STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505386	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marysville Care Center	1821 Grove Street Marysville, WA 98270

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 4 residents (Resident 1) reviewed for care planning. The failure to ensure the comprehensive care plan was person-centered to maintain and or attain the resident's highest practicable well-being placed the residents at risk of not receiving services that would meet their needs, adverse health effects and a decreased quality of life. Findings included .<RESIDENT 1>Resident 1 admitted to the facility on [DATE] with diagnoses to include nontraumatic intracranial hemorrhage (bleeding within the [NAME]), atrial fibrillation (irregular heartbeat), and presence of prosthetic heart valve, and long term (current) use of anticoagulants (blood thinning medication).Review of Resident 1's medication orders on 07/16/2025, documented Resident 1 had a medication order for Warfarin (a blood thinning medication) for a diagnosis of prosthetic heart valve. Review of Resident 1's comprehensive care plan on 07/17/2025, showed there was no care plan developed for the use of Warfarin medication to address potential adverse side effects or monitoring with medication use.In an interview on 07/17/2025 at 11:05 AM, Staff E, Certified Nursing Assistant (CNA), stated staff would know if a resident was taking a blood thinning medication as it would be on the Kardex (care guide for CNAs to provide care) so staff knew if there were any precautions for that resident and to look for bruising and any signs of bleeding. In an interview and record review on 07/17/2025 at 1:26 PM, Staff D, Licensed Practical Nurse (LPN), Nurse Manager, confirmed that there was no care plan in place for the use of Warfarin for Resident 1. In an interview and record review on 07/22/2024 at 4:00 PM, Staff B, Registered Nurse (RN), Director of Nursing (DNS), stated that the expectation is that blood thinning medications should be care planned but would not be on the Kardex. Staff B stated an anticoagulant care plan was initiated for Resident 1 on 02/18/2025 and resolved on 02/20/2025. Reference WAC 388-97-1020 (1)(2)(a)(3)

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
	505386	A. Building B. Wing	07/22/2025

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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 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - 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 interviews, and record review, the facility failed to ensure 1 of 4 sampled residents (Resident 1) reviewed for blood thinning medication (Warfarin) use were free from significant medication errors. Resident 1 experienced harm when they received two doses of a blood thinning medication when the medication was on hold, were hospitalized for a brain hemorrhage (bleeding within the skull), had an INR (International Normalized Ratio - a test to determine how long it takes for blood to clot) of 6.9 (normal range for resident 2. 5-3.5) and required Kcentra and Vitamin K (blood clotting medications used for urgent reversal of blood thinner medications) in the emergency room. This failure placed all residents receiving blood thinning medications at risk for significant medication errors, serious complications from bleeding and a diminished quality of life. Findings included. Review of a facility policy titled Anticoagulation Management, review date 11/19/2024 documented: - Review the MAR (medication administration record) for the previous day's anticoagulant order to ensure the anticoagulant was administered or held per physician order. - Review the MAR to ensure the PT/INR (Prothrombin Time Test - a test to determine how long it takes for blood to clot) has been completed as ordered. - Review the PT/INR/Coumadin Flowsheet is current with the PT/INR results, current dose, MD notification, dose change, and the next date for the PT/INR. - Review the medical record to ensure the physician was notified of the PT/INR results and any new orders have been noted - Review the MAR to ensure any new orders have been properly transcribed <RESIDENT 1> Resident 1 admitted to the facility on [DATE] with diagnoses to include nontraumatic intracranial hemorrhage (bleeding within the [NAME]), atrial fibrillation (irregular heartbeat), and presence of prosthetic heart valve, and long term (current) use of anticoagulants (blood thinning medication). Review of Resident 1's medical record showed Resident 1 was sent to the ER on [DATE]. Review of Resident 1's hospital records ED (Emergency Department) COURSE dated 07/12/2025 documented: - 12:32 AM-patient has a left temporal/occipital 4.1 cm intraparenchymal hemorrhage with surrounding vasogenic edema (fluid in the brain causing swelling and pressure within the [NAME]), no midline shift (movement of brain tissue from the center of the [NAME]). - 1:06 AM-INR is 6.9. Kcentra (blood clotting medication for urgent reversal of blood thinner medication) and Vitamin K (treatment used to normalize high INR) were ordered. Review of a document titled PT/INR/Coumadin Flow Sheet, documented Resident 1's INR range should be between 2.5-3.5. On 07/09/2025 the flow sheet documented Resident 1's INR result was 3.8, the MD was notified, and the dose change column documented to Hold medication and re-check the INR on 07/10/2025. There was no documentation on the PT/INR Flow Sheet for 07/10/2025. Review of Resident 1's MAR, dated July 2025, documented Resident 1 was administered Warfarin 1.5 mg at 5:00 PM on 07/09/2025 and 07/10/2025. Review of Resident 1's progress notes did not show alert charting or guardian notification for INR results of 3. 8 or an order to hold Warfarin on 07/09/2025. Review of Resident 1's progress note titled Transfer to Hospital Summary, dated 07/15/2025 at 5:16 PM, a late entry note entered by Staff B, Registered Nurse (RN), Director of Nursing, documented Review of notes from the hospital on [DATE] showed the resident had a brain bleed again and their PT/INR was higher in the ED when they returned. Staff B documented review of eMAR [electronic medical record] and provider notes showed the last PT/INR in the facility of 3.8 on 07/09/2025. Provider held coumadin at that time.In an interview on 07/17/2025 at 11:45 AM, Staff C, RN, stated the day shift nurse would obtain the INR and fill out the INR/Coumadin flow sheet to include INR result, current order, provider notification, new order and next INR date. Staff C stated that the provider makes the decision whether to change medication, hold medication and when they want the next INR done. Staff C stated that new orders would be entered into the computer and on the MAR. The nurse would make a progress note and the resident would be placed on alert charting if the INR was abnormal. In an interview and record review on 07/17/2025 at 1:26 PM, Staff D, Licensed Practical Nurse (LPN)/Nurse Manager, stated Resident 1's INR Flow Sheet documented an INR result of 3.8 on 07/09/2025, and orders were to hold the residents Warfarin and recheck the INR on 07/10/2025. Staff D stated Resident 1's INR would not have been checked on 07/10/2025 because that was a Thursday and INRs were only checked on Mondays, Wednesdays, and Fridays. Staff D stated the INR recheck date of 07/10/2025 was entered incorrectly because we don't check INRs on Thursday's. Staff D reviewed the July 2025 MAR and confirmed that documentation showed Resident 1 had received Warfarin 1.5 mg on 07/09/2025 and 07/10/2025. In an interview and record review on 07/22/2025 at 4:00 PM, Staff B stated Resident 1 received Warfarin 1.5 mg