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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a safe, clean, comfortable and homelike environment on 2 of 2 units and the main dining room. Failure to ensure a comfortable interior in the dining room, unit halls free of unpleasant odors, adequate supply of linens, and perform needed repairs in resident's rooms placed residents at risk for decreased quality of life.Findings included .<LINEN SHORTAGE> During an interview on 08/07/2025 at 9:58 AM, Resident 14 reported that last week they had to go to bed with a draw sheet as the staff had told them there were no clean sheets available. Resident 14 reported last night there were no top sheets so they had to use a draw sheet for a regular sheet. <RESIDENT ROOMS> During an observation on 08/04/2025 at 9:07 AM, the bed in room [ROOM NUMBER]B did not have a mattress on the frame. During an observation on 08/05/2025 at 8:28 AM, the bed in room [ROOM NUMBER]B did not have a mattress on the frame. During an observation on 08/05/2025 at 8:28 AM, the bed in room [ROOM NUMBER]B did not have a mattress on the frame. During an interview on 08/05/2025 at 10:48 AM, Staff M, Maintenance Director, observed the bed frame in room [ROOM NUMBER]B. Staff M stated the bed was broken but they did not know why the mattress had been removed. During an interview on 08/05/2025 at 10:52 AM, Staff M observed the bed frame for 9B. Staff M reported that they had noted the mattress had been removed from the bed frame but had not had a chance to replace it. Staff M did not know why the mattress had been removed. In an observation on 08/04/2025 at 9:32 AM, Resident 4's left side curtain was observed to be propped on the curtain rod, the rings to the curtains piled on the resident nightstand. In an interview on 08/04/2025 at 9:55 AM, Collateral Contact (CC) 1 stated they had visited their mother over the weekend and noticed the curtain rings were lying on the ground beneath the window, and that the left curtain was not hung up. CC1 stated they spoke with a staff member about the broken curtain, and it was said they would let Staff M, Maintenance Director, know about it on Monday as they did not work at the weekend. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 08/04/2025 at 11:41, the curtain rings were lying on Resident 4's nightstand, and the left curtain was propped over the curtain rod. In observations on 08/05/2025 at 8:06 AM, and 11:15 AM the curtain rings were lying on Resident 4's nightstand, and the left curtain was propped over the curtain rod. In an observation on 08/05/2025 at 12:45 PM, Staff I, housekeeper was overheard in Resident 4's room state to the resident there are some rings on your nightstand, I think they go to your curtains, I am going to move them over here. In an observation on 08/05/2025 at 1:12 PM, unknown staff member was overheard in Resident 4's room state I can't really close your curtains, I will tell maintenance to fix them for you. In an observation on 08/05/2025 at 1:49 PM, the rings and curtains were lying on the table. In an interview and observation on 08/06/2025 at 9:54 AM, Staff D, Registered Nurse exited Resident 4's room, the curtain was observed to be fixed and hanging appropriately. Staff D stated that Resident 4 was anxious and tearful, Staff D felt it was due to curtain having been broken. <LINENS> In an interview on 08/04/2025 at 10:54 AM Collateral Contact 1, (CC1)-Resident 37's family member, stated there was often not enough linens for bed changes. CC1 stated the facility goes through a lot of bedding and the facility needs more bedding or more staff to help wash it. CC1 stated the staff had told them about the shortage of linen. In an interview on 08/06/2025 8:53 AM Staff F, Laundry Supervisor, stated the facility had problems with linen being stashed in resident rooms. Staff F stated, Staff E, Laundry Aide, had a good system in place and had been doing inventory for the linens. Staff F stated they needed to go through and find the stashed linens and then order more. Staff F stated the facility had enough linens for each bed, but did not want to get lower. When asked if any concerns had been brought up to them about availability of linens, they stated night shift had voiced running out of clean linen. In an interview on 08/06/2025 at 8:58 PM Staff E, Laundry Aide, stated there was enough linen and were waiting on orders for linen. Staff E stated they were working on the inventory of linens which had been in process for a few months. In an interview on 08/06/2025 at 8:59 AM Staff K, Nursing Assistant Certified (NAC) stated they thought the laundry department needed more staff. Staff K stated they typically have enough linen. Staff K stated the laundry gets behind due to their working schedules and when they come in the morning they are trying to catch up. Staff K stated they often had to remind other staff not to throw out linens that are soiled with fecal matter. In an interview on 08/06/2025 at 3:39 PM Staff J, NAC stated the facility is often short online, almost daily. Staff J stated they had brought the lack of linens to the attention of the Administrator, Director of Nursing and Maintenance, with no resolution. Review of the facility census dated 08/04/2025 showed there were 33 residents residing in the facility. