

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER North Cascades Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4680 Cordata Parkway Bellingham, WA 98226	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035</p> <p>Based on interview and record review the facility failed to ensure the resident's Power of Attorney (POA) was notified timely for 1 of 2 sampled residents (Resident 1) reviewed for notification of change of condition. The facility failed to notify the POA timely of the start of an antibiotic for a respiratory tract infection and of a ground level fall. This failure placed all the residents' POA at risk of not being informed of residents' status.</p> <p>Findings included .</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses to include dementia, fractured hip, and depression.</p> <p>Review of a Late Entry, nursing progress note dated 03/28/2024, showed a new order was received for Levaquin (an antibiotic) for five days, Mucinex (nasal decongestant) for 10 days and Albuterol (medication used to treat bronchospasms) the family was notified, and Resident 1 was placed on alert by Staff B, Registered Nurse (RN).</p> <p>Review of nursing progress note dated 03/29/2024, showed Resident 1 was heard calling out for help and was found face down on the floor next to their bed. Staff B documented the family was noted to have been advised of Resident 1's unwitnessed fall.</p> <p>In an interview on 04/09/2024 at 4:20 PM, Staff B, stated they had not taken care of Resident 1, that Staff A, Licensed Practical Nurse, used their sign in credentials to document and Staff A was on duty and took care of Resident 1.</p> <p>In a phone interview on 04/10/2024 at 3:30 PM, Collateral Contact 1 (CC 1), Resident 1's POA, stated they had been in to see Resident 1 and Resident 1 was teary eyed, delusional, and obviously not their normal self. CC 1 stated they reported Resident 1's increased confusion to Staff A. CC 1 stated Staff A told them Resident 1 had been like that all day and said, Oh, you know your mom fell yesterday or the day before. CC 1 stated they had not been notified of Resident 1's fall or their increased confusion.</p> <p>(continued on next page)</p>		

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/12/2024 at 1:50 PM, Staff A stated they had just started working at the facility again and there was a lot going on. Staff A stated they assumed Resident 1's family had been notified was why they documented the resident's family had been notified. Staff A stated that when CC 1 was in the facility the day after Resident 1 fell was when they told them of Resident 1's fall and that Resident 1 was being treated for an upper respiratory infection.</p> <p>In an interview on 04/15/2024 at 11:59 AM, Staff C, RN, stated if a resident were to fall, they would notify the doctor, the Director of Nursing Services, Resident Care Manager, and the resident's family. Staff C stated they would document who they notified. Staff C stated if they notified the resident's family, they would document the name of the resident's family member.</p> <p>Refer to F658 CFR483.21(i) Meet professional standards of quality</p> <p>Refer to WAC: 388-97-0320(1)(a)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>37035</p> <p>Based on interview and record review the facility failed to ensure 1 of 2 new hired Licensed Practical Nurses (LPN) nursing staff (Staff A) received their credentials (username and password) to document in the facility's electronic medical record prior to working independently. This facility failed practice recorded Staff A, LPN falsely documented nursing notes, medication administration record (MAR) and treatment administration record (TAR) as completed by Staff B, Registered Nurse (RN).</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Electronic Signature, updated June 2016 showed authorized employees and contractors are assigned a credential, commonly a username with a password or pin, which is used as an electronic signature. An attestation statement is signed to certify that they have sole access to and are the sole user of the password/pin. Employees and contractors are instructed that they will not share their password/pin and that doing so will be grounds for disciplinary action up to and including immediate termination.</p> <p>Review of Staff B, Electronic Signature Attestation Statement, dated 02/20/2015, showed Staff B signed they acknowledged they were responsible and accountable for the use of their personal electronic signature password/pin. Staff B certified they would be the sole user of their password/pin and would have sole access to the password/pin. Staff B would not share their electronic signature password/pin with anyone at any time. Staff B understood that doing so would be grounds for disciplinary action up to and including termination.