STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505098	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shuksan Rehabilitation and Health Care	1530 James Street 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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to consistently provide pharmaceutical services (including procedures that interpret prescriber's orders, reflect current standards of practice, assure the accurate acquiring, dispensing, and administering of all drugs and biologicals) in place to meet the needs of each resident for 3 of 3 residents (Residents 1, 2, and 3) reviewed for medication management. Failure to ensure drugs and biologicals were administered per the physician order and standard of nursing practice placed residents at risk medication errors, unmet health care needs and a decreased quality of life. Findings included. Review of a facility's policy titled, Medication and Flexible Pass Time, dated 10/27/2023, documented to all medications will be passed according to the physician's orders and medication guidelines. The facility had a flexible medication pass in their policy which directed the Licensed Nurse (LN) that all morning mediations must be administered between the hours of 6:00 AM to 11:00 AM, noon medications were administered between 11:00 AM and 2:00 PM, Evening medications were administered between 2:00 PM and 7:00 PM, and hour of sleep (HS) medications were administered between 7:00 PM and 10:00 PM. Routine medications were defined as time specific orders and can be administered up to a hour before and a hour after the specific time. <RESIDENT 1>Review of Resident 1's March 2026 physician orders, included the following orders:-Acetaminophen (APAP - an over-the-counter medication used for mild pain and to reduce fevers) 1000 milligrams (mg) by mouth three times a day for pain, ordered 04/29/2025. Review of the general manufacture guidelines was to have a consistent interval of time between doses such as four to six hours (hrs.).- Levetiracetam (a medication used to treat seizures) 1000 mg by mouth twice a day for seizures. Review of Resident 1's 02/01/2026 through 03/16/2026 MAR, documented the APAP was scheduled three times a day in the morning using the facility's flex time schedule of AM (flex pass -- 6:00 AM - 11:00 AM), at 11:00 AM, and at 8:00 PM. The levetiracetam was scheduled twice a day at AM flex pass and 4:00 PM. Review of Resident 1's Medication Administration Audit Report (MAAR), dated 03/01/2026 through 03/16/2026, documented the APAP and carvedilol were not administered per the physician order or medication general guidelines. For example: 1. On 03/01/2026, the 11:00 AM dose of APAP was given 1:41 PM. This was one hr. 44 minutes outside the allotted 1 hr. administration after a medication was scheduled.2. On 03/04/2026, the 11:00 APAP was given 12:59 PM, 59 minutes late. The levetiracetam was given at 10:29 AM and the scheduled 4:00 PM dose was given at 8:46 PM, three hrs. and 46 minutes late.3. On 03/06/2026, the levetiracetam was given at 10:16 AM and 3:40 PM, five hours and 24 minutes apart from one another.4. On 03/10/2026, the APAP was given at 1:34 PM, 39 minutes late, and the 4:00 PM dose of levetiracetam was given at 8:15 PM, three hours and 15 minutes late. <RESIDENT 2>Review of Resident 2's 02/01/2026 through 03/16/2026 MAR, documented the APAP was scheduled three times a day in the morning using the facility's AM flex pass schedule, at 11:00 AM, and at 8:00 PM. There were four separate orders for carbidopa-levodopa 25-100 mg give two tablets at four different ordered times: 1). One hr. before breakfast scheduled at 6:00 AM. 2). One hr before or after eating scheduled at 11:00 AM, 3). One hr. before or after eating scheduled at 3:30 PM, and 4). One hr. before or after eating scheduled at 8:00 PM. Review of the posted mealtimes documented the assisted dining room served breakfast from 7:50 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER Shuksan Rehabilitation and Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1530 James Street Bellingham, WA 98225	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	AM to 8:00 AM, lunch from 12:30 PM to 12:40 PM, and dinner from 5:30 PM to 5:40 PM. Review of Resident 2's MAAR, dated 02/01/2026 through 03/16/2026, documented the APAP and carbidopa-levodopa were not administered per the physician order or medication general guidelines. For example: 1. The resident was administered their scheduled AM flex pass dose of Carbidopa-levodopa at 5:05 AM on 02/01/2026, at 5:05 AM on 02/10/2026, at 5:42 AM on 02/21/2026, at 5:27 AM on 03/01/2026, and at 5:04 AM on 03/15/2026. The order directed staff to administer the medication one hr. before breakfast, and breakfast was scheduled to be served between 7:50 AM and 8:00 AM. The medications reviewed were not administered per the physician order.2. The resident was administered their 11:00 AM scheduled Carbidopa-levodopa dose at 10:35 AM on 02/01/2026, at 10:40 AM on 02/10/2026, at 