

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Rock Hill Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observations, interviews, and record review, the facility failed to protect the resident's right to be free from physical abuse by an alleged unidentified male staff member for 1 of 3 sampled residents (Resident 1) reviewed for abuse. Resident 1 alleged an unidentified male staff member twisted their hand and caused bruising, swelling and pain to their left pinky. The failure to protect the resident from an unidentified staff member placed the resident at risk for potential ongoing abuse and a diminished quality of life. Findings included . Review of the facility policy titled, Abuse, revised on 10/20/2022, documented the organization recognizes and respects that each resident has the right to be free from abuse. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Resident 1 admitted to the facility with a diagnosis to include a fracture on both sides of their sacrum (a large bone at the base of the spine and sits between the hip bones and above the tailbone). Review of Resident 1's admission Minimum Data Set (an assessment tool) assessment, dated 07/06/2026, documented the resident had moderate cognitive impairment. Review of Resident 1's progress note, dated 07/05/2026 at 1:24 PM, Staff D, Registered Nurse (RN), documented Staff C, RN, reported to them around noon that a guy had come into the resident's room last night and twisted their left hand. Staff D documented Resident 1 had a 6 centimeter (cm) long bruise to the left pinky finger, an 11 cm bruise to the side of the left hand, and a 3.5 cm width by 5 cm length by approximately 1.25 cm diameter bruise on the back of the left hand that included below the left thumb. Review of a facility incident investigation, dated 07/05/2026, documented Resident 1 made an allegation of physical abuse from an unidentified male that resulted in Resident 1's left pinky finger and outer hand being bruised, swollen, and caused discomfort. Review of an x-ray result, dated 07/06/2026, documented Resident 1 had osteoarthritis (a joint disease) in their left hand and there was no fracture. Review of Resident 1's psychosocial well-being care plan, dated 07/08/2026, the resident was at risk for an alteration in their well-being due to an allegation of abuse. An intervention included to give the resident the opportunity to discuss their positive and negative feelings regarding nursing facility placement, dated 07/08/2026. In an interview on 07/14/2026 at 10:42 AM, Staff D stated they worked on 07/05/2026 when Resident 1 made an allegation of physical abuse. Staff D stated Staff C reported on 07/05/2026 around noon that Resident 1 made an allegation of physical abuse. Staff D assessed the resident's left hand and observed a bruise on their left pinky finger and on the outer part of the left hand. The resident complained of pain in this area. Staff D administered oxycodone (a narcotic pain medication) to the resident, called the on-call physician, and obtained an order to x-ray the resident's left hand. In an interview on 07/14/2026 at 11:02 AM, Staff C stated on 07/05/2026 around noon Resident 1's family member asked what happened to the resident's left hand. Staff C observed a faint bruise and swelling to Resident 1's left pinky finger and outer left hand. When Staff C asked Resident 1 what had (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occurred, the resident stated an unidentified male came into their room the prior night and twisted their left hand when the male attempted to take the resident's dog away from them. Staff C immediately reported the allegation to the resident's primary nurse, Staff D. In an interview and observation on 07/14/2026 at 12:58 PM, Resident 1 was observed sitting in a recliner visiting with a family member. The resident's left pinky finger was observed to have a faint bruise along the side and top of the finger, and the finger was slightly swollen. When asked what happened, the resident stated that a guy came into her room one night and attempted to remove their dog from the room. The unidentified person grabbed their left hand (the resident then took their right hand and grabbed the middle, ring, and pinky fingers and made a twisting motion) and twisted their hand. Resident 1 stated they threw a glass of water on the guy and they left the room. In an interview on 07/15/2026 at 3:37 PM, Staff A, Administrator, was asked regarding Resident 1's abuse allegation and identifying how the injury of unknown origin occurred. Staff A stated they would ask Staff B, RN/Director of Nursing Services, in the morning. A follow up phone call was held on 07/16/2026 at 11:35 AM with Staff A, Staff C, and Staff E, Licensed Practical Nurse (LPN)/Resident Care Manager. Staff A stated Staff B was not available to be interviewed. When asked how Resident 1's physical abuse allegation was ruled out, Staff A, Staff C and Staff E could not state how abuse was ruled out. Cross Reference with CFR 483.12(c)(2)(3) - F610 - Investigate/Prevent/Correct Alleged Violation Refer to WAC 388-97-0640(1)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview and record review, the facility failed to thoroughly investigate allegations of abuse including an injury of unknown origin and of an injury to an area not vulnerable to trauma for 1 of 3 sampled residents (Resident 1) reviewed for allegations of abuse. The failure not to conduct a thorough investigation, and correct actual or potential alleged violations left residents at risk for unidentified and/or repeated incidents, and a decreased quality of life. Findings included. Review of the facility policy titled, Abuse, revised on 10/20/2022, documented the facility is committed to developing and operationalizing policies and procedures that included protection of residents and for the preventions, identification, and investigation of abuse and neglect. The facility will review and investigate all allegations or observations of abuse. Review of a facility incident investigation dated 07/05/2026 at 1:05 PM, Staff D, Registered Nurse (RN), documented Resident 1 reported to Staff C, RN, the resident made an allegation of physical abuse. When Staff D interviewed the resident, they stated some guy came last night and twisted their left hand. The resident's left hand was