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	09/29/2025

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure food items were dated and labeled and expired items were discarded in the 2 of 3 sampled facility nourishment refrigerators (Quilceda and Havenwood) reviewed for safe/sanitary food storage. This failure placed residents at risk of consuming expired food, foodborne illness, and a diminished quality of life.Findings included.Review of the facility policy titled, Food from Outside Sources, revised date 05/06/2025, documented food stored in refrigerator should be labeled with the resident's name and room number. Items should be discarded if past expiration date. Review of facility policy titled, Food Safety, reviewed date 05/01/2025, documented leftovers must be dated and labeled properly and discarded after 72 hours. In an observation on 09/23/2025 at 10:22 AM, the nourishment refrigerator in Quilceda clean utility room was observed to include: a container strawberry with brown and fuzzy covering, labeled 09/04/2025, a package of mini maple pancakes and sausage with no resident's name, best before date was 09/01/2025, a chocolate pudding with no resident's name with best before date 09/13/2025, a container cherry tomatoes were mushy with some fluid inside the container labeled 09/04/2025, a container gelatin with best before date 08/24/2025, a bottle of ranch dressing with the manufacture printed expiration date 08/09/2025, a container of two pieces of chicken meat and one bag of baby carrots in a big plastic bag with a resident's name but no date, a bag of blueberries in the freezer with the manufacture printed expiration date 06/27/2025. Review of the refrigerator cleaning log taped outside the refrigerator; the last cleaning date was 09/11/2025. In a joint observation on 09/24/2025 at 10:13 AM with Staff O, Housekeeping Assistant, the nourishment refrigerator in Quilceda clean utility room was observed to still include the expired and unlabeled items listed above. Staff O stated they cleaned the refrigerator every week and they would discard expired or bad food. Staff O stated the expired food in the refrigerator should be thrown away. In an observation and interview on 09/24/2025 at 2:40 PM, Staff P, Registered Nurse (RN)/Unit Care Coordinator, the nourishment refrigerator in Havenwood nurses' station was observed to include: frozen bread in the freezer with best before date printed 08/18/2025, a bag of honey ham slices and a bag of Swiss slices labeled 9/20 with no name, opened container of ranch dressing and a bag of bagels labeled 9/20, in the bottom drawer, there was a bag containing of cottage cheese, pecan chips, and a can of pineapple, with no name or date, in the bottom drawer, there was a to-go container with leftover food with no name or date. Staff P stated the expired and unlabeled foods should be discarded. Staff P stated leftover foods were only kept for 72 hours. In an interview on 09/24/2025 at 10:40 AM, Staff J, RN, stated they needed to label residents' outside food with their names and dates received prior to putting it in the refrigerator. In an interview on 09/24/2025 at 10:46 AM, Staff K, Licensed Practice Nurse/Unit Care Coordinator, stated residents' outside food was supposed to be kept for a couple of days. Staff K stated they needed to discard the expired and unlabeled food. In an interview on 09/24/2025 at 11:57 AM, Staff Q, Housekeeping Director, stated when the housekeeper cleaned the refrigerator, they should have discarded the expired food and checked with the nurse for unlabeled outside food. Reference WAC 388-97-1100 (2)(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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a system was in place in which residents' records were complete, accurate, accessible, and systematically organized for 4 of 8 residents (Residents 3, 7, 54, and 86) reviewed for accurate and complete medical records. The facility failed to ensure the medical records reflected the behavior/psychotropic review documentation for 1 of 5 residents (Resident 3) failed to have accurate documentation for monitoring and consents for anti-anxiety medications for 1 of 5 residents (Resident 7), failed to include bed hold and discharge documentation for 1 of 2 (Resident 86) discharged residents, failed to ensure accessible documentation for hospice documentation for 1 of 1 resident (Resident 54). These failures to not maintain complete, accessible and accurate medical records placed residents at risk for medical complications, unmet care needs, and diminished quality of life. Findings included .<BEHAVIORS/PSYCHOTROPIC MANAGEMENT> <RESIDENT 7> Resident 7 admitted to the facility on [DATE] with diagnoses to include right hip fracture, anxiety and depression. Review of Resident 7's Electronic Health Record (EHR) showed a document titled 'Medication Consent (Buspirone)' an antianxiety medication, dated 08/13/2025. Review of this document showed the title was incorrect, the consent was for Bupropion (antidepressant medication), and the consent was dated 10/17/2024. The name of the medication and the date of the consent were labeled incorrectly in the EHR. Review of Resident 7's consent for Buspirone, dated 08/13/2025 showed Staff K, LPN Unit Care Coordinator, obtained and completed the consent. Review of Resident 7's Medication Administration Record (MAR) dated November 2024 showed the medication was discontinued on 11/21/2024. Review of Resident 7's MAR's dated November 2024, December 2024, January 2025, and February 2025 showed there was still an order to monitor for the side effects of Buspirone that was discontinued on 02/28/2025, which was over 3 months after the medication was discontinued. In an interview on 09/25/2025 at 10:45 AM, Staff K stated they were responsible to obtain medication consents for newly ordered psychotropic medications or when a new resident is admitted on a psychotropic medication. Staff K, LPN Unit Care Coordinator, stated that they review the consent with the resident and/or family including education regarding what type of medication was prescribed, possible side effects and what signs and symptoms were present before medication was initiated. Staff K verified they were the one who completed the Buspirone consent, dated 08/13/2025. Staff K verified that Resident 70 had stopped taking that medication in November of 2024. Staff K also verified that the document for Buspirone was not labeled correctly in the EHR and the consent was for Bupropion. Staff K stated they provide the consents