11:13 AM on 02/21/2026, at 10:57 AM on 03/05/2026, and at 11:09 AM on 03/15/2026. The scheduled 11:00 AM medication was administered approximately one hr. before the scheduled lunch time of 12:30 PM to 12:40 PM. The order directed staff to administer the medication one hr. before or after the meal.3. The resident was given their scheduled 3:30 PM Carbidopa-levodopa dose at 3:40 PM on 02/01/2026, at 4:20 PM on 02/10/2026, at 3:44 PM on 03/01/2026, and at 4:00 PM on 03/05/2026. The facility scheduled this dose at 3:30 PM, which was scheduled two hrs. prior to the scheduled dinner time of 5:30 PM to 5:40 PM. The order directed staff to administer the medication one hr. before or after the meal.4. The resident was given their scheduled 8:00 PM Carbidopa-levodopa dose at 7:32 PM on 02/01/2026, at 8:48 PM on 02/10/2026, at 8:35 PM on 02/21/2026, at 8:27 AM on 03/01/2026, at 8:08 PM on 03/05/2026, and at 7:50 PM on 03/15/2026. The order directed staff to administer the medication one hr. before or after a meal, dinner was the last scheduled meal.5. The resident's AM dose of APAP was scheduled on the facility's flex pass, the second dose was scheduled at 11:00 AM, and the third dose was scheduled at 8:00 PM. On 02/01/2026 the AM dose was given at 8:20 AM, and the second dose was given at 10:34 AM (the medication was given two hrs. and 14 minutes apart). On 02/10/2026 the AM dose was administered at 8:39 AM and the second dose at 10:40 AM (the medication was given one hr. and 59 minutes apart). On 02/21/2026 the AM dose was administered 8:24 AM, and the second dose at 11:13 AM (the medication was given two hrs. and 39 minutes apart). On 03/05/2026 the AM dose was administered at 8:20 AM, and the second dose at 10:57 AM (the medication was given two hrs. and 37 minutes apart) In an interview on 03/18/2026 at 12:03 PM, Staff C, Registered Nurse (RN), stated Resident 2 preferred their Parkinson's medication at certain times. Staff C stated would give the resident their morning Parkinson's med prior to the resident's breakfast was served in the dining room around 8:00 AM to 8:30 AM, and the noon medication between 11:00 AM and 11:30 AM. Staff C stated lunch was served in the dining room at 12:30 PM. Staff C they spread the administration of the APAP out as much as they could so the medication was not give close together. <RESIDENT 3>Review of resident 3's Order Summary Report Active Orders as of 03/18/2026, included the following orders:- APAP 1000 mg by mouth three times a day for pain, ordered 12/15/2025.- Carvedilol (a high blood pressure medication) tablet 6.25 mg twice daily for heart failure and high blood pressure, give after meals, ordered 12/16/2025. Review of Resident 3's 02/01/2026 through 03/16/2026 MAR, documented the APAP was scheduled three times a day in the morning using the facility's flex pass schedule, at 11:00 AM, and at 8:00 PM. The carvedilol was scheduled twice a day at AM (flex pass) and at 4:00 PM, which was not scheduled to give after a meal per the physician's order. Review of Resident 3's MAAR, dated 02/01/2026 through 03/16/2026, documented the APAP and carvedilol were not administered per the physician order or medication general guidelines. For example: 1. On 02/04/2026, the resident was administered the AM APAP at 10:14 AM and the 11:00 AM dose at 1:39 PM. The medication was administered for three hours (hrs.) and 25 minutes after the 10:14 AM dose and was given outside the allotted 1 hr. administration after a medication was scheduled.2. On 02/19/2026, the resident received the AM APAP at 7:54 AM, the 11:00 AM dose at 1:32 PM (one and a half hrs. late), and 7:06 PM. The carvedilol AM dose was given at 11:15 AM, and the 4:00 PM dose at 5:30 PM, a half hr. late.3. On 03/06/2026, the resident received the AM APAP at 11:32 (a half of an hr. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	late), and the 11:00 AM dose at 11:59 AM. The resident was given 2000 mg of APAP 27 minutes apart. The carvedilol AM dose was given at 11:33 AM (a half hr. late) and the 4:00 PM dose at 6:54 PM (one hr. and 54 minutes late). Review of Resident 3's physician order dated 02/10/2026, documented Fosfomycin Tromethamine (an antibiotic) 1 packet every 10 days in the evening urinary tract infection prophylaxis (to prevent onset of spread of disease before it occurs), give with breakfast. Review of Resident 3's 02/01/2026 through 03/15/2026, documented the Fosfomycin Tromethamine was scheduled for 4:00 PM. Review of Resident 3's Electronic Medical Record (EMR), showed no documentation to clarify the physician order to either administer the Fosfomycin Tromethamine in the evening or with breakfast. On 03/18/2026 at 4:45 PM, an interview was conducted with Staff A, Administrator, and Staff B, Registered Nurse (RN)/Director of Nursing Services. Staff B was asked about the conflicting information regarding Resident 3's Fosfomycin Tromethamine and the times the resident's APAP, a three time a day medication, and carvedilol, a twice a day