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a review of the inventory, undated, showed the facility had the following: Draw Sheets: 17188 Fitted Sheets:13/33 Soaker Pads: 8/13 Top Sheets: 38/118 Blankets: 34/49 Fuzzy Blankets: 5/9 <ODORS> On 08/04/2025 at11:00 AM there was a strong urine odor in the south hallway between rooms [ROOM NUMBERS]. Observed Staff I, Housekeeper, exit room [ROOM NUMBER] where the strong urine odor poured out into the hallway. Staff I, stated the resident in room [ROOM NUMBER] did not like their room cleaned. On 08/05/2025 at 9:43 AM there was a strong urine smell in the hallway near nurse's station in between North and South halls. On 08/06/2025 at 9:37 AM there was an overpowering odor of feces coming from the end of the south hall permeating the entire hall. The smell lingered for approximately an hour until the surveyor notified Staff H, Resident Care Manager, of the odor. <DINING ROOM> On 08/04/2025 at 8:47 AM observed the only dining room (DR) in the facility. The dining room contained six tables. Two of the tables lined up on the right side of the DR wall room and had various items on top. To the left of those tables were two large vending machines. On the left side of the DR were two freezer chests and a piano which transitioned into an alcove. The alcove contained additional refrigeration and freezer units. The piano was blocked by tray carts which contained soiled dishes awaiting to be washed. The wall directly across from the DR entrance had chairs lining the walls with a small coffee table. The flooring under the coffee table did not match the rest of the flooring. The flooring was separating at the seams and showed visible gaps. In an interview on 08/04/2025 at 8:47 AM Staff L, Dietary Manager stated the space within the facility is limited and the facility had considered separating the alcove in the DR with a wall. Staff L stated the two tables on the right side of the DR were for activities. In an observation on 08/04/2025 at 11:58 AM observed DR service for lunch. Observed seven residents in the DR. There were two sets of tables (two pushed together) parallel to each other located in the center of the DR. There was little room left in the DR for other residents if requested to have their meal there. In an interview on 08/06/2025 at 2:22 PM Staff M, Maintenance Director, stated the flooring in the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dining room was scheduled to be replaced within the year. Staff stated the flooring and mismatched flooring under the coffee table had been in the DR since before they were the maintenance director, three years. Reference WAC 388-97-0880(1)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of insulin (injectable medication that regulates blood sugar) in 2 of 2 medication carts (North and South carts) when reviewed for medication storage. This failure placed residents at risk of receiving expired medications, ineffective treatment, and a diminished quality of life.Findings included.On 08/06/2025 at 9:35 AM, an observation of the South medication cart was conducted with Staff D, Registered Nurse (RN). Three of six Glargine insulins (a man-made version of the human hormone insulin) were observed in individualized plastic bags, stored outside of the refrigerator. In an observation and interview on 08/06/2025 at 9:40 AM, Resident 4's Glargine insulin pen (a device that has a cartridge of insulin and a needle to administer insulin injections) was observed without a date which indicated when it was opened and/or removed from the refrigerator. Resident 26's had an open bottle of Glargine insulin, dated 07/04/2025, and an undated Glargine insulin pen. Staff D could not find any dates on the insulin pens when they were removed from the refrigerator and/or opened. Staff D stated the Glargine insulin bottle was expired. When asked how long insulin was good for when removed from the refrigerator and when opened, Staff D stated 28 days. On 08/06/2025 at 9:51 AM, an observation of the North medication cart was conducted with Staff C, RN. Resident 43's Glargine insulin pen was observed stored in the medication cart and was undated. Staff C stated insulin was good for 28 days when pulled from the refrigerator. Staff C stated Resident 43's insulin pen should have been dated.In an interview on 08/06/2025 at 10:34 AM, Staff B, Chief Nursing Officer, stated insulin was good for 28 days, and should be dated when removed from the refrigerator and opened.Review of Resident 4's physician order, dated 06/14/2025, showed administer Glargine insulin 20 units subcutaneously one time a day.Review of Resident 26's physician order, dated 07/10/2025, showed administer Glargine insulin 10 units every day. Reference WAC 388-97-1300(2)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview, the facility failed to develop, implement and maintain a process to ensure annual performance reviews were completed for 3 of 5 staff (Staff P, Q, R) and that Nursing Assistant Certified (NAC) staff had the required 12 hour annual in-service training for 4 of 5 staff (Staff O, P, Q, R) reviewed for competent nursing staff. The failure to ensure NAC's had annual performance reviews to assess areas of weakness so the facility could provide in-service training and/or NACs received 12 hours annual in-service training placed residents at risk of less than competent care and services from staff.Findings included.Review of the facility assessment, dated 2025, showed the Staff Development Coordinator monitored the required education and required hours of education of staff. Education and training would include areas of weakness as determined by the NAC annual performance reviews.