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	05/19/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to protect residents right to be free from neglect for 1 of 3 sampled residents (Resident 1) reviewed for falls. Facility staff failed to follow the plan of care which resulted in Resident 1 falling from their bed. This failure placed residents at risk for potential physical or mental harm, feeling safe, and a diminished quality of life.Findings included .Review of a facility policy titled Abuse-Identification of Types reviewed 04/01/2026 documented: Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Willful-is defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm Review of a facility policy titled Abuse-Prevention reviewed 04/01/2026 documented it is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation.Procedure- 2. Identify, correct and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur to include trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms if any.4. Identify, assess, care plan for appropriate interventions and monitor residents with needs and behaviors which might lead to neglect such as:h. Residents that require extensive nursing care and/or are totally dependent on staff for the provision of care. Review of the Nursing Home Guidelines the purple book, dated October 2015, Appendix B, Definition Diagram-Neglect documented;b. Neglect may result from a one-time act or omission by an individual or entity with a duty of care for nursing home residents. Individual or entity with a duty of care by an action or failure to act demonstrated a serious disregard of the consequences of such magnitude that: There was a clear and present danger to the resident's health, welfare, or safety. <RESIDENT 1>Resident 1 was admitted to the facility on [DATE] with diagnoses to include polyneuropathy (damaged nerves), muscle weakness, difficulty in walking, falls, and dementia. According to the Minimum Data Set (MDS-an assessment tool) assessment dated [DATE], the resident had no cognitive impairment.Review of Resident 1's care plan dated 05/05/2026, showed the resident required extensive two-person assistance with bed mobility to turn and position in bed.Review of Resident 1's Kardex (a care guide for staff to provide resident care) dated 05/06/2026 showed Resident 1 required extensive two-person assist with bed mobility to turn and position in bed.Review of the facilities Reporting Log dated May 2026, documented Resident 1 had a fall with findings of neglect.Review of a progress note dated 05/06/2026 at 2:17 PM, documented the certified nursing assistant (CNA) reported they were providing care for Resident 1 and the resident rolled off the bed. The resident complained of pain eight out of ten to their lower back.Review of a facility investigation dated 05/06/2026 showed Staff E, CNA, was providing care for Resident 1, rolled the resident to their side and the resident rolled off of the bed. Staff E stated they knew that Resident 1 required two-person assist for care and stated therapy had told them that morning that the resident was going to be a one person assist, Staff D, (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Rehab (DOR) stated that was not correct. The investigation concluded that Staff E by self-report was aware that the resident's plan of care showed the resident was a two-person maximum assist for bed mobility and decided to roll the resident with one person causing a fall to the ground when the resident reached for support.Review of a statement dated 05/26/2026 at 11:30 am, Staff E documented they were providing care for Resident 1, the resident was rolled away from them and rolled off of the bed onto the floor.Review of a statement dated 05/06/2026, Staff A, Administrator and Staff B, RN, Director of Nursing, documented an interview with Staff E. Staff E stated they were rolling Resident 1 away from them and the resident fell onto their right side. Staff E stated they had reviewed the resident's Kardex that morning and the resident was a two person assist. Staff E stated they talked with Staff D and told them the resident was a one person assist for bed mobility, but the care plan had not been updated.In an interview on 05/19/2026 at 1:55 PM, Staff F, CNA, stated the Kardex gives information about how to provide care such as bed mobility and how many people are required for assistance. Staff F stated the Kardex should be checked at the beginning of the shift. Staff F stated if a resident is a two person assist, they would not assist the resident by themself.In an interview on 05/19/2026 at 2:03 PM, Staff G, Licensed Practical Nurse (LPN), Nurse Manager, stated Staff E stated they had looked at Resident 1's Kardex and were aware the resident required two-person assistance. Staff E was unable to state why they had not followed the Kardex. Staff G stated staff are expected to follow the Kardex when providing resident care.In an interview on 05/19/2026 at 3:20 PM, Staff D, DOR, stated Staff E assisted them with their evaluation of Resident 1 on 05/06/2026 prior to 8:30 AM. Staff D stated they reviewed the resident's Kardex with Staff E and told Staff E the resident required two-person assistance for care and bed mobility and to always follow the resident's Kardex for care. Staff D stated they did not have a discussion with Staff E about changing the resident to one person assistance for care.In an interview on 05/19/2026 at 3:30 PM Staff C, LPN, Assistant Director of Nursing, stated staff are expected to follow the care plan and Kardex when providing care for residents.Reference WAC 388-97-0640(1)