medication, was scheduled to be administered. Staff B stated the Fosfomycin Tromethamine order was written weird and would clarify the order. <INTERVIEWS>In an interview on 03/16/2026 at 10:01 AM, Staff D Licensed Practical Nurse (LPN), stated they had the ability to give residents their morning AM medications between 6:00 AM and 11:00 AM. In an interview on 03/18/2026 at 10:53 AM, Staff F, LPN, stated the flex medication time meant they have from 6:00 AM to 11:00 AM to administer the medication. Staff F was asked if a twice a day medication was scheduled in the AM (flex time) and at 4:00 PM, how would they know what time to administer the 4:00 PM dose, Staff F replied they have flex time. Staff F stated if the medication was scheduled three times a day, they would administer the morning dose around 8:00 AM, and then ensure the next dose was given with enough time in between the two. In an interview on 03/18/2026 at 12:03 PM, Staff C, RN, stated medication flex time on the MAR meant medications were given from 6:00 AM to 11:00 AM. Staff C some medications had specific times they were to be administered. Staff C stated when a medication was scheduled three times a day, they tried to separate the time, so the medications were not given to close together. In an interview on 03/18/2026 at 1:33 AM, Staff B was asked regarding when a medication was ordered twice a day or three times a day how would the nurses know when the medication was administered to the resident. For example, if APAP was ordered three times a day, and the MAR was set up to administer the medication at AM (from 6:00 AM to 11:00 AM), at 11:00 AM, and at 8:00 PM, how would the LN know the exact time the AM dose was given before giving the 11:00 AM dose. Staff B stated it was documented on the MAR. Resident 3's March 2026 MAR was reviewed, and Staff B recognized that the MAR does not document the exact time the APAP was given. The ability to see when exact time when a medication was administered was by running a report. Reference WAC 388-97-1300(1)(b)(i-ii)(c)(i)(3)(a)(4)(d)

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NAME OF PROVIDER OR SUPPLIER Shuksan Rehabilitation and Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1530 James Street Bellingham, WA 98225	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observation, interview and record review the facility failed to have a functioning medication administration system to ensure the licensed nurse (LN) followed professional standards, medications were administered per the providers orders, medications were not omitted, and failed to follow facility policy regarding the ten rights to medication administration for 7 of 8 sampled residents (Residents 3, 11, 5, 6, 9, 8, and 10) reviewed for mediation administration. These failures placed residents at risk for potential negative adverse effects to mediations, complications, not receiving their medications as prescribed by the physician and a decline in their health status. Findings included. Review of a facility's policy titled, Medication and Flexible Pass Time, dated 10/27/2023, documented to all medications will be passed according to the physician's orders, and the nurse will follow the 10 rights to medication administration (note the policy did not indicate what the 10 rights to medication administration were). The facility had a flexible medication pass in their policy which directed the LN that all morning mediations must be administered between the hours of 6:00 AM to 11:00 AM. Review of the facility's policy titled, Medication Incident's and Errors, undated, documented a medication incident or error included an omission which was any dose of a medication that is not delivered to the resident. <MEDICATION ERROR>Review of Resident 3's physician order, dated 02/10/2026, documented the resident received one ten-gram packet of Fosfomycin Tromethamine (an antibiotic) every 10 days for urinary tract infection prophylaxis (to prevent onset of spread of disease before it occurs). Review of Resident 3's 02/01/2026 to 03/16/2026 Medication Administration Records (MAR's) documented the resident received the Fosfomycin Tromethamine on 02/10/2026, on 02/20/2026 a 9 was coded on the MAR, which directed staff to see the nurses progress notes. The next dose was administered on 03/02/2026, 20 days since the last dose of the medication was administered. Review of Resident 3's progress note, dated 02/19/2026, documented the LN phoned the pharmacy to inquire about the Fosfomycin Tromethamine. The LN documented that the pharmacy would send as much of the medication as their insurance would permit. On 03/18/2026 at 4:45 PM, an interview was conducted with Staff A, Administrator, and Staff B, RN/Director of Nursing Services. When asked about the missed dose of the Fosfomycin Tromethamine medication, both staff members were not aware of the omitted dose. <MEDICATION OBSERVATION>In a continuous observation on 03/16/2026 starting at 10:01 AM, Staff D, Licensed Practical Nurse (LPN), prepared six morning medications for Resident 11 which included Tylenol, duloxetine (an anti-depressant), a thyroid medication, a stimulant laxative, a medication used for gout, and a medication to treat an autoimmune (where the body's immune system attacks its own healthy cells/tissues/organs) disease. As Staff D prepared the resident's medications, they placed the resident's duloxetine (two tabs) in a plastic medication cup and prepared the remaining medications in a separate plastic medication cup. Staff D did not check the expiration date on each medication prepared. Staff D entered Resident 11's room, without knocking, addressing them by their first name (did not ask them for their name), and handed them the duloxetine. The resident asked what this medication was, Staff D said it was their duloxetine and Tylenol, the resident did not understand what was said and asked again, Staff D repeated what they stated, the resident still did not understand and asked again, Staff D stated it was their Tylenol. The resident took these two pills. Staff D handed the resident the second cup of medications, the resident asked what the medications were and Staff D stated it was their Tylenol. On 03/16/2026 at 10:33 AM, Staff D was observed to prepare Resident 5's medications. Staff D grabbed a bottle of acidophiles (a type of good bacteria probiotic) from the top drawer where the over the counter/house supply medications were kept. Staff D removed one pill from the bottle, went to put the medication away, and this surveyor asked for the medication bottle to check the expiration date. Staff D was asked if they checked expiration dates on medications and stated that they do not because the medication cart was filled at the beginning of the new year and proceeded with preparing the next five medications (an aspirin, vitamin D, iron, a medication for acid reflux, and a pain (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication). On 03/16/2026 at 10:38 AM, Staff D entered Resident 5's room without knocking, handed the resident a cup of water, did not verify the resident's name, and began to administer their medications one by one using a spoon. Each time Staff D gave the resident a pill, they stated, this is your medication, and did not inform the resident the name or what the medication was used for. On 03/16/2026 at 10:45 AM, the continuous medication observation ended. In an interview on 03/18/2026 at 1:40 PM, Staff C, Registered Nurse (RN), was asked what the facility's ten rights to medication administration were. Staff C stated five rights (the right time, documentation, route, dosage and the right resident) of medication administration. In an interview on 03/18/2026 at 1:57 PM, Staff F, LPN, was asked what the facility's 10 rights to medication administration were per. Staff F stated six rights (the right to refuse, right way to five the medication, right mediation, dosage, time, and the right resident) of medication administration. In an interview on 03/18/2026 at 2:45 PM, Staff G, RN, was asked what the facility's 10 rights to medication administration were. Staff G stated six rights (right documentation, to refuse, dosage, time, route, and resident) of medication administration. On 03/18/2026 at 3:48 PM, an interview was conducted with Staff A and Staff B. Staff B stated they would have to follow up on what were the facility's 10 rights to medication administration. <MEDICATIONS OMITTED ON 03/16/2026><RESIDENT 5>A review on 03/18/2026 at 12:10 PM, Resident 5's Medication Administration Records (MAR's), dated 03/15/2026, showed no documentation the resident received their 8:00 PM medications. Scheduled medications not documented as given were a medication to lower their cholesterol, a pain medication, and a probiotic. <RESIDENT 6>A review on 03/18/2026 at 12:15 PM, Resident 6's MAR's, dated 03/15/2026, showed no documentation the resident received their 8:00 PM medications. Scheduled medications not documented as given were an anti-anxiety and a medication to treat an overactive bladder. <RESIDENT 9>A review on 03/18/2026 at 12:25 PM, Resident 9's MAR's, dated 03/15/2026, showed no documentation the resident received the following scheduled 8:00 PM medications: a medication to lower their cholesterol, a stimulant laxative, an antipsychotic, and a blood pressure medication. <RESIDENT 8>A review on 03/18/2026 at 12:34 PM, Resident 8's MAR's, dated 03/15/2026, showed no documentation the resident received the following scheduled 8:00 PM medications: an antiviral medication, eye drops for glaucoma, a medication to lower their cholesterol, and a medication to treat nerve pain. <RESIDENT 10>A review on 03/18/2026 at 12:43 PM, Resident 10's MAR's, 03/15/2026, showed no documentation a medication to treat an overactive bladder was administered or the resident's blood sugar was monitored at 8:00 PM. On 03/18/2026 at 5:07 PM, an interview was conducted with Staff A and Staff B. Both staff stated no when asked if there had been any medication errors