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	09/04/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident care plans (CPs) were reviewed, revised, and accurately reflected residents' care needs for 1 of 3 sample residents (Resident 4) whose CP was reviewed for discharge planning and urinary status. These failures placed residents at risk for unmet care needs and diminished quality of life. Findings included.Resident 4 was admitted to the facility on [DATE] with diagnoses to include perineal (area between the genitals and the anus) and sacral (area between the bottom of the spine and tailbone) wounds, urinary incontinence, and cognitive impairment. Review of the Quarterly Minimum Data Set (MDS - an assessment tool) assessment, the resident had no cognitive impairment, was continent of their bowel and bladder, and did not have an indwelling urinary catheter. Review of Resident 4's discharge CP, date initiated 04/10/2025 and revised on 04/17/2025, showed the goal was to develop and follow full discharge plan with comprehensive assessment (the comprehensive assessment was completed with the admission MDS assessment dated [DATE]). The intervention was the resident wished to return home. Review of Resident 4's indwelling urinary catheter CP, revised on 04/28/2025, showed the resident had an indwelling Foley (a medical device that helps drain urine from the bladder) catheter present. Staff were directed to perform catheter care every shift. Review of Resident 4's July 2025 Medication Administration Record, showed the indwelling urinary catheter was removed on 07/25/2025. Review of Resident 4's nursing assistant documentation for the last 30 days, from 08/04/2025 to 09/02/2025, showed the resident was incontinent of bladder and no documentation the resident had an indwelling urinary catheter. In an observation and interview on 09/04/2025 at 8:35 AM, Resident 4 was lying in bed with no indwelling urinary catheter observed. The resident stated they wanted to go home. At 8:40 AM, Collateral Contact 1 (CC-1) and CC-2, the resident's family members, entered the room. The resident stated the doctor told them they needed a safe discharge. CC-1 and CC-2 stated the resident could not be discharged to their prior living situation because it was unsafe. In an observation and interview on 09/04/2025 at 10:15 AM, Resident 4 was sitting on the side of the bed with a hospital gown in place. There was no indwelling urinary catheter observed. In an interview on 09/04/2025 at 3:02 PM, Staff D, Registered Nurse/MDS Coordinator, was asked about Resident 4's continent status. Staff D stated their most recent MDS assessment showed the resident was continent of bowel and bladder. Resident 4's CP was reviewed with Staff D which showed the resident had an indwelling urinary catheter in place. Staff D acknowledge the CP should be updated. In an interview on 09/04/2025 at 3:20 PM, Staff I, Social Service Director, was asked about the discharge planning process and the discharge CP. Staff I stated the initial meeting to discuss the resident's status was done within the first 48 hours of admission and when the discharge CP was started. Resident 4's discharge CP was observed with Staff I. Staff I acknowledged the CP did not reflect the resident's current discharge goal and should be updated. Refer to WAC 988-97-1020 (2)(c)(d)(5)(b)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure clinical records were accurate for 2 of 3 residents (Residents 4 and 9) reviewed for wounds. The failure to ensure the residents' clinical records were accurate placed them at risk for unmet care needs, and for having records that did not reflect the actual care provided. Findings included . Review of the facility's Area of Focus: Basic Skin Management policy, revised on 11/21/2024, showed the resident would have:-A head-to-toe skin inspections upon admission/readmission, completed weekly and as needed by the nursing documented on the NRSG: Weekly Skin document in Point Click Care (PCC).-If a new [NAME] alteration/wound was identified, the nurse performed and documented an assessment/observation of the resident's skin.-Wound assessments/observations were required at a minimum of weekly and when there was a change. This was documented utilizing the PCC assessment NRSG WOT.