <p>Review of the facility policy titled Preservation of Residents' Rights, reviewed 09/26/2024, showed each resident has the right to be treated with dignity and respect. All activities and interactions with residents by any staff, temporary agency staff, or volunteers will focus on assisting the resident in maintaining and enhancing their self-esteem and self-worth and incorporating the resident's goals, preferences and choices. When providing care and services, staff should respect each resident's individuality, as well as honor and value their input.</p> <p><DINING ROOM></p> <p>Resident 4 admitted on [DATE] with diagnoses of traumatic brain injury. Resident 4 could understand verbalizations and responds with hand signs.</p> <p>In a continuous observation on 04/02/2025 from 12:00 PM until 1:13 PM, Staff N, Nurses Aide Certified, was seated next to Resident 4 to assist with their meal. Staff N did not converse with Resident 4 during the continuous observation including while assisting with providing drinks and bites of food.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/07/2025 at 11:10 AM, Resident 11 stated when they come into the dining room, they wait to get a menu and have to raise their hand to get staff attention. They said they will say, Hey, I need some drinks over here. Resident 11 stated they wait to get their meal, and others are done eating, and the housekeeper is waiting to clean. The resident said that the housekeeper will try to get them to take their tray to their room to finish eating. The resident stated they did not like to feel rushed so they tell the housekeeper if they had wanted to eat in their room, they would have stayed and ate in their room.</p> <p><RESIDENT COUNCIL MEETING></p> <p>On 04/07/2025 at 11:10 AM, Resident 214 stated they were concerned about the help. They stated they will ask for help and staff look at them then walk away, leaving them wanting to get from point A to point B.</p> <p>Resident 11 stated that when they need some type of help, or to be changed for some number of hours, the aides will come in and say they will let my aide know when they are back from break so they can help me. Resident 11 asked why they couldn't help them at that time.</p> <p>Resident 54 stated they have had a couple bloody noses, and they walk to their doorway and there is a nurse standing outside. The resident said they asked, Can you even look in on me? Resident 54 said sometimes they will hand them a cold bloody rag and just tell them Put this on your nose and squeeze The resident said they rarely get checked out by the nurse or their blood pressure taken. The resident said they had a problem related to respect and dignity. Resident 54 stated staff appear to not treat them like people. They stated staff do not knock before they come into their room or they knock and identify themselves, don't wait for their response and walk right in.</p> <p>Resident 8 said they don't mind staff walking in if they lay there for two to three hours in a sopping wet diaper. I am not an idiot. They will see what they see if they come in here unannounced.</p> <p>Resident 24 stated they have to dress themselves and make their bed and it should not be that way. The resident stated they had to share a bathroom with the next room, and it was not private.</p> <p>Resident 18 stated there was no staff to help you from 11:30 AM to 1:00 PM and they see 1-2 aides just sitting in the dining room awaiting the trays when they could be helping out on the floor.</p> <p>On 04/07/2025 at 11:16 AM, Resident 265 stated they would put their hand up to summon staff and the staff walk right by them. Resident 265 stated they might as well go home since they do everything themselves.</p> <p>Review of the grievance log showed no entries for these concerns for Resident 8, 11, 18, 24, 54, 214 and 265.</p> <p>In an interview on 04/07/2025 at 12:40 PM, Resident 8's allegation was reported to Staff A, Administrator. Staff A stated they were not aware of Resident 8's concerns and would begin an investigation.</p> <p>37890</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><URINARY CATHETERS></p> <p>Resident 44 admitted on [DATE] with diagnoses to include bladder dysfunction.</p> <p>In an observation on 04/04/2025 at 9:35 AM and 11:55 AM, Resident 44 had an uncovered clear catheter bag revealing dark yellow urine which was visible to those passing in the hall.</p> <p>RESIDENT 12</p> <p>Resident 12 required an indwelling urinary catheter related to obstruction of the urinary tract that impaired their ability to empty their bladder.</p> <p>In an observation on 04/02/2025 at 11:20 AM, Resident 12's door was open and a clear catheter drainage bag with urine and no privacy covering was observed connected to the lower frame of the bed and visible from the hallway.</p> <p>In additional observations on 04/03/2025 at 2:52 PM and 04/07/2025 at 8:01 AM, the resident's catheter bag remained attached at the end of the bed with no privacy cover and visible from the hallway when the door was open.</p> <p>In an interview on 04/09/2025 at 8:40 AM, Staff B, Director of Nursing Services (DNS), and Staff C, Regional Director of Clinical Services, were informed of the resident council concerns voiced. Staff B and C were not aware of the resident council concerns voiced by Resident's 11, 18, 24, 54, 214 and 265. Staff C stated they became aware of Resident 8's concerns from this surveyor on 04/07/2025. Staff C told Staff B they would be doing some off-hour visits. Staff B stated the facility was supposed to be using the type of urinary catheter bag that had a privacy flap attached. Staff B stated the residents come from the hospital with the non-privacy catheter bags and staff were supposed to switch the bags over to a privacy bag.</p> <p>51312</p> <p><Resident 266></p> <p>Resident 266 was admitted to the facility on [DATE]. Resident 266 was severely cognitively impaired and had a diagnosis of dementia (a syndrome that typically leads to deterioration in cognitive functioning).</p> <p>In an observation on 04/2/2025 at 10:21 AM, Staff E assisted Resident 266 in getting dressed. The resident's privacy curtain was not closed, and another staff member, Staff Z, entered the room, opening the door to the hallway. As a result, Resident 266 could be seen without clothes from the hallway.</p> <p>In an interview 04/09/2025 at 10:21 AM, Staff C, Regional Director of Clinical Services, stated staff should be pulling the privacy curtains around resident beds when providing care and any staff entering the room should knock and staff in the room should be stating resident care to ensure privacy.</p> <p>This is a repeat citation from survey dated 08/06/2024</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51312</p> <p>Based on observation, interview, and record review, the facility failed to ensure the physical environment accommodated resident needs for 2 of 2 residents (Residents 4, and 15) reviewed for accommodations of needs. This failure placed residents at risk for falls and unmet care needs.</p> <p>Findings included .</p> <p><Resident 4></p> <p>Resident 4 was a long-term resident of the facility with diagnoses that included traumatic brain injury (TBI) (an injury to the brain caused by an external force) and a voice and resonance disorder (functional speech deficits).</p> <p>Review of Resident 4's Care Plan on 04/03/2025 documented the following:</p> <ul style="list-style-type: none"> - Resident 4 had a soft-touch pad call light. - Staff were to ensure the call light was within reach and respond promptly to all requests for assistance. <p>During an observation on 04/03/2025 at 2:03 PM, Resident 4's call light was a push button style call light. Resident 4 pushed the call light a few times, and it was observed not to turn on. An unknown staff member entered the room, checked to see if the call light was working, and pushed the button; the call light worked.</p> <p>During an observation on 04/07/25 at 9:01 AM, Resident 4 was up in their wheelchair, and the push-button call light was out of reach.</p> <p>During an observation on 04/07/25 at 9:39 AM, Resident 4 was in a wheelchair, and the push-button call light was out of reach.</p> <p>During an observation on 04/07/25 at 1:26 PM, Resident 4 was up in their wheelchair in the room, and the push-button call light was out of reach.</p> <p>During an observation on 04/08/25 at 9:06 AM, Resident 4 was up in thier wheelchair in the room, and the push-button call light was out of reach.</p> <p><Resident 15></p> <p>Resident 15 was a long-term resident of the facility. According to the Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], Resident 15 was severely cognitively impaired and had delusions.</p> <p>Review of Resident 15's Care Plan on 04/04/2025 documented that the call light should be within reach of the resident.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 04/04/2025 at 1:58 PM, Resident 15 was lying in bed, with the call light noted on the floor out of their reach.</p> <p>During an observation on 04/04/2025 at 2:48 PM, Resident 15 was in lying bed, with the call light noted to be on the floor out of their reach.</p> <p>During multiple observations on 04/08/2025 at 9:10 AM, 10:20 AM, 11:35 AM, and 12:34 PM, Resident 15 was lying in bed, with the call light noted to be on the floor out of their reach.</p> <p>During an interview on 04/08/2025 at 1:05 PM, Staff C, Regional Director of Clinical Services stated that staff should ensure call lights were within resident reach at all times.</p> <p>Reference WAC 388-97-0860 (2)</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>36787</p> <p>Based on observation, interview and record review, the facility failed to ensure residents' medical information was maintained in a manner to ensure privacy and confidentiality when staff failed to secure the health records for 20 residents (Residents 7, 33, 35, 40, 44, 45, 46, 48, 51, 56, 57, 58, 59, 60, 114, 115, 119, 120, 121 and 165) on 1of 3 units reviewed for privacy and confidentiality. This failure placed residents at risk for violation of a resident's right to privacy and/or confidentiality, unwanted dissemination of personal health information, emotional distress and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Confidentiality of Information approved 02/04/2025, documented, Associates are responsible and accountable for the integrity and protection of business information and protected health information. They must protect information entrusted to them and must not inappropriately disclose, modify, or destroy such information. Associates who inappropriately disclose confidential information (either purposefully or through casual conversations) will be subject to corrective action, up to including termination.</p> <p>Health Insurance Portability and Accountability Act (HIPAA), a federal law enacted in 1996 that aimed to protect the privacy and security of sensitive patient health information. Specifically, HIPAA provided standards for how health care providers, health plans, and other organizations can handle and share protected health information.</p> <p>In an interview on 04/02/2025 at 2:55 PM, Resident 114 stated they had concerns with their pain medication orders compared with what they had received at the hospital. Resident 114 stated the nurse was frustrated and agitated with them and put a blank piece of paper down for them to write down what medications they thought they should be getting. The resident stated when they turned the paper over, they saw a Cart A report sheet that included everyone on the unit's personal information and diagnoses. Resident 114 showed this surveyor the picture of Cart A's undated report sheet that included Resident's 7, 33, 35, 40, 44, 45, 46, 48, 51, 56, 57, 58, 59, 60, 114, 115, 119, 120, 121 and 165's name, room numbers, diagnoses, how they take their medications and their code status. Resident 114 stated they were upset that the paper showed they were at the facility for anxiety disorder rather than the recent surgery they had. The resident stated they believed the involved nurse had been fired as they had not seen them since. The resident stated they had everyone from the administration in their room begging them to delete the photo.</p> <p>In an interview on 04/04/2025 at 11:30 AM, Resident 46 stated their husband got a letter in the mail that their private information was left out including vital signs, their diagnoses and address and a resident had taken a picture of it. Resident 46 stated that it was a HIPPA violation as they used to work at hospice. Resident 46 stated this was upsetting and distressing to them. The resident was concerned those details would be put on the internet and be there forever.</p> <p>In an observation on 04/04/2025 at 11:32 AM, central nurses' cart had a report sheet with two residents' weights, and it included their room number and bed location.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility Privacy or Security Event Reporting Form dated 03/12/2025 documented approximately 18 individuals were affected by the breach. The type of event was a loss or missing paperwork that included name, diagnosis/condition. The description of the event was the day shift nurse left their report sheet at the bedside of the resident in 114-2. The resident stated that it was left there by either the night nurse or day nurse. The facility identified the day nurse as the nurse involved who returned to the room to collect the paper. The event description noted the resident had taken a picture of the form that contained the residents' names, room numbers, code statuses and diagnoses. Follow up included the Resident in 114-2 would delete the photo when they felt they no longer needed the information.</p> <p>Review of a dated in-service on 03/13/2025 included the facility policy on confidentiality of patient health records and adhering to HIPAA standards for protecting health information and directed staff they must safeguard sensitive data.</p> <p>In an interview on 04/09/2025 at 8:15 AM, Staff C, Regional Director of Clinical Services stated they turned the HIPAA violations into their superiors to address. Staff B, Director of Nursing, was unaware of the incident with the report sheet revealing Unit A's personal medical information. Staff C stated report sheets should be safeguarded for privacy.</p> <p>Reference WAC 388-97-0360 (1)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation and interview, the facility failed to ensure the facility was maintained in a clean, comfortable, homelike and safe environment, for 2 of 3 halls including resident rooms (315, 102, 106, and 114). Failure to ensure the facility was free from dust, kept clean, and had laundered privacy curtains placed residents at risk for decreased quality of life, compromised dignity and potential infection control issues.</p> <p>Findings included .</p> <p><room [ROOM NUMBER]- Bed 1></p> <p>In an observation on 04/02/2025 at 9:56 AM, three large areas of brown matter were on the bottom portion of the outside of the privacy curtain.</p> <p><room [ROOM NUMBER]- Bed 2></p> <p>In an observation on 04/02/2025 at 2:45 PM, heavy dust was noted in the ceiling vent, around the privacy curtain rail and the hooks.</p> <p><room [ROOM NUMBER]- Bed 2></p> <p>In an interview on 04/03/2025 at 8:51 AM, Resident 46 stated their bathroom needs to be cleaner. The resident stated they share a bathroom with the room on the other side and often there was bowel movement on the toilet. Resident stated when their spouse visits, they take them to another bathroom.</p> <p>In an interview on 04/09/2025 at 12:43 PM, Staff A, Administrator, was informed of the environmental observations. Staff A stated they were starting to do room rounds and give a list of concerns to the maintenance department. Staff A stated the facility had enough privacy curtains to replace them upon discharge. They stated the environment was a work in progress. Staff A stated their expectation was rooms were to be clean, including high areas.</p> <p>51312</p> <p><room [ROOM NUMBER]></p> <p>In an observation on 04/04/2025 at 9:44 AM, the privacy curtain between the two beds had an orange stain approximately 1.5 feet long and 6 inches wide in areas, followed by multiple small brown stains all over it.</p> <p>In an interview on 04/09/2025 at 12:46 PM, Staff L, housekeeping, stated that housekeeping was responsible for cleaning room curtains and that room [ROOM NUMBER]'s curtains are dirty and need to be changed.</p> <p>This is a repeat deficiency from survey dated 05/01/2024</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>36787</p> <p>Based on interview and record review the facility failed to have a system in place that ensured grievances were initiated, logged, addressed, and timely resolved in response to residents' verbal conveyance of concerns for 3 of 3 resident council's (January, February and March 2025), who verbalized complaints during a Resident Council (RC) meeting. The facility's failure to initiate, log, investigate verbalized concerns, inform residents of the facility's findings and the actions taken, if any, prevented the facility from identifying care trends and determining if actions taken to resolve grievances were effective. These failures led to residents repeatedly reporting the same care issues without resolution and placed them at risk for feeling frustrated, unimportant, with diminished self-worth and decreased quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy, Grievance Program (Concern and Comment) revised 01/07/2025 documented the resident has the right to, and the facility must make prompt efforts by the facility to resolve grievances the resident may have. The facility will maintain recordkeeping of all complaints via the Concern & Comment Program including the date of the grievance was received, summary of grievance, steps to investigate, a statement as to whether the grievances was confirmed or not confirmed , any corrective action taken as a result of the grievances and the date the written decision was issued.</p> <p>Review of the Blue Card, titled, Concern & Comment Form, undated, stated the facility was committed to responding to the needs of our customers in a continuing effort to improve the quality of life for each of our residents. It is our desire to meet or exceed each of our residents and family's needs. The form was two sided, the first side used to describe the concern and if it was reported and how. The other side of the form was titled, FACILITY INVESTIGATION AND RESPONSE.</p> <p>A review of meeting minutes for 12/31/2024 revealed multiple unaddressed grievances. Residents requested fresh fruit for dessert. The kitchen manager reported they were locked into company menus and providers /suppliers and that fresh fruit is not offered , seasonal or otherwise. Residents reported inconsistent food temperatures in the dining room and hallway carts.