| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505318 | A. Building<br>B. Wing | 02/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Skagit Valley | 1462 West State Route 20<br>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 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to implement measures to prevent development of an avoidable pressure ulcer (PU) and provide ordered treatment for the PU for 1 of 3 residents (Resident 1) reviewed for PU's. Resident 1 experienced harm when they developed an avoidable unstageable PU (a full-thickness skin and tissue loss where the actual depth of the wound is hidden by slough (yellow, tan, gray, green, or brown necrotic tissue) or eschar (tan, brown, or black, hard, necrotic tissue) which caused pain and discomfort. this failure placed residents at risk for skin breakdown, unmet care needs and diminished quality of life. Findings included .The National Pressure Ulcer Advisory Panel (NPUAP) April 2016, showed a PU/Pressure Injury (PU/PI) definition and stages as:-A PU is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear (a combination of downward pressure and friction).-Medical device related PU/PIs were a result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.- Moisture Associated Skin Damage (MASD) was superficial skin damage caused by sustained exposure to moisture such as incontinence, wound exudate, or perspiration.Review of the facility policy titled, Pressure Injury Prevention and Unavoidable Pressure Ulcer/Injury, revised 06/12/2025 documented nursing staff would be provided with procedures to manage skin integrity and prevent PU. Procedures included residents were provided at a minimum pressure redistribution mattress, wheelchair cushion and repositioning.Review of the facility policy titled, Skin Integrity & Pressure Ulcer/Injury Prevention, revised 07/09/2024 documented nursing staff would be provided with procedures to manage skin integrity, prevent pressure ulcer/injury, and provide treatment and care of skin and wounds utilizing professional standards. Measures to maintain and improve the resident's tissue tolerance to pressure were implemented in the plan of care. All residents were at risk for PU/PI development upon admission, were to be provided, at the minimum, a pressure redistribution mattress, repositioning at least every two to four hours, and education to resident and significant others of the preventative skin care plan.Resident 1 admitted to the facility on [DATE] with diagnoses to include history of falling, muscle weakness, osteoarthritis (breakdown of cartilage in the joints), and scoliosis (curvature of the spine).Review of Resident 1's discharge summary from the hospital dated 09/03/2025 documented they had impaired mobility, had recent falls with no notation of skin issues.Review of Resident 1's facility admission nursing assessment dated [DATE] documented they had blanchable redness (red area of skin that turns paler when pressed-an early warning sign of potential PI) to their buttocks.Review of Resident 1's admission Minimum Data Set (MDS-an assessment tool) dated 10/13/2025 documented the resident was at risk for development of a PU. The MDS noted no refusals of care or behavioral issues. The Care Area Assessment (CAA-a tool to develop individualized<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505318 | A. Building<br>B. Wing | 02/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Skagit Valley | 1462 West State Route 20<br>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 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | care plan for a resident) dated 10/15/2025 documented the resident had pressure injury development risk factors due to their limited ability to participate in incontinence care as well as physical dependence on staff for position changes and offloading of bony prominences. The documented goal for Resident 1 was to minimize risk factors through assisted mobility, incontinence care and routine skin monitoring to detect early signs of pressure injury formation. Resident 1's was documented to need a special mattress or seat cushion to reduce or relieve pressure.Review of Resident 1's Braden Scale Assessment (assessment tool for predicating PU risk) documented on 10/7/2025 a score of 17, 10/19/2025 a score of 17, 10/27/2025 a score of 17, 11/03/2025 a score of 17, 12/03/2025 a score of 15, and 01/04/2026a score of 15 (scores of 15-18 indicated mild risk of developing a PU, the lower the score the higher the risk).Review of Resident 1's care plan dated 10/07/2025 documented that they were at risk for break in skin integrity with the goal for them to maintain intact skin with no skin breaks. Interventions included clean and dry skin after each incontinent episode and weekly skin checks. There were no other documented individualized interventions related to their redness to their buttocks at admission or risk for the development of a PU/PI.Review of Resident 1's facility progress notes dated 10/07/2025 through 01/08/2026 contained no documentation regarding education to the resident or their representative regarding repositioning, refusals of repositioning, their mattress, their wheelchair cushion or what measures were in place to prevent PU/PI.Review of Resident 1's facility nursing weekly skin integrity data collection dated 01/08/2026 documented the night nurse noted a small opening to the top of their gluteal fold.Review