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	06/18/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to ensure resident preferences for food were obtained and honored for 4 of 4 residents (Residents 5, 21, 35, and 45) reviewed for choices. The facility refused to allow residents the ability to safely consume food items that were brought from outside sources when they removed the ability to heat up their food. This resulted in the residents losing their ability to choose their meal of preference and snacks of choice. These failures placed residents at risk for decreased quality of life. Review of the facility policy titled Resident Rights, reviewed 09/10/2024 stated residents had the right to self-determination with access to people and services in and outside of the facility. Residents had the right to make choices about aspects of their life in the facility that are significant to the resident. Review of the facility policy titled Food from Outside Sources, dated 06/03/2024 documented that when there was food that required heating the facility should use a food thermometer and alcohol wipes to ensure food was heated properly .additionally facility staff should receive proper education on required food temperatures, and proper use of food thermometer. <RESIDENT 5> Resident 5 was admitted to the facility on [DATE] with diagnoses that included history of stroke, dysphagia (trouble swallowing), and diabetes. The Significant Change Minimum Date Set Assessment (MDS - an assessment tool) dated 04/11/2025 showed the resident had intact cognition, and behaviors. Review of an undated letter from Staff A, Administrator, addressed to residents, staff and family members. The letter stated that the facility had recent issues regarding purchasing and storage of food items. The letter stated the facility was happy to store appropriate items in the refrigerator, they would not be able to accommodate leftovers, frozen meals or hot dogs (or similar items) due to the are unable to store them per food safety guidelines. The letter included a guideline that stated small amounts of perishable food for a limited space were allowed, and they would not be able to accommodate any food that required heating. Review of Resident 5's care plan with a print date of 06/13/2025, showed a focus area related to their diabetes that due to the resident's stroke, resident states some foods seemed tasteless; therefore, the resident had been purchasing food from outside sources. The care plan dated 03/07/2025 instructed staff to provide them with choices about the residents' daily care and activities . (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/12/2025 at 1:44 PM, Resident 5 stated the facility stopped heating up food for them a few months ago. Resident 5 stated they were told by the facility the state would not allow it due to risk of burns. Resident 5 stated they used to like the food here at the facility, but due to their stroke their taste buds have changed, and they only prefer certain foods now. Resident 5 stated they started purchasing food from the grocery store to eat, the facility was heating their food up until recently when they told the residents they could no longer do that. Resident 5 stated there were other residents that were upset about the facility not heating up food and provided a name (Resident 35). <RESIDENT 35> Resident 35 admitted to the facility on [DATE] with diagnoses that included chronic pain, depression and diabetes. The Annual MDS dated [DATE] showed the resident had intact cognition. In a resident council meeting on 06/16/2025 at 2:48 PM, Resident 35 stated they were denied the choice to have microwave popcorn, as they were told recently by the facility in a letter that they could no longer heat up the microwave popcorn. Resident 35 stated they were offered pre-popped popcorn instead but stated that it did not really equal their preference to have microwave popcorn. <RESIDENT 21> Resident 21 was admitted to the facility on [DATE] with diagnoses that included malnutrition, depression and anxiety. The Quarterly MDS dated [DATE] showed the resident had intact cognition. In a joint interview on 06/17/2025 at 12:51 PM, Resident 21 and Collateral Contact 1 (CC1- residents family member), CC1 stated they had been bringing in frozen single meals for Resident 21 for a long time, as the resident does not like the food that much here at the facility. CC1 stated they would only bring a few at a time, label and date them for the facility. Resident 21 would then request one of the meals instead of what was offered at times for lunch or dinner. CC1 stated that a couple of months ago they were told they could no longer store or heat up the frozen dinners. CC1 was told the staff do not have time to heat up meals and the state regulations prevented them from doing so. Resident 21 stated they are making do. <RESIDENT 45> Resident 45 was admitted to the facility on [DATE] with diagnoses that included a stroke with right side weakness, and muscle weakness. The Quarterly MDS dated [DATE] showed that the resident had intact cognition. In an interview on 06/12/2025 at 2:09 PM, Resident 45 stated they were very unhappy with the facility, as they recently took away the ability for them to heat up food. Resident 45 stated they really enjoyed having their microwave popcorn for a snack, and now they are not able to have that. In an interview on 06/17/2025 at 9:57 AM, Staff K, Nursing Assistant Certified (NAC) stated they were aware that previously they were heating up food for residents. Staff K stated that management had put a stop to that, and no one was allowed to heat up food for the residents. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/17/2025 at 10:23 AM, Staff L, Licensed Practical Nurse (LPN) stated they have worked at the facility for over a year and was aware they were heating up food for residents but that it had recently changed. Staff L stated its hard telling residents they are not allowed to heat popcorn, many of them have so little left that it was hard to deal with. In a joint interview on 06/18/2025 at 11:03 AM, with Staff A and Staff B, Director of Nursing Services, Staff A stated the sometime in May of this year they changed their policy for food from outside sources because too many residents were having food either delivered from outside of the facility or family was bringing in frozen entrees. Staff A stated the staff were having to heat up a lot of food in the microwave. Staff A stated they did not have a place to store all the food or a centrally located microwave, and they were worried a resident may get a burn from food that was too hot, so they stopped heating up the food. Staff A stated they did not feel it was a sustainable task to ask their staff to do, and they (facility) had to decide between resident safety over resident rights. Staff B stated they did not feel their staff were capable of safely heating up food that followed the safety guidelines. Refer to F813 Reference WAC 388-97-0900(3)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure a clean, comfortable, homelike environment in 2 of 4 halls (shared bathroom between room [ROOM NUMBER]-215, and 114-115), in 1 of 3 shower rooms (community shower room for 400/500 halls), and 1 of 1 dining rooms. Failure to ensure the facility was clean, comfortable, and homelike placed residents at risk for decreased quality of life, compromised dignity, and potential infection control issues. Findings included . Review of the facility policy titled Resident Belongings and Home Like Environment, reviewed 05/15/2025 states the facility will provide a clean, safe, comfortable, homelike environment to the residents .homelike environment de-emphasizes the institutional character of the setting to the extent possible and supports a more home like environment .it was the responsibility of the facility staff to create and provide a homelike environment. <RESIDENT BATHROOMS> During an observation of the shared bathroom between rooms [ROOM NUMBERS] on 06/12/2025 at 10:13 AM, the bathroom had a powerful, unpleasant odor, the floor appeared to be sticky when walking on it, and there was an area of damaged tiles that appeared black/brown under the toilet, with gaps in tiles that had broken apart. The bathroom was dim and only had one working light bulb in the fixture. During an interview/observation on 06/12/2025 at 11:18 AM, Resident 22, in room [ROOM NUMBER], stated that they were informed by the housekeeper that their bathroom was dirty, and the housekeeper came in and cleaned it. It was observed to still have a heavy odor, broken tiles with brown/black stains under the toilet. During an interview on 06/17/2025 at 10:39 AM, Staff X, Nursing Assistant Certified (NAC), stated the resident bathroom between rooms [ROOM NUMBERS] smelled like urine, possibly, the tiles under the toilet appear to be broken and moldy, and the bathroom is dim from light bulbs being burned out. During an interview on 06/17/2025 at 10:57 AM Staff B, Director of Nursing Services (DNS), stated the resident bathroom between room [ROOM NUMBER] and 114's smells like urine, they were unsure of what the black /brown stains on the tile under the toilet were but it looks terrible and needs to be replaced, the burned out light bulbs needed to be changed and the floor was sticky. During an observation of the shared bathroom between rooms [ROOM NUMBERS] on 06/12/2025 at 11:39 AM, the bathroom had poor lighting, extremely strong odors, and broken floor tiles that were stained brown to black in a 4-foot by 3-foot area under the toilet. The wall on the right side of the toilet had paint scraped off the wall and the floor was sticky when walked upon. During an interview on 06/18/2025 at 8:32 AM Staff Y, NAC, stated the bathroom between rooms [ROOM NUMBERS] doesn't smell clean or good, there are scuff marks on the wall where the paint is coming off. Staff Y stated they were unsure what the black area was on the floor under the toilet, and that it doesn't feel home like. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<SHOWER ROOM> During an observation on 06/17/2025 at 10:30 AM, the large community shower room for hall's 300 and 400, had missing tiles in the shower area and lacked grout between the existing floor tiles. A small divider wall separating the shower area from a locker had broken tiles along the bottom. There was a strong musty odor possibly mold and mildew upon entering the room. The bathroom floor was uneven and sunken in some areas by two inches. Dust and dirt covered the floor outside the shower stall, medical equipment was disorganized throughout the bathroom, and trash cans were overflowing. During an interview on 06/17/2025 at 10:39 AM, Staff X stated that the bathroom smelled like someone had left a wet towel too long, causing mold, and that the shower stall had missing tiles, the floor was dirty, and the room needed a whole cleaning. During an interview on 06/17/22025 at 10:57 AM Staff B stated that the floor is uneven and there was no grout, missing tiles in the shower area, floors are unclean in the whole bathroom, the equipment needs to be organized, and that the bathroom does not feel home like. <DINING ROOM> In a continuous observation on 06/12/2025 at 12:12 PM, lunch meal service was scheduled for 12:20 PM in the main dining room. There were eight tables in the main dining room, the room was quiet, tables were bare, with only a tablecloth, a soda vending machine was in the corner of the dining room. The walls are stark with a few paintings scattered on the walls. There were eight residents in the room, several were sitting alone at table by themselves, several residents observed staring at the wall while they were waiting for their meal. There was no music playing, the television was turned off, the residents had no engagement while they waited for a meal. Several staff stood against the counter at the end of the dining room, with no engagement with the residents in the room. At 12:25 PM unknown staff member was observed standing over Resident 58 trying to get the resident to take a bite of food. At 12:41 PM, Staff M, Licensed Practical Nurse (LPN) was observed entering the dining room and administered medications to Resident 46 who was eating their lunch. In an observation on 06/13/2025 at 12:05 PM, there are five to six residents at various tables in the dining room, all sitting alone. There was no music heard, the television was turned off, no engagement, and no staff were present in the dining room. The meal was scheduled to be served at 12:20 PM. In a group interview at resident council on 06/16/2025 at 2:48 PM, Resident 3 stated it was difficult to get any assistance in the dining room as staff are not present or stand far away and do not engage with the residents. In an observation at 06/17/2025 at 12:05 PM, there were seven residents in the dining room waiting for lunch service, and three were sitting alone. There was no music heard, the television was turned off, no engagement in the dining room. The meal was scheduled to be served at 12:20 PM. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/17/2025 at 9:57 AM, Staff K, NAC stated staff duties in the main dining are to offer clothing protectors, provide drinks, serve the residents their meal, and then they wait to see if any resident may need anything or assist with eating if necessary. Staff K stated they used to play music or have a movie on while the residents waited for meals, they were not sure why that was not offered anymore. In an interview on 06/17/2025 at 10:23 AM, Staff L, LPN stated they will turn on the music or television if a resident requested it and added the dining room can be pretty dead. Staff L stated they used to have movies on often, and on Sundays they will have church music on after the service that was right before lunch. Staff L added that a lot of the residents there just sat and stared at nothing until the meal was served. In an observation on 06/18/2025 at 7:32 AM, there were six residents sitting in the dining room, no staff present, two of the residents were alone, and two were just staring at each other. There was no music heard, the television was turned off, no engagement in the dining room. The meal was scheduled to be served at 7:40 AM. In an interview on 06/18/2025 at 11:03 AM, Staff A, Administrator, was not aware the dining room was not homelike. Staff A stated the expectation was that staff would sit next to the residents if they needed assistance eating, and that nurses should not administer medications in the dining room during the meal service unless it was the resident's preference. Staff A stated they would expect the staff to engage with the residents during the meal service. Reference WAC 388-97-0880(1)(2)(5)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to conduct a thorough investigation of an injury of unknown source for 1 of 6 residents (Resident 30) to rule out abuse and neglect. This failed practice placed residents at risk for potential unrecognized abuse or neglect. Findings included . Review of the Facility Policy titled Abuse: Investigations review date 06/17/2024, stated the facility would investigate incidents of unknown source thoroughly to allow the Administrator to determine what actions are necessary (if any) for the protection of residents. Investigations would include, but were not limited to: - Conducting observations of the alleged victim including identification of any injuries as appropriate, the location where the alleged situation occurred, interactions and relationships between staff and the alleged victim and/or other residents, and interactions/relationships between resident to other residents; - Conducting interviews with, as appropriate, the alleged victim and representative, alleged perpetrator, witnesses, practitioner, interviews with personnel from outside agencies if appropriate. Resident 30 was a long-term care resident of the facility. According to the Quarterly Minimum Data Set (MDS, a required assessment tool) assessment dated [DATE], the resident had severely impaired cognition, impaired short term and long-term memory, and severely impaired decision making. Review of Resident 30's clinical record documented on 05/08/2025 a bruise and small abrasion on the resident's forehead was identified by Staff F, Licensed Practical Nurse (LPN). Staff F documented Resident 30 denied abuse or neglect but was not able to recall what had occurred. An incident investigation was completed and logged related to an injury of an unknown source. Review of the facility incident investigation dated 05/08/2025 included only a statement from Staff F stating that the injury had been found, the resident denied abuse and neglect, and that the provider and the resident's son had been notified. The resident record stated a skin check had been done with no additional findings and a monitor was entered in the Treatment Administration Record related to the bruise; however, there was no neurological assessment conducted related to an unwitnessed injury to the head. The note stated the resident's son had been in to visit that day and had noted the bruise, but there was no follow-up related to the time frame or circumstances from the son. There were no potential witness statements from other staff, residents or staff assigned to the resident to determine if any other individuals may have had knowledge or information related to the incident. In an attempted interview on 06/16/2025 at 8:51 AM, Resident 30 was observed self-propelling in their wheelchair into the hall. Resident 30 appeared alert, smiled, and had an activity calendar in their hands that they were motioning to, but were not able to articulate any words. Resident 30 did not respond to questions. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/17/2025 at 10:16 AM, Staff F stated that Resident 30 was able to communicate some needs but can't say the words. Staff F stated the resident recognizes staff and won't remember events but stated that Resident 30 will remember if they do not like something. Staff F stated when they found the bruise on Resident 30's forehead, they asked the resident what happened and the resident said they didn't know, the resident did not know a bruise was there, but they said nobody hurt them. Staff F stated Resident 30 would remember if someone hurt them, so that is how they ruled out abuse or neglect. Staff F stated they did an incident report, and they called to notify the son, who had stated they had seen the bruise when they came in to visit. Staff F stated the process was to protect the residents, and to notify the Administrator and Director of Nursing if there was any suspected abuse or neglect. Staff F was asked if they had obtained any other statements in order to determine what might have occurred and establish a time frame and Staff F stated they had not. Staff G, Registered Nurse, Resident Care Manager (RCM), added that their understanding of the process was that the floor nurse would initiate the investigation, which would include the resident assessment, notifications and getting statements from the staff who may have been involved and then the RCM would continue the investigation process. In an interview on 06/17/25 at 1:49 PM, Staff B, Director of Nursing Services stated the investigations should be complete and thorough and acknowledged that there had not been complete data gathering such as potential witness statements related to the investigation for Resident 30. Reference WAC 388-97-0640(6)(a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure timely completion and transmission of required Minimum Data Set Assessments (MDS) (a required assessment tool) for 1 of 3 residents (Resident 62) reviewed for discharge process. Failure to complete the required discharge assessment as required can impact the accuracy of the facility's quality measures and has the potential to affect facility payments. Findings included . The code of federal regulations (CFR) 42 requires skilled nursing facilities to provide a discharge assessment that accurately reflects a resident's status at discharge within 14 days of the resident's date of discharge and to encode/transmit that data to the Centers for Medicare and Medicaid Services (CMS) within 14 days. Resident 62 was admitted to the facility on [DATE] and discharged on 01/24/2025. Review of Resident 62's clinical record on 06/13/2025 showed there was no discharge MDS completed for Resident 62. The CMS system had flagged the resident file as being without any type of assessment for greater than 120 days. In an interview on 06/17/2025 at 9:59 AM, Staff D, MDS Coordinator, stated they run an audit report and discuss residents each day in the facility stand up meeting and stated that this assessment somehow got missed. Reference WAC 388-97-1000

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide assistance with Activities of Daily Living (ADLs - daily hygiene and other self-care tasks) for 4 of 7 residents (Residents 6, 7, 17, and 8) reviewed for ADLs. The failure to provide ADL assistance to residents placed residents at risk for poor hygiene, diminished feelings of self-worth, and other adverse health outcomes. Findings included . Review of a facility policy titled Activities of Daily Living (ADLs) review date of 09/01/2024, documented 'The resident will receive assistance as needed to complete activities of daily living (ADLs).' <RESIDENT 7> Resident 7 was a long-term resident at the facility. According to the Annual Minimum Data Set (MDS-an assessment tool) assessment dated [DATE], the resident was cognitively intact and was dependent (helper does all the effort) on staff for shower assistance. During observations on 06/13/2025 at 12:33 PM, 06/16/2025 at 8:33 AM, and 06/17/2025 at 8:36 AM, Resident 7's hair appeared greasy. Review of shower documentation in the electronic medical record, dated 05/17/2025 through 06/16/2025 with a print date of 06/16/2025, documented Resident 7 preferred to shower two times a week. It was documented that Resident 7 received showers on 05/19/2025, 05/26/2025, 05/29/2025, 06/02/2025, and 06/09/2025 and 1 refusal on 06/07/2025. <RESIDENT 6> Resident 6 was a long-term resident at the facility. According to the admission MDS dated [DATE], the resident was dependent on staff for showers and had mild cognitive impairment. During an observation on 06/13/2025 at 12:30 PM, on 06/16/2025 at 8:29 AM, and on 06/18/2025 at 8:22 AM, Resident 6's hair appeared greasy. Review of shower documentation in the electronic medical record, dated 05/18/2025 through 06/08/2025 with a print date of 06/16/2025, documented Resident 6 preferred to shower two times a week. It was documented that Resident 6 received a shower on 05/25/2025, 05/31/2025, 06/04/2025, and 06/07/2025, with one resident refused on 06/08/2025, one resident not available on 05/18/2025, and 06/01/2025, and one not applicable. <RESIDENT 17> Resident 17 was a long-term resident at the facility. According to the Annual MDS dated [DATE], Resident 17 had mild cognitive impairment and needed supervision or touching assistance (helper provides verbal cues or touch/steady assistance as resident completes activity) for showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/12/2025 at 2:27 PM, Resident 17 stated that they had tried to ask for a shower two different times, but staff said they were busy. Resident 17's hair appeared greasy. During an observation on 06/16/2025 at 8:28 AM, on 06/17/2025 at 10:00 AM, and on 06/18/2025 at 8:21 AM Resident 17's hair appears greasy. Review of shower documentation in the electronic medical record, dated 06/11/2025 through 05/21/2025, with a print date of 06/16/2025, documented Resident 17 prefers to shower one time a week. It was documented that Resident 17 received a shower on 06/11/2025 and Resident refused on 05/21/2025 and 05/28/2025. <RESIDENT 8> Resident 8 was a long-term resident at the facility. According to the admission MDS dated [DATE], Resident 17 was severely cognitively impaired and was dependent on staff for showers. During an observation on 06/18/2025 at 10:05 AM, Resident 8's hair appeared greasy. Review of shower documentation in the electronic medical record, dated 05/18/2025 through 06/01/2025, with a print date of 6/16/2025, documented Resident 8 prefers to shower 1 time a week. It was documented that Resident 8 received a shower on 05/25/2025 and 06/01/2025, and one not applicable on 05/18/2025. During an interview on 06/18/2025, Staff AA, Nursing Assistant Certified (NAC), the primary shower aid, stated that if a resident