

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/07/2025
NAME OF PROVIDER OR SUPPLIER  Alderwood Park Health and Rehab of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 2726 Alderwood Avenue Bellingham, WA 98225	

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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035</b></p> <p>Based on observation, interview and record review the facility failed to ensure a physician order was obtained and routine cleaning was provided for a CPAP machine (non-invasive ventilation machine that involves the administration of air usually through the nose by an external device at a predetermined level of pressure) for 1 of 4 residents (Resident 1) reviewed for respiratory care. This failed practice placed the resident at risk of respiratory infection, respiratory distress, lack of restful sleep and diminished quality of life</p> <p>Findings included .</p> <p>Resident 1 admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease with exacerbation (COPD - group of diseases that cause airflow blockage and breathing problems), obstructive sleep apnea (OSA - residents repeatedly stop and star breathing while they sleep) and chronic respiratory failure.</p> <p>Review of Resident 1's progress note dated 11/11/2024, showed Resident 1 had their CPAP machine brought into the facility from their home.</p> <p>Review of Resident 1's Admission Minimum Data Set (MDS-an assessment tool) assessment dated [DATE], showed no CPAP machine was coded.</p> <p>Review of Resident 1's current care plan showed a diagnosis of OSA with no care planned use of a CPAP machine.</p> <p>In an observation and interview on 01/06/2025 at 12:25 PM, Resident 1 had a CPAP machine on their nightstand next to their bed. Resident 1 stated the staff had not cleaned their CPAP machine.</p> <p>Review of Resident 1's Order Summary Report (consolidated view of all orders placed for a resident) printed on 01/07/2025, showed no order for a CPAP machine usage or an order for weekly cleaning.</p> <p>In an interview on 01/07/2025 at 4:14 PM, Staff A, Licensed Practical Nurse/ Resident Care Manager, stated they did not know Resident 1 had a CPAP machine and confirmed the resident did not have an order for the use of a CPAP machine.</p> <p>(continued on next page)</p>

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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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 01/07/2025 at 4:55 PM, Staff B, Registered Nurse, Director of Nursing Services, stated they had found the progress note where Resident 1 had their CPAP brought into the facility. Staff B confirmed there was no order for Resident 1's CPAP machine usage or cleaning.</p> <p>Refer WAC 388-97-1060 (3)(J)(vi)</p>		