| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505140 | A. Building<br>B. Wing | 04/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Highland Health and Rehabilitation of Cascadia | 2400 Samish Way<br>Bellingham, WA 98229 |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035<br><br>Based on observation, interview, and record review, the facility failed to ensure behavioral health needs were identified and met for 1 of 1 resident (Resident 2) reviewed for behavioral-emotional health. Failure to identify behavioral health needs and utilize person-centered interventions developed by an interdisciplinary team (IDT) placed residents with behavioral needs, at risk for unidentified behavior triggers, unmet behavioral needs, refusal of care, self-neglect, lack of behavioral services and support, loss of dignity, and diminished quality of life.<br><br>Findings included .<br><br>Resident 2 was admitted to the facility on [DATE] with diagnoses to include hip fracture, leukemia, chronic pain, anxiety disorder, and adjustment disorder with depressed mood.<br><br>Review of the Discharge Summary dated 04/03/2024, for the hospital stay from 03/24/2024 through 04/03/2024, showed Resident 2 had significant post operative disorientation, agitation, somnolence, and confusion. The summary noted this improved with the reduction of polypharmacy (taking five or more regular medications). The discharge exam showed Resident 2's mental status was alert and oriented to person, place, and time. The psychiatric section showed Resident 2's mood and affect were not dysphoric (very unhappy, uneasy, or dissatisfied). Resident 2's behavior was not inappropriate, and they did not exhibit disordered thought content.<br><br>Review of the Nursing Clinical Evaluation Summary progress note, dated 04/03/2023, showed Resident 2 was pleasantly confused. Resident 2 had some post-op delirium that was gradually improving. Resident 2 rated their pain at an eight out of ten, on the zero (no pain) to ten (severe pain) pain scale.<br><br>Review of the Nursing Health Status Note, dated 04/04/2024, showed Resident 2 was confused, alert and oriented to only self. Resident 2 was continuously taking off their clothing and incontinent brief on the night shift.<br><br>Review of Collateral Contact (CC) 3, Medical Doctor, progress note, dated 04/05/2024, showed Resident 2 had post operative delirium and the staff noted Resident 2's mentation waxed and waned. The physical exam section noted the resident was alert and oriented x 4 (person, place, time, and event), and mood and affect were appropriate. No behavioral health symptoms were addressed.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Admission Minimum Data Set (an assessment tool) assessment, dated 04/09/2024, showed the mood assessment had a total severity score of two indicating minimal level of depression. Resident 2's behaviors of verbal and other behavioral symptoms occurred on one to three days of the seven-day assessment period and no rejection of care was coded.<br><br>Review of the Behavioral Symptoms Care Area Assessment (CAA - a systematic process to interpret the triggered information from the MDS assessment to assess the potential problem and determine if the area should be care planned), dated 04/09/2024, showed Resident 2 had behaviors toward staff and behavior monitoring was in place. Long standing mental health problems associated with behavioral disturbance such as anxiety disorder, depressive disorder, pain, diabetes, and infection were noted that could cause behavior problems. Resident 2's behavioral symptoms were noted to be addressed in Resident 2's care plan to minimize risks.<br><br>Review of the Psychotropic Drug Use CAA, dated 04/09/2024, showed Resident 2 received two antidepressants. The resident's diagnoses were noted to be depression, anxiety, and adjustment disorder (excessive reactions to stress that involve negative thoughts, strong emotions, and changes in behavior). Resident 2's psychotropic drug use would be addressed in the care plan due to the resident's diagnoses and treatments and the resident's behaviors were monitored.<br><br>Review of Resident 2's current Care Plan showed the following focused behavioral health and psychotropic medication problems and associated interventions:<br><br>Use of antidepressant medication related to depression and adjustment disorder initiated on 04/09/2024. Interventions included to administer the physician ordered medication and monitor and document effectiveness and potential side effects.<br><br>Use of hypnotic medication or sleep enhancing supplements related to sleep apnea initiated on 04/09/2024. Interventions included to use non-pharmacological person-centered interventions and to give medications as ordered and monitor/document effectiveness and potential side effects.<br><br>Resident 2 had impaired cognition related to post surgical delirium evidence by yelling out, resistive to care, impulsive and disrobing initiated on 04/10/2024. Interventions included to use Resident 2's preferred name, reduce any distractions, keep the resident's routine consistent, monitor/document and report any changes to the physician, specifically changes in decision making, memory, recall, awareness, difficulty understanding others, level of consciousness and mental status. Use of a white board to reorient Resident 2 to place and time.