STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505393	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Cascades Health and Rehabilitation Center	4680 Cordata Parkway Bellingham, WA 98226

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on interview and record review, the facility failed to provide the required refund for 3 of 4 sampled residents and/or their resident representative (Resident 3, 4, and 6) within the required 30 days after the resident's discharge. This failed practice placed the resident and/or resident representative at risk of financial hardship. Findings included . Review of the facility's policy titled, Resident Refunds, updated May 2007, showed the Nursing Center processes refunds to resident or their estates within the earlier of 30 days from the date of the resident's death or discharge from the center. Where a third-party payor (such as Medicare or an HMO [Health Maintenance Organization]) has not paid the Center on behalf of the resident, amount billed to such third-party payor decreased the amount of any resident refund until the third-party's payment is made. The facility's policy had a handwritten notation, Waiting for Med [Medicare] B to payout prior to issue refund. Once Med B claim submitted will issue refund. In an interview on 06/03/2024 at 2:08 PM, Staff P, Business Office Manager, stated the facility's corporate office would not refund residents until the resident's insurance had been billed. Staff P clarified the company would not release funds until all the insurances had been billed. Staff P stated this process was implemented with the change of ownership in the facility. Review of Resident 4's account history, showed Resident 4 was discharged on [DATE] with a $1,784.00 refund due. Review of Resident 6's account history, showed Resident 6 was discharged on [DATE] with a $9,409.03 refund due. Review of Resident 3's account history, showed Resident 3 was discharged on [DATE] with a $687.81 refund due. In a phone interview on 06/20/2024 at 12:37 PM, Staff P stated they submitted for a refund request to their corporate office who was then responsible to refund the resident's money. Staff P confirmed no refunds had been provided to Resident 3, Resident 4, and Resident 6 at the present time. Refer to WAC 388-97-0300 (6)(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

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on interview and record review, the facility failed to ensure staff monitored, assessed, and implemented interventions to prevent the occurrence of avoidable pressure ulcer/pressure injuries (PI) for 1 sampled resident (Resident 1) reviewed for PI. Resident 1 experienced harm when they developed an avoidable Stage 3 pressure PI to their rib area and two avoidable unstageable PI's to their sacrum. This failed practice placed all other residents at risk of the development of a PI. Findings included . The National Pressure Ulcer Advisory Panel (NPUAP) PI definition and stages of PI's include: -A PI is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as the result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate (the skin temperature, humidity, and airflow next to the skin's surface), nutrition, perfusion (measures how well the circulatory system is working), co-morbidities, and condition of the soft tissue. Stage 3 PI is a Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining (occurs when significant erosion occurs underneath the outwardly visible wound margins resulting in more extensive damage beneath the skin surface) and tunneling (when a wound progresses to form passageways underneath the surface) may occur. Unstageable PI is an obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, and intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Resident 1 was admitted to the facility on [DATE], with diagnoses to include type 2 diabetes mellitus (medical condition in which the body doesn't use insulin properly), peripheral vascular disease (PVD - is a slow and progressive circulation disorder), and major depressive disorder. Review of the care plan focus problem, revised on 02/29/2024, showed Resident 1 was at risk for PI development, had admitted with a Stage 3 PI to their sacrum (a large bone at the base of the spine), had an electrical burn to their back, a laceration to the right side of their back and to the back of their head. The interventions included to follow facility policies/protocols for the prevention/treatment of skin breakdown, administer treatments as ordered and monitor for effectiveness, and administer medications as ordered. Staff were to monitor/document any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size, and stage. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the consulting wound care note, dated 04/03/2024, showed Resident 1 was being discharged from the consulting wound care services. The note showed Resident 1's chronic sacrum PI was closed and in the final remodeling phase (the final phase of the wound healing process) of wound healing. Staff were to continue offloading (a way to redistribute pressure) as much as possible with frequent position changes was recommended. Review of Resident 1's April 2024 Treatment Administration Record, showed the following information: -Sacrum wound care one time a day every Monday, Wednesday and Friday, cleanse with wound cleanser, apply skin prep to peri wound and allow to dry and apply bordered dressing, initiated on 03/29/2024 and discontinued on 04/17/2024. -Sacrum wound monitor every dayshift and evening shift for signs and symptoms of infection, initiated on 03/28/2024 and discontinued on 04/17/2024. -Weekly Skin Observation