of the provider note dated 01/08/2026 documented Resident 1 had an open area to the top of their gluteal fold which was painful. Resident 1's skin was examined and the open area was described as a very small and deep open area to the top of the gluteal fold, surrounding skin red, blanchable, with no signs of infection, no drainage, no odor.Review of Resident 1's wound care assessment provided by an outside wound healing company, dated 01/13/2026, documented that they had a PU/PI to their bilateral sacrum (tailbone) measuring 1.5 centimeter(cm) by 0.4 cm, unstageable. Recommendations included treatment with wound cleaner, skin prep, and use of Santyl (a prescription topical debriding agent used to remove dead tissue from chronic PU/PI), and covered with bordered form three times a week and as needed. Plan included support surfaces with pressure reducing mattress and wheelchair cushion.Review of Resident 1's medical record from 01/13/2026 through 02/19/2026 showed no physician's orders for a pressure reducing mattress or wheelchair cushion.On 02/20/2026 at 12:33 PM observed Resident 1's PU with Staff C, Licensed Practical Nurse, present. Staff C stated Resident 1 was not admitted with the PU. Resident 1 was initially lying down then positioned on their right side by Staff C, they were observed wearing an incontinent brief. The mattress was observed to be a standard mattress approximately three inches in height. Resident 1 was observed to have a 2.5 cm by 2.5 cm irregular bordered purple/yellow bruise on their left thigh. Resident 1's PU on their sacrum was observed with a dressing that was wrinkled and clumped up rather than smooth and stationary dated 02/12/2026 which contained moderate red/green/ brown drainage. Resident 1's PU was linear 1.0 cm by 1.5 cm with 0.3 cm depth, the wound bed light pink, 1 cm slough (dead tissue) visible at top of wound, no odor appreciated, and no signs of infection. Staff C stated the dressing was dated 02/12/2026.Review of Resident 1's Treatment Administration Record (TAR) for February 1-19, 2026, documented a physician's order dated 01/13/2026, to apply Santyl to sacrum topically every evening shift every three days for wound care. Wound Care orders documented to cleanse Resident 1's sacrum with normal saline, pat dry, apply skin prep to periwound (skin area surrounding a wound), apply Santyl and cover with foam dressing every evening shift for wound care. The TAR showed Staff D, Registered Nurse (RN), documented they had completed wound care/dressing change for<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505318 | A. Building<br>B. Wing | 02/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Skagit Valley | 1462 West State Route 20<br>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 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Resident 1 on 02/15/2026 and 02/18/2026.In an interview on 02/20/2026 at 2:29 PM Staff D, RN stated they thought they had completed the dressing changes on 02/15/2026 and 02/18/2026 but could not remember. When asked why the dressing was dated 02/12/2026 during wound care on 02/20/2026, Staff D stated they were new to the facility, could not find dressing supplies at the time of the ordered wound care (02/15/2026 and 02/18/2026) and applied Santyl to Resident 1's PU. Staff D provided no explanation as to why the dressing to the Resident 1's PU was dated 02/12/2026.In an interview on 02/20/2026 at 12:38 PM Staff B, Assistant Director of Nurses (ADON) stated Resident 1 admitted to the facility with their own bed and mattress. Staff B stated they did not know what kind of mattress was brought into the facility by Resident 1's family, the mattress was inspected by maintenance and Staff B did not know if nursing had evaluated the mattress. When asked what preventative measures were taken to prevent Resident 1 from development of a PU, Staff B stated the staff used standards of care to include offloading (removing pressure from bony parts of the body). Staff B stated Resident 1's care plan interventions included a wheelchair cushion, weekly skin checks, clean and dry skin after incontinent episodes, positioning them correctly with respect to the wheelchair cushion, encouraged repositioning and nutrition. When asked about the wheelchair cushion Resident 1 used prior to the development of their PU, Staff B stated they would need to locate the information and provide it later. Staff B stated Resident 1's PU was unavoidable, was not an injury of unknown source, and their age and comorbidities (presence of two or more diseases or medical conditions) resulted in the development of their PU. Staff B stated Resident 1 was very active within the facility, prior to the development of the PU and used their wheelchair throughout the facility to attend multiple activities and was educated about the importance of offloading. No information was provided with respect the Resident 1's wheelchair cushion prior to the development of their PU.In an interview on 02/20/2026 at 2:50 PM Staff E, Nursing Assistant Certified, stated they were familiar with Resident 1 and their care. Staff E stated they watched Resident 1 closely, helped them to the toilet and provided pericare. Staff E stated they had no knowledge of any PU for Resident 1, but if there were concerns about their skin, they would report it to the nurse. When asked about repositioning Resident 1, Staff E stated they do not reposition them