<br><br>Review of Resident 2's April 2024 Medication Administration Record and Treatment Administration Record, dated 04/03/2024 through 04/25/2024, showed the following:<br><br><Psychotropic and Narcotic Medications and Monitoring><br><br>Trazadone (an antidepressant and sedative) 100 mg daily for adjustment disorder.<br><br>Bupropion hydrochloride (HCL), an antidepressant, 75 mg two times daily for adjustment disorder with depressive mood.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prochlorperazine (an antiemetic and antipsychotic) 5 mg every six hours as needed for nausea- two doses.<br><br>Oxycodone HCl (a narcotic) 5 mg every four hours as needed for pain due to hip fracture and surgery - 77 doses.<br><br>Non-Pharmacological interventions prior to as needed pain medications - zero interventions were documented.<br><br>Observed for side effects of psych/behavioral medication - 13 episodes of restless agitation, no indication the provider was notified.<br><br>Observed for side effects of opioid medication - 12 episodes of restless agitation no indication the provider was notified.<br><br><Behavioral Health Monitoring began on 04/08/2024><br><br>2 days of depressive statements.<br><br>12 days of refusal of care.<br><br>8 days of withdrawal with activities.<br><br>4 days person centered interventions were effective.<br><br>Review of Resident 2's Nursing Assistant Certified (NAC) documentation report, from 04/03/2024 through 04/29/2024, showed the following:<br><br>11 episodes of depressive statements.<br><br>32 episodes of disrobing.<br><br>25 episodes of resistance to care.<br><br>33 shifts of behavioral symptoms.<br><br>Review of Nursing Progress Notes, from 04/03/2024 through 04/25/2024, consistently showed Resident 2 was alert, confused, and oriented to person. Resident 2 remained confused and had incidents of restlessness, attempts of getting out of bed independently, and disrobing.<br><br>Review of a Nursing Progress Note dated 04/10/2024 at 2:17 PM, showed Collateral Contact (CC) 4, Advanced Registered Nurse Practitioner (ARNP), was notified of Resident 2's episodes of restlessness and would be assessed today. No provider notes were completed on 04/10/2024.<br><br>Review of CC 4's progress note, dated 04/12/2024, showed a follow up visit which noted Resident 2 was slowly progressing with rehabilitation. Resident 2 was noted to be alert and oriented to person, place, time and event with no focal neuro deficits and appropriate mood and affect. No behavioral health concerns were noted or addressed.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of CC 4's progress note, dated 04/15/2024, showed Resident 2 was alert and oriented to person place time and event, no focal neurological deficits, mood, and affect were appropriate. No behavioral health concerns were noted or addressed.<br><br>Review of CC 5, ARNP, progress note, dated 04/17/2024, showed Resident 2 had complaints of nausea and sleepiness. No behavioral health concerns were noted or addressed.<br><br>Review of CC 5's progress note, dated 04/22/2024, showed Resident 2 was seen for a trending low potassium level. Resident 2 was uncomfortable and restless lying in bed. Resident 2 endorsed discomfort and irritability. The resident's potassium was discussed. No additional concern reported by nursing staff today. No behavioral health concerns were noted to be addressed.<br><br>Review CC 4's progress note, dated 04/24/2024, showed Resident 2 was alert and oriented to person, place, time, and event. Resident 2 was noted to be cooperative and had appropriate mood and affect. No behavioral health concerns were noted or addressed.<br><br>In a phone interview on 04/25/2024 at 10:35 AM, CC 2, Resident 2's friend, stated they had known Resident 2 for the past 15 to [AGE] years. CC 2 stated they had spoken with Resident 2 on 04/24/2024, in the middle of the afternoon and Resident 2 had soiled themselves. CC 2 stated Resident 2 reported they had called for over an hour and no one came to help them. CC 2 stated it seemed like a long time since Resident 2 fell , had surgery, they were still not able to put full weight on their leg so far, and they were not up walking.<br><br>In an observation and interview on 04/25/2024 at 2:30 PM, Resident 2 was lying in bed with only an incontinent brief that appeared to be wet with ripped up pieces scattered on the bed and the floor. Resident 2's call light was lying on the floor between their bed and the south wall of their room. The resident's bed did not have any sheets in place and the resident was without bed coverings. Resident 2 stated they had been laying there for hours and had called and yelled for help and nothing happened. Resident 2 stated the staff had come into their room that morning around 10ish. Resident 2 stated they would like to turn over but could not and could not find their call light.