to medical records, and they were responsible to name and date the uploaded documents in the EHR. In an interview on 09/29/2025 at 9:42 AM, Staff B, Director or Nursing Services, stated the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expectation was that medical records and documents were labeled with the correct name and date when being uploaded or scanned into the EHR. Staff B stated consents for psychotropic medications should be accurate and monitors for the medication class should be discontinued at the same time the medication is discontinued. <RESIDENT 3> Resident 3 admitted on [DATE] with diagnoses to include recurrent major depressive disorder, anxiety disorder, and post-traumatic stress syndrome (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). Review of the clinical record showed there was no interdisciplinary note about evaluating Resident 3's mental health diagnoses, mood and behaviors or the effectiveness of gradual dose reductions for psychotropic medications. In an interview on 09/26/2025 at 12:58 PM, Staff B, Director of Nursing Services (DNS) stated they had a monthly behavior meetings, and they evaluated for gradual dose reductions that were attended by Social Services, DNS, Pharmacist, and usually the psychiatric provider. Staff B stated they kept a binder of the reviews. Staff B stated the meeting notes should be in the medical records. Staff B provided a binder labeled, Behavioral Health Solutions that included psychotropic medication orders and handwritten notes about what was discussed at the meeting. Review of the Behavioral Health Solutions binder showed Resident 3 was discussed on 03/14/2025, 04/15/2025, 06/28/2025 and 09/18/2025. Review of the clinical record did not include documentation about the meetings on 03/14/2025, 04/15/2025, 06/28/2025 and 09/18/2025. In a joint interview on 09/29/2025 at 9:43 AM, Staff A, Administrator stated their expectation for medical records was filing, audits, and requesting medical records from other clinics and hospitals. Staff B, DNS stated they reviewed who went out to the hospital daily in stand up and they would request follow up records. Staff B stated they look for medical records when residents returned from physician appointments. In an interview on 09/29/2025 at 9:47 AM, Staff C, Regional Director of Clinical Services stated for psychotropic meetings, the resident's assessments are discussed and information discussed was documented in the binder located in the DNS office. Staff C stated the former DNS took the psychotropic assessment away. Staff C stated they now had an excel spreadsheet with the meeting details that surveyors can request. Staff C said the binder was an internal item. Staff C stated there should be a progress note detailing the meeting and gradual dose reduction discussions also included in the clinical record. <BED HOLD AND DISCHARGE> <RESIDENT 86> Resident 86 was admitted on [DATE] and hospitalized on [DATE]. In a record review on 09/25/2025 at 10:09 AM, Resident 86 did not have required discharge (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation, which would include the bed hold form and Notice of Transfer and Discharge (NOTD) form, documented in the electronic medical record (EMR) or the hard chart. In an interview on 09/25/2025, at 11:30 AM, Staff B confirmed that the bed hold form and NOTD form, for Resident 86, were not located in the resident's EMR or hard chart. Staff B stated that admissions keep all copies of the discharge paperwork. <HOSPICE> Resident 54 was admitted to the facility on [DATE] with hospice services. In an interview on 09/26/2025 at 9:20 AM Collateral Contact 1 (CC1), hospice nurse, stated there was a communication book located with the facility infection control nurse. CC1 stated the hospice staff documented in the communication book each time they came into the facility. CC1 stated if there were any changes to orders they were faxed to the facility and communicated to the nurses. On 09/26/2025 at 9:20 AM requested to review the hospice communication book from Staff H, Registered Nurse/Unit Coordinator. Staff H stated the hospice communication books were kept at the nurse's station. The hospice communication book was observed at the nurse's station and the contents were reviewed. The hospice book contained multiple handwritten notes from hospice staff for each visit since the start of Resident 54's hospice care. Review of Resident 54's EHR from 07/31/2025 through 09/26/2025 showed no notes from hospice visits. In an interview on 09/26/2025 at 9:25 AM Staff H, RN/Unit Coordinator, stated hospice communicated with the facility through fax if there are any changes of orders. Staff H stated hospice staff communicated with the facility staff after their visits. Staff H stated they didn't know how the information in the hospice binder was placed in the EHR for Resident 54. In an interview on 09/26/2025 at 9:56 AM Staff B, Director of Nursing Services stated all hospice records located in the binder should be uploaded into the resident's EHR. In an interview on 09/26/2025 at 9:58 AM Staff I, Medical Records, stated they were aware of a hospice book for Resident 54. Staff I stated the nurses reviewed the contents of the book and then provided it to them to upload into the residents EHR. In an interview on 09/29/2025 at 10:23 AM, Staff I, Medical Records Director stated they were responsible for uploading medical records into the EHR, credentialing and competency of physicians, stocking forms, and making new admission packets. Staff I stated they audited medical records on admit, quarterly, annually and on discharge to ensure the records were complete. WAC Reference 388-97-1720 (1)(a)(i)(ii)(iii), 4(a)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to address, respond to and/or resolve concerns and/or suggestions brought forward by the resident council (RC) for 6 of 6 months (March, April, May, June, July and August 2025) of RC minutes reviewed. Additional failed practice included the facility failure to maintain complete and accurate Resident Council meeting minutes that included details of concerns and grievances voiced during Resident Council meetings, and failures to log, report, investigate, and resolve concerns voiced by the Resident Council. These failures resulted in the same unresolved/unaddressed concerns being brought forward for consecutive months without resolution, and resulted in RC members feeling frustrated, unheard and powerless to affect the care they receive and/or their environment. Findings included .Review of the