reported since the surveyor entered on 03/16/2026. Staff B stated they passed residents medications on the PM shift on 03/15/2026. Staff B stated they thought they had administered the residents' hour of sleep (HS) and/or 8:00 PM medications when they worked. Both staff were made aware of the above medications were omitted for Residents 5, 6, 9, 8, and 10 and the potential for all HS and/or 8:00 PM medications were omitted for residents when they worked the PM shift on 03/15/2026. Staff A and Staff B were notified only a small sample of the residents who resided on the hallways Staff B had worked had been sampled for the omission of HS and/or 8:00 PM medication administration. Both staff stated they would investigate this. Reference WAC 388-97-1060(3)(k)(iii)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a treatment cart was locked/secured in the absence of a nurse for 1 of 2 treatment carts ([NAME] Lane treatment cart) observed, and proper labeling and storing of medications for 1 of 3 medication cart (Artist Lane medication cart) reviewed. These failures placed residents at risk of having unintended access and potential for ingestion of medications and biologicals that should be stored and locked. Findings included. Review of a facility policy titled, Medication and Flexible Pass Time, dated 10/27/2023, documented to keep the medication cart locked at all times.<[NAME] LANE TREATMENT CART>On 03/16/2026 at 8:07 AM, the [NAME] Lane treatment cart was observed to be unlocked. Staff D, Licensed Practical Nurse (LPN), was observed down the hallway at a medication cart. On 03/16/2026 at 8:12 AM, [NAME] Lane's treatment cart was observed to be unlocked. There were unidentified staff walking by the unlocked cart going to the dining room. On 03/16/2026 at 8:18 AM, Staff D stated they were the nurse responsible for the treatment cart located at the end of the hallway. Staff D was informed the cart was unlocked and stated it was to be locked. The treatment cart was observed with Staff D. In the top drawer was an open Derma Fungal cream (a medication used to treat superficial skin infections) and a bottle of simple odor eliminator, on the back of both items under the Warning section stated to keep out of reach of children. Two other drawers were opened and various treatments, ointments, and creams were present that could be easily removed from the unlocked cart. Staff D was asked about the treatment cart being unlocked, they responded the cart should not have been unlocked and the prior shift must not have locked the cart. Staff D clarified the prior shift goes off duty at 6:00 AM. <ARTISTS LANE MEDICATION CART>On 03/16/2026 at 8:38 AM, there was a small open tube of refresh eye drops (lubricant artificial tears eye drops used for external use only) placed in a small plastic medication cup on top of the medication cart. Staff C, Registered Nurse (RN), was approximately 10 feet [NAME] from the cart at a second medication cart preparing medications. Staff B acknowledged the eye drops were not to be there, stated the resident had refused their eye drops, and would take care of the drops immediately. In an interview on 03/16/2026 at 3:36 PM, Staff A, Administrator, was informed about the [NAME] Lane treatment cart and the eye drops left unattended on the Artist Lane medication cart with no licensed nurse present at the cart, Staff A stated that should not have occurred. In an interview on 03/16/2026 at 3:44 PM, Staff B, RN/Director of Nursing services, stated medication and treatment carts should not be left unlocked and medications should not have been left on top of the medication cart unattended. Reference WAC 388-97-1300(2)

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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. Based on observation, interview, and record review, the facility failed to follow standard infection control practices by not cleaning and disinfecting resident care equipment to include vital sign (VS) equipment and a glucometer (a small portable medical device used to measure the concentration of sugar in the blood) machine per the manufactures guidelines for 1 of 1 residents (Resident 5), consistently implement hand hygiene when preparing resident medications for 2 of 2 residents (Residents 11 and 5), placing on and removing Personal Protective Equipment (PPE) for 1 of 1 nurses (Staff D) observed for medication administration. These failures placed residents at risk of obtaining infections and a decreased quality of life. Findings included. Review of the facility's handouts for Donning (placing on) PPE, and Removing PPE, both handouts were from the Infection Prevention Manual for Long Term Care revised on 02/2018, documented on the Donning PPE hand out under Safe Work Practices to perform hand hygiene. Review of the Removing PPE hand out, documented to remove PPE at the doorway before leaving a resident's room. Additionally, under the Hand Hygiene section, the handout directed staff to perform hand hygiene