<STAFF P>Staff P, NAC, had a hire date of 01/10/2024. The facility provided documentation that showed Staff P had not had an annual performance review completed. Staff P had only 4.25 hours of in-service training. <STAFF Q>Staff Q, NAC, had a hire date of 11/11/2022. The facility provided documentation that showed Staff Q had not had an annual performance review completed. Staff Q had only 4 hours of in-service training. <STAFF R>Staff R, NAC, had a hire date of 08/31/2023. The facility provided documentation that showed Staff R had not had an annual performance review completed. Staff R had only 1.5 hours of in-service training. <STAFF O>Staff O, NAC, had a hire date of 01/31/2024. The facility provided documentation that showed Staff O had only 4.25 hours of in-service training. During an interview on 08/06/2025 at 11:47 AM, Staff A, Administrator, reported that staff performance evaluations and required 12 hours of education hours were not complete.During an interview on 08/06/2025 at 2:40 PM, Staff S, Human Resources/Payroll Coordinator, confirmed that Staff P, Q, and R did not have their performance review completed. Staff S stated the hours of education provided by the facility for Staff O, P, Q, and R was what the facility had documented for their annual in-service hours. Reference WAC 388-97-1680 (1)(2)(b)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review the facility failed to initiate, investigate, and resolve a grievance for 1 of 1 sampled residents (Resident 3) reviewed for grievances. This failure placed residents at risk for emotional distress and a diminished quality of life.Findings included.In a review of the facility policy titled, Complaints and Grievances revised on 10/15/2022 showed complaints/grievances may be verbal or written, they are acknowledged, investigated and the complainant apprised of progress toward a resolution.In a review of the facility policy titled, Complaints and Grievances revised on 10/15/2022 showed complaints/grievances may be verbal or written, they are acknowledged, investigated and the complainant apprised of progress toward a resolution. In an interview on 08/04/2025 at 11:29 AM Resident 3 stated they were missing seven pairs of rubber pants for two weeks. Resident 3 stated they had reported the missing rubber pants to at least four or five staff members. Resident 3 stated Staff E, Laundry Aide (LA), was the only staff allowed to take and launder their clothing. Review of the grievance log from February 2025 through July 2025 showed no logged entries for Resident 3's missing rubber pants. In a joint interview on 08/06/2025 at 1:30 PM Staff B, Director of Nursing Services and Staff H, Resident Care Manager/Registered Nurse both stated they were not aware of Resident 3 missing rubber pants. In an interview on 08/06/2025 at 3:15 PM Staff G, Registered Nurse stated they had not received any reports from Resident 3 about missing rubber pants. In an interview on 08/06/2025 at 3:18 PM Staff E, LA, stated Resident 3 had reported missing rubber pants, they currently had one pair remaining and used to have more. Staff E stated Resident 3 had recently been at the hospital and their daughter had come to rearrange their room and directed Resident 3 to ask their daughter. Staff E stated they did not fill out a grievance form on Resident 3's behalf and did not know how to do it. In an interview on 08/06/2025 at 3:20 PM Staff F, Laundry Supervisor, stated if a resident was missing an item it needed to be put on a grievance form and tracked. Reference WAC 388-97-0460

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure professional standards were met for 3 of 5 residents (Residents 3, 6, and 26) reviewed for unnecessary medication review. The facility failed to recognize and ensure parameters were met for blood pressure medication administration and diabetes (blood sugar levels in blood are unmanaged) medication management for the residents. The facility failed to notify the medical provider when the resident's blood sugar levels and blood pressures were beyond the ordered parameters. These failures placed the residents at risk for adverse outcomes, medication errors, complications, and unmet needs.Findings included .Review of the facility policy titled, Oral medication administration, dated 01/01/2018, documented medication was administered per physician orders and manufacturer directives. Vital sign parameters and side effects are monitored as indicated. <RESIDENT 3> Resident 3 readmitted to the facility on [DATE] with diagnoses to include diabetes mellitus, type two (chronic condition in which the body does not produce enough insulin or can't properly use insulin, creating high blood sugar). In an interview on 08/04/2025 at 11:44 AM Resident 3 stated they were prescribed insulin to manage their diabetes. Resident 3 stated they had recently been hospitalized with a very low blood sugar. In a review of Resident 3's Medication Administration Record (MAR) for July 2025 showed an order to check their Blood Glucose (BG) before meals and if their BG was less than 70 initiate low blood sugar protocols and notify the provider and if their BG was above 300 to notify the provider and follow their directive. The MAR for July showed