

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER Highland Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 Samish Way Bellingham, WA 98229	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047</p> <p>Based on observation, interview, and record review the facility failed to ensure resident with diabetes mellitus 2 (DM- a medical condition in which the body doesn't use insulin properly), received care and services needed to manage their blood glucose (BG - the amount of concentrated sugar in the blood) for 1 of 4 sampled residents (Resident 1) reviewed for diabetic management. This failure place other residents at risk for unmet care needs and medical complications.</p> <p>Findings Included .</p> <p>Review of the facility policy titled, Diabetes Mellitus, Guidelines for Management, revised 08/01/2023, documented the goal was to quickly restore normal cerebral function, prevent hyperglycemia (high BG) or hypoglycemia (low BG), recognize, treat, or prevent complications commonly associated with DM. Nurses were directed to document the resident's BG levels and frequency measured per physician orders, notification of the physician of the change in condition and/or diagnostic results, notification of family/responsible party of change in condition and update the resident care plan as necessary.</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses that included obstructive sleep apnea (intermittent airflow blockage during sleep), aortic stenosis (narrowing of the valve in the large blood vessel branching off the heart), DM Type 2.</p> <p>Review of the Quarterly Minimum Data Set (MDS- an assessment tool), assessment, dated 06/20/2024, showed Resident 1 was assessed to have a Brief Interview for Mental Status (BIMS - a structured cognitive interview) of a 15 out of 15 indicating they were cognitively intact.</p> <p>Review of Resident 1's care plan, dated 12/20/2023, showed they had DM with a goal of no complications through the review date of 12/13/2024. Interventions included:</p> <ul style="list-style-type: none"> - Administration of diabetic medications as ordered by the physician and to monitor/document side effects and effectiveness. - If hypoglycemic (their BG was below 70), treat per the hypoglycemic protocol and document treatment interventions/symptoms/assessment in the progress notes. <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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Monitor/record/report to the physician as needed any signs/symptoms of hypoglycemia including sweating, tremors, tachycardia, pallor, nervousness, confusion, slurred speech, lack of coordination, or staggering gait.</p> <p>There were no interventions for the nursing aides to follow related to Resident 1's diagnosis of DM type 2, and no documentation the resident used a continuous BG monitoring system.</p> <p>Review of the facility incident report dated 07/02/2024, showed Resident 1 was interviewed and voiced being fearful during the hypoglycemic episode on 06/03/2024. The facility incident report also showed that Resident 1's physician was notified of their hypoglycemic episode, that occurred on 06/03/2024, on 6/29/2024 (26 days after it occurred) which resulted in changes in Resident 1's insulin order.</p> <p>In an interview on 06/27/2024 at 9:50 AM, Resident 1 stated they had an episode of low BG sometime in the beginning of June 2024 starting around 2:00-2:30 AM. Resident 1 stated their BG monitor was beeping to alert them their BG was low. Resident 1 stated they got out of bed by themselves because no one was responding to the beeping of their monitor. Resident 1 stated they looked at the monitor, and their BG was very low at 47 milligrams per deciliter (Mg/dL - a normal BG range is 70-99 Mg/dL). Resident 1 stated they were awoken by the alarm on the machine and alerted them to their low BG. Resident 1 stated they had their call light on for a while and no one answered it, they waited an additional 15 minutes, and decided that they needed help. Resident 1 stated they were confused, out of breath (winded), sweating, and had a headache. Resident 1 stated they wheeled themselves in their wheelchair to the nurse's station, without the use of their oxygen. Resident 1 stated the nurse was at the nurse's station and they felt their BG was even lower at that point. Resident 1 stated they were feeling weak, the nurse wheeled them back to their room and got them juice and a peanut butter and jelly sandwich. Resident 1 stated that it took a while, about an hour, for their BG to return to an acceptable range. Resident 1 stated the incident aggravated them because they jeopardized my life.</p> <p>Review of Resident 1's progress notes from 06/01/2024 through 06/28/2024 showed no documentation the resident had low BGs levels on 06/03/2024.</p> <p>Review of Resident 1's June 2024 Medication Administration Record (MAR), showed an order, dated 11/30/2023, for the resident to have their BG checked daily at 3:00 AM if they had received a corrective (sliding scale) insulin dose in the evening. On 06/03/2024 at 5:30 AM, Resident 1's BG was documented as 118 Mg/dL. Resident 1's MAR showed they used a continuous BG monitoring system. Resident 1's MAR for June 2024 showed that none of the above orders were marked as being utilized on 06/03/2024.