STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505376	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Baker Care Center	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure their abuse and neglect policy was followed for an allegation of abuse for 1 of 1 resident (Resident 1). This failed practice placed Resident 1 and all other residents at risk of abuse and neglect. Findings included.Review of the facility's policy titled, Abuse and Neglect Policy, with a review date of 11/11/2025, showed it was the policy of the facility to follow effective procedures to protect and prevent abuse of residents which included to report allegations of abuse and neglect to the appropriate authorities and investigate allegations of abuse and neglect. Resident 1 was admitted to the facility on [DATE]. The resident's Minimum Data Assessment (MDS- an assessment tool) dated 04/16/2026 showed the resident was assessed as cognitively intact, with no mood or behavior symptoms. Review of the facility's April and May 2026 grievance and incident logs showed no grievance or incident involving Resident 1. Review of Resident 1's Clinical Census report showed Resident 1 was moved from the South hallway to the Medicare Hallway on 04/10/2026 until 04/20/2026. In a phone interview on 05/11/2026 at 8:17 AM, Resident 1's, Family Member/Collateral Contact (CC) 1, stated the prior week Resident 1 normally had a roommate but due to COVID, the resident had been isolated for 10 days in a private room. CC 1 stated the resident reported there were three men in their room groping them when they woke up naked. CC 1 stated Resident 1 reported they felt like they had been drugged, their room was dark, and the individuals in their room did not want to be seen. CC 1 stated Resident 1 identified one of the men in their room but could not identify the other two men. CC 1 stated the resident reported the incident to Staff B, Nursing Assistant Certified (NAC) and as Resident 1 indicated Staff B seemed to know this was occurring. CC 1 stated the resident had been very happy in the facility, and this was all quite a shock. CC 1 stated they were worried about reprisal of staff wanting to cover their behinds. CC 1 stated Resident 1 was very vulnerable. CC 1 stated they had reported the incident to the state's advocacy volunteer who indicated they would look into the matter. CC 1 stated they felt powerless. CC 1 stated the resident reported they had discussed the incident with other residents who reported this type of thing occurs. In an interview on 05/11/2026 at 12:41 PM, Resident 1 stated they had a COVID infection and were moved to a room by themselves. Resident 1 stated one night there was a loud crash and they woke up with no clothes or covers on with three males standing around groping them. Resident 1 stated they felt like they must have been drugged as they are usually a light sleeper. Resident 1 stated they reported the incident to Nursing Assistant Certified (NAC) Staff B, noting that residents frequently reported issues to this specific staff member. Resident 1 stated Staff B had said it was difficult to know how these things got started. Resident 1 stated they reported there were three guys in their room, two on the side of their bed and one at the foot of their bed. Resident 1 stated they felt frozen in emotion and could not speak. Resident 1 stated they reported the incident to Staff B a couple of days after they moved back to the room they are in now. In an interview on 05/11/2026 at 1:21 PM, the surveyor asked Staff B if Resident 1 had shared any information with them. Staff B stated they remember what the surveyor was asking about. Staff B stated they shared the information with one of the nurses but could not recall exactly which nurse. Staff B stated (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 reported a man was standing over them while they were on the Medicare Hall. Staff B stated they did not fill out a grievance report but had wanted to give information to the facility's administration. Staff B stated they believed they had said something to Staff C, RN/Case Manager, or one of the care managers. Staff B stated they reported the information verbally, it was a serious matter, and they always tell a care manager. Staff B stated Resident 1 had told them they did not want to get anyone else involved. Staff B stated Resident 1 had reported to them it was scary as there was a dark figure of a man standing over them. Staff B stated they did not believe they had filled out a statement. In an interview on 05/11/2025 at 1:38 PM, Staff C stated they vaguely recalled something involving Resident 1. Staff C stated the resident had COVID and they had woken up in the night scared. Staff C stated they would have to look into it as they could not recall the circumstances exactly. In an interview on 05/11/2026 at 2:30 PM, Staff D, NAC stated they had training in abuse and neglect and if a resident reported an incident of abuse or neglect they would tell someone like a nurse. Staff D stated they would fill out a form about what the residents reported and would tell a nurse. Staff D stated the forms were at the nurses' station in a binder. Staff D stated they had abuse and neglect training about a month ago. Staff D was asked several times if they would report an allegation to anyone else and Staff D did not indicate they would report the allegation to the State Agency. In an interview on 05/11/2026 at 2:55 PM, Staff A, NAC stated they always worked on the evening shift and had worked toward the end of the COVID outbreak. Staff A stated they had provided care for Resident 1 one time when the resident was in their usual hallway but had not provided care for Resident 1 during the outbreak. In an interview on 05.11.2026 at 4:15 PM, Staff E, NAC requested Staff F, Director of Nursing Services, to sit in on the interview. Staff E stated they had received training on abuse and neglect. Staff E was asked what they would do if a resident reported an allegation of abuse. Staff E stated they would talk it through with the resident and take the allegation to the nurse. Staff E confirmed they would not need to report the allegation to anyone else. After the interview Staff F stated they were glad they were able to observe the interview and could see where the facility needed to do some training. Reference WAC 388-97-0640 (2)(b)(5)(a)(6)(a)(b)(c)