</p> <p>Review of the meeting minutes for 01/28/2025 showed the residents requested fresh fruit and different snacks. Residents reported call light response time is too long.</p> <p>Review of the meeting minutes for 03/27/2025 showed the residents reported the call light response time was not good. Residents reported cold dinners, and the menu needed expanding.</p> <p>During the resident council meeting held on 04/07/2025 at 10:30 AM, the residents were asked about grievances and if they knew how to file a grievance:</p> <p><RESIDENT 11></p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 11 stated it depended on who received the grievance as to if there was follow up. Resident 11 stated they had been at the facility since September 2024, and it was not until February that staff came to inventory their belongings. Resident 11 stated they had missing items and had no way to prove it. Resident 11 was unsure what the inventory policy was. Residents 54, 24 and 118 shared similar concerns that no inventory was taken when they admitted .</p> <p><RESIDENT 54></p> <p>Resident 54 stated the staff are afraid to say anything or their job is in jeopardy. Resident 54 stated they were afraid to report things to multiple staff. Resident 54 stated they had a 10-foot cloth cord cell phone charge missing after admitting and had asked the lady up front for an cell phone charger and had not heard anything back. Resident 54 stated they replaced the charging cord. Resident 54 reported that another resident was wearing their local coffee shop shirt they wore the day they admitted , they reported they informed staff, and no one said anything to them about writing a grievance.</p> <p>In an interview on 04/07/2025 at 12:40 PM, Staff A, Administrator stated they had a grievance on the cell phone charger and heard the resident's girlfriend took it home but they had not had the chance to call them yet and they were working on this.</p> <p>In an observation and interview 04/07/2025 at 1:10 PM, Resident 54 was in Staff A's office interviewing them on the apple charger. Staff A stated Resident 54 had a new charger, and their girlfriend had brought it to them. Staff A held up blank blue grievance forms and said they were working on these.</p> <p><RESIDENT 18></p> <p>Resident 18 stated laundry items are delivered to the wrong room. Resident 18 stated they only get bananas for fruit and never apples or berries.</p> <p><RESIDENT 265></p> <p>Resident 265 stated they had asked staff for a week to help them fix their television (TV). The resident stated no one had offered them a grievance or helped them fill out a grievance form. The resident reported staff would look up at their TV but did not follow up. Resident 265 stated the staff told them to hook their TV up to the ROKU and they did not know how to do that. The resident stated the staff pass the buck, we need assistance that is why we are here. Resident 265 stated they were on a pureed diet and night staff were not aware of that and gave them potato chips and cookies for snacks. Resident 265 stated they tell the staff they are not supposed to have chips or cookies and staff responds the facility is out of everything. The resident stated they would like to have pudding or yogurt since they shouldn't have chips.</p> <p>In a follow up interview on 04/08/2025 at 8:13 AM, Resident 265 was asked resident if their TV had been fixed. They stated no. At 8:41 AM Staff K, maintenance director stated they were aware of Resident 265's TV issue and it was not on the maintenance log. At around 8:41 AM, Staff K reported the TV was up and running.</p> <p><RESIDENT 5></p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the resident council interview on 04/07/2025 at 11:44 AM, Residents were asked if the concern regarding not receiving fresh fruits and vegetables had been resolved. Resident 5 stated that was a bad subject and a joke.</p> <p><RESIDENT 118></p> <p>In the resident council interview on 04/07/2025 at 11:44 AM, Resident 118 stated at the hospital they had fresh fruits and vegetables and they would like melons, grapes, mixed berries and sliced apples.</p> <p>Review of the grievance log for January 2025 through March 2025, showed no logged grievances regarding the grievances reported from the resident council meetings nor any of the above grievances reported.</p> <p>In an interview on 04/08/2025 at 11:10 AM, Staff N, NAC stated if a resident was missing a shirt, they would look in the laundry first and if the item was not there they would keep an eye out for it in case the item showed up in another residents room. Staff N said they would pass the information onto the next shift. They stated they did not think there was a form to fill out. Staff N stated when a resident reported cold foods they would offer to warm their food up or get them another meal and they would fill out a complaint form. Staff N stated for maintenance requests, they would notify them of the issue, would in person and write the issue in the maintenance binder located at the north nurse station.</p> <p>In an interview on 04/08/2025 at 2:09 PM, Staff M, NAC stated the admission nurse completed the resident inventory. Staff M stated if a resident reported missing items they would give them a paper to fill out with the details, talk with laundry staff and the nurse so they could look for the item.</p> <p>In an interview on 04/08/2025 at 2:30 PM, Staff T, Registered Nurse stated if a resident was missing an item they would try to find out if they could find it or give them a blue sheet and notify social services to investigate it.</p> <p>In an interview on 04/09/2025 at 8:14 AM, Staff B, Director of Nursing Services stated their expectation was staff were to fill out a grievance for missing items and laundry would look for them. Staff B stated the nurse would ask the NAC to help with personal inventory. Staff A, Administrator stated they will offer to replace missing items or the resident can purchase them and provide a receipt for reimbursement.</p> <p>In an interview on 04/09/2025 at 10:24 AM, Staff G, Social Services Director they complete blue forms for grievances. Staff G stated When in doubt, fill one out. Staff G stated they needed to follow through with the grievance. They stated they complete the grievance forms for missing clothing, dentures. Staff G stated they had not heard of the missing clothing for Resident 114. Staff G stated Resident 265 just filled a grievance out for her yesterday, one for their TV not working, concern with call light response and also staff speaking in multiple languages. Staff G stated Staff A, Administrator was working on them. Staff G stated they had not heard of the TV issue until yesterday.</p> <p>Reference WAC 388-97-0460 (1)(2)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110</p> <p>Based on interviews, and record reviews, the facility failed to conduct thorough investigations for 3 of 3 allegations of abuse and/or neglect for (Residents 117, 164, and 216), 3 of 4 falls (Residents 46, 115, and 218), and 1 of 1 medication error (Resident 24) whose investigations were reviewed for thorough investigations. The failure to conduct thorough investigations placed residents at risk for repeat incidents, injury, and for unmet care needs due to a lack of thorough investigations after incident occurred. These failures placed residents at risk for repeated incidents and injuries.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Incident and Reportable Event Management, reviewed 09/25/2024 stated the facility would provide an environment free from accident hazards by identifying hazards and risk, evaluating and analyzing, implementing interventions, and monitoring the effectiveness and modification of interventions if necessary . to prevent recurrence the facility should evaluate what happened, who provided care, witnesses to event, why did it happen, and what mitigation efforts were done.</p> <p>Review of the facility policy titled, Abuse - protection of residents, reviewed 06/17/2024, stated the facility will ensure all residents are protected from harm during and after the investigation . the facility should notify all agencies as applicable.</p> <p><ABUSE/NEGLECT></p> <p>RESIDENT 216</p> <p>Resident 216 admitted to the facility on [DATE] with diagnoses that included benign prostatic hyperplasia (BPH - enlargement of the prostate gland that can cause difficulty and frequent urination), history of stroke with right side weakness, and muscle weakness.</p> <p>Resident 216's Admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE] documented the resident had a mild cognition impairment, and required substantial to maximum assistance for toileting, transfers and personal hygiene. They had occasional incontinence (inability to control) of the bladder and bowel.</p> <p>In a review of Resident 216's admission nursing progress note on 03/10/2025 the nurse documented the resident was alert and oriented to person, place, time, and events.</p> <p>In a review of Resident 216's care plan documented a focus area dated 03/10/2025 for urinary incontinence with interventions to assist with toileting as needed, ensure urinal was within reach, perineal care (cleaning of genitals and anus) as needed.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In a review of the facility investigation on 04/07/2025 (dated 04/02/2025) for the allegation of neglect that was reported to the facility for Resident 216 who reported they had been left lying in urine at night for over an hour. The investigation showed education was completed with staff on rounding timely, no education was provided in the investigation. The investigation included a question-and-answer sheet from twelve residents, two of which stated they did not feel the care needs had been met, and two residents reported they did not receive care in a timely manner. There was no [NAME] follow up included in the investigation, and the facility investigation stated residents were interviewed with no negative findings. The conclusion of the investigation was documented because they were not able to identify a staff member, therefore no abuse or neglect occurred. There was no documentation to support the facility had ruled out abuse and neglect, as the resident was alert and orientated and there was no interview included that they were interviewed, two other residents voiced concerns that were not addressed, there was no education with staff provided, and the investigation lacked a root cause analysis to rule out abuse and/or neglect.</p> <p>In an interview on 04/02/2025 at 3:17 PM, Resident 216 stated that at least two, to three times since their admission to the facility they have had nights where they have had to lay in their own urine for over an hour while they wait for someone to answer their call light. Resident 216's roommate (Resident 54) stated that they can get out of bed on their own and will go into the hallway to locate a staff member and it will feel like a ghost town, unable to find anyone to help.</p> <p>In an interview on 04/07/2025 at 2:01 PM, Staff D Nursing Assistant Certified (NAC) stated that Resident 216 required assistance with toileting, and that they were able to ask for assistance.</p> <p>In an interview on 04/08/2025 at 9:01 AM, Staff E NAC stated Resident 216 was alert and orientated and able to request help when needed. Staff E stated they had occasional incontinence and would need help to clean up at times.</p> <p>In an interview on 04/08/2025 at 9:51 AM, Staff F Licensed Practical Nurse (LPN) stated 216 residents were able to ask for assistance appropriately, had occasional incontinence, and required assistance for toileting and transfers.</p> <p><ABUSE></p> <p>Resident 117 admitted on [DATE] with diagnoses to include left hip fracture Parkinsonism, dementia and anxiety.</p> <p>Review of a progress note written by Staff H, LPN/Unit Care Coordinator (UCC) on 04/02/2025 at 4:14 PM, showed Resident 117 admitted from the hospital and required two-person max assistance with transfers and bed mobility . Bedfast most of the time. (Resident 117) exhibits anxiety and fear when turning/repositioning.</p> <p>Review of the care plan initiated on 04/02/2025 directed staff that Resident 117 required one person assist for bed mobility.</p> <p>In an interview on 04/03/2025 at 8:26 AM, Resident 117 reported when staff turn them sometimes, they were a little rough, and they turned them too quick and all of the above. Resident 117 stated there was supposed to be two people to turn them but when there was only one , there was trouble.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/03/2025 at 8:33 AM, Staff B, Director of Nursing (DNS), was notified of Resident 117's report of rough handling.</p> <p>In an interview on 04/04/2025 at 10:42 AM, Staff H, LPN/UCC stated Resident 117 had anxiety with transfers. Staff H stated they had heard in the report from the hospital the resident was anxious and fearful of transfers. The first initial assessment was put on the baseline care plan and then they revise them as they get to know the resident. Staff H said they had not put that information on the care plan at first but could add it as it would be useful information for staff who were caring for the resident.</p> <p>Review of the abuse allegation investigation included two statements from staff. There were no statements from other staff who cared for them to assist with identifying when the allegation occurred. The investigation did not include the finding that the staff knowledge of the residents' fear and anxiety during positioning and transfers was not transferred to the care plan as a means to prevent this allegation.</p> <p>In an interview on 04/09/2025 at 8:30 AM, Staff C, Regional Director of Clinical Services (RDCS) stated the expectation was they get statements from the shift the incident occurred on and they could have obtained more staff statements.</p> <p><FALLS></p> <p><RESIDENT 115></p> <p>Resident 115 admitted on [DATE] after hospitalization following a motor vehicle accident that resulted in a sternal fracture, fractured ribs, bilateral radius and ulna fractures, right humerus fracture and third toe fracture.</p> <p>In an interview on 04/03/2025 at 9:54 AM, Collateral Contact 4 , brother of Resident 115 stated their family member fell out of bed five days after admission. CC 4 said that their brother had surgery at the beginning of March after they broke both arms and hands in an accident. CC 4 stated the facility sent their family member out to the local hospital after the fall but the hospital did not x-ray the arms after the fall. CC 4 said the hardware was torn up and facility staff did not realize his left hand was torn up. CC 4 stated then (Resident 115) went two weeks before their follow-up orthopedic visit. At the visit, they did x-rays to check the healing process and his left hand , wrist and arm were a mess and screws were backing out. This required surgery and it was long after the fall so they had to deal with scar tissue and healing in the wrong place. CC 4 stated they were dissatisfied with the care and Resident 115 would be transferring to another facility that day.</p> <p>The fall investigation showed that on 03/14/2025 around 4:50 AM, an NAC called the nurse into the room, to find Resident 115 lying on their abdomen. The fall was unwitnessed, and the resident was unable to state what happened. Range of motion was checked prior to getting resident off the floor, on call Medical Doctor called and ordered to send resident to the emergency room as resident on Lovenox (blood thinner) injections. Resident returned to the facility with no new injuries. The NAC statement showed the resident received last toileting at 1:00 AM and had been checked on at 4:20 AM. Resident 115 was wearing nonskid socks on and the floor was dry. The fall scene investigation and nurse fall statement were not signed, making it unclear if the investigation was complete.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>RESIDENT 46</p> <p>Review of an un-witnessed fall investigation on 03/10/2025 at 2:53 PM, documented the nurse was notified by the NAC that Resident 46 had fallen in the bathroom and was found sitting in front of the toilet with their legs crossed. Resident 46 stated they got up from the toilet and fell hitting their head on the toilet seat. On 03/21/2025 the resident complained of right foot pain and an x-ray was obtained that revealed a right phalanx (toe) fracture.</p> <p>The investigation included a fall statement that showed a front wheel walker was present at the fall, a detail not present in the summary. The handwritten, unsigned statement showed it was unknown by staff when the resident was last toileted. The attached fall scene investigation showed Resident 46 transferred to the bathroom after getting up from the toilet and fell over onto their walker and hit their head on the toilet seat. The NAC caring for the resident was the first at the scene and they were unaware of the last time being toileted. There was no statement from the involved NAC. The conflicting information was not addressed.</p> <p>Review of a note from the Collateral Contract 5, facility contracted Advanced Registered Nurse Practitioner (ARNP) on 03/31/2025 showed Resident 115 went out to a Seattle hospital on 03/28/2025 for a planned follow up from the surgical intervention to lower left arm. Resident 115 went to ortho follow up a few days prior and follow up imaging demonstrated catastrophic hardware failure and severe shortening of the distal radius. This was suspected as a result from a fall out of bed of 03/14/2025. The resident was admitted to (Seattle hospital) and underwent left radius and ulna hardware removal, revision surgery to the radius fracture and ulna resection. Resident 115 readmitted to the facility on [DATE] for skilled therapy and nursing services.</p> <p>There was no addendum to the 03/14/2025 fall investigation or new investigation when the facility became aware of Resident 115's substantial injuries and hardware misplacement, requiring subsequent surgery and hospitalization .</p> <p>RESIDENT 218</p> <p>Resident 218 was admitted to the facility on [DATE] with diagnoses that included the history of falls with fracture to right femur (upper leg bone), Parkinson Disease (progressive, declining neurological disorder that primarily affects movement, and causes tremors), and depression. The Admission MDS dated [DATE] documented the residents had cognition impairment and required substantial to maximum assistance for transfers and bed mobility.