<br><br>In an interview on 04/25/2024 at 3:12 PM, Staff E, NAC, stated they did not get report when they came onto shift. Staff E stated the facility had a staff meeting at 2:30 PM and then they had passed water. Staff E stated Resident2 was usually first on their list of residents to check on. Staff E stated they had found Resident 2 lying in their bed, which was wet, and had particles of their incontinent brief on the floor. Staff E confirmed that Resident 2's call light was on the floor when they entered the resident's room. Staff E stated they usually would find Resident 2 in a similar state and would let the nurses know. Staff E stated behavioral interventions were in the electronic documentation system. Staff E was asked about Resident 2's person centered behavioral interventions. Staff E stated the behavioral interventions were very vague, like reapproach.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 04/26/2024 at 3:33 PM, Staff F, Social Services, was asked their involvement in the facility's residents' behavioral health care. Staff F stated they would check with residents, if a resident was having problems, they would set up the resident's behavior monitor and would complete a progress note. Staff F stated they reviewed residents' refusal of care every morning, Monday through Friday and on Mondays they completed a 72-hour review. Staff F stated Resident 2 had a care conference on admission and today. Staff F stated they had only implemented the behavioral health interventions for Resident 2 after the care conference today. Staff F stated they had spoken with Resident 2, who stated they were not refusing care and did not remember refusing care. Staff F stated they had notified the nursing staff.<br><br>In an interview on 04/26/2024 at 3:42 PM, Staff G, Licensed Practical Nurse/Resident Care Manager, stated in a way Resident 2 had been set in their ways. Staff G stated Resident 2 would state they were in pain, but they did not exhibit nonverbal signs of pain. Staff G stated as time progressed since Resident 2's admission, Resident 2 was not letting the staff assist them to dress or get up out of bed. Staff G stated Resident 2 did not want to keep their cloths on. Staff G stated they kept reapproaching, offering a fresh face, and they would educate Resident 2 on the risk and benefits of being clean and dry. Staff G stated their interventions should be documented in the resident's chart. Staff G stated Resident 2 refused all kinds of care every day. Staff G stated they thought a behavioral health referral was initiated after Resident 2's care conference. Staff G stated they had not assessed if Resident 2 had a history of this type of behavior. Staff G stated they had let Resident 2's providers know that they were refusing care and they had told them to keep reapproaching and educating the resident. Staff G stated reapproaching and educating the resident would eventually work.<br><br>In an interview on 04/26/2024 at 3:54 PM, Staff H, Physical Therapist Assistant, stated Resident 2 was very challenging to get to participate in therapy. Staff H stated they would approach the resident two to three times a day but Resident 2 was adamant they did not want to do anything. Staff H stated Resident 2 had minimal participation in therapy. Staff H stated Resident 2 reported that they were in a lot of pain and had complained of a lot of nausea. Staff H stated anytime Resident 2 refused therapy they would talk with the nursing staff about the resident's refusal, level of pain, and complaints of nausea. Staff H stated they would check with the nursing staff to see when Resident 2 had their pain medications and sometimes would get assistance from the NAC staff to help get Resident 2 up out of bed.<br><br>In an interview on 04/26/2024 at 4:29, Staff I, Physical Therapist, stated they had a meeting every morning and would discuss Resident 2's behaviors. Staff I stated they would read what happened the day before and discuss what they could do to help the resident. Staff I stated they discussed Resident 2's medication, the resident's nausea, vomiting, and they were unaware if anything had been changed. Staff I stated they had mentioned to try to monitor Resident 2's behaviors. Staff I stated Resident 2 would call out, sometimes would undress, their cognition was really off. Staff I stated as soon as Resident 2 would sit up, the resident would say they had enough for the day and decline the rest of therapy. Staff I stated they would try again another day and try different things with Resident 2 but Resident 2 would decline. Staff I stated Resident 2 would vomit just seeing the medication prior to taking their medication. Staff I stated Resident 2 had been independent in the community before they fractured their hip. Staff I stated maybe Resident 2 had a reaction to the anesthesia when they had their hip surgery.<br><br>In an observation on 04/26/2024 at 4:53 PM, Resident 2's door was open, and the resident was visible from the hallway. Resident 2 was lying in bed uncovered and undressed.