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	12/17/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure 1 of 3 residents (Resident 1) who were at risk of pressure injuries (PI), did not develop an avoidable PI. The facility failed to implement preventive PI interventions for Resident 1. This failed practice resulted in the development of a deep tissue injury (DTI) of Resident 1's left heel which caused the resident significant discomfort. This failed practice placed other residents at risk of pressure injuries, pain and decreased quality of life. Findings included. The National Pressure Ulcer Advisory Panel (NPUAP) Pressure Injury (PI- also known as a PU) definition and stages of PU's include:-A PI (PU) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present itself as intact skin or an open ulcer and may be painful. The injury occurs as the result of intense and/or prolonged pressure or pressure in combination with sheer. The tolerance of soft tissue for pressure and sheer may also be affected by microclimate (the skin temperature, humidity, and airflow next to the skin's surface), nutrition, perfusion (measures how well the circulatory system is working), co-morbidities, and condition of the soft tissue. Unstageable PI (PU) is an obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, and intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury (DTPI) is a persistent non-blanchable deep red, maroon, or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration, or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often preceding skin color changes. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness PI. Resident 1 was admitted to the facility 10/03/2025 with diagnosis to include a fractured left hip with surgical repair, morbid obesity, and neuropathy (a condition referred to damaged or diseased nerves, which may result in impair sensation). Review of Resident 1's admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], showed Resident 1 was not admitted with a PI and was at risk of developing a PI. Review of the admission Care Area Assessment (CAA) dated 10/09/2025, showed Resident 1 would be care planned at risk of developing a PI related to limited mobility and incontinence. Review of Resident 1's Skin Inspection Evaluation dated 10/03/2025, documented green boots (heel protective device) were placed on both feet after assessment. Review of Resident 1's care planned focus problem of potential for alteration in skin health related to surgical site dated 10/03/2025, showed Resident 1 was to be assisted to off load (reduction or removal of pressure and friction on a specific area of the body to promote healing and prevent further tissue damage) heels or use heel protective device boots when in bed. Review of Resident 1's planned focus problem of activities of daily living self-care performance deficit dated 10/04/2025, showed Resident 1 was dependent on two staff members for bed mobility with use of a turn sheet and verbal cueing. Review of Resident 1's Skin Inspection Evaluation dated 10/07/2025, documented a boggy/soft spot to the resident's left heel still present from admission but remains closed and painless. Review of Resident 1's direct care staff documentation for the Month of October 2025 showed no assigned task to assist to off load heels or use of a heel protective device when in bed was completed. Review of Resident 1's Treatment Administration Record (TAR) from 10/03/2025 to 10/13/2025, showed no use of protective heel devices or off-loading of the resident's heels were completed. Review of Resident 1's Skin Event dated 10/13/2025, showed the resident had developed a 5 centimeter (cm) by 7 cm, closed blister to the resident's left heel. Resident 1's statement regarding the possible cause of the skin issue was, it was from rubbing on the bed. The ordered plan implemented at the time of the skin issue was a dressing and protective heel boots. Review of an incident report dated 10/13/2025, showed Resident 1's left heel injury root cause analysis was due to the rubbing of the resident's heel while in bed, the resident's immobility, the resident's bed was too small for proper positioning, and the resident would lay on their back and again noted the bed was too small. The interventions were noted to offload the resident's heels in green heel boots and use of an Alternating Pressure Pump (APP) mattress. Review of Resident 1's TAR from 10/13/2025 to 10/31/2025, showed an