</p> <p>In a review of Resident 218's physician orders there was an order for a bolster mattress to define parameters of the bed, no specific instructions dated 03/23/2025. There was an order for a fall mat on the right side of the bed for safety, no instructions dated 04/01/2025.</p> <p>In a review of Resident 218's care plan focus dated 03/19/2025 that they were at risk for falls, with interventions to assist with activities of daily living, bed in a low position for safety, bolster mattress in place, call light within reach, complete a fall risk assessment, and fall mat to right side of the bed for safety.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In a review of the fall investigation dated 03/22/2025, Resident 218 had been found with their upper portion of the body (including their head) on the ground and the lower portion of the body still on the bed. The resident was unable to state how they became positioned that way. The investigation included statements from a NAC that stated the residents had possibly hit their head. The investigation included a neurological flow sheet dated 03/29/2025 (date of the residents fall 7 days later), there was no neurological flow sheet for the fall on 03/22/2025. The investigation included a NAC statement that read the staff need more help during mealtimes to help prevent the recurrence of falls, this concern was not addressed in the investigation.</p> <p>In a review of the fall investigation dated 03/29/2025, Resident 218 had been found on the right side of the bed, resident reported they were asleep then woke up on the floor. The investigation statements stated the head of the bed was up, the resident probably tilted to the side and fell out of the bed. The investigation did not show if the residents had their call light within reach, or if the bed was low. The intervention to prevent recurrence was to place a fall mat on the right side of the bed.</p> <p><MEDICATION ERROR></p> <p>RESIDENT 24</p> <p>Resident 24 admitted to the facility on [DATE] with diagnoses that included bipolar disorder (mental illness with extreme mood shifts), anxiety and post traumatic stress disorder (PTSD).</p> <p>Resident 24's Admission MDS assessment dated [DATE] documented the resident was cognitively intact and had pain medication for routine and as needed pain management, and that in the last five days had experienced pain.</p> <p>In a review of Resident 24's physician orders showed an order dated 01/03/2025 for hydrocodone-acetaminophen (APAP) 10milligrams (mg) - 325 mg (narcotic medication used to treat pain) give one tablet every six hours for moderate to sever pain, the order was discontinued on 02/10/2025. On 02/10/2025 the physician changed the pain medication to Hydrocodone-APAP 5/325mg (a less strong narcotic).</p> <p>In a review of facility investigation dated 03/17/2025, Staff B, DNS documented they were notified that Resident 24 had been given the hydrocodone-APAP 10/325mg instead of the hydrocodone-APAP 5/325mg. The investigation had a copy of the narcotic ledger (sign out page for nurses to log they administered a narcotic), showed the hydrocodone-APAP 10/325mg was administered 10 times by several nurses. The investigation summary determined the cause of error was that narcotic medications needed to be destroyed when they were discontinued. The investigation lacked thoroughness, to determine the error was the licensed nursing staff had administered narcotics to a resident 10 times, outside of the accepted professional standard for medication administration. The investigation had no education or disciplinary action for the nurses that did not follow professional standards.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/08/2025 at 2:44 PM, Staff H LPN/Resident Care Manager (RCM) stated that typically the investigations were started on the floor with the cart nurses, and then the RCMs ensure all the documentation such as orders, care plans, etc. was included. Staff H stated for all investigations related to abuse and neglect that are completed by the Administrator and for all other investigations the Director of Nursing Services (DNS) will complete. Staff H was not aware of the investigation for Resident 216 and was not a part of the investigation. Staff H stated they did not know Resident 218 well and were not aware of their fall history. Staff H was not aware of the medication error for Resident 24.</p> <p>In an interview on 04/08/2025 at 3:21 PM, Staff C, RDCS stated their expectations for all investigations were to ensure that they are complete and thorough. Staff C stated the investigation into Resident 216 had been completed by the DNS, who were not available. Staff C were asked if there was a follow-up to the negative responses in the investigation made by other residents, they stated they were not aware and would follow up. Staff C was asked to review the investigation and Staff C stated the investigation was not clear or thorough and did lack evidence to show whether neglect had occurred. Staff C was unaware of the incomplete fall investigations for Resident 218. Staff C was unaware of the medication error for Resident 24, and stated their expectation was there should have been education and disciplinary action for all the licensed nurses that administered the wrong narcotic.</p> <p>36787</p> <p><PRESSURE ULCER></p> <p>RESIDENT 46</p> <p>Resident 46 admitted to the facility on [DATE] after a prolonged hospitalization with multiple diagnoses to include diabetes, liver disease, cardiac disease, kidney disease, pulmonary disease, stroke with left sided hemiplegia and hemiparesis (weakness and paralysis), osteoarthritis, protein calorie malnutrition and chronic pain from fibromyalgia.</p> <p>Review of Resident 46's admission nursing evaluation on 01/29/2025 showed they had no pressure ulcers (PU's), or open areas were identified on the admit assessment.</p> <p>In an interview on 04/03/2025 at 8:45 AM, Resident 46 was sitting on the side of their bed with flip flops on, and a dressing was observed on their left heel. The resident stated the wound occurred after they fell in the bathroom where they had waited an hour for help, and no one came.</p> <p>Review of the pressure ulcer/injury incident report dated 03/20/2025 at 8:35 PM, showed Resident 46 developed an intact blister to their left heel measuring 1.2 centimeter (CM) by 1.2 cm. The incident report noted the resident had reported they had a blister to their left heel but did not include an resident interview about when or how the blister occurred. The incident investigation did not include the resident's medical diagnosis or risk factors. There were no statements from nursing staff who care for Resident 46 other than the nurse who initiated the investigation. There was no documentation that the residents footwear or air mattress settings were inspected. The report did not include the bed settings. The investigation lacked a root cause analysis.</p> <p>37890</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><DELAY IN PAIN MEDICATION></p> <p>RESIDENT 164</p> <p>Resident 164 admitted [DATE] with diagnoses which included aftercare for a total hip arthroscopy following a complicated hospital stay. Resident 164 discharged against medical advice on 03/19/2025.</p> <p>Review of a grievance form left by the resident on 03/19/2025 stated my pain medication seemed to be a problem for them to let me have every time I was put off for 15-30 minutes and by the time I received it I hurt so bad it wasn't enough to help. The grievance form was escalated to a reportable allegation on 03/19/2025.</p> <p>Review of Resident 164's hospital discharge orders to the facility dated 03/16/2025 documented an order for Oxycodone (an opioid pain medication) 2.5-5mg by mouth every three hours as needed.</p> <p>Review of Resident 164's electronic medical record orders showed the order for oxycodone had been incorrectly transcribed as: Oxycodone 2.5mg by mouth every three hours as needed (prn) for pain 7-10 (numeric pain scale) (omitting the 5mg availability).</p> <p>Review of the facility's investigation of the allegation showed there was a delay in oxycodone from the pharmacy related to an allergy alert that required clarification. Resident 164's medical record showed an allergy to Hydrocodone (also an opioid pain medication). The record showed no evidence of notification to the provider regarding a delay in receiving medication or to request any alternate orders. The investigation failed to identify the transcription error from the admission orders which would have allowed the resident 5mg of oxycodone instead of only 2.5mg every three hours for pain.</p> <p>Review of the state incident reporting log on 04/03/2025 showed the reported allegation from Resident 164 was not logged within five days as required.</p> <p>In an interview on 04/09/2025 at 10:57 AM, Staff A, Administrator, stated they had received the resident's grievance form and was told there had been a question about a possible allergy when they admitted . Staff A stated they questioned why the medication was not available but did not get a response back and stated they were not aware there had been an error in transcribing the pain orders. Staff A stated the allegation had not been logged within five days.</p> <p>This is a repeat deficiency from SOD 08/06/2024</p> <p>Reference WAC 388-97-0640(6)(a)(b)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110</p> <p>Based on interview and record review, the facility failed to ensure the recommendation of the Level II Preadmission Screen and Resident Review (PASARR) evaluation were incorporated into the plan of care upon receiving recommendations for 1 of 6 sampled residents (Resident 24) reviewed for coordination of PASARR and assessments. This failure placed residents at risk of not receiving the necessary mental health services and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Pre-admission Screening and Resident Review (PASARR), reviewed 09/26/2024 the Level II PASARR determination and evaluation report specify services to be provided by the facility .the recommendations are then incorporated into the person-centered care plan.</p> <p>Resident 24 admitted to the facility on [DATE] with diagnoses that included bipolar disorder (mental illness with extreme mood shifts), anxiety and post-traumatic stress disorder (PTSD). The Admission Minimum Data Set assessment dated [DATE], the resident was cognitively intact.</p> <p>In a review of Resident 24's Level 1 PASARR dated, 12/13/2024 the resident qualified for a Level II screening for a serious mental health condition(s).</p> <p>In a review of Resident 24's Level II psychiatric evaluation summary dated 12/16/2024, they concluded that the resident qualified for mental health services. The evaluation had recommendations for the facility as follows:</p> <ul style="list-style-type: none"> - key environmental focus, the resident had a fear of following, ensure environment was safe, - Staff approaches, the resident had history of past trauma with males, recommended female care for intimate care activities, - behavioral approaches, history of suicidal issues needs to have close relationship with the social service department. <p>In an interview on 04/02/2025 at 2:25 PM, Resident 24 stated they had some concerns they were worried about and had been told they had an assigned social worker at the facility, but they were not sure who that was.</p> <p>In a review of Resident 24's care plan on 04/02/2025, showed no area of focus for the resident's history of PTSD, male experience trauma, staff approaches, environmental focus areas, or behavioral approaches. No record of the Level II evaluation was incorporated into the plan of care for Resident 24.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/08/2025 at 12:02 PM, Staff G, Social Services stated they had been working at the facility for about six months. Staff G stated the expectation was when a resident had a Level II evaluation completed the recommendations would be incorporated into the care plan. Staff G was not aware of any recommendations that had been made in Resident 24's Level II psychiatric evaluation.</p> <p>In an interview on 04/08/2025 at 3:21 PM, Staff C, Regional Director of Clinical Services stated the expectation was that the interdisciplinary team (IDT) would be responsible for updating and revising the care plan. Staff C was not aware that Resident 24's care plan did not address any of the recommendations made in the resident's psychiatric evaluation, and stated they should have been incorporated into the care plan.</p> <p>In an interview on 04/09/2025 at 10:24 AM, Staff G, Social Service Director stated they were responsible for reviewing PASRR's for accuracy. Staff G stated they had been notified about the inaccurate PASRR's for Resident 24. Staff G stated they had a PASRR binder and tried to follow up on PASRR issues.</p> <p>Refer to WAC 388-97-1975(8)(10)</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on interview and record review, the facility failed to ensure 3 of 6 residents (Residents 15, 46, and 114) reviewed for pre-admission screening and resident review (PASRR), received the required screening for necessary services. This failure placed the residents at risk for unidentified mental health needs.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Pre-admission Screening and Resident Review, reviewed 09/26/2024 documented the facility will ensure that potential admissions are be screened for possible serious mental disorders or intellectual disabilities and related conditions. This initial pre-screening is referred to as PASRR Level I and is completed prior to admission to a nursing facility. A negative Level I screen permits admission to proceed and ends the PASRR process unless a possible serious mental disorder or intellectual disability arises later. A positive Level I screen necessitates an in-depth evaluation of the individual by the state designated authority, known as PASARR Level II, which must be conducted prior to admission to a nursing facility.</p> <p><RESIDENT 46></p> <p>Resident 46 admitted on [DATE] with diagnoses to include anxiety disorder, major depressive disorder and Post Traumatic Stress Disorder. Resident 46 was prescribed anti-depressants, anti-anxiety and anti-psychotic medications on admission.</p> <p>Review of the resident's Level I PASRR dated 01/29/2025, showed the hospital had provided an exempted hospital discharge as Resident 46 was likely to require fewer than 30 days of nursing facility services.</p> <p>Review of the clinical record showed there were no other PASRR evaluations after 01/29/2025.</p> <p>In an interview on 04/04/2025 at 2:40 PM, Staff C Regional Director of Clinical Services (RDCS) stated there were no other PASRR evaluations for Resident 46 and they had notified Staff G, Social Service Director (SSD) that the 30-day exemption box was checked, and they needed to complete a new PASRR.</p> <p><RESIDENT 114></p> <p>Resident114 was admitted to the facility on [DATE] with diagnoses to include anxiety disorder, and depression. The resident was taking anti-anxiety and anti-depressant medications on admit.</p> <p>Review of the resident's Level I PASRR dated 03/11/2025, revealed it did not document the resident's diagnosis of mood disorder, anxiety disorder therefore a Level II PASRR evaluation was not requested.</p> <p>Review of the clinical record showed there were no other PASRR evaluations after 03/11/2025.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>51312</p> <p><RESIDENT 15></p> <p>Resident 15 was a long-term resident of the facility. According to the MDS dated [DATE], the resident severely cognitively impaired and had delusions.</p> <p>Review of document named 'care plan' dated 08/21/2025: Resident 15 had a diagnosis of bipolar dementia (which causes shifts in a person's mood, energy, and behavior with various symptoms of cognitive decline) and was taking antipsychotic medication.</p> <p>Review of document named 'Level I PASRR' dated 06/29/2024, section IV. Service Needs and Assessor Data, the box for: Level II evaluation referral required was checked.</p> <p>Review of document named 'Level 1 PASRR' dated 05/02/2023, section IV. Service Needs and Assessor Data, the box for: Level II evaluation referral required for significant change was checked.</p> <p>In an interview on 04/04/2025 at 3:25 PM Staff A, Administrator stated Resident 15 did not have a level 2 PASRR.</p> <p>In an interview on 04/07/2025 at 9:54 AM Staff G, Social Service Director (SSD) stated they were working on Resident 15's PASRR 2 updates, the PASRR level 1 was before their time.</p> <p>In an interview on 04/07/2025 at 9:59 AM, Staff C, RDCS stated the level 2 PASRR for Resident 15 was never completed; it should have been reviewed and processed.</p> <p>In an interview on 04/09/2025 at 8:15 AM, Staff C, RDCS stated the expectations for PASRR evaluations was they expected them to be accurate.</p> <p>In an interview on 04/09/2025 at 10:24 AM, Staff G, SSD stated they were responsible for reviewing PASRR's for accuracy. Staff G stated they had been notified about the inaccurate PASRR's for Resident 24 and Resident 115. Staff G stated they knew Resident 46's PASRR was a 30-day exemption, and they had been at the facility over 30 days, and they needed a level II referral. Staff G stated they would get Resident 114's PASRR revised. Staff G stated they had a PASRR binder and tried to follow up on PASRR issues.</p> <p>Reference WAC 388-97-1915 (1)(2)(4)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview and record review, the facility failed to review and revise care plans for 2 of 6 residents (Residents 30 and 114) reviewed for care planning. These failures placed the residents at risk for unmet care needs, adverse health effects and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Comprehensive Care Plans and Revisions, revised 08/22/2023, showed the facility would ensure the timeliness of each resident's person-centered, comprehensive CP, and that the comprehensive CP was reviewed and revised by an interdisciplinary. The policy showed the facility would monitor residents over time to identify changes in condition and update the CP as warranted to reflect goals and interventions.</p> <p><RESIDENT 114></p> <p>Resident 114 admitted on [DATE] with diagnoses to include chronic obstructive pulmonary disease.</p> <p>In an interview and observation on 04/02/2025 at 3:20 PM, Resident 114 was observed to have edema bilaterally with their shoes indenting into the swelling. Resident 114 stated their edema (swelling) was from being up and not elevating their feet. The resident said they had slept in a chair nightly until recently and had a lot of pressure in both feet and they couldn't lift their legs into bed.