facility policy titled, Resident Council reviewed 09/26/2024, showed the Activities Director or Social Service Director will facilitate follow-up on all complaints, suggestions and ideas presented at the council meeting and will report results at the next meeting for the residents' information. This information will be included in the minutes. Each department director will be responsible for filling out a comment and concern form prior to the next meeting to provide his or her input.Review of the resident council minutes from 03/19/2025 showed old business from the prior month included out of facility activities. New business discussed was concerns over wheelchair cleaning. Review of the resident council minutes from 04/23/2025 showed old business from the prior month included the group wanting more out of facility activities, concerns over wheelchair cleaning and call lights. New business discussed was concerns over trash being left on tables and the group asked if nurses could answer call lights.Review of the resident council minutes from 05/21/2025 showed old business from the prior month included future activities and call light times. New business discussed was concerns over medications not being delivered on time and lots of employees on their cell phones. Residents requested going to a car show and other future activities.Review of the resident council minutes from 06/18/2025 showed the residents wanted to know about the bus getting fixed. The group voiced a concern about oxygen tubing not being replaced after it was left on the floor.Review of the resident council minutes from 07/23/2025 showed old business from the prior month included the juice machine getting repaired. New business discussed was they would like to go to the bowling alley. Concerns brought up were having to ask the nurses' aides for help twice, then finding the aides on their phones. Long call light times were brought up as well.Review of the resident council minutes from 08/27/2025 showed old business discussed was staff cell phone use and call light concerns. The group inquired about the status of the juice machine.The resident council meeting notes for March 2025 through August 2025 identified residents' issues and concerns were not escalated to a grievance investigation. The meeting minutes did not include written facility responses to the grievances, and often the concern(s) were not resolved and were carried over to the next month.Review of Grievance Log from March 2025 through 09/14/2025 showed grievances and recommendations from the RC were not escalated to a grievance form or the log. In the resident council meeting 9/24/2025 at 11:03 AM, Resident 58 stated the juice machine in Havenwood had been broken for 2 years. The resident stated they did not understand why the facility could not fix it. The resident stated the juice machine was brought up at every single resident council meeting. They said the van had been sitting there since 2020. They noted the license tabs were dated 2020. The resident stated they would like to go see the Lights of Christmas in [NAME], but the van was broken, and it had been for years. They stated out of facility outings were limited to where they could be pushed and they all wanted more outings. During the RC meeting, Resident 63 stated the facility should fix the juice machine and van instead of decorating. Resident 63 stated Why even come to these meetings. Nothing gets fixed.During the RC meeting, Resident 7 stated This is our home. They need to fix the van and juice machine. They get new administration all the time who say they are looking into it. There are excuses after excuses. They (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	say we need a smaller bus that doesn't require Commercial Driver's License (CDL) or other excuses. I feel like I am wasting words, why even complain or come to these meetings. Nothing changes. During the RC meeting Staff F, Activity Director stated that they literally push five to six residents in their wheelchairs to places in the community. Staff F stated outside activities take a lot of help to push the residents in their wheelchairs. Staff F said they kept getting different answers from administration about fixing the van. The RC group was asked if the RC group made suggestions about some of the rules, did the facility act on those suggestions, and considered the views of the RC and act promptly upon grievances and recommendations. Resident's 7, 18,19,33 ,44, 58, and 63 nodded their heads indicating no and/or stated no. When asked does the grievance official respond to the resident council groups concerns and provide a rational for their response? They responded no.In an observation on 09/29/2025 at 1:47 PM, the facility van was observed in the parking lot. The passenger side window by the lift had been broken and was covered with plastic. There was mold growing on the van. The tabs on the rear license plate showed the last registration was March 2020.In an interview on 09/29/2025 at 10:16 AM, Resident 32, Resident Council President said the group frequently brings up the juice machine and it was broken and needed to be removed. The resident stated the van was another repeat concern at the meetings each month. The resident said the facility did not respond in writing or verbally about their concerns and that communication with the group could be improved. The resident stated that the group not knowing about the Ombuds program, location of survey results and how to contact the state was on her. The resident stated the RC group knew they could come to her for contact information.In an interview on 09/29/2025 at 9:49 AM, Staff A, Administrator stated the facility van had a fuel line issue and they were going to dispose of it or sell it and get a smaller van. Staff A stated the juice machine would be getting fixed. Reference: (WAC) 388-97-0920 (4) (5)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that current legal guardian documents were in the resident's medical record and did not provide written and verbal information related to formulating an advance directive for 1 of 5 (Resident 4) residents reviewed for advance directives. These failures placed the resident at risk of not having correct or updated legal guardian documents to verify the accurate guardian and to allow the legal guardian to formulate an advance directive to express their medical care preferences.Findings included .Resident 4 was admitted to the facility on [DATE] with diagnoses to include personal history of traumatic brain injury (occurs when an