<RESIDENT 4> Resident 4 was admitted to the facility on [DATE] with diagnoses to include perineal (area between the genitals and the anus) and sacral (area between the bottom of the spine and tailbone) wounds. Review of the admission Minimum Data Set (MDS – an assessment tool), dated 04/16/2025, showed the resident had: one stage I (intact skin with a localized area of non-blanchable redness) PU, three stage II (a partial thickness skin loss with the top inner layers of the skin exposed) PU's, one stage III (a PU with full thickness tissue loss. Subcutaneous, which means under the skin, fat may be visible, but bone, tendon or muscle are not exposed. Slough, which means dead tissue, may be present but does not obscure the depth of tissue loss PU), five Deep Tissue Pressure Injury (DTPI or DTI - intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue), and Moisture Associated Skin Damage (MASD - superficial skin damage caused by sustained exposure to moisture such as incontinence, wound exudate, or perspiration) Review of the Quarterly MDS assessment, dated 08/05/2025, Resident 4 had a current stage III PU. Review of late entry progress noted, dated 05/28/2025 for 04/11/2025 (48 days late), showed Resident 4 had: - A 0.7 centimeter (cm) by 0.4 cm by 0.3 cm left buttock stage II PU. - A 3.6 cm by 1.5 cm by 0.2 cm left buttock stage II PU. - A 2 cm by 2 cm left buttock DTI. - A 2 cm by 0.5 cm excoriated, red, purple non-blanchable area on their left buttock. - A 7 cm by 5 cm with a “0.3 cm by 0.3 cm open, dark purple skin in center on-blanchable DTI on their coccyx and a 7 cm by 4 cm DTI on their coccyx - A 2.4 cm by 2.2 cm right ankle DTI. - A 6.3 cm by 5.8 cm by 0.3 cm right buttock stage II. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The entire right buttock was documented as dark purple, non-blanchable, indicative of a DTI extending from left buttock down into groin area with varying shades of dark purple non-blanchable skin. Review of Resident 4's skin integrity care plan, revised on 05/06/2025, showed the resident had a stage III PU on their sacrum (a triangular bone at the base of the spine and connects the spine to the pelvis) and their at risk for unavoidable pressure injury development or decline of skin integrity, date initiated on 04/17/2025. Interventions included performing weekly skin assessments. Review of Resident 4's “NRSG: Weekly Skin” in PCC showed the following skin checks documented: -04/17/2025 – refused. No other weekly skin assessment documented in PCC. -04/30/2025, 13 days after last weekly skin assessment, – blank. No other weekly skin assessment documented in PCC -05/08/2025 – refused. No other weekly skin assessment documented in PCC -05/19/2025, 10 days after last weekly skin assessment, – three inches of MASD on right inner buttock. -05/25/2025 – 50 cent piece size open wound to their right buttock. -06/08/2025, 14 days after last skin assessment, – dressing to buttocks/left hip region. -06/22/2025, 14 days after last skin assessment, – open area to right buttocks, two thin cuts on right buttocks. -06/29/2025, 07/06/2025, 07/13/2025, 07/21/2025, 07/27/2025, and 08/03/2025, – open area to right buttock. -08/17/2025, 14 days after last skin assessment, – right buttock open area was decreasing in size, and measured approximately 1 cm by 2 cm. -08/24/2025– open area dressing was clean, dry and intact. Refer to wound observation tool. -08/31/2025, and 09/04/2025 - open area dressing was clean, dry and intact. Followed by United Wound Healing (a contracted wound care company), refer to observation tool for measurements. Review of Resident WOT's in PCC showed assessments completed on: - 04/11/2025, refer to above late progress note. - 05/28/225 (48 days after last WOT assessment), 8.0 cm by 6.0 cm by 0.1 cm right buttock “pressure. ” - 08/05/2025 (69 days after last WOT assessment), 1.2 cm x 0.7 cm by 0.2 right buttock stage III. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 08/12/2025, 0.6 cm by 0.5 cm by 0.1 cm right buttock stage III. - 08/19/2025, 1.2 cm by 0.5 cm by 0.2 cm right buttock wound. - 08/26/2025, 2.5 cm by 1.7 cm by 0.2 cm right buttock wound. - 09/02/2025, 2.0 cm by 1.5 cm by 0.2 cm right buttock wound. In an observation and interview on 09/04/2025 at 8:40 AM, Resident 4 was lying in bed, and Collateral Contact 1 (CC-1) and CC-2, the resident's family members, were present in the room. Resident 4 stated she had a sore on the right side of their bottom, and it was a “little bugger.” When asked how long they had the wound, Resident 4 and CC-1 stated the resident developed several wounds prior to their admission to the hospital. In an observation and interview on 09/04/2025 at 10:15 AM, Resident 4 was sitting on the edge of the bed. Staff G, Licensed Practical Nurse (LPN), performed wound care to the resident's sacral area. Two small pinpoint open areas were observed on the right side of the buttocks. The wounds were clean, with no drainage, and the base of the wound bed had red tissue. Staff G stated the two wounds were visibly approximately 0.1 cm to 0.2 cm. Staff G stated the wounds have improved significantly since admission to the facility. In an interview on 09/04/2025 at 12:42 PM, Staff A, Administrator, was asked about the facility's documentation process regarding skin concerns. Staff A stated the PU's/Pressure Injuries were documented using the wound observation tool in PCC. In an interview on 09/04/2025 at 1:43 PM, Staff J, LPN, stated weekly skin checks were done weekly and documented on the weekly skin check assessment tool. Staff J stated PU's were documented weekly using the WOT. In an interview on 09/04/2025 at 2:35 PM, Staff E, RN/Care Manager, was asked about the skin assessment tools in PCC and when they were to be completed. Staff E stated weekly skin assessments were done by the floor Licensed Nurse (LN) every week and documented on the weekly skin tool, the WOT's were done with assessment of the resident's PU's by Staff C, RN/Assistant Director of Nursing, and the skin integrity update form was completed by the floor LN as needed. <RESIDENT 9> Resident 9 was admitted to the facility on [DATE], with the most recent admission on [DATE], with diagnoses to include Multiple Sclerosis (MS) (chronic autoimmune disease that affects the central nervous system), Chronic Obstructive Pulmonary Disease (COPD) (lung disease that cause airflow obstruction and breathing problems) and malnutrition. Review of Resident 9's quarterly MDS assessment showed they had moisture associated skin damage (MASD) and no pressure ulcer (injuries to the skin and the tissue below the skin that are due to pressure on the skin for a long time). Review of Resident 9's weekly skin check dated 06/10/2025 showed they had an open area on their coccyx, approximately the size of a quarter. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 9's provider note dated 06/13/2025 showed the resident had a pressure ulcer of their sacral region that was not visualized that day and family had requested a wound care referral. Review of Resident 9's weekly skin check dated 06/15/2025 showed they had an open area with no further description. Review of Resident 9's weekly skin check dated 06/24/2025, 07/01/2025, 07/08/2025, 07/15/2025 showed the same documentation, that they had an open area to their coccyx that measured 1.6cm long and 3cm wide. Review of Resident 9's care plan showed they had a pressure ulcer and was followed by the wound care clinic, initiated on 06/25/2025. Review of Resident 9's medical record showed no wound note documentation during the month of June, 2025. Review of Resident 9's wound note, dated 07/09/2025 showed they had an open wound which had progressed to a Stage II Pressure Ulcer. In a joint interview on 09/04/2025 at 3:30 PM, Staff A, Staff B, and Staff C. Staff C stated their expectation was that if a nurse documented the resident had an open area, it would be documented clearly and measured. Staff C stated the nurse that documented Resident 9's weekly skin was a brand-new nurse who did not know how to document skin conditions correctly. Staff C stated they had completed teaching related to skin documentation with that specific nurse due to incorrect documentation. Staff C stated Resident 9 had MASD and their skin was excoriated and had no wound/pressure ulcer until documented on 07/09/2025. Staff A stated Resident 9's family had a history of taking the resident to appointments without facility staff knowledge. Staff C stated the resident did have a wound care referral due to family request of the provider on 06/25/2025 but did not actually have a pressure ulcer at that time. Staff C stated it was understandable that the documentation related to Resident 9's skin was confusing and inaccurate. Refer to WAC 388-97-1720 (1)(a)(i-iv)(b) (2)(a-m)