

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505318	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/02/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Skagit Valley		STREET ADDRESS, CITY, STATE, ZIP CODE  1462 West State Route 20 Sedro Woolley, WA 98284	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890</b></p> <p>Based on observation, interview, and record review the facility failed to ensure pharmacy services were provided to meet the needs of 3 of 4 residents (Resident 1,2, and 3) reviewed for medications. The failure to ensure medications were acquired and administered as ordered on the day of admission and follow facility processes for medications not available placed residents at risk for adverse events related to missed medications.</p> <p>Findings included .</p> <p>&lt;Resident 1&gt;</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses to include Bipolar Disorder (a mood disorder), Seizure Disorder, Tremors (related to medication side effects), and Thyroid disorder.</p> <p>Review of the admission progress note dated 06/26/2026, showed Resident 1 arrived at the facility at 12:15 PM on 06/26/2024. The resident returned to the hospital on 06/27/2024 and had not returned to the facility.</p> <p>Review of Resident 1's admission orders and Medication Administration Records (MAR) for June 2024 showed:</p> <ul style="list-style-type: none"> <li>- An order for Quetiapine Fumarate (treats bipolar disorder) Oral Tablet 200 MG (milligrams) at bedtime. Review of the MAR for the evening of 06/26/2024 showed a blank space with no documentation that the resident had or had not received the medication</li> <li>- An order for Benztropine Mesylate Oral Tablet 1 MG twice a day (for altered mental status.) Review of the MAR for the evening of 06/26/2024 showed documentation of code 10 by Staff C, Licensed Practical Nurse (LPN). The reference key showed that 10 meant other, see nurse notes. Review of the corresponding nursing progress note showed the entry was documented on 06/26/2024 at 4:06 PM and the entry stated only new admit.</li> <li>- An order for Lamotrigine Oral Tablet 100 MG twice a day (for seizure disorder). Review of the MAR for the evening of 06/26/2024 showed documentation of 10 by Staff C. The corresponding progress note was entered at 4:06 PM and stated, new admit.</li> </ul> <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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/02/2024 at 11:26 AM, Staff C, Licensed Practical Nurse (LPN), stated that new admission medications arrived from the pharmacy the next day. Staff C stated the pharmacy usually delivers medications around midnight. When asked what the process was for the medications that were due that first evening, Staff C stated they could go to the Omnicell (an automated medication dispensing cabinet, stocked with the most frequently used medications), or they could call the pharmacy to have the medication satellited earlier. Staff C stated they were not sure what else they would do if they were not able to get a resident's medication from the Omnicell or satellited.</p> <p>Record review of the Omnicell inventory list (dated 05/10/2023), attached to the Omnicell, showed Quetiapine was listed as available in the Omnicell. Benzatropine and Lamotrigine were not included on the inventory list.</p> <p>In an interview on 07/02/2024 at 12:00 PM, Staff B, Registered Nurse (RN)/Director of Nursing Services (DNS), reviewed the pharmacy records and stated the pharmacy delivery for Resident 1 arrived on 06/27/2024 at 03:10 AM. Staff B noted the 2023 date on the Omnicell inventory and placed a call to the pharmacy to request an updated inventory for the Omnicell and request a report of the Omnicell activity for 06/26/2024. Staff B stated the expectation would be to use the Omnicell or call the pharmacy and the resident's provider if a medication was not available.</p> <p>In an observation on 07/02/2024 at 12:34 PM, Staff C, LPN opened the medication cart to show Resident 1's medication cards which were still in the cart. Staff C showed each card and it was observed that none of the cards had any medications dispensed out of them. Staff C was asked to review their documentation for Resident 1 on 06/26/2024 at 4:06 PM. Staff C stated they documented new admit to show that the medications were not available because the resident had just admitted . When asked if those medications had been available in the Omnicell, Staff C stated they did not know. Staff C stated they did not know if anyone had called the pharmacy asking to have any medication satellited to the facility. Staff C was unable to state why or how they determined that Resident 1 ' s medication would not be available during their shift, when they documented that at 4:06 PM. Staff C stated they did not know if anyone had notified the resident's provider that those medications had not been received or administered.