STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505318	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Skagit Valley	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interview and record review the facility failed to provide resident focused care through consistent monitoring, assessment and evaluation of the residents' condition and develop interventions for urinary tract infections (UTI) for 1 of 5 sampled residents (Resident 1), reviewed for quality of care. This failure placed residents at risk of medical complications, unmet care needs, and diminished quality of life. Findings included . Review of McGreer's criteria (set of surveillance definitions used to identify infections in long-term care settings) showed the constitutional criteria for a UTI (a set of signs and symptoms that indicate a patient may have an infection, even if diagnostic testing has not confirmed it) included fever, acute change in mental and/or functional status and leukocytosis (high white blood cell count). Resident 1 readmitted to the facility on [DATE] with diagnoses that included recurrent UTI, type two diabetes mellitus (chronic disease with high levels of sugar in the blood), and Parkinson's disease (a disorder of the central nervous system that affects movements). Review of Resident 1's discharge hospital note dated 05/15/2024 showed they had been hospitalized and treated for UTI with sepsis (a life-threatening condition that happens when the body's immune system has an extreme response to an infection). Review of Resident 1's Brief Interview for Mental Status (BIMS-an assessment used to determine cognitive function) dated 05/20/2024 showed a score of 15 out of 15 which indicated they were cognitively intact. Review of Resident 1's Admission Minimum Data Set (MDS-an assessment tool) dated 05/20/2024 showed they had not had a UTI in the last 30 days. Review of the Care Area Assessment (CAA- a systematic process to interpret the triggered information from the Minimum Data Set assessment to assess the potential problem and determine if the area should be care planned) dated 05/28/2024 showed Resident 1 was incontinent of urine, had chronic UTI's, and the care plan problem showed they were at risk for skin breakdown with the goal of assisted toileting. There was no additional problem, goals or interventions identified related to Resident 1's history of chronic UTI's. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's nursing assessment evaluation for bowel and bladder training dated 05/15/2024 and 08/15/2024 showed the resident was a candidate for timed toileting or a scheduled voiding program. Review of Resident 1's care plan dated 05/15/2024 showed no care plan was in place to address Resident 1's history of chronic/recurrent UTI's or their candidacy for timed/scheduled voiding. The care plan showed Resident 1 required two-person assistance for peri care and brief changes. Review of Resident 1's progress note dated 08/16/2024 at 7:16 AM showed their brief was soiled with enough dark brown urine to alert the oncoming nurse to encourage them to drink more fluids. No vital signs were located in Resident 1's electronic health record for 08/16/2024. No documentation was found that the resident's representative or provider were notified of this finding. Review of Resident 1's progress note dated 08/17/2024 at 9:57 PM showed the resident had some confusion, no nausea, no complaints of pain or discomfort with urination, no urinary frequency, amber colored urine, and stable vital signs. The plan was to continue to monitor for a UTI. No vital signs were located Resident 1's electronic health record for 08/17/2024. No documentation was found that the resident's representative or provider were notified. Review of Resident 1's progress note dated 08/18/2024 at 10:05 PM showed they were noted to be incontinent of dark amber colored urine with odor, and discharge. Resident 1 stated they were prone to developing UTI's. Resident 1 was encouraged to drink fluids and monitoring for UTI continued. No vital signs were located Resident 1's electronic health record for 08/18/2024. No documentation was found that the resident's representative or provider were notified. Review of Resident 1's progress note dated 8/19/2024 at 6:58 AM showed they were on alert for UTI symptoms and had discomfort with urination but no fever. No vital signs were located in Resident 1's electronic health record after the noted discomfort with urination. No documentation was found that the resident's representative or provider were notified. Review of Resident 1's progress note dated 08/19/2024 at 8:40 PM showed a urine sample was collected from them at 3:00 PM, the on-call provider was contacted, and their representative requested they be transported to the hospital at around 7:15 PM. Resident 1's representative reported the resident had a history of recurrent UTI's and they were known to escalate quickly. Review of Resident 1's electronic health record showed vital signs for 08/19/2024, prior to being sent to the hospital. No other vital signs were located for the time frame in which Resident 1 had been on alert. Review of the emergency department encounter dated 08/19/2024 at 9:08 PM showed Resident 