Tool evaluation every Tuesday, completed on 04/02/2024, 04/09/2024 04/16/2024 and 04/23/2024. -Monitor blister wound to the back right side daily, cleanse and leave open to air, monitor for infection on dayshift, evening shift and night shift initiated on 02/28/2024 through night shift on 04/30/2024. Review of the Discharge Minimum Data Set (MDS-an assessment tool) assessment, dated 04/30/2024, showed Resident 1 had no PI's or a non-removable dressing. Review of the hospital's scanned photo, scanned date 04/30/2024, showed Resident 1 had PI's to their right rib area and on their buttocks. Review of the hospital wound care progress note, dated 04/30/2024, showed Resident 1 had the following wounds: - A stage 3 PI measuring 2.5 cm (centimeters) x 1.6 cm x 0.4 cm to the right ribs. - An unstageable PI measuring 0.5 cm x 0.5 cm x 0.3 cm to their left sacrum. - An unstageable PI measuring 0.6 cm x 0.6 cm x 0.4 cm to their right sacrum. In a co-interview on 05/29/2024 at 2:45 PM, Staff A, Registered Nurse (RN)/Director of Nursing Services, and Staff B, RN. Staff B stated Resident 1 was seen by the consulting wound care provider and remember they resolved Resident 1's wounds. Staff B stated the resident's pressure injuries were resolved on 04/23/2024 and if they reopened the staff should have let them know and they should have obtained a treatment order for a wound care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 05/30/2024 at 2:43 PM, Staff C, RN/MDS Nurse, stated they looked at the skin evaluation sheets, or the consulting wound clinic care notes when they coded PI on the MDS assessment. Staff C stated they had assigned skin nurses now to verify what was on the skin sheet was accurate. Staff C stated if there were any discrepancy they would talk to the nurses and verify with the skin nurse prior to coding the MDS. Staff C stated if they were in doubt about the documentation they would conduct an observation of the resident's skin. Staff C stated as of 04/10/2024, Resident 1's PI had resolved, but did know they had a skin tear. Staff C stated on 04/29/2024 Resident 1 had no current PI's. In an interview on 06/03/2024 at 2:30 PM, Staff D, Licensed Practical Nurse (LPN), stated the Nursing Assistant Certified (NAC) would inform the nurse if a resident had skin break down. Staff D stated, they would evaluate the resident, obtain a treatment order, and notify the RN. Staff D stated that if you place a checkmark on the skin check as yes, for a new skin issue, the electronic medical records system auto populated a skin evaluation to be completed. Staff D stated the + sign on the skin checks only means the skin check was completed. Staff D stated you would have to look in the evaluations section of the medical records to see the documentation if there was a new skin issue. In an interview on 06/03/2024 at 2:36 PM, Staff E, NAC, stated if they noted changes in a resident's skin they would tell the charge nurse, In an interview on 06/03/2024 at 2:56 PM, Staff F, NAC/ Staffing Coordinator, stated the NACs should let the nurse know if a resident had a new PI. In an interview on 06/18/2024 at 12:19 PM, Staff B stated they had completed Resident 1's skin check to their bottom on 04/12/2024, with another nurse, and the resident had no open areas. Staff B stated they had completed skin check on 04/24/2024, with another nurse, and did not note any skin breakdown for Resident 1 at that time. Staff B stated Resident 1 was sent to the hospital emergency roiagnom on [DATE]. In an interview on 06/18/2024 at 2:45 PM, Staff G, NAC, stated they believed they had provided a shower on 04/26/2024 for Resident 1 and did not see any skin break down during the shower. Staff G stated they did not usually provide direct care for Resident 1. Staff G stated they were aware Resident 1 had skin breakdown in the past but on 04/26/2024 they did not note any skin breakdown. Refer to WAC 388-97-1060(3)(b) F686 repeate in last 15 mon: 06/09/2023 S/S G

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on observations, interviews, and record reviews the facility failed to ensure 1 of 1 sampled resident (Resident 2) was free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) as required. The facility failed to ensure person-centered behavioral interventions were in place, appropriate indications for use, and diagnoses were present for psychotropic medications. Resident 2 had a decline in their function, increase in falls, and a decline in their cognition after the start of psychotropic medications. These failures placed residents at risk of receiving unnecessary psychotropic medications and for medication-related complications. Findings included . As referenced in the State Operations Manual Appendix PP, date 02/03/2023, referenced the Food and Drugs/Drug (FDA) Safety Information, anti-psychotic medications have serious side effects and can be especially dangerous for elderly residents. The use of anti-psychotic medications without an adequate rationale, or for the sole purpose of limiting or controlling expressions or indications of distress without first identifying the cause, there is little chance that they would be effective, and they commonly cause complications such as movement disorders, falls with injury, stroke, and increased risk of death. The FDA Boxed Warning for second-generation anti-psychotics, showed Elderly patients with dementia-related psychosis treated with atypical anti-psychotic drugs are at an increased risk of death. Resident 2 was admitted to the facility on [DATE] with diagnoses to include parkinsonism, dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems) without behavioral