</p> <p>Review of an exam note written by Collateral Contact 5, Advanced Registered Nurse Practitioner on 03/21/2025 showed bilateral acute edema (new onset of swelling in both legs) was noted, non-pitting. Likely due to post surgical findings and not having their feet and legs elevated due to sleeping in a chair upright due to pain. Order for low dose torsemide ordered, expect some improvement. CC 5 recommended elevating the residents' legs while sleeping and ordered to start Torsemide (diuretic) 10mg once daily with hold parameters.</p> <p>Review of the March Medication Administration Records showed Resident 114 was started on Torsemide once a day for edema with parameters to hold the medication if the systolic blood pressure was less than 110 on 03/21/2025.</p> <p>Review of the care plan with a print date of 04/03/2025 showed no care plan revisions implemented when the resident developed a new onset of lower extremity edema in both feet, started Torsemide or the provider's recommendation to elevate the residents' legs in bed.</p> <p>47047</p> <p><RESIDENT 30></p> <p>Resident 30 was admitted to the facility on [DATE] with diagnoses which included history of falling, depression and anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a review of Resident 30's progress notes showed on 12/24/2024 a referral was made to the facility's contracted mental health provider as they were calling family with stories/events that never happened.</p> <p>In a review of Resident 30's provider progress notes dated 01/23/2025 showed they were started on an anti-anxiety medication for 14 days to address their agitation, after a care conference was held. Resident 30 had recently been treated for pneumonia.</p> <p>In a review of Resident 30's provider progress notes dated 03/11/2025 showed they were complaining of anxiety and requested their anti-anxiety medication be restarted. Resident 30 was started on an anti-anxiety, different from the one on 1/23/2025, medication for 14 days.</p> <p>In a review of Resident 30's care plan dated 03/20/2023 showed they were at risk for change in their mood/behavior related to changes in their medical condition. The care plan did not address Resident 30's use of an anti-anxiety related to agitation and their treatment for pneumonia, use of two different anti-anxiety medications within a two-month period of time, and referral to the facility's contracted behavioral health services.</p> <p>In an interview on 04/02/2025 at 8:15 AM, Staff B, Director of Nursing Services (DNS) and Staff C, Regional Director of Clinical Services stated care planning was a team effort. Staff B stated the admitting nurse completed the baseline care plan, the comprehensive care plan is done by the MDS nurse and revisions are by the Resident Care Managers.</p> <p>In an interview on 04/09/2025 at 10:43 AM Staff C stated the care plans needed to be updated to reflect the resident's current care needs/issues.</p> <p>This is a repeat deficiency from 05/01/2024.</p> <p>Reference WAC 388-97-1020</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>51312</p> <p>Based on observation, interview, and record review, the facility failed to provide 1 of 1 resident (Resident 4) access to a communication device. This failure placed the resident at risk for unmet care needs by decreasing the resident's ability to participate in daily living activities.</p> <p>Findings Included .</p> <p><Resident 4></p> <p>Resident 4 is a long-term resident of the facility. Resident 4's diagnosis includes traumatic brain injury (TBI, an injury to the brain caused by an external force), voice and resonance disorder (functional speech deficits).</p> <p>During a joint interview on 04/03/2025, at 4:04 PM, Collateral Contact 2 (CC2) and Collateral Contact 3 (CC3) stated that the facility is no longer using Resident 4's Tobii communication device. They stated that they were told staff had not been trained on the device, which had resulted in staff members not knowing how to operate it.</p> <p>A review on 04/04/2025 of the document named 'Care Plan' documented that Resident 4 could see, hear, and understand well but was unable to speak. Resident 4 could answer 'yes' or 'no' questions with a thumbs 'up or thumbs 'down'.</p> <p>In observations on 04/04/2025 at 8:30 AM, 9:41 AM, 10:10 AM, 10:50 AM, 1:56 PM, and 2:47 PM, Resident 4's communication device turned off and located in the corner of the resident's room.</p> <p>In observations on 04/07/2025 at 9:01 AM and 10:36 AM, Resident 4's communication device was turned off in the corner of the resident's room.</p> <p>During an interview on 04/07/2025 at 3:06 PM, Staff Y, Nursing Assistant Certified (NAC), stated they had never used Resident 4's communications device, and they communicated with Resident 4 using thumbs up or down and sometimes blinking.</p> <p>During an interview on 03/07/2025 at 3:30 PM, Staff BB, NAC, stated they did not know Resident 4 had a communication device, and they communicated with hand signals.</p> <p>During an interview on 04/07/2025 at 2:34 PM, Staff F, Licensed Practical Nurse (LPN) stated they had never used Resident 4 's communication device.</p> <p>During a joint interview on 04/08/2025 at 1:33 PM, with Staff AA, a Speech Therapist (ST), and Resident 4, Resident 4 was asked if they would like to use the Tobii speech device. Resident 4 expressed a 'yes' preference by giving a thumbs up. When asked the following questions, Resident 4 responded with a 'no' preference:</p> <p>- Do the NACs ask you if you need or want water? No.</p> <p>(continued on next page)</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Do the NACs ask you what time you want to go to bed? No.</p> <p>- Do the NACs ask you if you want to participate in activities? No.</p> <p>Staff AA set up the speech device and prompted Resident 4 to find text related to their needs. Resident 4 successfully navigated the device and selected the option 'Take a shower.' Staff AA then inquired if Resident 4 would like to take a shower, to which Resident 4 responded with a thumbs-up. Staff AA noted that one reason the device had not been used frequently was that the staff lacked training on its use, and Resident 4 affirmed this with a thumbs-up.</p> <p>This is a repeat deficiency from 05/01/2024.</p> <p>Reference WAC 388-97-1060(2)(a)(v)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890</p> <p>Based on observation, interview and record review, the facility failed to ensure there was an activity program to meet individual resident needs for 3 of 4 residents (Residents 4, 15, and 25) reviewed for activities. This failure placed residents at risk of becoming bored and depressed when not provided meaningful engagement throughout the day, and a diminished quality of life.</p> <p>Findings included .</p> <p>RESIDENT 25</p> <p>Resident 25 admitted [DATE] with diagnoses which included history of a stroke and vascular dementia and required total assistance for activities of daily living and participation in activities.</p> <p>Review of the Annual Minimum Data Set (MDS, a required assessment tool) dated 12/29/2024, documented that Resident 25 did not participate in the activity interview and staff responded to the questions on behalf of the resident. The MDS identified the resident activity preferences as: listening to music, being around animals/pets, doing things with groups, participating in favorite activities, going outside when the weather is good, participating in religious activities.</p> <p>Review of Resident 25's Activities care plan documented Resident 25 needs encouragement and support with participating in activities for leisure, entertainment and socialization and included interventions including:</p> <ul style="list-style-type: none"> - Resident 25 will be offered a variety of activities to engage in with others while in a group setting. have the supplies needed to work on self-driven activity pursuits that they enjoy, - Resident 25 will receive Staff support with accessing activities of choice, - Activity choices will be tailored to fit the resident's needs, preferences and abilities, - Activities staff will make attractive alternatives available if Resident 25 is unable or unwilling to participate in their original activity, - Provide activities that are compatible with physical and mental capabilities; Compatible with known interests and preferences; Adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), Compatible with individual needs and abilities; and Age appropriate. <p>In an observation on 04/03/2025 at 3:22 PM, Resident 25 was sitting in their wheelchair alone in their room with music playing on the TV. Their head was leaning forward to the right, and they were moving their head up and down in a repetitive nodding motion. The weather was observed to be sunny and warm and other residents were observed outside the facility in the courtyard.</p> <p>In similar observations throughout the survey:</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/04/25 at 8:47 AM, Resident 25 was in their wheelchair alone in their room with music playing on their TV.</p> <p>On 04/04/25 09:22 AM, Resident 25 was sitting in their wheelchair alone in their room with music channel on TV. Resident 25's head was nodding to the right and forward in a purposeful/repetitive manner. When attempting to speak to the resident and using their name, their head stopped nodding and they appeared to pay attention to voice, but did verbally respond back and began nodding with their head again after the short pause.</p> <p>On 04/07/25 at 9:44 AM, Resident 25 was in their room alone asleep in their wheelchair.</p> <p>There were no observations of Resident 25 outside of their room other than the time it took to be assisted with meals in the main dining room. Resident 25 was not observed to attend any group activities or have any one to one activity interactions from staff. The only activity observed was that the staff turn on the TV set in room and set it to a music station.</p> <p>In an interview on 04/07/2025 at 9:10 AM, Staff U, Nursing Assistant Certified, stated Resident 25 gets up for meals in the dining room. Staff U stated Resident 25 always bobbed their head like that. Staff U stated Resident 25 has gone to activities sometimes and stated they can listen. Staff U did not know what types of activities Resident 25 liked other than music and stated they had only seen the resident in group activities with music.</p> <p>In an interview on 04/07/2025 at 2:36 PM, Staff V, Activities Director, stated the facility had a one to one program for residents who chose not to, or for other reasons, were not able to participate in other group activities. Staff V stated Resident 25 had been at some group activities but would yell out and become disruptive. Staff V was not aware of what was on Resident 25's activity care plan and was asked if there was a one-to-one program in place for Resident 25. Staff V stated there was not one and did not know why not.</p> <p>51312</p> <p><Resident 15></p> <p>Resident 15 was a long-term resident of the facility. According to the MDS dated [DATE], Resident 15 was severely cognitively impaired and had delusions.</p> <p>During review of Resident 15's Care Plan on 04/04/2025, documented that Resident 15 will accept room social visits at least 1x per week and will attend at least 1 group activity a week.</p> <p>During multiple observations on 04/04/2025 at 8:32 AM, 9:44 AM, 12:58 PM, 1:58 PM, and 2:48 PM, Resident 15 was in bed on back.</p> <p>During multiple observations on 04/07/2025 at 8:19 AM, 9:03 AM, 9:40 AM, 10:38 AM, 11:16 AM, 1:28 PM, and 2:12 PM, Resident 15 is in bed on back.</p> <p>During an interview on 04/02/2025 at 3:05 PM, Collateral Contact 6, (CC6) stated that Resident 15 refuses to go to activities.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/07/2025 at 1:34 PM, Staff V, Activities Director, stated that they do not know Resident 15, and Resident 15 is not getting any 1:1 visits.</p> <p><Resident 4></p> <p>Resident 4 is a long-term resident of the facility. Resident 4's diagnosis includes traumatic brain injury (TBI)(an injury to the brain caused by an external force), voice and resonance disorder (functional speech deficits).</p> <p>During review of Resident 4's Care Plan on 04/04/2025, documented that:</p> <p>* [NAME] will show satisfaction with activity opportunities and attend at least 4 group activities offered a week as evidenced by remaining in activity and smiling or giving thumbs up.</p> <p>During an observation on 04/04/25 at 09:41 AM, Resident 4 was in their wheelchair in their room, and the TV was off. Resident 4 indicated that they were bored with a thumbs-up.</p> <p>During an observation on 04/04/25 at 10:10 AM, Resident 4 was in their wheelchair in their room, and the TV was off. Activity of ' CULTURE COOKING/INTL SALAD BAR' was happening in the activities center.</p> <p>During an observation on 04/07/25 at 10:36 AM, Resident 4 was in their wheelchair in their room. Concurrently, a resident council meeting and coffee time took place in the activities room.</p> <p>During an interview on 04/08/25 at 1:05 PM, Staff C, Regional Nurse Corporate (RNC), the personnel designated for activities are responsible for conducting assessments and ensuring that residents' activity preferences are addressed on a daily basis. Staff C indicated that Resident 4 should be asked whether she would like to participate in activities.</p> <p>During an interview on 04/07/2025 at 1:34 PM, Staff V, Activities Director, indicated that they are not currently participating in resident care planning. They also noted that resident participation in activities is documented only for one-on-one interactions, and that preferences for activities are not assessed at the time of resident admission.</p> <p>Reference WAC 388-97-0940(1)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview and record review, the facility failed to ensure of 2 of 6 residents (Residents 4 and 114) reviewed received care and treatment in accordance with professional standards of practice and received the necessary care and services to attain or maintain their highest practicable level of well-being. These failures placed residents at an increased risk of adverse health events, discomfort and unmet care needs.</p> <p>Findings included .</p> <p><EDEMA MANAGEMENT></p> <p><RESIDENT 114></p> <p>Resident 114 admitted on [DATE] with diagnoses to include chronic obstructive pulmonary disease.</p> <p>Review of the admission note on 03/11/2025 at 3:48 PM showed Resident 114 had a history of hyperlipidemia (high cholesterol) and hypertension (high blood pressure). There was no mention of edema (swelling).</p> <p>Review of the residents diagnoses list in the clinical record showed they had no known cardiac related diagnoses including hyperlipidemia and hypertension.</p> <p>In an interview and observation on 04/02/2025 at 3:20 PM, Resident 114 was observed to have edema bilaterally with their shoes indenting into the swelling. Resident 114 stated their edema was from being up and not elevating their feet. The resident said they had slept in a chair nightly until recently and had a lot of pressure in both feet and couldn't lift their legs into bed.</p> <p>Review of an exam note written by Collateral Contact 5, Advanced Registered Nurse Practitioner on 03/21/2025 showed bilateral acute edema (new onset of swelling in both legs) was noted, non-pitting. CC 5 documented the edema was likely due to post surgical findings and not having their feet and legs elevated due to sleeping in a chair upright due to pain. CC 5 ordered low dose Torsemide (diuretic) and noted they expected some improvement. CC 5 recommended elevating the residents' legs while sleeping and ordered to start Torsemide 10mg once daily withhold parameters.</p> <p>Review of the March Medication Administration Records showed Resident 114 was started on Torsemide once a day for edema with parameters to hold the medication if the systolic blood pressure was less than 110 on 03/21/2025.</p> <p>Review of a progress note on 03/22/2025 at 1:02 PM documented the resident was on alert charting for having a new order of furosemide 10 mg rather than the prescribed drug Torsemide. The notes documented there were no signs or symptoms noticed during this shift. There was no edema or cardiac assessment.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan with a print date of 04/03/2025 showed no care plan revisions had been implemented when the resident developed a new onset of lower extremity edema in both feet, started Torsemide or the provider's recommendation to elevate the residents' legs in bed.</p> <p>Review of Resident 114's medical record showed Resident 114 had the following weights obtained since admit; 03/12/2025, 03/13/2025, 03/14/2024, 03/25/2025, 03/26/2025 and 04/05/2025. There was no further assessment of or evidence that the resident's weight was obtained, or edema was re-assessed while on alert status. There were no interventions to decrease the edema in the Treatment Administration Record (TAR).</p> <p>In an interview on 04/08/2025 at 2:30 PM, Staff T, Registered Nurse caring for Resident 114 stated the resident started to have swelling in both of their legs and Torsemide was started. Staff T stated if a resident had swelling, they would report it to the provider, listen to their lungs, do daily cardiac weights, and look at leg circumference. Staff T said there should be parameters in place and if the resident gained more than three to five pounds then they would need to notify the provider. Staff T stated they had not looked at the resident's feet today. Staff T looked at the clinical record and stated they had not been obtaining daily weights on Resident 114.</p> <p>In an interview on 04/09/2025 at 8:15 AM, Staff C, Regional Director of Clinical Services stated their expectation was that nurses should monitor Resident 114's weight and edema.</p> <p>In an interview on 04/09/2025 at 10:11 AM, Staff I, Registered Nurse/ Unit Care Coordinator stated their expectation for Resident 114 would be to look into their medical history to see if they had congestive heart failure, notify the provider, monitor weights and edema, listen to their lungs, place the resident on alert monitoring, obtain compression socks and elevate the residents lower extremities. Staff I confirmed there were no interventions on the care plan or TAR for the new onset of edema. Staff I stated they were not at the facility that week.</p> <p>51312</p> <p><Resident 4></p> <p>Resident 4 is a long-term resident of the facility. Resident 4's diagnosis includes traumatic brain injury (TBI- an injury to the brain caused by an external force), voice and resonance disorder (functional speech deficits).</p> <p>Review of Resident 4's after-visit summary from neurology, dated 03/06/2025, documented referrals for physical therapy, rheumatology, and speech therapy.