external force causes damage to the brain), aphasia (language disorder that affects ability to speak, understand, read and write), and communicating hydrocephalus (accumulation of cerebrospinal fluid in the brain's ventricles).Review of Resident 4's Electronic Health Record (EHR) showed they had a legal guardian as their responsible party. Review of the EHR showed no legal documents in their medical record.Review of Resident 4's EHR showed there was no verbal or written documentation provided for the legal guardian to formulate an advance directive.In an interview on [DATE] at 12:49 PM, Collateral Contact 2 (CC2), Resident 4's legal guardian, stated the first time they had been requested by the facility to provide legal guardianship documents was approximately the week before the interview. CC2 stated that there had been a change to the most recent legal guardianship documents as they removed a co-guardian and replaced them with another individual.Review of Resident 4's care plan conference, dated [DATE], CC2 was requested to provide a copy of their legal guardian documents. In an interview on [DATE] at 2:30 PM, Staff A, Administrator, stated the facility had documents in the resident's paper chart and provided a document of legal guardianship, with CC2 listed as a legal guardian. This document was issued on [DATE] and expired on [DATE]. Staff A stated that the legal guardian had been asked to provide the guardian documents on [DATE]. Staff A provided no further documentation related to current legal guardian documents or advance directive documents that were provided to the legal guardian. Reference WAC: 388-97-0280 (3)(c)(i-ii)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an injury of unknown source with significant injury for 1 of 1 resident (Resident 5) reviewed for reporting. The facility's failure to report delayed appropriate oversight and investigation, placing residents at risk for harm and unidentified abuse and/or neglect.Findings included .The State of Washington's Nursing Home Guidelines-The Purple Book dated October 2015, Prevention and Protection, Incident Identification, Investigation, and Reporting directs what nursing home facilities report. The facility should report to the Department by telephone and via the reporting log when there was reasonable cause to believe violations have occurred involving abuse, neglect, abandonment, mistreatment and injuries of unknown sources. Facility would report to the department within two hours if there was serious bodily injury; or within 24 hours, if there was not serious bodily injury.Resident 5 re-admitted to the facility on [DATE] with diagnoses to include pneumonia, falls, and encephalopathy (brain disease that alters brain function).Review of Resident 5's care plan dated 06/16/2025 documented they were at risk for falls and to keep their bed in the lowest position.Review of the facility incident report, dated 06/17/2025, documented Resident 5 was found in their room on the floor next to their bed. Resident 5 was documented to complain of right hip pain, and x ray was done, and a hip fracture was identified. Resident 5 was sent to the emergency room. The incident report documented an unwitnessed fall and Resident 5 could not state what occurred. The incident report did not document if the state hotline had been notified of Resident 5's fracture. The incident report did not contain information about if Resident 5's care plan was being followed.In an interview on 09/25/2025 at 2:15 PM Staff B, Director of Nursing Services, stated they were unaware of the need to make a report to the state hotline and deferred to Staff C, Director of Clinical Services.In an interview on 09/25/2025 at 2:16 PM Staff C, Director of Clinical Services stated falls with serious injuries that were not witnessed, and the residents were not able to state what occurred, a report needed to be made to the state hotline. Refer to WAC 388-97-0640(5)(a)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to incorporate the recommendations from the Level II Preadmission Screening and Resident Review (PASRR a federally required screening of all individuals who has a serious mental illness (SMI) and or intellectual disability (ID) prior to admission to a Medicaid-certified nursing facility or a significant change of condition) report into the resident's assessment, and care planning for 1 of 1 resident (Resident 2) reviewed for PASRR. Facility failure to incorporate the PASRR recommendations into the residents' assessment and care plan delayed the implementation of recommendations and left the residents at risk for unmet mental health and activity needs and a diminished quality of life.Findings included . Review of the facility policy titled, Pre-admission Screening and Resident Review (PASARR) reviewed 09/26/2024, showed the facility must incorporate the recommendations from the PASARR level II determination and the evaluation report into a resident's assessment, care planning and transitions of care. Resident 2 admitted to the facility on [DATE] with diagnoses to include mood disorder, anxiety and development disorder of speech and language. Review of the clinical record showed a Level I PASRR was completed prior to admission for Resident 2 on 06/16/2025. The resident was assessed to need a Level II evaluation referral for SMI and also ID. The assessment noted the resident had a history of anxiety and depression and developmental delay. Review of the clinical record on 09/24/2025 showed there were no level II PASRR's in Resident 2's electronic health record (EHR). Review of the Level II PASRR completed 07/18/2025, provided after request on 09/24/2025 included the residents' goal to return to their apartment with their birds. The assessment documented that Resident 2 would often make threats when they were afraid. The recommendation was to ask the resident several questions about their needs or wants to get an understanding of how to proceed. The assessment documented that Resident 2 was often not listened to because they came off strong or would throw something or hit when they don't agree. The recommendation was to give Resident 2 time to express their concerns in a healthy way. Review of the follow up Level II PASRR completed 08/12/2025 included Resident 2's mental health history and approaches to be utilized by staff to identify triggers and mitigate the resident's outbursts. The PASRR included Resident 2's need for slowing down and listening when they were agitated. The evaluation noted Resident 2 needed people who would listen through the