assessed, and a bruise was present on the left little finger, left side of the hand, back of left hand, and below the left thumb. The resident complained of pain and tenderness when their left hand was touched. Staff D documented in the morning of 07/05/2026, when they took Resident 1's blood pressure on the left arm the resident did not complain of any pain nor was there any bruising observed on their left pinky finger and/or hand. Review of Resident 1's incident investigation, dated 07/05/2026, documented the resident had hallucinated about their dog, was confused who staff were and why they would not bring them their dog. The resident made an allegation of physical abuse from an unidentified male who came into their room last night, attempted to remove the resident's dog from their lap, and in the process twisted Resident 1's left hand causing an injury. The resident's left hand was assessed and noted to have bruising on the left pinky finger and outer part of their hand, swelling and discomfort. The facility summary documented abuse and neglect were ruled out, and it was reasonable to conclude the resident was having hallucinations as charted, and the resident revealed no care issues or physical abuse. Review of Staff C's witness statement, dated 07/05/2026, documented Resident 1 made an allegation of abuse on 07/05/2026 around noon that an unidentified man came into their room last night and attempted to take the resident dog from them. The unidentified male grabbed and twisted Resident 1's left hand when they did not relinquish their dog to the unidentified male. The resident could not give a description of the man except for their clothing. Staff C reported the allegation to Resident 1's primary nurse, Staff D. Review of Staff H, Nursing Assistant Certified (NAC), witness statement, dated 07/05/2026 at 2:45 PM, documented they had worked the evening and night shift on 07/04/2026 and had not entered Resident 1's room or heard of any concerns. Review of Staff G, NAC, witness statement, dated 07/07/2026, documented they were assigned to Resident 1 on 07/04/2026. Staff G documented every time they went into the room another staff member was with them. There was no documentation about whether the resident had bruise, pain or swellings on their left hand. Review of Staff F, NAC, witness statement, dated 07/09/2026, documented they did not work with Resident 1 on the night of 07/04/2026. There were no other witness statements to review. In an interview on 07/14/2026 at 10:42 AM, Staff D stated they were Resident 1's primary nurse on 07/05/2026, day shift. Staff C was in the resident's room earlier on 07/05/2026 to take their blood pressure (B/P). They assisted Resident 1 to sit at the edge of the bed and placed a B/P cuff on their left arm. Staff C stated they did not notice any bruising to their left hand, the resident did not complain of any pain to their left hand, nor did they bring up any allegation of an unidentified male being in their room last night. In an interview on 07/14/2026 at (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:02 AM, Staff C stated they were working as a NAC and were assigned to Resident 1 on the day shift on 07/05/2026. Staff C stated around 10:30 AM they provided care to Resident 1 and they had no concerns, no complaints of pain, and there was no bruise observed on their left hand. Staff C stated when they returned to care for Resident 1 around noon, was when the resident's family inquired what happened to the resident left hand. Resident 1 proceeded to state that an unidentified male had entered their room last night and twisted their left hand when the resident would not give the unidentified male the resident's dog. In an interview and observation on 07/14/2026 at 12:58 PM, Resident 1 was observed sitting in a recliner visiting with a family member. The resident's left pinky finger was observed to have a faint bruise along the side and top of the finger, and the finger was slightly swollen. When asked what happened, the resident stated that a guy came into her room one night and attempted to remove their dog from them. The resident stated when they would not hand over their dog, the unidentified male grabbed their left hand and twisted it. When asked if they could describe the male, Resident 1 stated they were white and were in their late 40's - 50's. Resident 1 stated they had not seen the male since the incident. On 07/14/2026 at 1:13 PM, Staff B, RN/Director of Nursing Services, was updated Resident 1 identified the unidentified as being a white male in their late 40's to 50. In an interview on 07/14/2026 at 2:31 PM, Staff G stated they worked with Resident 1 on 07/04/2026 and 07/05/2026. Staff G stated at no time did the resident complain of any pain in their left hand, they did not observe any bruising, and the resident had not reported any allegation of physical abuse to them. In an interview on 07/15/2026 at 3:37 PM, Staff A, Administrator, was asked regarding Resident 1's abuse allegation and the lack of the facility investigator identifying how the injury of unknown origin occurred on Resident 1 left hand. Staff A stated they had informed Staff B regarding how the information that was reported to them, on the sequence of events when the resident was provided care that morning there was no mention of the allegation and their left hand was not injured. Resident 1 made the allegation of physical abuse around noon on 07/05/2026. Staff A stated they would ask Staff B, RN/Director of Nursing Services, in the morning and follow up with the compliant investigator. A follow up phone meeting was held on 07/16/206 at 11:35 AM with Staff A, Staff C, and Staff E, Licensed Practical Nurse (LPN)/Resident Care Manager. Staff A stated Staff B was not available to be interviewed. Resident 1's abuse allegation investigation, dated 07/05/226, was reviewed with Staff A, Staff C, and Staff E. The staff were asked, based on the summary of the investigation, how the resident hallucinating a factor contributing to their left-hand injury and no other factors were investigated. Staff A stated they were aware through talking with Staff C and Staff D, Resident 1 did not have any concerns the morning of 07/05/2026. Staff A, Staff C, and Staff E acknowledge Resident 1's allegation of abuse was not thorough. Refer to WAC 388-97-0640(6)(a)(b)		