Resident 3 had BG over 300: 7/24/2025 at 4:00 PM BG 309 07/29/2025 at 4:00 PM BG 373 07/30/2025 at 4:00 PM BG 314 In a review of Resident 3's Electronic Medical Record (EMR) showed no documentation of the provider being notified of their BG's levels over the prescribed parameter. In an interview on 08/06/2025 at 12:46 PM Staff D, Registered Nurse (RN) stated they follow the physician's orders. Staff D stated if a resident had BG out of parameters, they would notify the physician by phone and complete a Situation, Background, Assessment and Recommendation (SBAR) form. Staff D stated they get report at shift change of any resident who had high or low BG levels. <RESIDENT 6> Resident 6 admitted to the facility on [DATE] with diagnoses to include diabetes mellitus type two and high blood pressure. Review of Resident 6's MAR for July and August 2025 showed they were prescribed medication for high blood pressure and insulin (a medication injected under the skin to regulate blood glucose level) for diabetic management. The MAR directed the staff to hold their blood pressure medication if Resident 6's Diastolic Blood Pressure (DBP-the pressure in the blood vessels between heartbeats) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was less than 70 and notify the provider if their BG level was above 349. The MAR for July and August 2025 showed Resident 6 should have had their blood pressure medication held 24 out of 31 days for the month of July and on 08/01-08/03/2025 as their DBP was less than 70. The MAR showed that Resident 6 had BG levels above 349 as follows: JULY 2025: 07/07/2025 BG 365, 07/10/2025 BG 385, 07/14/2025 BG 542, 07/15/2025 BG 383, 07/23/2025 BG 354, 07/24/2025 BG 558 and 07/25/2025 BG 350 AUGUST 2025: 08/03/2025 BG 358 In a review of Resident 6's EMR showed no documentation of their provider being notified of low DBP or high BG or high blood pressure medication being held per physician orders. In an interview on 08/06/2025 at 1:09 PM Staff B, Director of Nursing Services, stated there was a dashboard in their electronic charting system that notified the nursing staff of high BG and low DBP to prompt the nursing staff to contact the provider. No other information was provided. <RESIDENT 26>Resident 26 admitted to the facility on [DATE] with diagnoses that included primary hypertension (high blood pressure). Review of Resident 26's physician orders showed the resident had an order for metoprolol tartrate oral tablet, give 37.5 milligrams twice a day, hold if the systolic (SBP – upper blood pressure number) was less than 120 or if their heart rate was less than 60 beats per minute (bpm). Review of Resident 26's electronic medication administration record (EMAR) for July 2025 documentation reflected the residents SBP was less than 120 on 4 of the 31 days in July. The licensed nurse administered the medication. Review of Resident 26's EMAR for June 2025 documentation reflected the residents SBP was less than 120 on 10 of the 30 days in June. The licensed nurse administered the medication. Review of Resident 26's EMAR for May 2025 documentation reflected the residents SBP was less than 120 on 9 of the 31 days in June. The licensed nurse administered the medication. In an interview on 08/07/2025 at 8:57 AM, Staff H, Registered Nurse/Resident Care Manager stated that if the licensed nurse found a resident's vital signs were outside the parameter of the physician ordered medication, they expected the staff to not administer the medication. Staff stated they should notify the physician and document in the medical record. In an interview on 08/07/2025 at 10:19 AM, Staff B, Director of Nursing Services stated their expectation for all licensed staff was if any resident's vital signs were outside the parameter of the physician order, they were to not administer the medication. Staff B expected their staff to notify the physician, and document in the medical record. Reference WAC 388-97-1060(3)(k)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 of 4 residents (Resident 13) reviewed for activities of daily living, received adequate bathing according to the resident's plan of care. This failure placed the resident at risk of poor hygiene and a diminished quality of life.Findings included.Resident 13 admitted to the facility on [DATE].During an interview on 08/04/2025 at 9:10 AM, Resident 13 reported they preferred two showers a week, but had not had a shower in the last month. Resident 13 reported that they needed their beard trimmed but the staff only did that when they received showers. Resident 13 was noted to have a long beard.Review of Resident 13's Kardex (specifies resident's care needs), dated 08/05/2025 showed they preferred two showers each week and if resident could not tolerate a shower, then staff were to provide a bed bath.Review of Resident 13's last 30 days of bathing documentation, dated 08/05/2025, showed they had received showers on 07/08/2025, 07/12/2025 and 07/15/2025. The documentation showed Resident 13 had refused a shower on 07/29/2025 and 08/02/2025. The documentation showed that a shower was Not applicable/Not attempted (NA) on 07/22/2025 and 07/26/2025. There was no documentation that a bed bath had been provided.During an interview on 08/05/2025 at 10:16 AM, Staff Q, Nursing Assistant Certified (NAC), reported Resident 13 did not typically refuse showers unless they had a visitor. Staff Q had documented the shower