outbursts to understand what they needed. The evaluation noted that the resident wanted to go home to their birds and didn't always have the words or understanding of why they needed to follow doctor directives in order to heal correctly. The resident needed to be asked why they were doing things, so that staff could figure out how to help them. The evaluator included two examples that occurred at the facility such as they were not taking their antibiotics and it wasn't until the evaluator asked why, that they found out the antibiotics made them feel sick; at that time, the evaluator asked facility staff about an anti-nausea medication before the antibiotic to help them with feeling sick. Resident 2 understood, and the problem got resolved. Another example was that the resident took the foot board off their bed and put it under their bed. The staff were upset with them for doing this and put it back on. When Resident 2 was asked why they did that, they stated it was because it was putting pressure on their amputated foot. The staff then understood and replaced the footboard with an extended bed and mattress. These are just a few of the examples of what the resident goes through to communicate and be understood. Review of Resident 2's care plan, initiated on 06/30/2025, did not include Level II PASRR recommendations. In an observation on 09/26/2025 at 10:46 AM, Resident 2 was up in their wheelchair at the nurses' station and was frowning. Resident 2 stated everything was screwed up. The resident stated they would like a peanut butter and jelly sandwich in the middle of the night, so their blood sugar wouldn't drop. Resident 2's caregiver from their life skills group was present and stated, You look grumpy again today. Resident 2 confirmed they were grumpy. In an (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 09/25/2025 at 10:52 AM, Staff B, Director of Nursing Services (DNS) provided the level II PASRR recommendations for Resident 2, that were not in the medical record. Staff B stated Resident 2 was about to be discharged and they were anxious, and they cried for attention. Staff B stated PASRR recommendations should be on the care plan. In an interview on 09/25/2025 at 11:42 AM, Staff D, Social Services Director stated the level II from Developmental Disability Administration (DDA) was not in the EHR. In an interview on 09/29/2025 at 10:32 AM, Staff T, Regional Director of Clinical Services stated they were unaware of any PASRR concerns. Refer to WAC 388-97-1915(1)(2)(a-c) .

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASRR) assessments were completed timely for all residents following significant change in status for 1 of 5 residents (Resident 20) reviewed for possible serious mental disorders and related conditions. This failure resulted in a potential inability to receive and benefit from Level II PASSR services for Resident 20 and placed other residents at risk for a decreased quality of life. Findings included . Review of the facility policy titled, Pre-admission Screening and Resident Review (PASRR), reviewed 09/26/2024, showed the nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. Resident 20 was admitted to the facility on [DATE] with diagnosis of anxiety disorder. Review of the care plan developed 08/12/2024 showed the resident had a history of anxiety and depression. The care plan was revised on 04/29/2025 to include Resident 20 reporting falls that did not occur and injuries that were not substantiated. Review of Resident 20's admission Minimum Data Set (MDS) assessment dated [DATE] and Quarterly MDS dated [DATE] documented the resident was not experiencing hallucinations (perception of having seen, heard, touched, tasted or smelled something that was not actually there) or delusions (false belief that persists despite evidence proving it is false). The resident required extensive assistance to get out of bed. Review Resident 20's Level I PASRR, dated 08/07/2024, showed the resident had serious mental illness indicators including mood and anxiety disorder. The PASRR indicated a Level II PASRR referral was indicated for recurrent major depressive disorder and mixed anxiety depressive disorder. Review of Resident 20's Level II PASRR invalidation assessment, dated 08/08/2024, showed the reason for invalidation was Resident 20 did have one or more serious mental illness and did not have symptoms of serious mental illness. Review of Resident 20's psychiatric provider visit note dated 02/28/2025 at 10:30 AM, showed the resident was experiencing delusions. Review of Resident 20's psychiatric provider visit note dated 03/15/2025 at 9:30 AM, showed the resident was experiencing delusions. Review of Resident 20's psychiatric provider visit note dated 05/08/2025 at 9:30 AM, showed staff reported the resident was experiencing ongoing persecutory delusions regarding staff. Resident 20 reported they started hallucinating when they had COVID and it was all in their head. Review of Resident 20's psychiatric provider visit note dated 07/18/2025 at 9:45 AM, showed the resident was experiencing increasing delusions per chart review. Review of Resident 20's psychiatric provider visit note dated 08/21/2025 at 9:15 AM, showed delusions were evident on exam. Review of a health status note on 09/08/2025 at 2:21 PM, showed Resident 20 stated they did not need exercise and reported several delusions of walking down the hall by themselves with their walker the previous day. The provider was notified of continued delusions and inconsistencies in memory accuracy. In an interview on 09/23/2025 at 9:21 AM, Resident 20 stated that one time they snatched a cane from the physical therapy (PT) equipment room and walked out of the facility and down the block. They stated they walked down the block and called their brother to tell him they could walk. In an interview on 09/24/2025 at 1:10 PM, Resident 20 stated their family owned a castle in [NAME], a [AGE] year old brewery in Minnesota and that they had been a published author since they were sixteen. They stated their son had junk movers come, and they took their 125 books, [NAME] press badge. Resident 20 stated they had been invited to join Queen [NAME]. Review of the clinical record showed there was no significant change in PASRR referral when Resident 20 began experiencing delusions. In an interview on 09/25/2025 at 10:50 AM, Staff B, Director of Nursing Services (DNS) stated Resident 20 had delusions and at first, they thought they had borderline personality disorder. Staff B stated Resident 20 should have a PASRR revision for the delusions. In a follow up interview on 09/29/2025 at 11:24 AM, Staff B, DNS stated (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Staff D, Social Services Director, confirmed they did not send off the level II PASRR for Resident 20 when they began experiencing delusions. In an interview on 09/29/2025 at 9:50 PM, Staff B, DNS stated they had been unaware of any PASRR issues in the facility. Reference (WAC): 388-97-1975 .