</p> <p>Review of Resident 1's MAR dated June 2024, showed the resident had orders in place if they experienced hypoglycemic symptoms which included:</p> <p>- Ordered on 11/28/2023, for the nurse to check their BG as needed for hypoglycemic or hyperglycemic symptoms (shakiness, sweating, headache, nausea, confusion). If their BG was less than 70, initiate the facility's hypoglycemic protocol and notify the doctor as indicated. If their BG was more than 300, notify the doctor and follow directives for hypoglycemic/hyperglycemic symptoms.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Ordered on 11/28/2023, for the nurse to follow the hypoglycemia protocol as needed for hypoglycemia. If their BG less than 70 Mg/dL and the resident was able to take food/drink by mouth staff were to follow the 15/15 rule. The 15/15 rule was 1)give 15 grams (gm) of a fast acting carbohydrate, 2) recheck the resident's BG in 15 minutes, 3) if the BG was still less than 70, give another 15 gm fast acting carbohydrate, 4) recheck second BG in 15 minutes, if not above 70, give additional 15 gm quick carbohydrate and notify the physician for further orders and 5) once above 70, provide a protein snack or assist to next meal.</p> <p>- Ordered on 04/12/2024, for the nurse to give Glucose Oral Gel 77.4 percent (%), give 20 grams by mouth as needed for the hypoglycemia protocol. May repeat in 15 minutes if hypoglycemia persisted.</p> <p>In an interview on 06/28/2024 at 11:45 AM, Staff C, Licensed Practical Nurse (LPN), stated they could not recall if they received report that Resident 1 had a low BG at the beginning of June 2024. Staff C stated if a resident experienced a low BG episode, there was a protocol that was required to be followed which included providing something for the resident to eat and/or providing the ordered interventions. Staff C stated if a resident had low BGs and interventions were provided, the expectation was that it would be documented in the resident's clinical record. Staff C stated Resident 1 used a continuous BG monitoring device that provided continuous monitoring of their BG levels. Staff C stated Resident 1's device stayed in their room, and they thought the device kept a record of resident's past BGs. When asked to show the record for 06/03/2024 from Resident 1's device, they were not able to locate it and stated they would have to search the internet to find out how to obtain it.</p> <p>In an interview on 06/28/2024 at 11:47 AM, Staff D, Nursing Assistant Certified (NAC), stated they worked the evening/overnight shifts routinely. Staff D stated they could not recall the day, but around 5:00 AM the nurse alerted them while on break that Resident 1 had low BG levels, but they had taken care of it. Staff D stated they had informed the nurse and the other aide they were going on break. Staff D stated when Resident 1's glucose monitoring device beeped, they informed the nurse. Staff D stated they did not finish their break, checked in on Resident 1 who was eating in their room, and checked their BG monitor, however, could not recall the reading.</p> <p>In an interview on 06/28/2024 at 12:00 PM, Staff B, Registered Nurse (RN)/Director of Nursing [NAME] (DNS), stated Resident 1 had not shown any low BG per the MAR on 06/03/2024. When asked about the continuous glucose monitoring system Resident 1 utilized, Staff B stated they had not cross referenced the history of the device with the documented BG in the medical record.</p> <p>On 06/28/2024 at 12:15 PM, Staff A, Administrator, stated they did not have a policy or procedure on how to use/gather information from Resident 1's continuous BG monitoring system. Staff A accessed Resident 1's BG monitoring system history which showed Resident 1 had BG below 70, as low as 50, during the early morning of 06/03/2024 from approximately 2:00 AM until 5:00 AM.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/01/2024 Staff E, LPN, stated Resident 1 had experienced low BGs levels on and off and they had woken them up on a semi-regular basis to have them eat/drink something. Staff E stated they always checked Resident 1's BG at 3:00 AM and rechecked them at the end of their shift. Staff E stated Resident 1's BG levels had dropped into the 50's-60's at times, when it happened, they assessed the resident and asked how they were feeling. Staff E stated when Resident 1's BG were around 112 Mg/dL, they were on high alert for the resident and any changes in their BG. Staff E stated if Resident 1's alarm had been going off after the 3:00 AM check, they would have done a recheck of their BG and documented the information in the resident's clinical record. Staff E stated they were the nurse on 06/03/2024 when Resident 1 had low BG levels and they recalled the resident's BG had been in the 60's around 5:00 AM. Staff E stated they were at the nurse's station when Resident 1 had wheeled themselves to the nurse's station, they made them eat a peanut butter and jelly sandwich and drank a glass of milk. Staff E stated they did not notify the physician, had thought they placed the resident on alert, and gave report to the oncoming nurse but should have documented the resident's low BG in the nursing progress notes. Staff E stated they were in and out of Resident 1's room throughout the night as their roommate required medications and care. Staff E stated they checked the resident's BG at 3:00 AM. When asked about the printout from Resident 1's glucometer for 06/03/2024, Staff E stated they would have heard the glucometer alarm and must not have. Staff E stated they had read the paperwork that came with the BG monitors, and it was available to all the nurses at the nurse's desk.</p> <p>Refer to WAC 388-97-1060 (1)(2)(b)</p>		