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an observation and interview on 04/29/2024 at 11:27 AM, Resident 2 was lying in bed uncovered with only an incontinent brief. Resident 2 stated they were sick to their stomach. Resident 2 stated they were nauseated over the weekend. Resident 2 stated the staff wanted them to do things they were not capable of doing. Resident 2 stated they were unable to sit up in a chair for over an hour. Resident 2 stated the staff wanted them to eat their meals in the dining room but when they would ask the staff to take them back to their room the staff would tell them they did not have time to do that. Resident 2 stated that they did not participate with therapy because it was uncomfortable and hurt. Resident 2 stated they were not a wuss, but the staff wanted them to do things that were very painful. Resident 2 stated they had cancer, and they were supposed to go to the cancer center but had not. Resident 2 sated they were left to use their incontinent brief to go to the bathroom and had to wait for the staff to come clean them up. Resident 2 stated half the time they did not sleep, the other night a NAC came into their room around 2:00 AM and asked them what they were doing. Resident 2 stated they told them they were lying there, and the NAC told them to go to sleep. Resident 2 stated they used to be happy and in a good mood ready to do things, wanted to go places and was nothing like that now.<br><br>In an interview on 04/29/2024 at 1:13 PM, Staff B, Director of Nursing Services, stated Resident 2 had post anesthesia delirium. Staff B stated Resident 2 had some refusals and periods where they would be hot, then would be cold and would take off their clothes. Staff B stated they had been working with Resident 2's provider and had notified the resident's power of attorney. Staff B stated they had identified Resident 2's refusals and they had been combative with care. Staff B stated Resident 2's behavioral interventions were to give them space and to reapproach which was the most effective. Staff B stated they had notified Resident 2's providers of the resident's delirium, and the providers were on the same page of reapproaching the resident. Staff B stated they had been monitoring Resident 2's behaviors and using their approaches. Staff B stated they recognized Resident 2 needed more behavioral support.<br><br>Refer to WAC 388-97 1060 (1) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035<br><br>Based on interview, and record review the facility failed to ensure pharmacy services were provided to meet the residents needs for 3 of 4 residents (Resident 1, 2, and 3) reviewed for new admissions. The facility's failure to ensure medications were acquired and administered as ordered on the day of admission and the facility's failure to follow their process for when medications were not available placed residents at risk of diminished quality of health and diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's in-service titled, Education: Admission Medications, initiated on 03/18/2024, showed when a resident admitted to the facility, make sure to go through all the proper channels to ensure delivery of the resident's medication. 1) Fax new orders to the pharmacy, 2) If orders have not yet arrived, pull the medication from the Cubex (modular medication dispensing machine), 3) If the medication was unavailable in the Cubex, call the pharmacy to have the medications satellited to the facility, 4) Always give over the counter medications.<br><br><RESIDENT 1><br><br>Resident 1 was admitted to the facility on [DATE], with diagnoses to include aftercare for heart bypass surgery, anxiety, and depression.<br><br>Review of a faxed prescription for tramadol (opiate narcotic pain medication) 50 mg (milligram) three times daily was signed by the discharging hospital provider for Resident 1. The fax was scanned and noted to be received by the facility on 04/17/2024 at 12:57 PM.<br><br>Review of Resident 1's discharge summary orders, dated 04/17/2024, showed tramadol HCl 50 mg was to be given three times daily.<br><br>Review of Admission Summary progress note, dated 04/17/2024 at 1:22 PM, showed Resident 1 was admitted to the facility.<br><br>Review of the care plan dated 04/17/2024 showed Resident 1 had acute pain related to their incision after their bypass heart surgery. The interventions included to give medication as ordered.<br><br>Review of Resident 1's Medication Administration Record (MAR), dated 04/17/2024 through 04/26/2024, showed the following information:<br><br>- On 04/17/2024 evening shift their pain was rated at an eight on a zero (no pain) to 10 (Severe pain) pain scale.<br><br>- There was no tramadol administered on 04/17/2024 to treat the resident's reported pain.<br><br>- Tramadol 50 mg three times daily was started on 04/18/2024 at 9:00 AM.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In a co-interview on 04/26/2024 at 2:40 PM, Collateral Contact 1, Resident 1's family member, stated on the first day Resident 1 was admitted to the facility there was a problem with Resident1's medication, tramadol. Resident 1 stated they were supposed to get their medications and the nursing staff stated the order was not on the chart, then they said they had to call the doctor. Resident 1 stated finally at 3:00 AM, they received their tramadol. Resident 1 stated it was pretty painful to not receive their pain medication.