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	08/07/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff were compliant with Infection Prevention and Control Guidelines and standards of practice for 1 of 4 staff members (Staff T, Nursing Assistant Certified - NAC) reviewed for hand hygiene, 1 of 3 residents (Resident 35) reviewed for transmission-based precautions (TBP), and 1 of 1 residents (Resident 5) reviewed for oxygen use. The facility failed to ensure the staff were wearing appropriate personal protective equipment (PPE) in accordance with recommended national standards, failed to ensure staff were compliant with appropriate hand hygiene practices during meal tray delivery, and failed to ensure oxygen tubing supplies were stored and maintained properly. These failures placed all residents and staff at risk of potential infection.Findings include .Review of the facility policy titled, Transmission Based Precautions Conventional Plan, revised 06/16/2025 documented enhanced based precautions (EBP) refer to infection control interventions designed to reduce transmission of multi-drug-resistant organisms that employ the use of targeted gown and gloves use during high contact resident care activities . residents recommended for EBP are residents with open wounds, and indwelling medical devices such at catheters (tubing inserted into the body to drain urine). Review of the facility policy titled, Hand Hygiene, revision 02/11/2022 documented hand hygiene is the single most important procedure for prevention the spread of infection . opportunities for hand hygiene such as before touching a resident, after touching resident, after leaving the residents room, after removing gloves, after any contact with residents belongs or objects.During an observation on 08/04/2025 at 11:49 AM, Staff T, NAC was observed to remove a lunch tray from cart in the hallway and brought it into room [ROOM NUMBER] and placed it on the resident’s bed table, remove the cover from meal tray, exited the room and did not perform hand hygiene. Staff T removed another lunch tray and entered room [ROOM NUMBER], placed the lunch tray on the bed table and exited the room and did not perform hand hygiene. Staff T removed another lunch tray from the cart and entered room [ROOM NUMBER]. Staff T placed the lunch tray on the bed table for the resident in 6B. Staff T was observed touching resident’s silverware with bare hands to cut up the food for them and applied seasoning to the food. Staff T then exited the room, did not perform hand hygiene, removed another lunch tray from the cart and brought it to the resident in room [ROOM NUMBER]A and placed it on their overbed table. The resident did not want lunch and asked Staff T to remove the tray. Staff T was observed to remove the lunch tray from the room and put it on the cart with the other lunch trays that still needed to be passed. No hand hygiene was performed. At 11:54 AM, Staff T removed a lunch tray from the cart and entered room [ROOM NUMBER]. Staff T was observed to place the lunch tray on the bed table, touched personal items in the room and readjusted the bed table. Staff T then used the silverware to cut up the resident’s food with their bare hands. Staff T exited the room and did not perform hand hygiene. Staff T removed another lunch tray from the cart in the hallway and brought it to room [ROOM NUMBER] where they were observed handling the silverware to cut up the resident’s food with bare hands. Staff T exited the room and did not perform hand hygiene. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/04/2025 at 11:59 AM, Staff T did not respond when asked when hand hygiene should be done during meal pass. Staff T reported that they had not done hand hygiene while passing lunch trays. <HAND HYGIENE>In an observation on 08/04/2025 at 11:39 AM, Staff T, Nursing Assistant Certified (NAC) was observed to remove a lunch tray from the meal cart in the hallway, no hand hygiene was observed prior to handling tray. Staff T entered room [ROOM NUMBER], where a resident resided placed lunch tray down in the resident room, exited and did not perform hand hygiene. Staff T then grabbed another lunch tray from the meal cart and entered room [ROOM NUMBER]. Staff T were observed to touch with their bare hands the residents belonging, including their walker, and personal items on their bed table. Staff T, then placed the lunch tray on the over the bed table and removed the cover off the plate. Staff T were then observed to touch with the bare hands the resident’s silverware and cut up the resident’s food for them. Staff T left the silverware for the resident to use. Staff T exited the resident room, was observed to not perform hand hygiene, and walked into room [ROOM NUMBER] and was observed to assist with repositioning of another resident with their bare hands. The staff then touched the residents’ linens to assist in scooting them up in bed. Staff T then left the resident room and did not perform hand hygiene and entered the kitchen. At 11:44 AM Staff T exited the kitchen, dropping two