when they are sleeping, but when they were awake, they helped them and kept them clean.In an interview on 02/23/2026 at 9:02 AM Collateral Contact 2 (CC2), Resident 1's family member stated they became aware of the PU on Resident 1's sacrum when they were using the bathroom. CC 2 stated Resident 1 was being assisted in the bathroom by facility staff when they heard Resident 1 complaining of pain to their sacrum. CC 1 stated they asked the facility staff why Resident 1 was in pain and they stated it was due to the PU on their sacrum.In an interview on 02/23/2026 at 11:45 AM Staff F, RN, stated Resident 1 had a pressure ulcer and there were treatment orders in place. When asked what interventions were put into place for Resident 1 related to their pressure ulcer, Staff F stated there were orders for wound care and dressing changes and the nurses and nursing aids would monitor them to ensure they were not positioned on the PU. Staff F stated they did not have any charting system to document when they monitored Resident 1's positioning.In an interview on 02/23/2026 at 11:55 AM Staff G, NAC stated Resident 1 had a wound on their sacrum and they complained of pain from it. Staff G stated they assisted Resident 1 in repositioning with pillows when in bed. Staff G stated Resident 1 had no refusals to reposition when working with them and if they had they would notify the nurse. Staff G stated there was no specific charting/documentation for repositioning for Resident 1. Reference WAC 388-97-1060 (3)(b) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505318 | A. Building<br>B. Wing | 02/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Skagit Valley | 1462 West State Route 20<br>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 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure broken window locking devices were repaired and window screens were available and repaired timely for 2 of 3 rooms (rooms [ROOM NUMBERS]) reviewed for safe, functional and comfortable environment for residents, staff and the public. These failures placed residents and the public at risk of potentially avoidable accidents, lack of dignity and diminished quality of life.Findings included . In an interview on 02/19/2026 at 12:50 PM Collateral Contact 1, (CC1) Resident 1's family member stated there was a concern about the window in Resident 1's room, room [ROOM NUMBER]. CC 1 stated Resident 1 moved into the room on 10/30/2025 and the window locking mechanism on the left window panel was broken and there was no window screen. CC1 stated there was nothing in place to secure the window and posed a safety risk as anyone from inside or outside could push the window to the side to enter or exit Resident 1's room. CC1 stated instead of fixing the window by replacement of a new locking mechanism, the facility placed a screw in the window frame so the window could not be opened all the way, however the window could be tilted in the frame to bypass the screw, which allowed access to enter or exit Resident 1's room and posed the same safety concern. CC1 stated the most recent solution was a placement of a wooden dowel (wooden rod) placed between the sliding windows to prevent any access from outside the building. CC1 stated they had spoken to Staff A, Administrator, several times and had received communication that the window had been fixed.In an observation on 02/23/2026 at 10:48 AM observed the windows in rooms 106, 107 and 108 with the permission of the residents residing in each room. Observed room [ROOM NUMBER] to have a screw in the left side window frame, no window screens, no locking mechanism for the left side, and a dowel placed between the two windows. Observed room [ROOM NUMBER] to have window screens and functional locking mechanisms in both the right and left windows. Observed room [ROOM NUMBER]'s window to have a locking mechanism on the left side of the window, which was intact and functional, however the right side of the window had a locking mechanism which was missing the knob that was used to lift the lock up (open) and down (close). The window on the right was in a locked position. The windows had screens in each of the windows, the left window screen with a hole in the bottom left corner.In an electronic communication with Staff A on 02/23/2026 at 11:15 AM documented there were no maintenance requests documented for room [ROOM NUMBER] related to the window and communication was made in person to the maintenance director.Review of an electronic communication received 02/23/2026, documented and email between CC 1 and Staff A dated 11/07/2025 at 6:17 PM documented Resident 1's room, left window has a lock and is secured.In an interview on 02/23/2026 at 12:38 PM Staff H, Maintenance Director, stated they had worked at the facility since June of 2025. When asked about information they could provide about room [ROOM NUMBER] and the locking mechanism missing from the window. Staff H stated they had heard about the window locking mechanism missing a few weeks ago and placed a screw in the frame where the locking mechanism would lock into. When asked if the window could be tilted to bypass the screw and from the inside or outside, the stated essentially yes. Staff H stated there is now a wooden dowel set between the windows. Staff H stated there was no documentation or maintenance requests only conversations with nursing staff and Staff A.Reference: WAC 388-97-3220 (1) |