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise care plans to accurately reflect resident conditions and needs for 2 of 4 residents (Resident 5 and 82) reviewed for falls and dental. This failed practice had the potential for unmet resident care needs.Findings Included.Review of the facility policy titled, Comprehensive Care Plans and Conferences, reviewed 08/29/2025 documented the resident's care plan must be reviewed after each assessment and revised based on changing goals, preferences and needs of the resident and in response to current interventions.<FALLS>Resident 5 re-admitted to the facility on [DATE] with diagnoses to include pneumonia, falls, and encephalopathy (brain disease that alters brain function).Review of the facility state reporting log documented Resident 5 had unwitnessed falls on 06/16/2025, 06/17/2025, 07/12/2025 and 08/24/2025.Review of the facility incident report dated 06/16/2025 documented Resident 5's bed would be placed in the lowest position as an intervention.Review of the facility incident report dated 06/17/2025 documented Resident 5 was sent to the emergency room.Review of the facility incident report dated 07/12/2025 documented Resident 5 was placed in an area where they would be seen by staff frequently and their room was within sight of the nurse's station.Review of the facility incident report dated 08/24/2025 documented Resident 5 was checked on hourly.Review of Resident 5's care plan showed they were at risk of falling with an intervention to keep their bed in the lowest position.In a joint interview on 09/25/2025 at 1:36 PM with Staff E Assistant Director of Nursing (ADNS), Staff B DNS, Staff E stated when a resident falls, an investigation is completed. Staff E stated they try to determine the cause of the fall and implement interventions. Staff E stated they discussed falls during clinical rounds and updated the care plan. Staff B stated they thought the care plan was updated with the interventions described in the incident reports for Resident 5.<ORAL CARE>Resident 82 admitted to the facility on [DATE] with diagnoses to include history of a stroke and facial weakness.Review of Resident 82's care plan dated 03/19/2025 for activities of daily living had no interventions related to oral care needs.Review of Resident 82's dental note dated 09/11/2025 documented the daily oral hygiene plan was to brush their teeth twice daily.In an interview on 09/29/2025 at 10:21 AM Staff G, Nursing Assistant Certified stated they brush resident's teeth during morning care prior to breakfast. When asked how they know how to care for a resident Staff G stated they review the Kardex (or the care plan.In an interview on 09/29/2025 at 10:36 AM Staff H, Registered Nurse/Unit Care Coordinator stated a resident's oral care needs were documented in their electronic health record and the task was automatically placed in the charting for the nursing aides. Staff H stated Resident 82 required total assistance for oral care. Staff H stated a care plan should be in place to address Resident 5's oral care needs. Staff H stated dental hygienist notes were reviewed after their visit, and any recommendations should have been in Resident 82's care plan.WAC 388-97-1020 (1)(a)(5)(b)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that services provided met professional standards for 2 of 3 (Resident 6 and 70) residents reviewed for professional standards. Resident 6 did not receive prescribed bowel medications when they experienced constipation and Resident 70 had a change in condition that required monitoring and new medication orders that were not documented timely. These failures placed residents at risk of not being appropriately monitored during a change in condition, effectiveness or side effects of new medications, constipation, pain, and a decreased quality of life. Findings included. Review of the facility policy titled Bowel Protocol, revised date 09/16/2024, documented the facility in coordination with the resident's attending practitioner would implement standing orders to address a lack of bowel movement. <RESIDENT 6> Resident 6 readmitted to the facility on [DATE]. Review of Resident 6's bowel elimination record from 09/09/2025 to 09/23/2025, documented the resident had no bowel movement from 09/16/2025 to 09/20/2025 (five days). Review of Resident 6's care plan, initiated date 10/22/2024, documented the goal of the focus area for constipation was to have a normal bowel movement at least every three days, and one of the interventions was to follow the facility's bowel protocol. Review of Resident 6's Medication Administration Record (MAR) dated 09/16/2025 to 09/20/2025, documented the following medications for constipation were ordered; Miralax powder daily as needed for constipation; senna oral tablet every 12 hours as needed for constipation; milk of magnesia suspension as needed for constipation for no bowel movement for three days; Bisacodyl suppository as needed for constipation if no results from milk of magnesia. The MAR showed these medications were not administered. Review of Resident 6's progress notes from 09/16/2025 to 09/20/2025, there was no documentation about the resident's bowel movement assessment or any intervention provided. In a record review and interview on 09/25/2025 at 11:42 AM, Staff B, Director of Nursing Services, stated there was no documentation that nurses provided any intervention about constipation for Resident 6 during 09/16/2025 to 09/20/2025. Staff B stated they expected nurses to follow the bowel protocol and administer medication orders when residents had no bowel movement for three days. <RESIDENT 70> Resident 70 was admitted to the facility on [DATE], with diagnoses to include intestinal adhesions with complete obstruction (bands of scar tissue that cause obstructions in the intestines), spinal stenosis (narrowing of the spine) and radiculopathy (pinched nerve in the spine). In an observation on 09/22/2025 at 9:15 AM, Resident 70 was observed sitting up in their wheelchair at the sink in their room. Resident 70 started to gag and then had emesis (vomited), staff came to assist