immediately after removing all PPE. <MEDICATON ADMINISTRATION OBSERVATION>In a continuous observation on 03/16/2026 starting at 10:01 AM, Staff D, Licensed Practical Nurse, was observed to prepare Resident 11's medications without performing hand hygiene. Staff D placed two pills in a small (30 cubic centimeter) clear medication cup and five additional medications in a second similar plastic cup. Staff D was observed to handle both medication cups in the palm of their contaminated hands and enter Resident 11's room. After Resident 11 took their medications by placing the medication cup to their mouth and drinking some water, Staff D then threw the two medication cups in the garbage can, exited the room, went back to their medication cart to document the medications were administered, did not perform hand hygiene and proceeded to Resident 3's room. At 10:17 AM, Staff D was then observed to perform hand hygiene before they entered Resident 3's room. At 10:17 AM, Staff D was then observed to perform hand hygiene before they entered Resident 3's room. On 03/16/2026 at 10:24 AM, Staff D was observed to perform hand hygiene, place on a gown and gloves and enter Resident 5's room that had a sign on the wall outside of their room to place on a gown and gloves during high contact resident care. Staff D checked the resident's blood glucose, exited the room with their PPE in place, walked down the hall about eight feet, discarded an item in the sharps container attached to the medication cart, placed the glucometer directly on top of the cart, removed their gown and gloves in the hallway, placed their PPE in a trash can, went back to the medication cart to put the glucometer away, and did not perform any hand hygiene. Staff D then placed on a gown and gloves without performing hand hygiene, enter Resident 5's room with the VS cart. The VS cart was observed to have a blood pressure cuff, a pulse oximeter (a noninvasive medical device that measures how efficiently the blood is carrying oxygen), and a thermometer. At 10:30 AM, Staff D exited Resident 5's room with the VS cart, walked down the hallway with their PPE in place, placed the VS cart next to the medication cart, walked back to the trash can in the hallway, removed their PPE, and proceeded to prepare Resident 5's medications without performing hand hygiene or sanitizing the VS cart nor the items contained in the VS cart. On 03/16/2026 at 10:38 AM, after Staff D had prepared Resident 5's medications without performing hand hygiene, walked to Resident 5's room, performed hand hygiene, placed on a gown and gloves, and entered Resident 5's room. After Staff D administered Resident 5's medications, they exited the room with their PPE in place, walked down to the trash can in the hallway, removed their PPE, placed their PPE in the trash can, walked back to their medication cart, and without performing hand hygiene started to document in the electronic medical record. On 03/16/2026 at 3:36 AM, Staff A, Administrator, was asked about the lack of trash cans inside resident rooms who were on any type of precautions and required PPE. Staff A stated that was unusual and would speak with Staff H, Infection Preventionist Nurse, when they work next about these concerns. <GLUCOMETER CLEANING>Review of the glucometer manufactures maintenance regarding cleaning and disinfecting (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER Shuksan Rehabilitation and Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1530 James Street Bellingham, WA 98225	

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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	guidelines, under option 2 directed that the glucometer be cleaned by wiping the outside of the meter with a lint-free cloth dampened with soap and water or with isopropyl alcohol (70-80%) On 03/16/2026 at 10:24 AM, Staff D was observed to gather Resident 5's glucometer from a small black storage bag and entered Resident 5's room. Staff D was observed to check the resident's blood sugar, informed the resident of the results, exited the room, and placed the glucometer directly on top of the medication cart. Staff D was observed to pick up the dirty glucometer, place it back into the storage bag, opened the medication cart drawer, store the black bag, and closed the drawer without cleaning the device first. Staff D began to prepare Resident 5's morning medications without performing hand hygiene. In an interview on 03/16/2026 at 11:02 AM, Staff D stated they were to clean the glucometer after use by using an alcohol pad. Staff D was asked why this was not done after Resident 5's glucometer was used and prior to putting away in the black bag. Staff D did not respond. On 03/18/2026 at 5:07 PM, an interview was conducted with Staff A and Staff B. Staff B stated they followed the manufactures guidelines regarding how to clean the glucometer. Staff A stated they have one type of glucometer, and each resident had their own. Reference WAC 388-97-1320(1)(a)(c)(5)(b)(c)(e)