</p> <p>During an interview on 04/03/2025 at 4:04 PM, Collateral Contact 2 (CC2), Resident 4's family member, stated they had given the facility the after-visit summary from neurology, but there was no follow-up by the facility.</p> <p>During an interview on 04/09/2025 at 10:13 AM, Staff P, Licensed Practical Nurse (LPN), stated no appointments for Resident 4's follow-ups have been made.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/09/2025 at 10:22 AM, Staff H, LPN/Unit Care Coordinator (RCM), stated that referrals should go to social services, but social services have had staffing issues. Staff H stated that the RCMs are taking over, but they have been on carts and haven't be able to.</p> <p>During an interview on 04/09/2025 at 10:38 AM, Staff G, Social Services, stated that RCMs should review the paperwork, send out the referrals, and then make the appointments.</p> <p>This is a repeat deficiency from 05/01/2024.</p> <p>Reference WAC 388-97-1060(1)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview and record review, the facility failed to provide care and services to prevent pressure ulcers for 2 of 3 residents (Residents 15 and 46) reviewed for pressure ulcers. The facility failed to implement a turning/repositioning program for residents with decreased mobility and decreased functional ability resulting in the development of stage II pressure ulcers. Resident 46 did not receive thorough and ongoing skin assessments that included observing for change in risk factors, pressure points, and evaluating effectiveness of interventions. These failures placed Resident 15 and 46 and other residents at risk for the development of a pressure ulcer.</p> <p>Findings included .</p> <p>The National Pressure Ulcer (also known as a pressure injury) Advisory Panel (NPUAP) Pressure Injury (Ulcer) definition and stages included:</p> <ul style="list-style-type: none"> - A pressure injury (PI) was a 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 as intact skin or an open ulcer and may be painful. The injury occurred as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities, and condition of soft tissue; - A Stage 2 PI was partial-thickness skin loss with exposed dermis. The wound bed was viable, pink, or red, moist, and may also present as an intact or ruptured serum-filled blister. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel; and - An unstageable PI was 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). <p>The 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.</p> <p>The Resident Assessment Instrument (RAI) Manual defined the stage of a pressure ulcer (PU) as followed:</p> <ul style="list-style-type: none"> - A stage II PI (ulcer) was described as partial thickness loss of the skin; - A stage III PI (ulcer) was described as a full thickness loss of the skin; - An unstageable PI (ulcer) was a full thickness skin and tissue loss was obscured by slough (non-viable tissue) or eschar (dead or devitalized tissue); and <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- A Deep Tissue Injury (DTI) was described as intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, or purple discoloration.</p> <p><Facility Policy></p> <p>Review of the facility policy titled, Skin Integrity & Pressure Ulcer/Injury Prevention and Management, revised 07/09/2024, showed the facility would provide the necessary treatment and services, consistent with professional standards of practice, to a resident with PU/PI to promote healing, prevent infection, and prevent new ulcers from developing. The policy showed preventative measures identified to maintain and improve the resident's skin condition were implemented in the Care Plan (CP) including repositioning at least every 2-4 hours as consistent with the resident's overall goal and medical condition and the use of a pressure redistribution mattress.</p> <p><RESIDENT 46></p> <p>Resident 46 admitted to the facility on [DATE] after a prolonged hospitalization with multiple diagnoses to include diabetes, liver disease, cardiac disease, kidney disease, pulmonary disease, stroke with left side hemiplegia and hemiparesis (weakness and paralysis), osteoarthritis, protein calorie malnutrition and chronic pain from fibromyalgia</p> <p>Review of Resident 46's admission nursing evaluation on 01/29/2025 showed they had no pressure ulcers (PU's) or open areas were identified on the admit assessment.</p> <p>Review of Resident 46's Braden Scale for Predicting Pressure Sore Risk (an assessment tool to determine a resident's risk for developing PU's), dated 01/29/2025, revealed the resident was at high risk for pressure sores.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment on 01/31/2025 showed Resident 46 was at risk for developing pressure ulcers (PU's)/injuries and they had no unhealed pressure ulcers/injuries. The MDS assessment showed the resident was not on a turning/repositioning program, did not receive a pressure reducing device for their chair and was not receiving nutrition intervention to manage skin problems. The resident did not refuse care.</p> <p>Review of the Care Area Assessment (CAA) dated 01/31/2025 revealed the resident had no PU's at present with risk factors to include impaired mobility with incontinence. The goal was to maintain skin free of pressure injuries through assisted mobility, incontinence care, and routine skin checks to identify any early signs of potential skin breakdown. The assessment documented anticipation Resident 46 would make gains with therapy sessions and ongoing healing and that their overall risk factors for pressure injuries may be reduced. The CAA showed to continue plan of care with preventing the development of pressure ulcers.</p> <p>Review of the Kardex (directives for nursing assistants), print date 04/03/2025, directed staff to encourage and assist with turning and repositioning. Resident 46 was to wear a foam boot when in bed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the skin care plan was not developed until 02/21/2025 and showed the resident has potential/actual impairment to skin integrity. The goal was for the resident to have no complications related to skin through the review date. The interventions directed staff to clean and dry skin after each incontinent episode, educate resident/family/caregivers of causative factors and measures to prevent skin injury and encourage and assist with turning and repositioning and resident was to wear a foam boot when in bed.</p> <p>Review of a nursing progress note titled, communication with physician on 03/21/2025 at 2:34 AM documented Resident 46 had developed a pressure blister to their left heel, which measured approximately 1.2 cm by 1.2 cm. The nurse documented they had cleansed the blister with normal saline, patted it dry and covered the blister with nonadherent adhesive dressing and the resident was to wear a foam boot when in bed.</p> <p>Review of the January, February and March 2025 Treatment Administration Record (TAR) showed there were no weekly skin evaluations scheduled. The heel boot compliance monitoring was not set up to monitor every shift until 03/21/2025. There were 47 shifts that documented - (negative sign) and seven shifts had no documentation. Further, the TAR's showed no documentation regarding the desired settings for the low air loss mattress for optimal pressure relief.</p> <p>Review of the assessments showed Resident 46 had the following weekly skin integrity data collection assessments:</p> <p>04/05/2025</p> <p>03/20/2025</p> <p>03/18/2025</p> <p>02/26/2025</p> <p>02/19/2025</p> <p>02/12/2025</p> <p>02/05/2025</p> <p>There were no weekly skin integrity data documented on 03/05/2025, 03/12/2025, 03/19/20205, 03/26/2025, 04/02/2025 and 04/09/2025.</p> <p>Review of the weekly skin evaluation dated 03/20/2025, showed an unopened pressure blister to the left heel was discovered and measured 1.2 centimeter (cm) by 1.2 cm. The skin was described as fragile.</p> <p>Review of the wound observation tool on 03/28/2025 documented the stage II pressure ulcer facility acquired 3/21/25 measuring 1.8 cm by 1.5 cm with no depth. Resident 46 voiced discomfort related to blister, and staff applied cushioned dressing to the blister for protection.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the wound observation tool on 04/03/2025 documented the left heel pressure ulcer measuring 1.7 cm by 1cm with no depth .tender .Resident seen on weekly wound rounds today. Left heel fluid filled blister remains intact and has decreased in size.</p> <p>Review of the January 2025 Nursing Assistant (NA) documentation showed Resident 46 required extensive assistance for repositioning. There was no documentation the residents refused any repositioning or the adherence or tolerance to position changes.</p> <p>Review of the February 2025 NA documentation showed Resident 46 required limited to extensive assistance for repositioning. There was no documentation the residents refused any repositioning or the adherence or tolerance to position changes.</p> <p>Review of the March 2025 NA documentation showed varied assistance was needed from independent to extensive assistance for repositioning. There was no documentation the residents refused any repositioning or the adherence or tolerance to position changes.</p> <p>Review of the April 2025 TAR showed the left heel dressing change was not completed on 04/2/2025 and 04/03/2025.</p> <p>In an interview on 04/03/2025 at 8:45 AM, Resident 46 was sitting on the side of their bed wearing thin flip flops and a dressing was observed on their left heel. The resident stated the wound occurred after a fall in the bathroom where they had waited an hour for help, and no one came.</p> <p>In an observation on 04/04/2025 at 9:48 AM, Resident 46 was lying with their feet off the side of the bed wearing flop flops. The resident stated their left foot hurt, and their right foot had a broken toe so both feet were out of commission otherwise they would be up and down these halls.</p> <p>In observations on 04/04/2025 at 11:32 AM, 12:07 PM, 1:25 PM and 2:44 PM, Resident 46 was resting in bed with no boots on.</p> <p>In observations on 04/07/2025 at 8:20 AM, 9:19 AM, 10:04 AM, 1:18 PM, Resident 46 was in bed, both heels were resting directly on the mattress and there was no boot on. There was a similar observations at 2:21 PM. The resident was asked about their heel boot and said they had never worn boots since admission. There were no boots at bedside.</p> <p>In an observation on 04/08/2025 at 8:15 AM, Resident 46 was lying in bed with both heels directly on the bed. There were no green boots observed on the resident or in the room.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an observation on 04/08/2025 at 9:36 AM, Resident 46 stated that staff had put their legs on pillows a couple times. The resident stated that the staff was thinking of getting them a boot. Staff R, Licensed Practical Nurse performed a dressing change to the left heel. The skin was intact, and the wound base was brown. Staff R commented there was some redness around the wound, but no drainage or odor. Resident 46 stated, It hurts around it, why does it hurt so bad? Staff R stated Let's try to float your heels and keep them off the bed. There were some boots in the corner. It is a little red so let's elevate it. Resident 46 stated there were no boots in the room. This was confirmed by Staff R searching the room including the closet. Resident 46 stated the nurse needed to find them a kid boot and they hadn't even opened the bag from a long time ago so they didn't even know if they fit. The resident stated it was not their job to make sure the staff put the boot on. Staff R stated they would ask therapy to get the resident a boot.</p> <p>In an observation and interview on 04/08/2025 at 11:06 AM, Resident 46 was in bed and showed their left leg with a heel protector in place and commented I have been booted.</p> <p>In an interview on 04/08/2025 at 11:10 AM, Staff N, Nurse's Aide Certified (NAC) stated they were caring for Resident 46, and they had no skin issues and wore no special devices.</p> <p>In an interview on 04/08/2025 at 2:09 PM, Staff M, NAC said they were not sure if Resident 46 had any skin issues.</p> <p>In an interview on 04/08/2025 at 2:30 PM, Staff T, Registered Nurse (RN) stated Resident 46 had a left heel wound and an intervention that required them to wear a boot, but they never wore it. Staff T commented maybe the boot was not comfortable. Staff T said they asked the resident about the boot once but could not recall their response.</p> <p>In an interview on 04/09/2025 at 10:11 AM, Staff I, RN Unit Care Coordinator stated they participated in wound rounds and Resident 46 had an intact heel blister they were watching. Staff I stated they were unsure how the wound developed but the resident was high risk for pressure ulcer development. Staff I said the resident was on an air mattress and they were not aware of any other interventions. Staff I said the expectation for wounds were weekly skin checks, wound rounds, air mattress and float heels to prevent pressure.</p> <p>In an interview on 04/09/2025 at 9:15 AM with the Staff B, Director of Nursing Services and Staff C, Regional Director of Clinical Services (RDCS) was held. Staff B, DNS stated Resident 46 had been on an air mattress since admission and they delivered the green boot to the room as it was their intervention when the pressure ulcer developed. Staff B and C were not aware the resident had not worn the green boot since it was care planned on 03/21/2025. Staff B said the expectation was weekly skin checks, weekly wound rounds and interventions were on the care plan. Staff C said they had a contract with a wound healing company, but they were unable to find a provider that would come in. They stated a provider is in training and will begin visits in June. Staff B stated it had been a month since the wound provider last visited.</p> <p>Nursing documentation did not contain evidence of ongoing assessment, implementation of interventions and re-evaluation of interventions consistent with professional standards. The nursing documentation did not reflect a proactive approach to skin management.</p> <p><Resident 15></p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 15 was a long-term resident of the facility. According to the MDS dated [DATE], Resident 15 was severely cognitively impaired and had delusions.</p> <p>Review of Resident 15's 'Care Plan' reviewed on 02/04/2025, documented the following: Resident 15 should have a foot cradle and a wedge in order to minimize pressure to feet, and that Resident 15 has a large blister on the left plantar surface of foot.</p> <p>Review of Resident 15's Visual/Bedside Kardex' reviewed on 02/04/2025 documented the following: Always keep foot cradle and wedge on bed to minimize pressure injuries to feet.</p> <p>During multiple observations on 04/08/25 at 9:10 AM, 10:20 AM, 11:35 AM, and 12:34 PM, Resident 15 was in bed in an upright position. The resident was positioned toward the lower end of the bed, with the last two toes of the right foot pressing against the baseboard and the left foot pressing against the baseboard on the plantar surface.</p> <p>During an interview on 04/08/2025 at 1:05 PM, Staff C, Regional Director of Clinical Services (RNC), stated that residents should be turned and repositioned every 2 hours and that the Kardex should be followed.</p> <p>Reference WAC 388-07-1060(3)(b)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890</p> <p>Based on interview and record review, the facility failed to ensure treatment and services were provided to increase, maintain and/or prevent a decline in Range of Motion (ROM) mobility for of 2 of 4 residents (Resident 4, and 25) reviewed for limited ROM and restorative nursing services. The facility's failure to ensure assessment and implementation of restorative nursing services placed residents at risk for functional decline and increased dependence on staff for activities of daily living.</p> <p>Findings included .</p> <p><RESIDENT 25></p> <p>Resident 25 admitted [DATE] with diagnoses which included history of a stroke and vascular dementia and bilateral contractures of the shoulders, elbows and hands. Resident 25 was wheelchair bound and required total assistance for activities of daily living and participation in activities.</p> <p>In an observation on 04/03/2025 at 3:22 PM, Resident 25 was in their room sitting up in a tilt in space wheelchair. Resident 25's lower body was turned toward the left with one leg dangling off the footrests and their upper body was leaned toward the right and over the edge of the backrest. Resident 25's head was not supported by the headrest and their head was down and leaning to the right with the resident moving their head up and down in a repetitive nodding motion.</p> <p>In an interview on 04/03/2025 at 3:25 PM, Staff S, Nursing Assistant Certified (NAC) stated Resident 25 was dependent on the staff for care needs and was non-verbal except occasionally calling out. Staff S directed questions about exercises to the nurse stating Resident 25 was stiff and they used a pillow under their side, but they were not aware of any exercises or stretches being done for Resident 25.</p> <p>In an observation on 04/07/2025 at 7:51 AM, Resident 25 was in their room sitting in their wheelchair which was tilted back. Resident 25's head was leaned forward and to the right unsupported by the headrest. Resident 25's upper body was rigidly leaning toward the right, and a pillow was positioned along the resident's right side.</p> <p>Review of the most recent occupational therapy discharge notes dated 12/13/2024 documented discharge recommendations for Resident 25: Restorative Nursing Aide to perform bilateral range of motion/stretch and splint application and stated the program had been established, training completed and the prognosis to maintain current level of function was listed as excellent with consistent staff support.</p> <p>Review of Resident 25's Treatment Administration Record with a start date of 12/13/2024 documented nursing was to place the resident's bilateral hand splints on at 8:00 PM each evening and remove them at 8:00 AM each morning per OT recommendations. Review of the record showed the range of motion and stretching recommendations were not included prior to placing the splints.</p> <p>51312</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><Resident 4></p> <p>Resident 4 was a long-term resident of the facility. Resident 4's diagnosis included traumatic brain injury (TBI) (an injury to the brain caused by an external force) and a voice and resonance disorder (functional speech deficits).