the resident and Staff J, Registered Nurse (RN) Unit Nurse, was alerted the resident had (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emesis. In an observation on 09/22/2025 at 10:08 AM, Resident 70 was observed lying asleep in bed with an emesis basin positioned in their lap. In an observation on 09/23/2025 at 10:29 AM, Resident 70 was observed lying in bed, asleep with an emesis basin on the overbed table. In an observation and interview on 09/24/2025 at 9:29 AM, Resident 70 was sitting up in bed, with the emesis basin on the over bed table that was within reach. Resident 70 stated they felt nauseated again today and felt dizzy with movements. Resident 70 stated that Staff J, RN Unite Nurse had contacted the Provider related to their nausea and dizziness, but had not heard anything further. In an interview on 09/24/2025 at 2:14 PM, Resident 70 stated they no longer felt nauseated, but still felt dizzy when changing positions to lying or sitting. Resident 70 stated Staff J, RN Unit Nurse, had not returned to give an update related to contacting the Provider. Resident 70 stated they hope it would be soon and maybe they would have to wait until 09/25/2025 to hear back. Review of Resident 70's Medication Administration Record (MAR) dated September 2025, showed the resident received the medication Zofran (anti-nausea medication) which was ordered by the Provider and given as a one-time dose on 09/22/2025. An order for Meclizine (anti-vertigo/dizziness medication) was ordered by the Provider on 09/24/2025 to be given two times daily for seven days. Review of Resident 70's progress notes showed no documentation since 09/19/2025. There was no documentation related to their nausea, emesis, Provider notification, change in condition, or medications that had been ordered. In an interview on 09/25/2025 at 2:34 PM, Staff J, RN Unit Nurse, stated that they had been Resident 70's assigned nurse on 09/22/2025, 09/23/2025, 09/24/2025 and 09/25/2025. Staff J stated they would document the progress notes if a resident had a change in condition, nausea, emesis, new medication orders and if the Provider had been contacted. Staff J stated that it should be documented in an alert note. When asked about Resident 70's lack of documentation, they stated they had just done late entries related to their nausea, emesis, and medication orders and verified they had not documented in their progress notes until today. In an interview on 09/29/2025 at 9:42 AM, Staff B, Director of Nursing Services, stated their expectation was that documentation related to change in condition, new nausea or emesis, Provider contact and new medication orders would be timely. Staff B stated that the resident should have been on alert documentation, meaning every shift should document on the resident's status for at least 72 hours. Reference WAC 388-97-1620(2)(b)(i)(ii)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 2 residents (Resident 86), reviewed for hemodialysis (medical procedure that uses a machine to filter and clean the blood when the kidneys are failing), had consistent, completed and accurate assessments on the facility's dialysis communication form (a form containing vital information about the resident which is sent to the dialysis center for coordination of care and services). This failure placed the resident at risk for medical complications and unmet care needs.Review of facility policy Area of Focus: Dialysis, dated 11/19/2024 documented to initiate the Pre/Post Dialysis Communication Form to be sent to the dialysis clinic with the resident, obtain vital signs of the resident upon return from dialysis and complete the Pre/Post Dialysis Communication Form, and to maintain dialysis transfer form in the resident's medical record.Findings included.<RESIDENT 86>Resident 86 was admitted to the facility on [DATE] with diagnoses to include End Stage Renal (kidney) Disease requiring hemodialysis.Review of the dialysis communication forms showed two completed communication forms in Resident 86's electronic health record (EHR). Resident 86 had a total of five dialysis days during their stay at the facility, revealed three dialysis communication forms were not accounted for. Resident 86 was scheduled for dialysis on Mondays, Wednesdays and Fridays. Dialysis communication forms were not completed on 07/25/2025, 07/28/2025, and 08/1/2025.During a phone interview on 09/25/2025 at 2:57 PM, Staff B, Director of Nursing and Staff K, Licensed Practical Nurse/Unit Care Coordinator, stated that the procedure for dialysis communication forms was that the resident took the forms in a binder to dialysis and was to return to the facility with the forms completed. Staff B confirmed that Resident 86 only had two completed dialysis communication forms and that they would look for the missing ones.In an interview on 09/29/2025 at 10:32 AM Staff B, DNS stated they could not locate the missing dialysis communication forms for Resident 86 and they had requested them from the local dialysis center.Reference: WAC 388-97-1900(1), 6 (a-c)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a dementia care plan that addressed the significant mental and psychosocial needs of the resident, established personalized and achievable goals, and identified interventions to promote a person-centered environment for 1 of 2 residents (Resident 5) reviewed for dementia care. These failures placed residents at risk for unmet psychosocial needs, increased behaviors and decreased quality of life.Findings included .Review of the facility policy titled Care of the Cognitively Impaired (Dementia Care) reviewed 09/02/2025 documented the facility's procedure to provided dementia care services included the following:I . Identify, address, and/or obtain necessary services for the dementia care needs of residents;2. Develop and implement person-centered care plans that include and support the dementia care needs, identified in the comprehensive assessment;3. Develop individualized interventions related to the resident's symptomology and rate of progression (e.g., providing verbal, behavioral, or environmental prompts to assist a resident with dementia in the completion of specific tasks);4. Review and revise care plans that have not been effective and/or when the resident has a change in condition;5. Modify the environment to accommodate resident care needs; or6. Achieve expected improvements or maintain the expected stable rate of decline.