hot beverage containers to room [ROOM NUMBER], and were not observed to perform any hand hygiene. At 11:47 AM, Staff T grabbed another lunch tray from the meal cart and walked to room [ROOM NUMBER], placed the tray on the bed table, grabbed a cup from the resident’s room and walked to the kitchen, no hand hygiene was observed. At 11:49 AM, Staff T pushed a second meal cart down to the other unit, no hand hygiene was observed. <TRANSMISSION BASED PRECAUTIONS>In an observation on 08/06/2025 at 10:07 AM, Staff T, NAC were observed to enter room [ROOM NUMBER], where there was a sign outside that room that stated the resident was on EBP. Staff T were observed to place gloves on their hands and enter the room. Staff T were then observed to assist the Resident 35 from the bedside commode. Staff T was observed to only be wearing gloves for PPE. Staff T were asked what the sign outside the room was instructed. Staff T stated that it was just a precaution and that you may have to use some of the PPE in the bin (they pointed at a PPE bin filled with gloves, gowns, mask and eye protection). Staff T stated they assist Resident 35 to use the restroom all day, that Resident 35 had an indwelling device and they do not ever wear anything but gloves in the room. Staff T was not able to explain what the purpose of EBP was, or when it was the appropriate time to use it with a resident. In an interview on 08/07/2025 at 10:19 AM, Staff B, Director of Nursing Services and Infection Preventionist stated that their expectation for all staff in the facility about EBP, where they were implemented when a resident had an open wound or indwelling device for all high contact care areas. Staff B stated toileting would be considered a high contact care area. Staff B stated it was their expectation that all staff were performing hand hygiene either with hand gel or hand washings for all interactions with residents and their belongs, during meal tray pass and they should be gelling in and out of every resident room. Staff B was not aware of the observations made during meal tray pass or observations of care for EBP. <RESIDENT 5> Resident 5 was admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician order, dated 11/29/2024, showed Resident 5 received supplemental oxygen (O2) as needed for comfort and/or a change in their respiratory status. A physician order was received on 07/12/2025 for the resident to receive medication via a nebulizer (a small machine that turns liquid medicine into mist that could be easily inhaled) as needed every six hours for shortness of breath or wheezing. Review of Resident 5’s 07/01/2025 through 08/05/2025 Medication Administration Record and Treatment Administration Record (TAR), showed no direction to the nurse to change the O2 and nebulizer tubing. In an observation on 08/04/2025 at 12:30 PM, Resident 5 was in their room. The O2 concentrator (a medical device that provides pure O2) was stored against the wall, not in use and the O2 tubing with a nasal canula (NC - a tube that delivers O2 into the nose) was touching the floor. Resident 5 stated they did not know the last time they used it, but thought they used it when having some difficulty breathing. In an observation on 08/05/2025 at 8:08 AM, Resident 5 was using their oxygen concentrator. The NC was draped over their nose. When asked about using the O2, Resident 5 placed the NC prongs were placed into their nares. In an observation on 08/06/2025 at 8:45 AM, Resident 5 was sitting on the side of their bed. The O2 tubing was hung across a positioning bar on the right side of the bed and the and was not in a plastic bag. There was a nebulizer machine observed on top of a nightstand in the corner of their room. The nebulizer tubing was not dated, the mask was connected to the tubing, appeared dirty, and was not in a plastic bag. In an observation on 08/06/2025 at 11:17 AM, Resident 5’s O2 tubing was observed hanging over the positioning bar on the bed, the NC was resting in a shoe next to their bed, and the nebulizer was in the same position. In an interview on 08/06/2025 at 11:18 AM, Staff C, Registered Nurse, stated O2 and nebulizer tubing was changed weekly and as needed. Staff C stated the tubing should be labeled, dated when changed, and stored in a bag when not in use. Staff C located the O2 tubing was dated 08/03/2025 with blue ink. Staff C observed Resident 5’s NC in the resident’s shoe. Staff C stated if O2 tubing was observed on the floor or touching any other surface, it should be replaced. In an interview on 08/06/2025 at 11:25 AM, Staff N, Nursing Assistant Certified (NAC), stated the nurse or the NAC could change the residents O2 tubing. Staff N stated the tubing was not labeled/dated when changed. In an interview on 08/06/2025 at 2:24 PM, Staff B, Chief Nursing Officer, stated O2 and nebulizer tubing were changed weekly. Staff B stated the nebulizer should be taken apart, cleaned, air dried, and stored in a bag. Staff B stated the nurse would document on the TAR when the O2 or nebulizer tubing was changed. Refer to WAC: 388-97-1320 (1)(a)(c)