</p> <p>During an interview on 04/03/2025 at 4:04 PM, Collateral Contact 2, Resident 4's mother, stated that Resident 4 is not currently on a restorative program and should be getting range-of-motion activities daily to prevent worsening of contractures.</p> <p>Review of Resident 4's Care Plan on 04/04/2025, documented the following restorative nursing programs:</p> <p>Program#1: PASSIVE Range of motion/gentle stretching to left upper and lower extremity with left hand splint placement, Active Assist Range of motion to right upper and lower extremity 3-6x/week for at least 15 mins.</p> <p>Program #2: SPLINT/BRACE Apply brace to left hand and neck brace in the morning and off at night.</p> <p>The goals were stated that (Resident 4) would have no worsening in upper extremity contracture.</p> <p>Review of Resident 4's medical record on 04/04/2025 showed that the care planned restorative programs were not occurring.</p> <p>In an interview on 04/04/2025 at 10:44 AM, Staff Q, Director of Therapy Services, stated the facility did not currently have a restorative program and they needed one, but did not have enough staff. Staff Q stated the facility had one restorative aide, but they were always working on the floor. Staff Q stated that residents were reviewed by nursing quarterly and as needed and they tried to see as many as they could under part B therapy services but could not recall having discussed Resident 25's positioning or wheelchair head rest issues.</p> <p>In an interview on 04/07/2025 at 2:01 PM, Staff D, NAC stated they were a restorative aide at the facility for years but had not worked as a restorative aide for a while as the facility did not have enough staff to do the restorative program. Staff D stated they wanted to start the restorative program back up but they had been on the floor.</p> <p>In an interview on 04/09/2025 at 10:51 AM, Staff A, Administrator stated the facility was struggling to hire or train restorative nursing aids and acknowledged that the facility did have one full time staff with restorative training, but that staff member had not been being utilized in that role related to staffing needs on the floor.</p> <p>This is a repeat deficiency from 05/01/2024.</p> <p>Reference WAC 388-97-1060(2)(b)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident's care plan was reviewed, updated, and implemented for 1 of 4 residents (Resident 218) for falls and failed to ensure residents who engaged in smoking were assessed for adequate supervision to prevent injury from burns for 2 of 2 residents (Residents 24 and 54) reviewed for accidents. These failures placed all residents at risk for lack of consistent interventions, unmet care needs, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Fall Management, revised 03/11/2025 documented the facility will assess residents upon admission/readmission, quarterly and with change in condition, and with any fall event for risks and will identify appropriate interventions to minimize the risk of injury related to falls, facility was required to provide adequate supervision to prevent accidents.</p> <p><FALLS></p> <p>Resident 218 was admitted to the facility on [DATE] with diagnoses that included the history of falls with fracture to right femur (Upper long bone in leg), Parkinson Disease (progressive, declining neurological disorder that primarily affects movement, and causes tremors), and depression.</p> <p>Resident 218's Admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE] documented the residents had cognition impairment and required substantial to maximum assistance for transfers and bed mobility. The assessment documented that the resident was at risk of falling due to their diagnosis and history of falls with fracture with a care area assessment focus for falls that documented the facility should focus on minimizing risk for falls on the care plan.</p> <p>Review of Resident 218's fall risk assessments dated 03/19/2025, 03/22/2025, and 03/29/2025 showed the residents there were a high risk for falls.</p> <p>Review of Resident 218's care plan focus area revised 03/27/2025, the resident was at risk for falls. Interventions dated 04/01/2025 included a fall mat on the right side of the bed for safety, and the bed in the lowest position for safety. Other interventions were the call light to remain within reach, staff need to complete a fall assessment if necessary and assist them with activities of daily living as needed.</p> <p>In a review of the fall investigation dated 03/29/2025 (residents second fall since admission) the investigation stated the resident had leaned over in bed and fell , bed was low, so a fall mat was added to right side of the bed for safety reasons.</p> <p>In observations on 04/02/2025 at 9:24 AM, and 10:09 AM, Resident 218 was observed lying in the bed on their back. The bed was not in a low position, and a fall mat was placed on the left side of the bed. The resident's room was located at the end of a dead-end hallway.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation on 04/03/2025 at 8:45 AM, Resident 218 was observed lying in the bed on their back. The bed was not in a low position, and a fall mat was placed on the left side of the bed.</p> <p>In an observation on 04/03/2025 at 1:07 PM, Resident 218 was observed to be curled in the fetal position at the foot of their bed (which was at transfer height). The head of the bed was up, and there was an over the bed table placed over the bed, the residents' head was under the table on the bed and their body curled at the foot of the bed. The resident's wheelchair was parked on the right side of the bed, with the brakes on, one of the foot pedals was angled outward. The resident stated they fell into the bed. The residents stated they climbed into the bed on their own after they were assisted back to their room after lunch. The fall mat was on the left side of the bed. Shortly after an unnamed staff member walked down the hallway and stated, oh my they need help.</p> <p>In an observation on 04/03/2025 at 2:32 PM, Resident 218 was observed lying on their back in bed and a fall mat was placed on the left side of the bed.</p> <p>In an observation on 04/04/2025 at 9:03 AM, Resident 218 was observed lying on their back in bed and a fall mat was placed on the left side of the bed.</p> <p><SMOKING></p> <p>RESIDENT 54</p> <p>Resident 54 was admitted to the facility on [DATE] with diagnoses that included tobacco use, neuropathy (nerve damage that causes numbness and weakness) and history of falls.</p> <p>Resident 54's Admission MDS dated [DATE] documented the resident had intact cognition, with impairments to one side of the residents upper and lower extremities and answered yes to tobacco use.</p> <p>Review of Resident 54's physician orders showed an order dated 08/25/2024 for a nicotine skin patch one time a day for smoking cessation. The order was discontinued 10/28/2024.</p> <p>Review of Resident 54's psychological evaluation completed 09/26/2024 the residents reported they had been smoking cigarettes, with a history of smoking for the last [AGE] years.</p> <p>Review of Resident 54's care plan on 04/02/2025 showed no area of focus for the resident's tobacco use.</p> <p>Review of Resident 54's medical record on 04/02/2025, there was no record of an assessment completed by the facility that the resident had the ability to smoke safely.</p> <p>In an interview on 04/02/2025 at 2:50 PM, Resident 54 stated they currently smoked and had their supplies locked up with a nurse.</p> <p>RESIDENT 24</p> <p>Resident 24 admitted to the facility on [DATE] with diagnoses that included nicotine dependence, bipolar disorder (mental illness with extreme mood shifts), anxiety and post-traumatic stress disorder (PTSD).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 24's Admission MDS assessment dated [DATE] documented the resident was cognitively intact, current tobacco use was answered no.</p> <p>Review of Resident 24's admission nursing assessment completed on 12/23/2024, documented the resident was listed as a current smoker, no smoking cessation was offered as resident declined.</p> <p>Review of Resident 24's physician orders showed an order dated 12/23/2024 for a nicotine skin patch one time a day for smoking cessation. The order was discontinued 12/31/2024 related to refusals.</p> <p>Review of Resident 24's assessments, dated 03/06/2025 documented a smoking assessment that the resident was deemed safe to smoke independently.</p> <p>Review of Resident 24's care plan on 04/02/2025, documented no area of focus for the resident's tobacco use.</p> <p>In an interview on 04/02/2025 at 8:56 AM, Staff A, Administrator stated they had a few residents that were known to smoke off site. Staff A stated they had assessments in place to ensure the safety of the residents. Staff A stated they would provide a list of the names of the residents.</p> <p>On 04/02/2025 at 11:13 AM, the facility provided a list of residents known to smoke and listed Resident 54 and Resident 24 to be known current smokers in the facility.</p> <p>In an interview on 04/02/2025 at 2:25 PM, Resident 24 stated they smoke occasionally, maybe once or twice a month. The residents stated their smoking supplies were locked up with the Administrator (Staff A).</p> <p>In an interview on 04/07/2025 at 2:01 PM, Staff D, Nursing Assistant Certified (NAC) stated that the care plan was their guide to direct what type of care each resident required. Staff D stated the facility was a non-smoking facility and was not aware of any residents who smoked. Staff D stated that all residents that are a high fall risk were to be kept within eye sight of the nurses station, and are usually a priority to get up last for meal and lay down first after meals. Staff D stated that when a resident was at high fall risk the interventions to prevent injury, or falls would be located on the care plan. Staff D confirmed that Resident 218 had a high fall risk, and that they had their bed in low position, and a fall mat was on the left side of the bed. Staff D was not aware the care plan stated right side of the bed. Staff D stated they were not aware that Residents 24 and Resident 54 were current smokers.</p> <p>In an interview on 04/07/2025 at 9:01 AM, Staff E, NAC stated that the care plan was what drove the type of care each resident required. Staff E stated, Resident 218 was a known high fall risk, and they had a fall mat on the left side of the bed. Staff E was not aware the care plan directed staff to place a fall mat on the right side of the bed. Staff E stated they were not aware that Residents 24 and Resident 54 were current smokers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/08/2025 at 9:51 AM, Staff F, Licensed Practical Nurse (LPN) stated the care plan was where the staff would go to direct what type of care each resident required. Staff F stated the update of the care plan and completion of assessments were usually completed by the nurse management team. Staff F was not aware of any current smokers in the facility, and when a resident admitted with history of smoking, they would usually offer a patch to assist with smoking cessation. Staff F confirmed that Resident 218 was a fall risk, and they usually try to assist them back into bed after meals, as they like to lay in their bed.</p> <p>In an interview on 04/08/2025 at 2:44 PM, Staff H, LPN/Care Coordinator stated it was the job of the entire interdisciplinary team (IDT) to ensure the care plans for residents were updated and revised as needed. Staff H stated the facility was a non-smoking facility and was not aware that Resident 24 or Resident 54 had a history of smoking. Staff H stated the expectation was that when residents were deemed a fall risk the care plan has accurate and updated intervention to prevent injury or further falls. Staff H was not aware that Resident 218' s interventions to prevent injury or fall had not been implemented by staff correctly.</p> <p>In an interview on 04/08/2025 at 3:21 PM, Staff C, Regional Director of Clinical Services confirmed that their expectation was the entire IDT was responsible for ensuring the care plans for residents were updated, and revised. Their expectation was that all staff implemented interventions appropriately. Staff C was not aware of any current smokers in the facility, and stated the expectation would be that if a resident was smoking and accurate assessment for safety would be completed and the care plan would be updated. Staff C was not aware that Resident 218' s interventions to prevent injury or fall had not been implemented by staff correctly.</p> <p>In an interview on 04/08/2025 at 3:30 PM, Staff A stated the facility was not storing any smoking supplies for any residents at this time. Resident 24's son had taken their supplies home, and they were not aware that Resident 54 had any supplies. Staff A stated when they learned that there were residents in the facility that were smoking, they had advised the IDT to complete assessments on the residents for safety and update the care plans accordingly. Staff A was not aware that the medical records for Resident 24 and Resident 54 had not been updated.</p> <p>This is a repeat deficiency from 05/01/2024.</p> <p>Reference WAC 388-97-1060(3)(g)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51312</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate hydration for 2 of 2 residents (Residents 15 and 266) reviewed for hydration. These failures placed residents at risk for inadequate intake and dehydration and for a decreased quality of life.</p> <p>Findings Included .</p> <p><RESIDENT 266></p> <p>Resident 266 was admitted to the facility on [DATE]. Resident 266 was severely cognitively impaired and had a diagnosis of dementia (a syndrome that typically leads to deterioration in cognitive functioning).</p> <p>A review of the document named 'Nutrition: Assessment/Nutritional Data Collection' dated 04/07/2025 documented that Resident 266's daily fluid needs are 1386-1438 milliliters.</p> <p>During observations on 04/03/2025 at 1:59 PM and 3:22 PM, Resident 266 was resting in bed with no fluids at the bedside.</p> <p>During an observation on 04/04/2025 at 9:38 AM, Resident 266 was in bed with breakfast on the bedside table, which included a 4-ounce cup of juice that they had already drunk. No other fluids were present.</p> <p>During an observation on 04/04/2025 at 10:26 AM, an unknown staff member entered to give Resident 266 medication. After receiving a pill and water, Resident 266 remarked, That water tastes so good. When asked if they wanted more water, Resident 266 replied, No. The staff then administered another pill, and Resident 266 repeated, That water tastes so good, before the staff left.</p> <p>During an observation on 04/04/2025 at 12:49 PM, Staff W, Nursing Assistant Certified (NAC), was standing at the end of Resident 266's bed when the resident stated, 'I am thirsty.' Staff W helped the resident into bed and then left the room, with no fluids present at the bedside or in the room.</p> <p>During an observation on 04/04/2025 at 1:54 PM, 2:03 PM, and 2:46 PM, Resident 266 was in her room with no fluids present at the bedside or in the room.</p> <p>During observations on 04/07/2025 at 8:59 AM, 9:37 AM, 10:35 AM, 11:13 AM, and 1:25 PM, Resident 266 was in their room with no fluids present at the bedside or in the room.</p> <p>During an observation on 04/07/2025 at 3:03 PM, a small plastic cup with some water was on bedside table out of the resident's reach.</p> <p>During an observation on 04/08/2025 at 9:04 AM, 10:24 AM, and 3:02 PM, Resident 266 had small plastic cup of water on bedside table, table was out of reach.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/08/2025 at 3:02 PM, Staff X, Licensed Practical Nurse, stated that Resident 266 could not reach the small plastic cup because the bedside table was on the other side of the room.</p> <p>During an interview on 04/07/2025 at 3:06 PM, Staff Y, NAC, stated that the NACs ask residents if they need water and refill their cups twice a day. However, Resident 266 does not have a cup, which means they are not receiving water throughout the day.</p> <p><Resident 15></p> <p>Resident 15 was a long-term resident of the facility. According to the Minimum Data Set (MDS-an assessment tool) assessment dated [DATE], the resident was severely cognitively impaired and had delusions.</p> <p>A review of the document named 'Nutrition: Assessment/Nutritional Data Collection' dated 11/01/2024 documented that Resident 15's daily fluid needs are 2450 milliliters, and daily intake should be monitored, and a diet of nectar-thick liquids (nectar-thick fluids are thicker than fruit nectars but not as dense as a thick shake).</p> <p>During observations on 04/03/2025 at 2:01 PM and 3:41 PM, Resident 15 was in their room with no fluids present at the bedside or in the room.</p> <p>During observations on 04/04/2025 at 1:54 PM and 2:48 PM, Resident 15 was in their room with no fluids present at the bedside or in the room.</p> <p>During observations on 04/07/2025 at 9:40 AM, 10:38 AM, and 11:16 AM, Resident 15 was in their room with no fluids present at the bedside or in the room.</p> <p>During observations on 04/08/2025 at 10:20 AM, 11:35 AM, and 12:34 PM, Resident 15 was in their room with no fluids present at the bedside or in the room.</p> <p>During an interview on 04/08/2025, at 1:05 PM, Staff C stated that residents should have water at their bedside and NACs should be refilling residents' water cups two times a day and as needed, unless they are nothing by mouth. Additionally, residents on special diets should have extra liquids, and staff should offer water frequently.</p> <p>This is a repeat deficiency from 05/01/2024.</p> <p>Reference WAC 388-97-1060(3)(i)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890</p> <p>Based on interview and record review the facility failed to ensure pain management was provided in accordance with the resident's physician's orders for one of three residents (Resident 164) reviewed for pain management. Failure to ensure prompt delivery and administer medications per the provider orders resulted in Resident 164's dissatisfaction with their care contributing to discharge against medical advice from the facility and placed residents at risk for diminished quality of life.</p> <p>Findings included .</p> <p>Resident 164 admitted [DATE] with diagnoses which included aftercare for a total hip arthroscopy following a complicated hospital stay. Resident 164 discharged against medical advice on 03/19/2025.</p> <p>Review of a grievance form left by the resident on 03/19/2025 stated my pain medication seemed to be a problem for them to let me have every time I was put off for 15-30 minutes and by the time I received it I hurt so bad it wasn't enough to help. The grievance form was escalated to a reportable allegation on 03/19/2025.