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	12/23/2025

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

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medically related social services and to advocate for 1 of 2 cognitively impaired residents (Resident 1) reviewed for advanced directives. The facility failed to advocate, educate, and obtain appropriate legal assistance in the development of an advanced directive and placed residents at risk of not having their rights and wishes honored. Findings included. Review of a facility policy titled, Advanced Directives and Advanced Care Planning (ACP) last reviewed 09/26/2025 documented each time a resident was admitted to the facility, quarterly, and when a change in condition was noted in the resident's condition, the facility reviewed the advance directive and advance care planning information. The review focused on if the existing advanced directives and ACP matched the current goals of care for the resident. The social services director or designee documented conversations in the medical record and assisted as needed with updating the documents that need revision in accordance with state and federal requirements. Review of the facility job description titled, Social Services Assistant revised 05/11/2026 documented in the position summary, that the Social Services Assistant provided assistance to the Social Services department to ensure all medically related emotional and social needs of patients are met in accordance with all applicable laws, regulations, and Life Care standards and must be able to assist social worker(s) in supporting patients and families through education, financial planning assistance, liaison with community agencies, etc.Resident 1 admitted to the facility on [DATE] with diagnoses to include developmental/intellectual disability, anxiety, depression, and obstructive and reflux uropathy (urinary blockage causing urine backup). Review of Resident 1's Brief Interview for Mental Status (BIMS-cognitive screening tool) documented on 05/07/2025 and 03/26/2025 a score of 2 out 15 indicating severe cognitive impairment , on 11/04/2025 and 07/02/2025 a score of 3 out of 15 indicating severe cognitive impairment, and on11/28/2025 a score of 15 out of 15 indicating no cognitive impairment. Review of Resident 1's Physician Order for Life Sustaining Treatment (POLST) dated 03/24/2025 documented the resident (Indicated by signature) wanted Cardiopulmonary Resuscitation (CPR) done as a life sustaining measure; no other medical interventions were marked. Review of Resident 1's progress notes from 03/24/2025 through 11/28/2025 documented the following:- On 10/03/2025 at 10:31 PM the nurse notified the provider that resident had appeared to be less interactive and decreased appetite and noted resident was a full code (all life sustaining measure to be taken) and refused some of their medications.- On 10/05/2025 at 3:51 PM the nurse obtained new orders for Resident 1 from the provider and notified the Power of Attorney (POA).- On 10/05/2025 4:03 PM Resident1 was noted to refuse their oral and intravenous (IV) medications and pulled out their IV access but allowed blood glucose check.-On 10/06/2025 at 8:30 AM Resident 1 was seen by the psychiatric provider with noted refusals to eat or drink and non-communicative behavior. Resident 1 was noted to be hospitalized and presented with severely altered mental status and declining physical health. The provider noted nursing staff reported that their mental functioning was now comparable to that of a 3-4-year-old child, had become increasingly withdrawn, and often maintaining a statue-like posture with limited eye contact. Additionally noted that Resident 1's presentation represented a decline from their condition a month ago when they were still able to communicate to some degree and they were now largely non-verbal and unresponsive to attempts at interaction.- On 10/06/2025 at 5:56 PM Resident 1 was noted to return from the hospital and to be apathetic towards others and self, and unwillingness to interact with most providers or support staff. Resident 1's emergency contact was notified and information provided about their recent changes and concerns noting the contact was with Collateral Contact 3 (CC 3 -Resident 1's family member) who voiced concern and planned to visit tomorrow evening and speak with resident. -On 10/06/2025[SW3] a provider note documented that Resident 1 had worsening medical status starting 10/2/2025, they had been refusing care, oral medications and interactions with a noted change in her mental status, presented as staring in space on our interaction which was unusual to them as at their baseline as they had been able to communicate basic needs.-On 10/07/2025 at 8:33 PM CC 3 was noted to be in the facility visiting Resident 1 and reported to nursing they were trying to become Resident 1's POA and responsible party. CC 3 reported that they would bring a Notary Public for Resident 1 to sign papers to grant them POA. Resident 1 was noted to be confused about who CC 3 was and could not recall their name only stated that were their very good friend. -On 10/14/2025 at 10:34 AM Staff C, Social Services Assistant called CC 3 and asked if they were able to attend Resident 1's procedure scheduled for 10/20. CC 3 stated they