<br><br><RESIDENT 2><br><br>Resident 2 was admitted to the facility on [DATE] with diagnoses to include diabetes (serious condition where your blood glucose level is too high) and leukemia (a cancer of the blood).<br><br>Review of Resident 2's MAR, from 04/03/2024 through 04/25/2024, showed an order for Steglatro for diabetes to start on 04/04/2024. The documentation for the administration of the Steglatro was blank on 04/04/2024 and 04/05/2024 for the scheduled 8:00 AM dose.<br><br>Resident 2's MAR, from 04/03/2024 through 04/25/2024, showed an order for Imatinib Mesylate, one time a day related to leukemia, to start on 04/04/2024. On 04/04/2024 the 8:00 AM dose was coded NN. The key at the end of the MAR showed NN was a code for Other / See Nurse Notes.<br><br>Review of Resident 2's progress note, dated 04/04/2024, showed, Held Imatinib this A.M. r/t (related to) pharmacy needed prior authorization r/t high cost. Medication approved by CEO (Chief Executive Officer) today.<br><br><RESIDENT 3><br><br>Resident 3 was admitted to the facility on [DATE] with a diagnosis to include Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination).<br><br>Review of Resident 3's MAR, dated 04/11/2024 through 04/29/2024, showed an order for carbidopa-levodopa (a medication for Parkinson's disease) three times daily. The MAR showed the carbidopa-levodopa medication was not administered until the morning of 04/12/2024.<br><br>In an interview on 04/26/2024 at 4:05 PM, Staff A, Licensed Practical Nurse/ Staff Development Coordinator, stated when they received a new resident admission, the orders were faxed over from the admitting facility and then they were faxed to the pharmacy. Staff A stated two nurses checked the orders and the orders were activated after the two nurses have completed the medication checks. Staff A stated they faxed the orders to their contracted pharmacy and would receive the medication either at 6:00 PM or 3:00 AM, depending on when they faxed the orders to the pharmacy.<br><br>In an interview on 04/29/2024 at 12:16 PM, Staff A , stated Resident 1's tramadol was given on 04/18/2024 but was not documented as administered on the electronic medical record (EMR). Staff A stated they were starting education with the nurses on ensuring there was documentation on the EMR of medication administration. Staff A stated Resident 1's medication arrived at the facility at 3:00 AM, and Resident 1 was given their tramadol at 3:20 AM on 04/18/2024. Staff A stated they had started education with the nurses on 03/18/2024 on a lot of different things including on medication training after they had notice the residents needed to get their medication in a better fashion.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 04/29/2024 at 1:13 PM, Staff B, Registered Nurse/Director of Nursing Services, stated they were not 100% sure why Resident 1 and Resident 2 medications were not administered timely. Staff B stated they provided education to the staff each time a resident does not receive their medication on admission. Staff B stated that when they received information on an admission, they processed the resident's orders super-fast, and it could have been that they were<br><br>Refer to WAC 387-97-1300(1)(b)(i)(ii) |

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>37035<br><br>Based on observation, and interview, the facility failed to provide a clean and sanitary environment for 1 of 1 residents' shower room. This failed practice decreased Resident 4's desire to bathe, did not promote a clean and comfortable environment for the residents to be bathed and placed the residents at risk of a diminished quality of life.<br><br>Findings included .<br><br>In an interview on 04/29/2024 at 11:43 AM, Resident 4, stated the shower room was filthy. Resident 4 stated the grout was black and the tub was filthy. Resident 4 stated it was just awful and they did not like to take a shower. Resident 4 stated if the shower room was cleaned, they would like to take a shower every three days but as it was, they would rather have a bed bath than take a shower in the shower room.<br><br>In an observation and interview on 04/29/2024 at 11:37 AM, Staff C, Nursing Assistant Certified, stated they wiped the shower stall down with sanitizer wipes after each resident was showered. Staff C asked about the observed black debris on the threshold directly in front of the shower stall and the black debris on the north wall of the shower room next to the shower stall. Staff C stated the black debris just stayed there. Staff C stated housekeeping cleaned the shower room weekly. Staff C stated the tub did not work when asked about the debris in the tub.<br><br>In an observation and interview on 04/29/2024 at 1:06 PM, Staff D, Housekeeping, stated they sanitize the surfaces in the shower room. Staff D stated they thought the building was old when asked about the dark debris in front of the shower stall. Staff D stated the dark debris on the threshold of the shower stall was built up grime.<br><br>Refer to WAC 388-97-3220(1) |