</p> <p>Review of Staff A, Electronic Signature Attestation Statement, dated 03/27/2024, showed Staff A signed they acknowledged they had received, read, and fully understood the Electronic Signature Attestation Policy. Staff A acknowledged they were responsible and accountable for the use of their personal electronic signature password/pin. Staff A certified that they would be the sole user of their password/in and would have sole access to the password/pin. Staff A would not share their electronic signature password/pin with anyone at any time. Staff A understood that doing so would be grounds for disciplinary action up to and including termination. Staff A understood that any known or suspected security breach involving electronic signatures would be immediately reported to the facility's Compliance Officer.</p> <p>Review of the first-floor nurse's working schedules from 03/28/2024 through 04/12/2024 showed the following shifts and assignments for Staff A and Staff B:</p> <p>03/28/2024 Staff A oriented with Staff B on Cart A on the evening shift and Staff B worked Cart B on the night shift.</p> <p>03/29/2024 Staff A worked Cart A and Staff B worked on Cart B on the evening shift.</p> <p>03/30/2024 Staff A worked Cart A on the evening shift and Staff B worked on Cart B on the evening and night shift.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>03/31/2024 Staff A worked Cart A and Staff B worked Cart C on the evening shift and Staff A worked A Cart and Staff B worked B Cart on the night shift.</p> <p>Review of the charting for the following residents on Cart A from 03/28/2024 through 04/12/2024 showed documentation was completed by Staff B, yet was completed by Staff A for the following residents with their associated assignment and room number:</p> <p>Resident 1 (1A - 111-2) - 03/28/2024, 03/29/2024 (was struck out), 03/31/2024 (was struck out),</p> <p>Resident 2 (1A - 113-1) - 03/29/2024, 03/31/2024.</p> <p>Resident 3 (1A 111-1) - 03/30/2024.</p> <p>Resident 4 (1A 110-1) - 03/31/2024.</p> <p>Resident 5 (1A 109-2) - 03/30/2024.</p> <p>Resident 6 (1A 109-1) - 03/28/2024, 03/29/2024, 03/30/2024, 03/31/2024.</p> <p>Resident 7 (1A 107-1) - 03/31/2024</p> <p>Resident 8 (1A 105-1) - 03/28/2024</p> <p>Review of the MAR and TAR from 03/28/2024 through 03/31/2024 showed documentation Staff B administered medication and/or treatments, yet Staff A completed the administration for the following residents with their associated assignment and room number:</p> <p>Resident 1 (1A 111-2)</p> <p>Resident 2 (1A 113-1)</p> <p>Resident 3 (1A 111-1)</p> <p>Resident 4 (1A 110-1)</p> <p>Resident 6 (1A 109-1)</p> <p>Resident 7 (1A 107-1)</p> <p>Resident 8 (1A 105-1)</p> <p>Resident 9 (1A 108-1)</p> <p>Resident 10 (1A 104-1)</p> <p>Resident 11 (1A 102-2)</p> <p>Resident 12 (1A 103-1)</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/12/2024 at 4:28 PM, Staff E, RN/Acting DNS, stated they had heard that Staff A had charted under Staff B's password. Staff E stated they needed to get a hold of Staff A, but they had a phone number that was turned off. Staff E stated Staff A had said Staff F, prior RN/DNS, had told them it was okay to use Staff B's password. Staff E stated Staff A had said there was only one resident they had charted on under Staff B's credentials. Staff E stated they were aware Staff A corrected only Resident 1's progress note charting. Staff E stated Staff G and Staff F were investigating the issue.</p> <p>In an interview on 04/15/2024 at 4:40 PM, Staff G, stated they had provided education to the staff to ensure everyone else had their own passwords and they had Staff B change their password credentials. Staff G stated they completed a risk management and completed strike out documentation for the reported three days, 03/27/2024, 03/28/2024 and 03/29/2024. Staff G stated they were going to have Staff B along with Staff A make the corrections, but Staff A had quit. Staff G stated now they were going to have Staff B make a note that the documentation under Staff B's name was documented by Staff A.</p> <p>In a phone interview on 04/17/2024 at 1:42 PM, Staff F, stated they had hired Staff A back after checking their background. Staff A stated the scheduler had talked to Staff A about orientation and Staff A had said they only needed one day to orient as they were used to the work. Staff F stated someone had told them Staff A needed their credentials and they had told Staff D to send for Staff A's credentials ASAP (As Soon As Possible) as Staff A was scheduled to work the medication cart. Staff F stated Staff D reported they would submit for Staff A's credentials and thought Staff D would provide Staff A with their credentials. Staff F stated they were unaware Staff A did not receive their credentials. Staff F stated they were interviewing Staff B for Resident 1's fall when they found out that Staff A was using Staff B's credentials. Staff F stated they had tried to call Staff A, but their contact number was not working. Staff F stated they had asked Staff A and Staff B to come in early to work to correct the charting issues.</p> <p>Refer to WAC 388-97-1620(2)(b)(i)(ii)</p>		