

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER MT Baker Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2905 Connelly Avenue 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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) received the necessary care and services to attain or maintain the highest practicable physical level of well-being. Failure to ensure Resident 1 received care in accordance with a physician order and their care plan when they received a bath and not a shower. This failure potentially placed the resident at risk of medical complications and a decreased or diminished quality of life. Findings included .Resident 1 was admitted to the facility on [DATE] with diagnoses to include vesicointestinal fistula (abnormal opening between the bladder and the intestines) and colovaginal fistula (abnormal opening between the colon and the vagina).Review of Resident 1's admission Minimum Data Set assessment (a resident assessment tool), dated 7/27/2025, showed the resident had a Brief Interview for Mental Status (BIMS - a structured cognitive interview) score of 09 which indicated the resident had moderate cognitive impairment.Review of Resident 1's Activities of Daily Living (ADL) care plan, date initiated 07/21/2025, showed they were to have only a shower related to their urinary and gastrointestinal fistulas.Review of Resident 1's Kardex (a guide the care staff use to help direct the resident care), dated 07/21/2025, showed they were to have only a shower related to their urinary and gastrointestinal fistulas.Review of Resident 1's documentation survey report (Nursing Assistant Certified (NAC) documentation in the electronic health record) dated August 2025 showed the resident received a bath on 08/21/2025 by Staff B, NAC.In an interview on 01/07/2025 at 1:46 PM, Staff B, NAC, stated they reviewed a resident's care plan and Kardex to know what kind of assistance and care they need. Staff C stated that the documentation code for shower was different from a bath. Staff C confirmed they documented Resident 1 received a bath on 08/21/2025.In an interview on 01/07/2025 at 2:09 PM, Staff A, Registered Nurse (RN)/Director of Nursing Services (DNS), stated care plans were used to make sure staff knew how to provide a residents personal care. Staff A stated they would expect staff to follow the care plan and not give baths when they were to only receive showers. Reference WAC: 388-97-1060(1)(2)(c)		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 505376
		If continuation sheet Page 1 of 1