STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505296	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis of Bellingham	3121 Squalicum Parkway Bellingham, WA 98225

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43954 Based on interviews and record review, the facility failed to ensure that notification of changes had been communicated to the resident and/or resident representative for 1 of 3 (Resident 1) residents reviewed for notifications of change. These failures placed residents and/or representatives at risk of not being informed of resident changes in health status or transfers out of the facility. Findings included . Resident 1 admitted to the facility on [DATE], with diagnoses to include schizoaffective disorder (condition that includes schizophrenia and a mood disorder symptoms), encephalopathy (brain disease that alters brain function or structure), major depressive disorder and anxiety. Review of Resident 1's medical record showed a Guardian listed as their responsible party and emergency contact. Review of a Resident 1's progress notes dated 12/20/2024 showed notifications were not documented as being made related to abnormal lab values or their transfer to the hospital on 12/20/2024. In an interview on 01/13/2025 at 10:57 AM, CC1, Guardian of Resident 1, stated the facility had not communicated with them when the resident had abnormal lab values or when Resident 1 was transferred to the hospital. CC1 stated they received the information from the hospital staff after Resident 1's arrival. CC1 stated the facility had an option to leave a voicemail for them at any time during the day or night and there was also an option to talk with whomever was on call for any emergencies. CC1 stated neither of these options were utilized. In an interview on 01/13/2025 at 2:07 PM, Staff C, Licensed Practical Nurse (LPN), Unit Manager stated they attempted to call CC1's Guardian, but did not make contact before the resident was transferred to the hospital. Staff C stated they did not wait to leave a message or utilize the on-call option for emergencies. Staff C stated they spoke with CC1's office when someone from the office called after being notified by the hospital that Resident 1 had been transferred. In an interview on 01/13/2025 at 3:20 PM, Staff B, Registered Nurse (RN), Director of Nursing Services (DNS) stated it was their expectation that any resident changes, medical or psychosocial changes, and transfers would be communicated to the Resident's representative. (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
	505296	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis of Bellingham	3121 Squalicum Parkway Bellingham, WA 98225

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC: 388-97-0320 (1)(b)(d)