refuses a shower, staff should re-approach the resident, and if they still refuse, nursing staff should be alerted, and it should be charted. However, shower aids get pulled to the floor to work frequently. Staff AA then looked in the schedule book and stated that Resident 8 had only received a shower 2 times in 30 days, with no other documentation. During a joint interview on 06/18/2025 at 10:05 AM, Staff A, administrator, and Staff B, Director of Nursing, stated that the facility does not use contract NACs, and if a callout happens, they pull the shower aid or the restorative aid. They would expect that the staff shower the residents the next day if they are pulled, but if it's not documented in PCC then it was not done. Reference WAC 388-97-1060(c)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were provided with interventions to maintain or prevent declines in range of motion (ROM) for 1 of 3 residents (Resident 27) reviewed for positioning and mobility. Failure to apply splints and braces as ordered can result in increased contracture (permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff), decreased mobility, and/or increased pain and diminished quality of life. Findings included . Resident 27 was admitted to the facility on [DATE] with admitting diagnoses to include stroke with hemiplegia (muscle weakness on one side of the body) and hemiparesis (weakness or inability to move one side of the body). According to the Quarterly Minimum Date Set (MDS - an assessment tool) assessment dated [DATE] resident was cognitively intact, receiving restorative nursing program and was wearing splints. Review of Resident 27's physician orders with a print date of 06/13/2025 documented, left wrist splint, on in AM and off at bedtime and left ankle splint on each day for six hours. These orders were dated 10/10/2024. In an observation and interview on 06/12/2025 at 2:35 PM, Resident 27 stated that the staff were not putting on their splints daily and the resident was not wearing any splints during the observation. In an observation on 06/16/2025 at 9:40 AM, Resident 27 was not wearing any splints. In an observation and interview on 06/16/2025 at 1:14 PM, Resident 27 was not wearing splints. Resident 27 stated that the only time they wear their splints was when they work with the Restorative Aid (RA), and this usually happens twice a week. Resident 27 stated that they should be wearing their splints every day. In an observation on 06/16/2025 at 1:41 PM, Resident 27 was in bed and not wearing any splints. In an interview on 06/16/2025 at 2:06 PM, Staff K, Nursing Assistant Certified (NAC) stated that the RA's were the ones that apply Resident 27's splints. In an observation on 06/16/2025 at 3:57 PM, Resident 27 was in bed and not wearing any splints. In an observation/interview on 06/17/2025 at 8:41 AM, Resident 27 was not wearing any splints. Resident 27 denied that they had refused to wear their splints when offered. In an interview on 06/17/2025 at 10:00 AM, Staff R, NAC stated that RA's were the ones that put the splints on Resident 27. Staff R stated they had not been told they were to put splints on the resident. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/17/2025 at 10:40 AM, Staff S, Licensed Practice Nurse (LPN) stated that RA's put on the splints for Resident 27. In an interview on 06/17/2025 at 1:22 PM, Staff T, RA, stated their schedule alternates with another RA except Mondays, both were off on Mondays. Staff T stated that when they are short NACs on the floor they get pulled and are not able to work with residents on their restorative programs. Staff T added that they worked on the floor 3 days last week which meant residents were not seen for their Restorative Program. When asked about Resident 27's splint, they stated that they put the splint on resident's left arm and braces to both feet. They added that the resident was supposed to wear them at least 6 hours a day but Resident 27 was not able to tolerate wearing the splints that long and usually wears them less than two hours daily. Staff T stated they document in Resident 27's electronic chart when they put on the splint and how long the resident wore them. Staff T stated that they don't know who applies the splint and braces for residents when they get pulled to work on the floor. In an interview on 06/17/2025 at 2:30 PM, Staff U, RN Care Manager stated they were not sure who is supposed to apply Resident 27's splints and/or braces when RA's get pulled to work on the floor. In an interview on 06/18/2025 at 9:36 AM, Staff O, RA stated that Resident 27's splints and braces should be applied daily however on the days that they get re-assigned to work on the floor, they were not able to apply resident's splints and braces. Staff O stated lately they have been pulled to work on the floor almost every day and when that happens no one applies the residents splints and braces. Record review of Resident 27's Task documentation under Nursing Rehab/Restorative on 06/18/2025 for the last 30 days documented Number of minutes spent providing splint or brace assistance. The documentation showed only seven of the last 30 days had minutes documented, Record review of Resident 27's Medication and Treatment Administration (MAR/TAR) Records for April, May and June of 2025 did not show any documentation regarding resident's splints or braces. In a joint interview on 06/18/2025 at 10:04 AM, Staff A, Administrator, Staff B, Director of Nursing Services (DNS) and Staff C, Assistant Director of Nursing Services (ADNS), Staff B stated that when RA's gets pulled to the floor, the nurses were supposed to apply splints or braces to residents. When asked where the nurses document that information, Staff B stated that it should be in the MAR/TAR. Staff C agreed and stated it should be in the TAR. Staff B reviewed Resident 27's MAR/TAR and stated that there was no documentation in the residents' chart regarding splint/braces usage. Reference WAC 388-97-1060(3)(d)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to provide meals that were palatable and at an appetizing temperature per 1 of 1 resident groups (Residents 3, 