1's chief complaint was fever/confusion and was found to have UTI with sepsis, temperature of 100.2 degrees Fahrenheit (F), and was tachycardic (rapid heart rate). Resident 1 was described as declining in the last week and getting weaker, slower to respond and confused. Resident 1 presented as minimally verbal. Resident 1 was hot to the touch and when given fluids, perked up a little bit. Resident 1 was noted to present with a fever of 101.8 F at the facility, prior to transport. Labs were completed and showed Resident 1 had sepsis and a urinalysis suggestive of infection and was started on intravenous antibiotics and fluids. Resident 1 was admitted to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/22/2024 at 2:24 PM Collateral Contact 1 (CC 1), Resident 1's representative, stated Resident 1 was sick on 08/16/2024 and when they visited on 08/18/2024 they were told a urine analysis could not be completed until the following day after a meeting to discuss the residents' symptoms. CC1 described Resident 1 as sick, did not look well, and had not gotten dressed for the day as their usual routine for church. CC1 stated Resident 1 has had UTI's with sepsis several times before and was concerned the facility had not check their urine sooner. CC 1 stated Resident 1 left the facility with a fever of 101.8 degrees F. In an interview on 08/27/2024 at 12:45 PM Staff C, Licensed Practical Nurse (LPN)-Infection Preventionist (IP), stated the facility followed McGreers Criteria to determine if and when an infection was present and if treatment with an antibiotic was necessary. Staff C stated if a nurse felt there were signs and symptoms of a UTI then they would place the resident on alert, notify the provider, and follow the McGreers criteria. Staff C stated that they were aware of Resident 1's symptoms through daily rounds every morning and Resident 1 did not meet the criteria for a UTI until 08/19/2024. Staff C stated Resident 1 had reported having a history of UTI's. In an interview on 08/27/2024 at 1:01 PM Staff D, Nursing Assistant Certified (NAC) stated they had cared for Resident 1 in the past, was familiar with the resident and described them as soft spoken, but able to state their needs if given ample time. Staff D stated Resident 1 required assistance with changing their brief and with peri care. Staff D stated if they had a resident showing signs/symptoms of a UTI, discoloration of urine or odor, they would report that to their nurse. In an interview on 08/27/2024 at 1:18 PM Staff E, Registered Nurse (RN) Unit Coordinator, stated they completed Resident 1's admission on 05/15/2024 to include the care plan. Staff E stated Resident 1 did not have a care plan in place related to recurrent UTI's and should have had one. Staff E, after reviewing Resident 1's hospital discharge summary dated 05/15/2024, stated the care plan should have contained signs/symptoms of UTI specific to them to include high blood sugar, urinary frequency, and confusion. In an interview on 8/27/2024 at 1:27 PM Staff F, LPN-MDS Coordinator, stated they could not locate recurrent UTI's on Resident 1's diagnosis list. Staff F stated Resident 1 should have been marked as having a UTI within the last 30 days on their Admission MDS. Staff F stated they did not know why recurrent UTI's had not been placed on the diagnosis list and noted Resident 1's recurrent UTI's should have been included in their CAA, but they had not addressed it. Staff F stated part of the process in completing the MDS and CAA process included reviewing hospital records. In an interview on 08/27/2024 at 2:45 PM with Staff G, LPN-Unit Coordinator, stated Resident 1 had transferred to their unit from another unit in the facility on 06/13/2024 and they did not know their diagnoses. Staff G stated the process for putting a resident on alert for UTI would include monitoring for signs and symptoms of a UTI which could include change in urine color, burning with urination, discomfort and odor. When asked if a resident's vital signs would be checked during alert status, Staff G stated they would check them and vital signs should be taken each day a resident is on alert. Staff G stated there should be communication with a provider if a resident is experiencing a change in condition and is being placed on alert. Staff G stated they did not know the process for placing a resident on a timed or scheduled toileting plan. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a joint interview with Staff A, Administrator, and Staff B, Director of Nursing Services, Staff B stated the expectation in developing care plans started during the admission process and included looking at medical conditions and building upon the care plan as more information was obtained. Staff B stated the protocol for placing a resident on alert varied depending on the reason they were on alert. They stated the alert status was for 3 days, it was placed in the computer which triggered the nurses to document on that alert and the findings of what they were monitoring. Staff B stated being on alert does not necessitate notification to the provider. Staff B stated all residents are scheduled for daily vitals per provider orders. Refer to WAC 388-97-1060(1)(3)(c)