<RESIDENT 5>Resident 5 admitted to the facility on [DATE] with diagnoses to include dementia, anxiety and mood disturbance. According to the admission Minimum Data Set (MDS - an assessment tool) assessment, dated 05/31/2025, showed the resident had severe cognitive impairment, no behavioral symptoms, and they had non-Alzheimer's dementia.Review of Resident 5's Care Area Assessment (CAA- an assessment of a specific resident care or medical issue, to holistically analyze the plan of care) dated 07/29/2025 documented resident had severe cognitive impairment but was able to understand consistent, simple, directive sentences. Care plan considerations included reduced distractions, provide Resident 5 with necessary cues, report any change in cognition and/mood to the physician and to anticipate their needs. NA (Not Applicable) was entered for family/resident input and referral to other disciplines related to the care area.Review of Resident 5's September 2025 Medication Administration Records (MARS) showed the facility had administered the antipsychotic medication Quetiapine for three separate orders to include Quetiapine for dementia with behavioral disturbance and Quetiapine for dementia with psychosis (a mental disorder characterized by a disconnection from reality).Review of Resident 5's September 2025 (09/01/2025-09/22/2025) MARS showed behaviors exhibited included:1) A total of 11 instances of verbal/physical aggression across 66 shifts were recorded. 2) A total of 19 instances of tearfulness.3) A total of 27 instances of increased agitation was recorded.Review of Resident 's care plan, showed no documentation the facility had care-planned interventions for how staff were to treat the resident's behaviors of increased agitation, tearfulness, or verbal/physical aggression.In a review of Resident 5's clinical record on 09/29/2024, no documentation was found that the facility had assessed the resident's dementia, how long they'd had dementia, how the resident's dementia manifested in their behaviors, or what had been effective or ineffective in treating the resident's dementia and behaviors in the past.In an interview on 09/26/2025 at 2:00 PM Staff B, Director of Nursing Services, stated Resident 5 was on Quetiapine and it was ineffective because they were still very agitated. Staff B stated Resident 5 was referred to mental health on 9/23/2025 due to their continued agitation and ineffectiveness of Quetiapine. Staff B stated they facility conducted behavioral health meetings as an interdisciplinary team, but detailed notes/assessments were not completed in Resident 5's medical record.In an interview on 09/26/2025 at 2:38 PM Staff L, MDS/Registered Nurse stated they completed the CAA dated 07/29/2025 related to Resident 5's cognition. Staff L stated Resident 5 had family/representatives that could provide input, but information was not gathered because the resident lived alone prior to admission.In an interview on (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/29/2025 at 9:06 AM Staff H, RN/Unit Care Coordinator stated Resident 5's dementia was shown by them talking out, not talking appropriately, speaking to people not there, and they were not situated in reality. Staff H described Resident 5 as speaking in word salad and acting out in aggression verbally and/or physically when attempting to interact with them. Staff H stated Resident 5 lived in their mind and they showed fear with little understanding of what was going on around them.In an interview on 09/29/2025 at 9:13 AM Staff G, Nursing Assistant Certified (NAC), stated Resident 5 had dementia and some days were better for them than others. Staff G stated Resident 5 does not make sense when they are attempting to verbally communicate, their responses are not related to what is happening in the moment. Staff G stated they communicate with Resident 5 slowly, directly, and in a calm manner on their level, making eye contact. Staff G stated they told Resident 5 there was nothing to be upset about, described what they would be doing, calmly and in a soft tone of voice and repeated steps to the care being provided. Staff G stated Resident 5 had hit out and described them as being fearful more than angry. Staff G stated they had access to both the Kardex and the care plan for Resident 5 and neither had directions or interventions on how to care for them when they were striking out or verbally agitated. Staff G stated they know how to care for Resident 5 from training and experience.Refer to WAC 388-97-1060 (1)

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	09/29/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interviews, the facility failed to ensure 1 of 4 medication carts and treatment carts (Pilchuck unit) had secured medications. These failures placed residents at risk for unauthorized access to medications and biologicals, and potential drug misuse.Findings included.<PILCHUCK TREATMENT CART>On 09/25/2025 at 11:12 AM observed the Pilchuck unit treatment cart unlocked. The treatment cart was in front of the Pilchuck nurse's station. All drawers opened and contained creams and ointments in the top drawer. There were several staff, to include two housekeepers and Staff M, Nursing Aide Certified, who walked by the opened treatment cart. Staff N, Registered Nurse (RN), was assigned to Pilchuck unit, was not within sight of the cart and was located on the second hallway of Pilchuck. Staff N was located exiting a resident's room when asked to check the treatment cart. Staff N stated they had not used the treatment cart, but then stated they had, and it had not been open for more than 10-15 minutes. Staff N stated the cart does not always lock when pushed in. Staff N stated the treatment cart should be locked when not attended.<PILCHUCK MEDICATION CART>On 9/29/2025 at 10:20 AM observed keys in the lock for the narcotics box of the Pilchuck unit medication cart, with no nurse in attendance. The medication cart was located outside of the nurse's station pushed up against the wall. Staff G, NAC were charting within the nurse's station. Staff H, RN was in their office, located across from the nurse's station.On 09/29/2025 at 10:22 AM Staff H, RN was requested to observe the Pilchuck Medication Cart and removed the keys from the lock. Staff H stated the key were inside of the lock to the narcotics located within medication cart. Staff H stated the medication cart should always remain locked when unattended by the assigned nurse.In an interview on 09/29/2025 10:28 AM Staff B, Director of Nursing Services stated that all medications carts are expected to be locked when unattended by the nurse assigned.WAC 388-97 -1300 (2), 2340