19, 35, 46, 59, and 182), 3 resident interviews (Residents 19, 37, and 45), and 2 of 3 resident dietary grievances (Residents 46, and 50) reviewed. These failures resulted in residents experiencing dissatisfaction with their meals and placed residents at risk for decreased quality of life and weight loss. Findings included . In an interview on 06/12/2025 at 2:15 PM, Resident 45 stated they did not think the fish was fresh and stated the facility uses the wrong seasonings, and the meats are too tough. Resident 45 stated they took the microwave away and we can't have popcorn anymore. In an interview on 06/12/2025 at 2:20 PM, Resident 19 stated food options were limited, lots of chicken fried or country fried, not a lot of variety. In an interview on 06/12/2025 at 10:06 AM, Resident 37 stated the food tasted bad, they offer other options, but the options are also not good. In an observation of the facility lunch meal service and tasting of a facility test tray on 06/16/2025 at 12:50 PM, the test tray left the kitchen at 12:43 PM. The meal included a barbecue burger which was a burger patty which had been hot held in a metal tray of barbecue sauce, French fries, and included the alternate main meal option of a hot dog in a bun. The burger temperature had cooled to 115 degrees (f) and was very thick with barbecue sauce, the bun was smashed and not visually appealing. The hot dog bun was wet and soggy. The French fries were dry and cardboard like, not palatable at all and barely warm. In a group meeting during the facility resident council on 06/16/2025 at 2:48 PM, Resident 46 stated the facility toaster was broken, we can't get toast, and stated the food quality was inconsistent. All residents in attendance (Residents 3, 19, 35, 46, 59, and 182) stated the lunch today was terrible, heavy with barbecue sauce and the French fries were hard you could use them as nails. This was stated to be typical. Resident 182 stated they would like their food to be heated; it arrives very cold and that they are upset that they cannot use a microwave. Residents are buying their own food because they don't like the food here but then can't have their food heated. All residents (Residents 3, 19, 35, 46, 59, and 182) stated that they eat their food cold, and they were told by the kitchen that food is warm when it leaves the kitchen but sits in the hall way too long until it is cold and then staff are not allowed to heat it up. Refer to F 813 related to facility policy regarding heating of resident foods. Review of the facility grievance log and grievance investigations documented Resident 46 filed a grievance dated 05/08/2025 stating they received chicken that was not cooked and asked for another piece that they did not receive. Review of the facility resolution of the grievance stated they would ensure communication between the resident and kitchen regarding meal corrections but did not address the stated issue of chicken being undercooked. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 50 filed a grievance dated 06/07/2025 stating meals were cold or overcooked, French fries were overbaked and hard or undercooked. The grievance also included numerous specific complaints about preferences. The grievance resolution per the facility was that the residents' preferences would be updated but did not address the concern related to food temperature or quality. In an interview on 06/17/2025 at 12:36 PM, Staff E, Food Services Director, confirmed the kitchen does not reheat resident foods. Staff E stated they were involved in concerns or grievances related to the resident foods and stated they recalled Resident 46's grievance related to raw chicken and stated it was not possible, as the facility received pre-cooked chicken from that food vendor. Staff E stated they had not been directly involved so could not speak to whether there had been an issue with the temperature. Staff E stated there was a food committee where they meet with residents to discuss food issues. Staff E stated the facility had no fryer, so things like French fries specifically which are frozen, are baked in the oven, then held on the steam table under foil. Staff E also stated they also had onion rings that they had not ordered before, but they were also baked and held, and they do not keep well on the steam table. Staff E stated they were not sure why the menu included so many fried items when they had no fryer, but the menus come from corporate. Staff E stated they had just gotten permission to order a toaster, and the complaint of not having toast was accurate. In an interview on 06/17/2025 at 1:49 PM, Staff A, Administrator, stated they reviewed the grievances and were aware of some of the resident specific food complaints, and stated they believed that the resident concerns had been addressed. On 06/18/2025 at 11:03, Staff A stated they had not tried any of the facility food themselves. Reference WAC 388-97-1100(1)(2)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents' menus and individual food plans met the nutritional needs and preferences for 1 of 2 residents (Resident 7) reviewed for food preferences. The failure to ensure residents received foods that met their nutritional needs, and their individual preferences placed residents at risk for weight loss, dissatisfaction with their food and diminished quality of life Finding included . Review of facility policy titled Food Allergies and Intolerances review date 04/29/2025 documented that each resident receives and the facility provides food that accommodates resident allergies, intolerances and preferences. The Director of food and Nutrition identifies menu items that contain the food item(s) related to allergy/intolerances and ensures those items are not used in foods prepared and served to identified residents. <Resident 7> Resident 7 was a long-term resident at the facility with a diagnosis that included malnutrition, dysphasia (difficulty swallowing), and was being provided with extra calories by a percutaneous endoscopic gastrostomy (PEG) tube (a way of delivering nutrition directly to the stomach). According to the Annual Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], Resident 