refusal for Resident 13 on 07/29/2025. Staff Q reported that it was an error in documentation as they had not worked in the hall where Resident 13 resided and resident had not refused any showers from them in the recent past.During an interview on 08/05/2025 at 10:42 AM, Staff K, NAC, reported if they did not have enough time to complete an assigned shower, they relayed that information to the oncoming shift to try to complete or try to do the next day. Staff K had documented NA for Resident 13's showers on 07/22/2025 and 07/26/2025. Staff K reported they had ran out of time on those two shifts and could not complete Resident 13's shower.During an interview on 08/05/2025 at 11:25 AM, Staff B, Chief Nursing Officer, reported they were not aware Resident 13 had not had a shower provided since 07/15/2025. Staff B reported they would check with the staff. No further information was provided. Refer to WAC 388-97-1060 (2)(c)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pharmacy recommendations were completed in the medical record for 2 of 6 residents (Residents 26 and 30) reviewed for unnecessary medications. This failure placed the residents at risk for delay in necessary medication changes, incomplete medical records, and adverse side effects.Finding included . Review of the facility policy titled, Pharmacy Services, dated 11/28/2017 documented the facility will collaborate with the pharmacist in a timely manner to develop an implementation of pharmaceutical services and address the needs of the residents consistent with state and federal requirements and standards of practice. Review of the facility policy titled, Unnecessary medications, revised date 04/22/2025, documented the facility will conduct an Abnormal Involuntary Movement Scale (AIMS) test of all residents receiving antipsychotic medications. Psychoactive medications should be evaluated after 14 days after admission or start date. <RESIDENT 26>Resident 26 admitted to the facility on [DATE] with diagnoses that included Review of Resident 26's physician orders on 08/05/2025 documented the resident was prescribed an anti-psychotic (treatment for psychosis) medication three times a day. Review of pharmacy recommendation dated 07/11/2025, for Resident 26 documented the facility had not conducted an AIMS test for the resident, and it was overdue. The document was noted by the nurse practitioner that they agreed it needed to be completed. The document was also had noted written at the bottom of the page, with unknown initials and dated 08/01/2025.Review of Resident 26's medical record on 08/07/2025 documentation showed the last AIMS conducted was in January/2025. <RESIDENT 30>Resident 30 admitted to the facility on [DATE] with diagnoses that included schizophrenia (sever mental disorder with delusions, hallucinations, and disorganized thinking and speech). Review of Resident 30's physician orders on 08/06/2025 documented the resident was prescribed an anti-depressant (treatment for depression) medication every four hours as needed, with start date of 06/15/2025 and no end date. Review of the pharmacy recommendation dated 07/11/2025, for Resident 30 documented that the resident had been on a psychoactive medication as needed past the 14-day evaluation date, and if necessary, what was new duration and rationale. The provider agreed to a 14-day duration and documented the rationale. The document was also had noted written at the bottom of the page, with unknown initials and dated 08/01/2025.Review of Resident 30's medical record on 08/07/2025 documentation showed the antidepressant medication had a start date of 06/15/2025 and no end date. In an interview on 08/07/2025 at 8:57 AM, Staff H, Registered Nurse/Resident Care Manager (RCM) stated that the pharmacy recommendations go to the Director of Nursing Services (DNS) and then they divide them up based on unit. Staff H was shown the pharmacy recommendations for Resident 26 and Resident 30 and stated that the unknown initials at the bottom of the document were theirs. Staff H stated they mark them when they are completed. Staff H was asked to look at the medical records for Resident 26 and Resident 30 to show where the recommendations had been completed in the medical record. Staff H was unable to locate the AIMS for Resident 26 anti-psychotic medication use, or a stop date for Resident 30's anti-depressant medication. Staff H stated I must not have completed them. In an interview on 08/07/2025 at 10:19 AM, Staff B, Director of Nursing (DNS) stated AIMS were to be completed every 6 months, however they usually do them every quarter as that was how often they review the resident's medical record. Staff B stated the RCMs were given the monthly pharmacy recommendation to ensure the provider reviews the recommendation and that they are completed timely. Staff B was not sure why the recommendations for Resident 26 and Resident 30 were marked noted, however not completed in the medical record. Reference WAC 388-97-1300(4)(c)

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

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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 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. 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 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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]. 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)