disturbance, anxiety disorder, unspecified depression, mood disturbance and psychotic disturbance. Review of the Annual Minimum Data Set (MDS- an assessment tool), assessment dated [DATE], showed Resident 2 received an antidepressant daily along with an opioid (type of medication used to reduce pain), and was assessed to have a Brief Interview for Mental Status (BIMS - a structured cognitive interview) of a 15 out of 15 indicating they were cognitively intact. Review of Resident 2's care plan showed the following focus problems and related interventions: Resident 2 experienced anxiety and had as needed lorazepam/Ativan (an antianxiety medication), initiated on 08/09/2023, available when other interventions did not work. Interventions included: Offer a supervised walk down the hall if the resident was getting up and down constantly. Encourage the resident to toilet if a walk was not effective. Encourage the resident to attend social activities. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Speak in short sentences, avoid information overload. Resident 2 used an antidepressant medication daily related to depression initiated on 04/03/2023. Interventions included: Administer antidepressant medication as ordered. Monitor/document side effects and effectiveness each shift. Alert the Resident Care Manager/ Social Services of depression i.e. difficulty falling or staying asleep. Monitor/document and report adverse reactions to antidepressant therapy to include decline in activity of daily living ability, gait changes, balance problems, and falls. Social services to offer one to one support during periods of depression. Resident 2 used antipsychotic medication related to Parkinson's Disease, revised on 03/21/2024. Interventions included: Administer psychotropic medications as ordered, monitor for side effects and effectiveness each shift. Offer distraction by reading the bible during episodes of distress with psychosis or depression. Redirect Resident 2 from distress by asking them to sing. Discuss with the Medical Doctor (MD) regarding the ongoing need to use medication, review behaviors, interventions, alternative therapies attempted and their effectiveness. Review of Resident 2's March 2024 Medication Administration Record (MAR), showed the following medications and monitors: Escitalopram oxalate (Lexapro) 20 milligram (mg) an antidepressant daily related to anxiety disorder and depression started on 03/31/2023 through 03/10/2024, then decreased to 10 mg daily. Seroquel 25 mg, one time a day, an antipsychotic medication related to unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety from 03/06/2024 through 03/22/2024. Seroquel 25 mg, two times daily, related to unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety starting on 03/23/2024. Ativan /lorazepam (an antianxiety medication) 0.25 mg started on 02/26/2024 through 03/06/2024 every six hours as needed and from 03/13/2024 through 03/21/2024 every eight hours as needed. Review of the March MAR showed the resident (received 16 doses of Ativan.) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ativan /lorazepam, 0.5 mg three times daily related to anxiety, hold for sedation started on 03/21/2024. Melatonin 3 mg as needed supplement nightly, started on 10/19/2023. Review of the March MAR showed the resident received 4 doses melatonin.) Review of Resident 2's March 2024 Treatment Administration Record (TAR), showed the following behaviors being monitored: The resident had 20 episodes of anxiety exhibited by unsafe behavior while walking around which could not be redirected 03/01/2024 through 03/21/2024. The resident exhibited no episodes of having difficulty falling or staying asleep, started on 04/03/2023. Behavior Monitoring: getting up/down repeatedly, wishing they could die, unsafe walking with interventions of provide a bible, ask them to sing or play religious music, offer a walk, or pray with them started on 03/21/2024 through 03/31/2024. There were no episodes documented. Review of a nursing progress note, dated 03/05/2024 at 2:53 PM, showed the Advanced Registered Nurse Practitioner/Neurologist discontinued Resident 2's lorazepam and started Seroquel 25 mg at bedtime. Review of nursing progress note, dated 03/13/2024 at 5:24 PM, showed the primary provider was contacted regarding Resident 2's agitation the last few days and an order was received for Ativan 0.25 mg every eight hours as needed (the note did not describe the resident's behaviors they were exhibiting.) Review of Resident 2's April 2024 MAR, showed no changes from the March 2024 MAR. The resident received escitalopram oxalate daily, Seroquel twice daily, and Ativan three times a day. The resident received 14 doses of Melatonin as needed for sleep. Review of Resident 2's April 2024 TAR, showed the following behavior monitors: Behavior Monitoring: getting up/down repeatedly, wishing they could die, unsafe walking with interventions of provide a bible, ask them to sing or play religious music, offer a walk, or pray with them started on 03/21/2024. There were no episodes documented. Difficulty falling or sting asleep started on 04/03/2023. There were no episodes documented. Review of the April 2024 facility incident log showed Resident 2 had aexperienced falls on 04/26/2024 and 04/27/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the psychiatric evaluation note on 04/18/2024, showed a recommendation to consider a taper, and/or to discontinue, the Ativan gradual dose reduction (GDR is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) for anxiety disorder as evidence by risk of withdrawal symptoms, behavior disturbance, dependency, worsening anxiety, delirium