7 was cognitively intact. Review of Resident 7's care plan on 06/17/2025, documented the resident had allergies that included gluten (a substance present in grains, especially wheat that can cause illness in people). Review of Resident 7's meal tray cards documented h following: - On 06/16/2025-Allergies/dislikes gluten, eggs, mushrooms, mayonnaise, tomato products. - On 06/17/2025-Allergies/dislikes gluten, eggs, mushrooms, mayonnaise, tomato products. During an observation/interview on 06/16/2025 at 1:11 PM, Resident 7 was given a hamburger, with mayonnaise already on the bun and barbeque sauce on the patty, along with two battered onion rings. Resident 7 stated it was not good, and she prefers not to eat mayonnaise and is unsure if the onion ring has gluten. During an observation/Interview on 06/17/25 12:31 PM, Resident 7 was given gluten-free pasta and tomato sauce for lunch. The resident stated they do not like tomatoes and will not eat lunch. During an interview on 06/17/2025 at 10:25 AM, Staff E, Food Services Director, stated that to ensure residents do not receive food items they do not like or have an allergy to, they use meal tray cards with a list of dislikes and allergies. Then they can substitute foods that residents do not like. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview on 06/18/2025 at 10:05 AM, Staff A, Administrator, stated that resident preferences regarding food should be met, and Resident 7 should not have gluten or disliked items on their tray. In an interview on 06/17/2025 at 12:48 PM, Staff E, Food Services Director, stated the facility had gluten free pasta, bread and buns but stated their food vendor does not stock many other gluten free options. Staff E stated the lunch meal on 06/16/2025 included onion rings which contained gluten. Staff E stated there were no other alternatives available for the onion rings so any resident who received onion rings would have received gluten. Reference WAC 388-97-1120 (2)(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure foods were prepared under sanitary conditions for 1 of 1 facility kitchens, and to ensure expired items were discarded from 1 of 2 nourishment refrigerators. These failures places resident at risk for food borne illness. Findings included . In an observation of nourishment refrigerators on 06/17/2025 at 11:28 AM, the nourishment refrigerator in the main dining room was observed to include an opened carton of thick and easy supplement which was dated as opened on 06/15/2025. Further observation of the carton showed a manufacturer printed expiration date of 06/13/2025. In observations of meal preparation and tray line on 06/16/2025 between 11:17AM and 12:48 PM the following was observed: - At 11:44 AM, Staff H, Cook, was observed to reach under a table for an item that had dropped on the floor, which was observed to be a meal ticket. Staff H disposed of the ticket in a nearby trash can, doffed (removed) gloves, and donned (put on) a new pair of gloves without performing hand hygiene. - At 12:06 PM, Staff H changed gloves and did not perform hand hygiene prior to donning new gloves. - At 12:15 PM, Staff H was noted to have bare hands and was observed to lean over the tray line area to place a container of chopped onions into the food holding zone, and while leaning, was observed to place their bare hand onto one of the clean plates and did not replace that plate. - At 12:16 PM, Staff H was observed to have bare hands while cutting a sandwich in half and their bare hands came in contact with the top of the plate and sandwich. In an interview on 06/16/2025 at 12:45 PM, Staff H acknowledged that hand hygiene was required between glove changes and had not realized that there had been bare hand contact with any items. In an interview on 06/17/2025 at 12:36 PM, Staff E, Food Services Manager, stated that Staff H was going too quickly. Staff E stated the facility staff get the supplement cartons directly from them in the kitchen and there should not have been any expired items given out, stating they go through and remove expired items, so Staff E was not sure how an expired item got missed. Reference WAC 388-97-1100 (2)(3)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on interview and record review, the facility failed to ensure their policy for foods brought in from outside sources was implemented. The facility failed to ensure safe and sanitary storage, handling and consumption of the foods brought into the facility. This failure placed residents at risk for decreased quality of life related to an inability to exercise their rights and preferences to have food items of their choice brought into the facility and safely stored and consumed. Findings included . Review of the facility policy titled, Food from Outside Sources, 06/03/2024 stated that when food required to be heated the facility should use a food thermometer and alcohol wipes to ensure food was heated properly . additionally facility staff should receive proper education on required food temperatures, and proper use of food thermometer. In a review of an undated letter from Staff A, Administrator addressed to residents, staff and family members. The letter included an attachment, that stated they were only allowed to store a small number of items for the residents and would no longer allow staff to heat up food items, including frozen items, hot dogs, and microwave popcorn. In a joint interview on 06/18/2025 at 11:03 AM, with Staff A and Staff B, Director of Nursing Services, Staff A stated the letter, and attachment was sent out sometime in May of 2025. Staff A confirmed that residents were not allowed to have food heated up, and they had limited space available to the residents for storage of food. Staff A stated they felt it was a burden to ask their staff to heat up food for the residents safely. Staff B stated they did not feel their staff could follow proper safety measures to heat up food for the residents. Refer to F561 No associated WAC reference