</p> <p>Review of Resident 164's hospital discharge orders to the facility dated 03/16/2025 documented an order for Oxycodone (an opioid pain medication) 2.5-5mg by mouth every three hours as needed.</p> <p>Review of Resident 164's electronic medical record orders showed the order for oxycodone had been incorrectly transcribed as: Oxycodone 2.5mg by mouth every three hours as needed (prn) for pain 7-10 (numeric pain scale) (omitting the 5mg availability).</p> <p>Review of Resident 164's pain assessment and resident centered pain goals dated 03/16/2025 showed the resident's acceptable level of pain was 6 out of 10. Review of Resident 164's pain monitor showed on 03/16/2025 their pain level was documented at level 7 on both day and evening shift with no corresponding administration of prn oxycodone. The resident did receive prn Tylenol (non-opioid over the counter pain medication which was also available as needed for lesser level pain.</p> <p>On 03/17/2025 at 1:44 PM Resident 164 received a dose of 2.5mg oxycodone for pain level 7 with no follow-up documentation of effectiveness.</p> <p>On 03/18/2025 at 9:31 AM Resident 164 received a dose of 2.5mg oxycodone for pain level 8 with no follow-up documentation of effectiveness.</p> <p>On 03/18/2025 at 2:30 PM Resident 164 received a dose of 2.5mg oxycodone for pain level 7 with no follow-up documentation of effectiveness.</p> <p>On 03/18/2025 at 9:52 AM Resident 164 received a dose of 2.5mg oxycodone for pain level 7 with no follow-up documentation of effectiveness.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's investigation of the allegation showed there was a delay in oxycodone from the pharmacy related to an allergy alert that required clarification. Resident 164's medical record showed an allergy to Hydrocodone (also an opioid pain medication). The record showed no evidence of notification to the provider regarding a delay in receiving medication or to request any alternate orders. The investigation failed to identify the transcription error from the admission orders which would have allowed the resident 5mg of oxycodone instead of only 2.5mg every three hours for pain.</p> <p>In an interview on 04/09/2025 at 10:57 AM, Staff A, Administrator, stated they had received the resident's grievance form and was told there had been a question about a possible allergy when they admitted . Staff A stated they questioned why the medication was not available but did not get a response back and stated they were not aware there had been an error in transcribing the pain orders.</p> <p>Reference WAC 388-97-1060 (1)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient qualified nursing staff were available to provide care and services as evidenced by information provided in resident (Residents 14, 46, 5, 116, and 216) and resident council group interviews. The facility had insufficient staff to ensure residents received Restorative Nursing Program (RNP) services as evidenced by Restorative Nursing staff removed from restorative nursing duties to cover direct care duties impacting 2 of 4 residents (Residents 4, and 25) reviewed for limited ROM and restorative nursing services. These failures placed residents at risk for a delay in repositioning and toileting assistance, a decrease in resident safety and health needs and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility assessment dated [DATE], showed the facility assessment did not address the staffing needs specific to the resident population and acuity of the facility.</p> <p><RESTORATIVE NURSING SERVICES></p> <p><Resident 25></p> <p>Record review for Resident 25 documented therapy discharge recommendations dated 12/13/2024 for Restorative Nursing Aides to perform bilateral range of motion/stretching each evening prior to splint application. Review of the record showed the range of motion and stretching recommendations were not being completed prior to placing the splints.</p> <p><Resident 4></p> <p>Review of Resident 4's Care Plan on 04/04/2025, documented the resident had been set up for two restorative nursing programs for range of motion and splints.</p> <p>Review of Resident 4's medical record on 04/04/2025 showed that the care planned restorative programs were not occurring.</p> <p>In an interview on 04/04/2025 at 10:44 AM, Staff Q, Director of Therapy Services, stated the facility did not currently have a restorative program, stating they needed one but did not have enough staff. Staff Q stated the facility had one restorative aide, but they were always working on the floor.</p> <p>In an interview on 04/07/2025 at 2:01 PM, Staff D, NAC stated they were a restorative aide at the facility for years but had not worked as a restorative aide for a while as the facility did not have enough staff to do the restorative program. Staff D stated they wanted to start the restorative program back up, but they had been on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/09/2025 at 10:51 AM, Staff A stated the facility was struggling to hire or train restorative nursing aids and acknowledged that the facility did have one full time staff with restorative training, but that staff member had not been being utilized in that role related to staffing needs on the floor.</p> <p>36787</p> <p><RESIDENT INTERVIEWS></p> <p>In an interview 04/02/2025 at 10:52 AM, Resident 14 stated residents had voiced concerns that meal trays were late, and they were not surprised by that as the staffing was always short.</p> <p>In an interview on 04/02/2025 at 11:35 AM, Resident 216 stated staffing was worse in the middle of the night, and they had to wait over an hour at times. Resident 216 stated the waits were rough when they had to go to the bathroom, and they had a urinary tract infection.</p> <p>In an interview on 04/02/2025 at 2:50 PM, Resident 54 stated at nighttime the staff did not check on them, and they had to wait for a long time to get their call light answered. Resident 54 stated they empty their own urinal because the staff won't do it at night.</p> <p>In an interview on 04/02/2025 at 3:17 PM, Resident 216 stated they have had at least two to three times at nighttime where they had to lay in urine for over an hour while they waited for someone to come answer their call light. Resident 216's roommate interjected and stated they could confirm that, as they would get up and go look for staff, but it was a ghost town in the hall.</p> <p>In an interview on 04/03/2025 at 8:48 AM, Resident 46 stated when they needed help, they wait and wait. The resident stated they need what they need and a lot of times they could hear staff laughing in the hall while their call light had been on. Resident 46 stated when they fell , they called their husband and wanted to call 911. The resident stated that when they fell , they told the staff their call light had been on for over an hour. Resident 46 said they heard call lights beeping all the time.</p> <p>In an interview on 04/03/2025 at 9:32 AM, Resident 116 stated staff would poke their head in and say they would help them and then the staff left into wonderland and did not come back. Resident 116 stated they had waited 40 minutes for help on two occasions on the night shift.</p> <p><REVIEW OF RESIDENT COUNCIL MEETING MINUTES></p> <p>Review of the 01/28/2025 resident council meeting minutes documented residents complained that call light response times were too long.</p> <p>Review of the 02/25/2025 resident council meeting documented residents complained about call light response times and resident needs being met.</p> <p>Review of the 03/27/2025 resident council meeting documented residents complained call light response times were not good.</p> <p><RESIDENT COUNCIL MEETING></p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/07/2025 at 11:04 AM, the following statements were made:</p> <ul style="list-style-type: none"> - Resident 18 stated there is no one to help you from 11:30 AM to 1:00 PM as there were either one to two aides that just sat in the dining room waiting to assist the residents. Resident 18 stated those staff could be helping out on the floor. - Resident 5 stated the staff tell them that the new administration came in and immediately changed staff hours. Resident 5 said there was to be no more overtime, and the aids had no recourse, they either have to leave or they have to live with it. Resident 5 stated staff were doing more double shifts for a while. The resident said staff told them they were tired, they bust their bottoms. - Resident 11 stated the staff feel like they have to work so much because they are dedicated, and they did not want to say no. - Resident 8 stated some staff complained about working 16 hours. Resident 8 stated they had to lie there for 2 or 3 hours in a sopping wet diaper. - Resident 54 stated they waited an hour for their call light to be answered from 11:30 AM to 1:00 PM. - Resident 118 stated their main concern was the length of time to wait is 30 minutes or an hour and a half to have your call light answered. Resident 118 stated it was disgusting and embarrassing to soil themselves and they had to help themselves to the bathroom to avoid accidents. <p>In an interview on 04/08/2025 at 11:10 AM, Staff N, NAC stated when lunch arrived later than normal it was hard to do all the care needed before shift change. Staff N stated the north and south set (staff assignment) and maybe another aide were to cover the floor during meal times.</p> <p>In an interview on 04/09/2025 at 8:26 AM, resident staffing concerns were reviewed with Staff A, Administrator, Staff B, Director of Nursing and Staff C, Regional Director of Clinical Services. Staff A stated the issue with floor coverage during meal times was they had to have 5 NAC's off the floor to assist with 5 residents who required one on one feeding assistance. Staff A commented they only had 5 aids on during night shift. Staff C stated they needed to address the call light coverage on the floor and get to the root cause of the call light concerns.</p> <p>Reference WAC 388-97-1080(1), 1090 (1)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview and record review, the facility failed to ensure mental and psychosocial health needs were identified and met for 2 of 2 residents (Residents 30 and 114) reviewed for behavioral-emotional health. Failure to identify mental health needs and utilize person-centered interventions developed by an interdisciplinary team placed residents with behavioral needs, at risk for unidentified behavior triggers, unmet behavioral needs, refusal of care, self-neglect, lack of behavioral services and support, loss of dignity, loss of autonomy and diminished quality of life.</p> <p>Findings included .</p> <p><RESIDENT 114></p> <p>Resident 114 was admitted to the facility on [DATE] with diagnoses to include depression, anxiety disorder and cognitive communication deficit.</p> <p>Review of the admission Minimum Data Set (MDS-an assessment tool) assessment on 03/14/2025 showed Resident 114 was taking an antidepressant. The mood interview showed the resident reported that they had little interest or pleasure in doing things, felt down, depressed or hopeless, had trouble falling asleep, felt tired with little or no energy and moved and spoke so slowly that other people could notice for the past 12-14 days. The assessment showed the resident was socially isolating.</p> <p>Review of Resident 114's psychosocial wellbeing Care Area Assessment (CAA), dated 03/14/2025, documented they had episodes of little interest or pleasure in doing things. The resident's goal was to progress with therapies and be discharged back to the community, prioritizing these above general activities of interest that would be important to the resident when not in a skilled care facility. The assessment anticipated that the resident would return to having pleasure/interest in things when they have progressed to ability to discharge back to community home setting.</p> <p>Review of a progress note on 03/11/2024 at 10:09 PM, showed the resident was emotional and crying.</p> <p>Review of a progress note on 03/13/2025 at 12:36 PM, documented Resident 114 scored 19 out of 27 on the PHQ-9, an assessment for depression which indicated moderately severe depression and social services was to follow up as resident would like a referral to behavioral health services (BHS).</p> <p>Review of the clinical record documented Resident 114 had no BHS visits or referrals for services.</p> <p>In an interview on 04/09/2025 at 8:15 AM, Staff C, Regional Director of Clinical Services stated they would investigate why Resident 114 had not been referred to BHS. Staff C stated referrals should be documented in the chart.</p> <p>In an interview on 04/09/2025 at 10:24 AM, Staff G, Social Services Director stated they were unaware of the BHS referral for Resident 114. Staff G stated the process was they get updated on referrals at the daily clinical meeting.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/09/2025 at 12:40 PM, Staff J, Registered Nurse/MDS nurse stated that they assessed Resident 114 and their PHQ-9 was high, so they made a referral to Staff G. Staff J stated the expectation was that residents receive behavioral help when indicated and referrals should be timely.</p> <p><Resident 30></p> <p>Resident 30 was a long-term resident of the facility. According to the MDS dated [DATE], the resident was severely cognitively impaired.</p> <p>Review of a provider note dated 12/23/2024, documented that the provider had placed a referral for Behavioral Health Services.</p> <p>During an interview on 04/08/2025 at 2:04 PM, Staff G, Social Services, stated that they are responsible for behavioral health referrals. Then stated that the MDS nurse documented Resident 30's PHQ-9 and that the resident refused service.</p> <p>Review of Resident 30's 'CAA worksheet', with a print date of 04/09/2025, documented that Resident 30 had a diagnosis of depression and was taking medication, and their PHQ-9 (depression assessment) score indicated depression. No documentation of the resident refusing a Behavioral Health Referral.</p> <p>No associated WAC reference.</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview and record review, the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for 5 of 8 residents (Residents 5, 8, 11, 24 and 54) reviewed for medically related social services. Failure to assure resident safety, ensure residents were informed of their care, treatment and services available to them, and continuously monitor, thoroughly assess, and advocate for resident's rights placed residents at risk for harm, diminished quality of life and unmet care needs.</p> <p>Findings included .</p> <p>According to the facility's Director of Social Services (SSD) job description, dated 12/06/2016, the primary purpose of the SSD was to plan, organize, develop, and direct the overall operation of the facility's Social Services Department in accordance with applicable laws, regulations and company standards. The facility's established policies and procedures were to ensure that medically related social and emotional social needs of residents were met, act as an advocate and provide education to staff regarding resident rights, as well as chart appropriately and timely.</p> <p><RESIDENT COUNCIL></p> <p>In the resident council meeting on 04/07/2025 at 10:43 AM, residents were asked about grievances. The following interviews occurred:</p> <ul style="list-style-type: none"> - Resident 54 stated they had asked to meet with the social worker and they were not sure why the facility had one as they didn't help them. Resident 54 asked what the role of the social worker was. - Resident 5 stated they had not met the social worker, and they wanted to know about their role. The resident stated that (Staff G) the social worker tells them they do not have time for this. - Resident 8 stated they had tried to meet with social services and called (Staff G's) name in the hall several times and they will not answer them, and they walk off. - Resident 24 stated they asked Staff G, Please can I have a meeting with you, and they dismissed me, that hurts me. Resident 24 stated they understood that Staff G had a lot on their plate, but they still needed help. - Resident 11 stated Staff G came up to them and said they were ready to take care of what I needed. Resident 11 stated they were busy and told them so, and they said do it now or never, I have 65 residents to take care of. Resident 11 stated I felt terrible. I know (Staff G) has no assistant, but I will not go to (Staff G) anymore. <p>In an interview on 04/09/2025 at 10:24 AM, Staff G, SSD stated they were responsible for meeting new admits, completing a baseline care conference, complete care conferences for discharges and as requested. Staff G stated they participated in the psychotropic meetings, clinical meetings. Staff G acknowledged there were PASRR's that needed to be revised.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/09/2025 at 12:43 PM, Staff A, Administrator stated the facility needed to add another social worker to support Staff G. Staff A stated they were trying to assist and support Staff G, as there were several residents who needed more support.</p> <p><MENTAL HEALTH SUPPORT></p> <p>Review of the facility assessment dated [DATE] showed the facility had multiple residents with behavioral health disorders including anxiety, psychosis, Post Traumatic Stress Syndrome and bipolar disorders, and residents with dementia and traumatic brain injuries. The facility assessment indicated the facility was able to provide care for these conditions. The facility did not use this data to comprehensively assess the staffing or competency needs. The facility assessment noted the facility staffed based on the needs and acuity of residents.</p> <p>According to the facility matrix provided on 04/10/2025, 61% of the residents were identified as taking at least one psychotropic medication.</p> <p>In an interview on 04/09/2025 at 9:11 AM Staff C, Regional Director of Clinical Services stated their expectation was that social services documented interactions and assessments, followed up on PASRR assessments and assisted with care conferences and care planning.</p> <p>No additional information was provided.