</p> <p>In an interview on 07/02/2024 at 12:53 PM, Staff D, RN/Unit Coordinator, stated their job was completing admissions and processing medication orders for the new admissions. Staff D stated they had done the admission for Resident 1 on 06/26/2024. Staff D stated medication orders were reviewed before the resident arrived and the ARNP (Nurse Practitioner/Provider) also reviewed the medication orders to ensure they were correct. The medication orders were sent to the pharmacy when the resident arrived and were delivered late that night. Staff D stated the nurses should pull medications out of the Omnicell but stated they did not check the Omnicell inventory as part of their admission process. When asked what the process was when a medication was not available, Staff D stated they just have to wait until the pharmacy delivers. Staff D stated the pharmacy would not send anything satellite unless it came from their IV (intravenous) pharmacy, which delivered earlier. Staff D stated the nurses should notify the provider if they were unable to get a medication for a resident.</p> <p>In a follow-up interview on 07/02/2024 at 2:00 PM, Staff B, DNS stated after review of the Omnicell activity report, there had been no medications pulled out of the Omnicell for Resident 1 on 06/26/2024.</p> <p>&lt;Resident 2&gt;</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 2 admitted [DATE] at 12:19 PM with diagnoses which included recent fall with fracture, pain, cardiac conditions and shortness of breath.</p> <p>Review of Resident 2's admission orders and MAR dated June 2024 showed:</p> <ul style="list-style-type: none"> <li>- An order for Memantine HCl (treats memory loss) Oral Tablet 10 MG, 1 tablet by mouth two times a day. Review of the MAR for the evening of 06/25/2024 showed code of 10 with corresponding nursing progress note stating, Pending delivery. Memantine was listed as an available medication in the Omnicell.</li> <li>- An order for Rosuvastatin Calcium Oral Tablet 20 MG, 1 tablet by mouth one time a day for Hyperlipidemia (high levels of fats in the blood). Review of the MAR for the evening of 06/25/2024 showed code of 10 with corresponding nursing progress note stating, Pending delivery. Rosuvastatin was not listed as an available medication in the Omnicell.</li> <li>- An order for Symbicort Inhalation (inhaler) Aerosol 80-4.5 MCG/ACT 2 puffs for shortness of breath. Review of the MAR for the evening of 06/25/2024 showed code of 10 with corresponding nursing progress note stating, Pending delivery. Symbicort was not listed as an available medication in the Omnicell.</li> <li>- An order for Voltaren External Gel 1 % to affected area topically four times a day for pain. Review of the MAR for 06/25/2024 and 06/26/2024 showed coded 7 consecutive administrations coded as 10 with corresponding nursing progress notes stating, Pending delivery. Voltaren was not listed as an available medication in the Omnicell.</li> </ul> <p>In an interview on 07/02/2024 at 1:28 PM, Resident 2 stated there were a couple things they didn't have at first. Resident 2 stated they couldn't recall everything, but remembered they had wished they had their pain ointment for their knee because it took the edge off and they didn't have that until a few days after admission.</p> <p>Record review showed no documentation the provider had been notified of medications that were not available or not administered for Resident 2 on admission.</p> <p>&lt;Resident 3&gt;</p> <p>Resident 3 admitted on [DATE] with diagnoses which included encephalopathy (damage or disease affecting the brain) and psoriasis (skin condition characterized by patchy rash).</p> <p>Review of Resident 3's admission medication orders and MAR dated June 2024, showed:</p> <ul style="list-style-type: none"> <li>- An order for Lactulose Oral Solution 20 GM/30ML (treats accumulation of ammonia (a gas) in the blood) give 30 ml (milliliters) by mouth three times a day. Review of the MAR for the evening of 06/10/2024 showed code of 10 with corresponding nursing progress note stating, On order. Lactulose was not listed as an available medication in the Omnicell.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- An order for Betamethasone Valerate External Cream 0.1 % apply to scaling areas topically one time a day for psoriasis. Review of the MAR for the evening of 06/25/2024 showed code of 10 with corresponding nursing progress note stating, On order. Betamethasone was not listed as an available medication in the Omnicell.</p> <p>Record review showed no documentation the provider had been notified of the medications that were not available or not administered for Resident 3.</p> <p>In an interview on 07/02/2024 at 2:00 PM, Staff B, DNS stated they had received an updated list of the medications available in the Omnicell and they were reviewing the pharmacy delivery and admission process.</p> <p>Refer to WAC 388-97-1300(1)(b)(i)(ii)</p>		