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff were compliant with Infection Prevention and Control Guidelines and standards of practice for 1 of 1 residents (Resident 30) reviewed for Transmission Based Precaution (TBP-are a set of infection control measures used in healthcare settings to prevent the spread of infectious diseases that are transmitted through contact with an infected patient, their bodily fluids, or contaminated surfaces or objects), 1 of 2 residents (Resident 13) reviewed for Enhanced Barrier Precaution (EBP-infection control intervention designed to reduce transmissions of multi-drug resistant organisms (MDROs in nursing homes) and 1 of 3 residents (Resident 27) observed during personal care. These failures placed residents and staff at risk for potential infection from cross contamination of infectious organisms. Findings included . According to the facility policy titled Enhanced Barrier Precautions with a revised date of 04/22/2025, stated EBP were indicated for residents with any of the following, indwelling medical devices (examples are urinary catheters). Examples of high-contact resident care activities requiring gown and glove use include device care and urinary catheters. <ENHANCED BARRIER PRECAUTION> <RESIDENT 13> Resident 13 was admitted to the facility on [DATE] with admitting diagnoses to include obstructive and reflux uropathy (blockage or obstruction of the urinary tract). Review of Resident 13's care plan printed on 06/13/2025 documented that the resident had an indwelling foley catheter (a flexible tube inserted into the bladder through the urethra to drain urine) and was on EBP. In an observation on 06/13/2025 at 1:25 PM, Staff O, Nursing Assistant Certified (NAC), observed emptying the foley catheter bag of Resident 13. Staff O was only wearing gloves and not wearing a gown. According to Staff O, the EBP sign on the resident's door was for Resident 13 due to the resident having a foley catheter. When asked why they did not follow the required personal protective equipment (PPE - equipment worn to minimize exposure to hazards that cause serious workplace illnesses), Staff O stated that they did not have to wear a gown when emptying a foley catheter. <PERSONAL CARE> <RESIDENT 27> Resident 27 was admitted to the facility on [DATE] with admitting diagnoses to include stroke with hemiplegia (muscle weakness on one side of the body) and hemiparesis (weakness or inability to move one side of the body). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 06/16/2025 at 9:40 AM, Staff Q, NAC and Staff P, NAC, were getting ready to provide pericare (process of cleaning the genital and anal area of the body) to Resident 27. After Staff P provided pericare, they took the dirty brief off and then placed a clean brief on to the resident without changing gloves. And with the same gloves, Staff P took resident's gown off and assisted resident in putting on their clothes. With the same gloves, Staff P went and set up resident's electric wheelchair, touching the things that were on resident's wheelchair such as the cushions and the handlebar and controls of the wheelchair. In an interview on 06/16/2025 at 10:21 AM, Staff P stated that they change gloves when their gloves were visibly soiled. When asked if their gloves were dirty after pericare, they stated that it was dirty and should have changed gloves after they provided pericare for Resident 27. In an interview on 06/17/2025 at 12:35 PM, Staff N, Licensed Practical Nurse (LPN)/Infection Control Nurse, stated that they were responsible in conducting staff education on Infection Control practices. Staff N stated that they do in-services, trainings, and audits. When informed of my observations regarding not wearing appropriate PPE on an EBP resident and not performing hand hygiene during pericare, Staff N stated they will have to do more training with staff. <TRANSMISSION BASED PRECAUTIONS> <RESIDENT 30> Review of Resident 30's medical record showed documentation dated 06/11/2025 at 11:01 PM, stating that Resident 30 was experiencing loose stools, and a decrease in oral intake. The note stated the provider had ordered laboratory testing which included a stool culture to rule out Clostridium Difficile (C. Diff) (a toxin present in the stool, spread by person to person contact with infected material such as surfaces.) C. Diff required Contact level precautions which state to gown and glove prior to entering the room and hand hygiene required soap and water due to the ineffectiveness of alcohol-based hand sanitizers to kill C. Diff spores. In an observation on 06/12/2025 at 1:48 PM, Resident 30's room was observed to have a sign on the door indicating Enhanced Barrier precautions (EBP), which included the requirement to wear PPE (gown, gloves) only related to high-risk activities, and to perform hand hygiene when entering and exiting the room, with hand sanitizer being sufficient. Staff J, NAC was observed to enter and exit the resident's room, without donning a gown or gloves, and was observed to perform hand hygiene using hand sanitizer on the way out of the room, which was in accordance with the posted EBP signage. In an interview with Staff J on 06/12/2025 at 1:50 PM, Staff J stated they were aware that Resident 30 was not feeling well, and they had been in to see if the resident had wanted anything. Staff J stated they did not know anything more but that they followed the instructions on the signs, so if they were going to go in to provide care for the resident, they would have put a gown and gloves on. In an interview on 06/12/2025 at 1:53 PM, Staff I, Registered Nurse, stated Resident 30 was having loose stools yesterday and they were checking labs. Staff I stated they had not been able to obtain a stool culture yet because Resident 30 had not had any more stool since they had received the order, but that Resident 30 should be on Contact Enteric precautions while they were ruling out the C. Diff. Staff I stated they did not notice that the sign posted was not correct, so staff were only following precautions for EBP. At 2:48 PM, the signage was noted to have been updated to Contact. (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 B. Wing	06/18/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-1320(1)(a)(c)