</p> <p>Refer to F644 - 483.20(e) Coordination of PASARR and Assessment</p> <p>Refer to F645- 483.20(k)(1)-(3) PASRR screening</p> <p>Refer to F740- 483.40 Behavioral Health Services</p> <p>Refer to F758- 483.45(e)(1)-(5) Free from unnecessary psychotropic medications</p> <p>Reference WAC 388-97-0960 (1)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110</p> <p>Based on interview and record review, the facility failed to act on the consultant pharmacist's monthly medication regimen review (MRR) recommendations in a timely manner for 2 of 5 residents (Residents 14, and 30) reviewed for unnecessary medications. Failure to act timely on the pharmacist's recommendations placed all residents at risk for experiencing adverse side effects, medical complications, and a decreased quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Medication Regimen Review, revised 06/01/2024, the provider should address the consultant pharmacist's recommendations no later than their next scheduled visit.</p> <p><RESIDENT 14></p> <p>Resident 14 admitted to the facility on [DATE] they have diagnoses that include hyperlipidemia (high levels of fats in blood), diabetes, and history of heart attack.</p> <p>In a review of Resident 14's MRR recommendations dated 11/21/2024 the pharmacist documented a fasting lipid panel (blood test to check the levels of fats in the blood) was ordered on 08/07/2024 by the physician, please upload the results into the medical record.</p> <p>In a review of Resident 14's laboratory results on 04/07/2025 the fasting lipid panel was not completed until 01/13/2025, five months after the order was completed.</p> <p>In a telephone interview on 04/08/2025 at 10:30 AM, Collateral Contact (CC) 1, Pharmacist stated they performed MRR once a month at the facility, around the third week of the month. CC1 stated the facility would usually have access to their report within 72 hours of completion. CC1 stated their expectation was that an MRR that required action would be completed within 30 days of the request.</p> <p>In an interview on 04/08/2025 at 3:21 PM, Staff C, Regional Director of Clinical Services (RDCS) stated the expectation was the facility would complete all MRR requests within 30 days. Staff C stated the MRR for Resident 14 should have been done back in August originally, and then again should have been caught during the November review. Staff C stated they were not sure what occurred or why it was completed five months late.</p> <p>47047</p> <p><RESIDENT 30></p> <p>Resident 30 was admitted to the facility on [DATE] with diagnoses which included history of falling, depression and anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a review of Resident 30's monthly pharmacy review dated 10/23/2024 showed a recommendation for Basic Metabolic Panel (BMP-blood test that provides important information about a person's metabolism, fluid balance and kidney function) to be completed to assess their kidney function. The note showed that Resident 30 had not had an assessment of kidney function in the last year.</p> <p>In a review of Resident 30's monthly pharmacy review dated 01/23/2025 showed a repeated recommendation from 10/23/2024 for a BMP to be completed to assess their kidney function. The recommendation was noted by a registered nurse and the nurse practitioner on 02/05/2025 with directions to complete a BMP and at least every 6 months thereafter.</p> <p>In a review of Resident 30's monthly pharmacy review dated 03/16/2025 showed a repeated recommendation for a BMP to be completed.</p> <p>In a review of Resident 30's electronic health record showed there were no labs completed on or after 10/23/2024.</p> <p>In an interview on 04/04/2025 at 1:34 PM Staff H, Licensed Practical Nurse (LPN)-Unit Coordinator, stated the pharmacy recommendations are reviewed by the provider and lab results are found in the electronic medical record under results. When asked about the pharmacy recommendation for Resident 30 to have a BMP, they stated they had given all the information they could.</p> <p>In an interview on 04/04/2025 at 2:41 PM Staff C, RDCS, stated they found the pharmacy recommendation from January 2025 which was noted by the nurse practitioner and a facility nurse, but unable to locate any orders or documentation of the BMP being completed.</p> <p>Reference WAC 388-97-1300 (1)(c)(iii), (4)(c)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>36787</p> <p>Based on interview and record review, the facility failed to consistently offer and/or provide a nutritional snack when ordered or requested for 4 of 6 resident's (5, 11, 54, and 265) residents reviewed for dining preferences. This failure to provide nutritional snacks at non-traditional times and meet resident choices placed residents at risk for inadequate nutrition.</p> <p>Findings included .</p> <p><REVIEW OF RESIDENT COUNCIL MINUTES></p> <p>Review of the resident council meeting minutes on 01/28/2025 documented the concern of residents wanting more snacks and different snack options.</p> <p><RESIDENT COUNCIL></p> <p>In an interview with resident council representatives on 04/07/2025 at 11:36 AM, Resident's were asked do you received snacks at bedtime or when you request them? Residents responded.</p> <p>Resident 5 stated they asked for snacks and staff tells them there are only saltine crackers available.</p> <p>Resident 11 stated the staff fill the snack bins after breakfast and lunch and will give you graham crackers. Resident 11 stated they would like a snack at 10:30 at night since they are up late but staff report there is nothing left.</p> <p>Resident 54 stated they ask for snacks a lot and staff say there aren't any. Resident 54 stated they would like Jello.</p> <p>Resident 265 stated they were on a pureed diet and night staff were not aware of that and gave them potato chips and cookies for snacks. Resident 265 stated they tell the staff they are not supposed to have chips or cookies, and staff would respond, the facility is out of everything. Resident 265 would like to have pudding or yogurt since they shouldn't have chips.</p> <p>In a joint interview on 04/09/2025 at 10:00 AM with Staff B, Director of Nursing and Staff C, Regional Director of Clinical Services stated the expectation is snacks are passed at night. Staff C said everyone should be offered a snack and they will investigate that. Staff B stated Snacks are in the standard orders.</p> <p>No additional information was provided.</p> <p>Reference: (WAC) 388-97-1120 (1)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>51312</p> <p>Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food under sanitary conditions in the facility kitchen. This failure placed residents at risk for cross-contamination and foodborne illnesses.</p> <p>Review of document titled 'Sanitation and food safety' with a revision date of 09/08/2022 documented under Procedure that:</p> <p>Staff will wash their hands.</p> <ul style="list-style-type: none"> * After handling raw or unwashed foods * After handling dirty dishes, soiled equipment or utensils * During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. * Before donning gloves to initiate a task that involves working with food. <p>During an observation on 04/02/2025 at 12:47 PM, Staff EE, Food Service Director (FSD), entered the kitchen from his office, did not wash his hands, put on gloves, and prepared chicken for the residents.</p> <p>During an observation on 04/02/2025 at 2:24 PM, Staff DD, dietary aid, placed dirty dishes into the dishwasher. Once the dishwasher had completed its cycle, the clean dishes were removed without proper handwashing. Staff DD performed this task multiple times.</p> <p>During an interview on 04/02/2025 at 2:24 PM, Staff DD stated that the dishes they took out of the dishwasher were clean, and they were waiting for them to dry before putting them away. Staff DD mentioned that they should wash their hands before touching clean dishes.</p> <p>During an interview on 04/02/2025 at 3:28 PM, Staff EE, FSD indicated that dirty dishes should be removed from the cart and placed in the dishwasher. Afterward, staff should wash their hands before handling the clean dishes from the dishwasher.</p> <p>During an observation on 04/07/2025 at 9:12 AM, dust was present on the rack above the food service area that held measuring cups. The rack above the second food prep area, contained spices, and had dust accumulation. The stove top hood showed signs of dust. The food prep sink, where knives were stored on the wall, had debris splashes on the surrounding area. The front of the steam table used during food distribution had drips of moisture. The fan directly above the food prep area contained a significant amount of dust.</p> <p>WAC 388-97-1100(3)</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>37890</p> <p>Based on interview and record review, the facility failed to document a facility-wide assessment to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies.</p> <p>Findings included .</p> <p>Review of the facility assessment provided by the facility dated 07/30/2024, included the names of the prior facility Administrator and Director of Nursing Services. The facility assessment only included a Part I template and failed to include the following required elements:</p> <ul style="list-style-type: none"> - The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; - The staff competencies that are necessary to provide the level and types of care needed for the resident population; - The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; <p>The facility's resources, including but not limited to, all buildings and/or other physical structures and vehicles;</p> <ul style="list-style-type: none"> - Equipment (medical and non- medical); - Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; - All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; - Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and - Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. <p>In an interview on 04/02/2025 at 1:40 PM, Staff A, Administrator, stated the facility assessment provided was the most current and they were unable to provide any further information.</p> <p>No associated WAC reference.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>37890</p> <p>Based on interview and record review, the facility failed to ensure the Quality Assessment and Performance Improvement (QAPI) program self-identified deficiencies and failed to develop/implement effective plans of action to sustain plan of corrections for previous deficiencies. Failure to have an effectively functioning QAPI program that consistently self-identified deficient practices led to repeated deficiencies, and a pattern of deficiencies that placed residents at repeated risk for unmet needs that could negatively impact their safety, quality of life and quality of care.</p> <p>Findings included .</p> <p>Review of the facility QAPI plan/policy dated 01/21/2025 documented the facility's QAPI committee was responsible for ensuring compliance with state and federal requirements and for continuous improvement in quality of care and customer satisfaction.</p> <p>Review of the facility [NAME] 3 facility report showed the following repeat deficiencies from Statement of Deficiencies dated 08/06/2024:</p> <p>F - 0550 - 483.10(a)(1)(2)(b)(1)(2) - Resident Rights/exercise Of Rights S-S= E</p> <p>F - 0610 - 483.12(c)(2)-(4) - Investigate/prevent/correct Alleged Violation S-S= E</p> <p>Review of the facility [NAME] 3 facility report showed the following repeat deficiencies from Statement of Deficiencies dated 05/01/2024:</p> <p>F - 0584 - 483.10(i)(1)-(7) - Safe/clean/comfortable/homelike Environment S-S= E</p> <p>F - 0657 - 483.21(b)(2)(i)-(iii) - Care Plan Timing and Revision S-S= D</p> <p>F - 0676 - 483.24(a)(1)(b)(1)-(5)(i)-(iii) - Activities Daily Living (adls)/mntn Abilities S-S= D</p> <p>F - 0684 - 483.25 - Quality of Care S-S= D</p> <p>F - 0688 - 483.25(c)(1)-(3) - Increase/prevent Decrease In Rom/mobility S-S= D</p> <p>F - 0689 - 483.25(d)(1)(2) - Free of Accident Hazards/supervision/devices S-S= E</p> <p>F - 0692 - 483.25(g)(1)-(3) - Nutrition/hydration Status Maintenance S-S= D</p> <p>F - 0758 - 483.45(c)(3)(e)(1)-(5) - Free from Unnec Psychotropic Meds/prn Use S-S= D</p> <p>WAC 388-97-1080 - Nursing Services</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/09/2025 at 11:09 AM, Staff A, Administrator, acknowledged the findings of repeat deficiencies and stated they could not speak to prior leadership. Staff A stated that the expectation of the QAPI team was to follow the processes established, hold staff accountable and be consistent. Staff A stated they were focused on retention of management staff.</p> <p>Reference WAC 388-97-1760(1)(2)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview, and record review the facility failed to ensure the staff were compliant with Infection Prevention and Control Guidelines and standards of practice for 2 of 3 units. The facility failed to ensure the staff used appropriate hand hygiene practices during personal care, and disposal of soiled garbage in accordance with infection control standards of practice. This failure placed all residents and staff at risk of potential infection.</p> <p>Findings included .</p> <p>Review of the facility polity titled, Hand Hygiene, revised 12/04/2020, documented hand hygiene should be completed before and after any resident contact, before applying gloves (donning), after removal of gloves (doffing), contact with potential contaminated personal protective equipment and after any potential contact with infectious materials i.e., blood, bodily fluids, or contaminated surfaces.</p> <p>Review of the facility policy titled, Clostridium Difficile reviewed 06/04/2024 documented the facility would care for residents with suspected and actual Clostridium difficile (C. Diff) in accordance with local, state, and federal guidelines. The physical action of washing and rinsing hands under such circumstances is recommended as alcohol gel has poor activity against spores.</p> <p><RESIDENT 116></p> <p>Resident 116 was placed on enteric precautions (specific infection control measures) on 04/04/2025 for suspected C. Diff (inflammation of the colon caused by Clostridium difficile bacteria, resulting in diarrhea and pain).</p> <p>In an observation on 04/04/2025 at 8:24 AM, a new contact enteric precaution sign was observed on room [ROOM NUMBER]'s door. The Personal Protective Equipment (PPE) bin was placed against the trash bin outside the room. There were soiled gown straps going from the trash receptacle into the top drawer of clean PPE bin. Staff O, Nursing Assistant Registered (NAR) left room [ROOM NUMBER] with their mask on and did not remove it. Staff M, Nursing Assistant Certified (NAC) came out of the room with a surgical mask on. Staff O and M used hand gel only and walked down the hall with full bags of soiled linens in their hands. The masks were not removed after exiting room [ROOM NUMBER] and walking down the hall.</p> <p>In an interview on 04/04/2025 at 9:07 AM, Staff M, NAC stated they provided care to Resident 116 and had to do a complete bed linen change. Staff M stated they were informed the resident had C. Diff, so they had to wear full PPE, and they put on a gown, mask, gloves and eye protection. Staff M stated they used hand sanitizer going into room [ROOM NUMBER] and hand sanitizer going out of the room. Staff M stated they washed their hands when disposing of the soiled linen down the hall.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/04/2025 at 9:49 AM, Staff O stated when providing care to Resident 116 then had put on a gown, gloves and mask. They stated they stripped the residents bed, put new bedding on and disposed of dirty bedding. They stated they disposed of the dirty linen and sanitized their hands when they left the room. Staff O stated they were told the residents had C. Diff and they did have loose stools. Staff O stated they were to follow the posted signs on the door.</p> <p>In a continuous observation on 04/04/2025 at 9:18 AM, Staff L, housekeeping assistant bagged up soiled linen from the trash can outside of room [ROOM NUMBER]. Staff L had gloves on, then removed them and with no hand hygiene performed before putting new gloves on. Staff L closed their cart, and their soiled left gloved hand went into their left scrub pocket, then donned new gloves, without performing hand hygiene. Staff L went into room [ROOM NUMBER] to get their trash and placed their left hand into their left pocket to get a trash bag out. No hand hygiene was observed until interview with Staff L at 9:22 AM. Staff L stated they would read the posted signs outside the room to know about any infection control precautions. Staff L stated they were unsure what enteric precautions were. Staff L then asked if they should have been wearing a gown when collecting the soiled garbage from outside the room of 104.</p> <p>In observations on 04/07/2025 at 10:10 AM, 1:24 PM, 2:01 PM, and 2:51 PM, the clean PPE cart was right up to the soiled garbage can.</p> <p>In an observation on 04/08/2025 at 8:37 AM, Staff M opened the door to room [ROOM NUMBER] and was observed inside the room wearing a gown and gloves with no mask on.</p> <p>In an interview on 04/08/2025 at 12:52 PM, Staff P, Infection Preventionist stated their expectation for hand hygiene was before and after contact with the resident, when leaving rooms, passing trays, and if they go to the bathroom. Staff P stated staff should wash their hands vigorously after contact with C. Diff.</p> <p>51312</p> <p><Resident 266></p> <p>Resident 266 was admitted to the facility on [DATE]. According to the MDS dated [DATE], Resident 266 was severely cognitively impaired.</p> <p>During an observation on 04/02/2025 at 10:21 AM, Staff E, NAC, entered the room of Resident 266 without performing hand hygiene. Staff E provided perineal care and assisted the resident with a brief change. Staff E then assisted Resident 266 with dressing, moving the wheelchair, and using a walker, without conducting hand hygiene or changing gloves during the process. Staff Z, NAC, entered Resident 266's room to assist with a transfer without performing hand hygiene. Staff Z assisted with the transfer and then brushed the resident's hair.</p> <p>During a joint interview on 04/02/2025 at 10:24 AM, Staff Z indicated that proper hand hygiene was not performed upon entering resident 266's room. Staff E noted that hand hygiene and a glove change should have been carried out after performing perineal care and changing the brief.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 4/4/2025 at 10:26 AM, Staff Z entered the room of Resident 266 without performing hand hygiene. Staff Z provided perineal care and assisted the resident with a brief change. They then assisted Resident 266 with dressing, without conducting hand hygiene or changing gloves during the process.</p> <p>During an interview on 4/4/2025 at 10:40 AM, Staff Z indicated that hand hygiene should be performed upon entering the resident's room and after completing perineal care. However, Staff Z also stated that hand hygiene was not performed.</p> <p>Reference WAC 388-97-1320 (1)(a)(c)</p>		