STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505140	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Health and Rehabilitation of Cascadia	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)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on observation, interview and record review, the facility failed to ensure there was sufficient nursing staff for 3 of 4 sampled residents (Residents 1, 2, and 4) reviewed for care and services. The facility had insufficient nursing staff to answer call lights and to provide care and services for a cognitively impaired resident resulting in the residents having unmet needs. These failures placed all residents at risk for accidents and diminished quality of life. Findings included . Definition: Reasonable Person Concept: a standard used to determine whether an individual's actions or responses align with what a hypothetical reasonable person would do under similar circumstances. It defines the behavior expected of an ordinary, prudent, and rational individual. <RESIDENT 1> Resident 1 admitted to the facility on [DATE] with diagnoses to include dementia (a condition where a person has a loss of cognitive functioning and has impairments with thinking, remembering and reasoning to such an extent it interferes with their daily life and activities). According to the admission Minimum Data Set (MDS - an assessment tool) assessment, dated 07/31/2024, the resident had severe cognitive impairment, needed or wanted an interpreter to communicate with healthcare staff as English was their second language, and they were dependent (dependent - helper does All of the effort, resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and personal hygiene), were frequently incontinent of urine and occasionally incontinent of bowels, and they had a condition or chronic disease that may result in their life expectancy to be less than six months. In an observation/attempted interview on 08/06/2024 at 8:45 AM, Resident 1 was lying in bed, their call light was at the foot of the bed and not within their reach. The lower half of the resident's body was uncovered, their groin and legs were exposed and visible from the doorway, their incontinent brief was off them and laying on the bed. The bedside table with their drinks was positioned away from the bed and not within their reach. The resident was awake, but they did not respond when spoken to. An interpreter was obtained to assist with the interview and Resident 1 was unable answer interview questions appropriately despite the interpreter's assistance. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505140	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Health and Rehabilitation of Cascadia	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)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint observation on 08/06/2024 at 8:55 AM, Staff A, Director of Nursing (DON), was asked to come in the room to observe the resident. Upon entering Resident 1's room, Staff A observed the resident and immediately left and said they were going to get a nursing assistant. In an interview on 08/06/2024 at 9:45 AM, Staff A, DON, was asked their impression of the observation of Resident 1 on 08/06/2024 at 8:55 AM, they stated that it was disappointing but not out of the norm for the resident as they have had rejections of cares, they throw items, they undressed themselves, they threw their call light, and there was a language barrier. Based on the Reasonable Person Concept, a reasonable person in Resident 1's condition would not have wanted to be left with their legs and groin uncovered and visible from the doorway, they would have wanted their call light to be within their reach, and they would have wanted their bedside table with their drinks to be within their reach. <RESIDENT 2> Resident 2 admitted to the facility on [DATE] with diagnoses to include a below the knee amputation, bipolar disorder (a disorder that causes extreme mood swings that includes emotional highs and lows (depression), psychosis, morbid obesity, difficulty in walking, generalized muscle weakness and abnormalities of gait and mobility. According to the quarterly MDS assessment, dated 06/28/2024, the resident had no cognitive impairment. Review of Resident 2's care plan, print date 08/07/2024, showed they were at risk for falls due to impaired mobility. Review of an incident investigation, dated 06/05/2024, showed Resident 2 complained their call light had been on for over an hour. The facility concluded the resident was having increased behaviors and was manipulating staff with contributing factors of lack of communication between nursing assistants at lunch and break times and there was a miscommunication about who was supposed to be answering the resident's call light during a break. In an interview on 08/06/2024 at 12:35 PM, Resident 2 was asked about the incident where their call light went unanswered by staff for over an hour, they stated it was on dayshift, They couldn't get help, so they ended up having a bowel movement their pants. Resident 2 stated just that morning, I ended up peeing in my pants after they waited over 20 minutes for help to come take them to the bathroom and no staff came. Resident 2 stated call lights taking too long was not specific to a certain shift or day, but it happened a lot. Resident 2 stated there was just not enough help here. In an interview on 08/07/2024 at 9:03 AM, Staff A, DON, stated she had talked to Resident 2, and they were trying to figure out a solution for their toileting needs. <RESIDENT 4> Resident 4 admitted to the facility on [DATE] with diagnoses to include a fractured vertebra, generalized muscle weakness, difficulty in walking, and a history of falls. According to the admission MDS assessment, dated 05/16/2024, the resident had no cognitive impairments, they had a history of a fall in the last month prior to admission, and had a fracture related to a fall six months prior to admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505140	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Health and Rehabilitation of Cascadia	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)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a call light observation on 08/06/2024, Resident 4's call light was observed to come on at 12:45 PM, and it was turned off at 12:47 PM. In an observation/interview on 08/06/2024 at 12:52 PM, Resident 4 was asked if staff had taken care of their needs when they used their call light. The resident stated they had used their call light prior to this interview to get help to go to the bathroom, but the staff member that came in was informed of the resident's need to use the bathroom, turned the call light off, took their lunch tray and left the room without helping them go to the bathroom. Resident 2 stated they were supposed to have help to transfer, and they can't wait too long after they had fluids, or they would have to get themselves up. Resident 4 stated they had two falls since they admitted to the facility. Resident 4 stated they needed more help around here, that the staff want them to call for help to get up, but then no one came to help, then when they came, they just took their lunch tray away and didn't help them go to the bathroom. The resident pointed to a sign on their wall that read Call for assistance, do not attempt to self-transfer! Resident 4 was observed to get up out of bed and start walking toward the bathroom without assistance. Review of Resident 4's current care plan, as of 08/07/2024, showed they had a problem/focus area of an actual fall related to attempting to self-transfer and increased weakness. An intervention included in this focus area was to encourage the resident to request assistance when ambulating. In an interview on 08/06/2024 at 1:14 PM, Staff B, Shower Aide/Nursing Assistant Certified (NAC), stated there was not enough staff working to get all their work done, they stated they were currently working with just three nursing assistants. Staff B stated they were the shower aide but get pulled to work the floor as a nursing assistant, and it was difficult to get their showers done. Staff B stated Staff C, NAC, had gone home sick before breakfast today, but that they were on light duty anyway and not much help. In an interview on 08/06/2024 at 1:26 PM, Staff A, DON, stated staff were not supposed to turn off residents' call lights if they had not taken care of their needs. Refer to WAC 388-97-1080 (1)