and consider taper and discontinue of Seroquel 25mg bid, with a cross titrate to Depakote 125mg bid for mood disturbance/dementia ; no psychotic disorder diagnosis to support use of antipsychotic Seroquel . Review of Resident 2's MAR, dated 05/01/2024 through 05/23/2024, showed the following medications and monitors: Escitalopram oxalate 10 mg daily related to anxiety disorder and depression. Seroquel 25 mg twice daily related to unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Ativan 0.5 mg three times daily related to anxiety disorder, hold for sedation. Ativan 2 mg/ml (milliliter) 1 ml as needed every two hours. (the resident received one dose on 05/19/2024). The resident received eight doses of Melatonin 3 mg as needed supplement nightly. Review of Resident 2's the May 2024 TAR showed the following behavior monitors: The resident exhibited 24 episodes of getting up and down and two episodes of delusions/paranoia. The resident had difficulty falling or staying asleep on 05/28/2024. Review of the Significant change MDS assessment, dated 05/16/2024, showed Resident 2 received an antidepressant medication, an antianxiety medication, and an antipsychotic medication daily along with a daily opioid. Resident 2 was assessed to have a BIMS of four out of 15 with a notable decline in cognition (the resident's BIMS scored was 15 out of 15 on their 02/14/2024 MDS assessment). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Cognitive Loss Care Area Assessment (CAA a systematic process to interpret the triggered information from the MDS assessment to assess the potential problem and determine if the area should be care planned), dated 05/16/2024, showed the Cognitive Loss CAA triggered related to Resident 2's worsening cognition. Resident 2 had Parkinson's disease and dementia. Found neurology note indicating Resident 2 had Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), not just Parkinsonism (an umbrella term that refers to brain conditions that cause slowed movements, rigidity (stiffness) and tremors.) Resident 2 had a decline in their cognition BIMS was a four. Resident 2 struggled to stay focused, would become frustrated when they could not remember, and then refused to participate with the remainder of the assessments for pain and depression. Resident 2 appeared to understand the questions but did not want to respond and was sometimes understood. Resident 2 needed time to respond and needed the questions repeated. Resident 2 was hard to understand at times. Resident 2 tended to mumble when they spoke but was able to follow directions. Resident 2 did appear to be able to make their basic needs known. Resident 2 remained at risk for further decline cognitively as Parkinson's was a degenerative disease and likely had Parkinson's related to dementia. Resident 2 had a history of depression and tended not to initiate cares or conversation. Resident 2 had started to see a counselor (see note 05/16/2024). Refer to Plan of Care to ensure needs were being met. Review of Resident 2's psych follow up note, dated 05/16/2024, showed the plan/recommendation was to discontinue Ativan 0.5 mg three times daily for anxiety disorder as evidence by restlessness/agitation; risk of withdrawals with short acting frequent dosing, risk of dizziness, falls, behavior disturbance, and confusion. Review of Resident 2's nursing progress note, dated 05/18/2024 at 2:21 PM, showed a new order was received for Ativan 2 mg/ml for 0.5 to 1 ml every two hours as needed for anxiety. Review of the facility's May 2024 incident logs showed Resident 2 fell twice on 05/01/2024, 05/03/2024, 05/16/2024, 05/18/2024 and 05/31/2024. In an observation on 05/20/2024 at 4:16 PM, Resident 2 was lying in bed with their eyes closed and appeared to be asleep. In an interview on 05/20/2024 at 4:34 PM, Staff H, Registered Nurse (RN), stated if the provider progress notes obtained physician orders, they should pop up in their electronic medical record system. Staff H was asked who would see the orders, Staff H stated, That was a good question. Staff H stated the medication cart nurses did not read the provider notes. Staff H stated normally the providers would input their orders into their electronic medical system or they would hand write an order. In an interview on 05/20/2024 at 4:50 PM, Staff I, RN, stated maybe the Resident Care Manager read the psych provider's progress notes, did not know who reviewed them, but they did not have time to read the psych notes. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/20/2024 at 4:50 PM, Staff A, RN/Director of Nursing Services, stated they worked with the pharmacy and social services to make sure there was a GDR done every quarter. Staff A stated that staff should utilize nonpharmacological interventions first. Staff A stated they made sure the residents had the right diagnoses with the right medications. Staff A confirmed there were no stop dates on two different as needed Ativan orders for Resident 2. Staff A stated the psych provider did not prescribe. Staff A stated the main provider reviewed the psych providers recommendations. Staff A stated they let the provider know what the recommendations were and was not sure if that was documented but was discussed in the morning meetings. Staff A was asked how the nursing staff knew which amount of Ativan to give from the order for Ativan 2 mg/ml for 0.5 to 1 ml, Staff A did not provide a response. In a phone interview on 05/22/2024 at 5:15 PM, Collateral Contact (CC) 1, Resident 2's family member, stated they did not like the medication Resident 2 was taking. CC1 stated they felt Resident 2 was over sedated and after Resident 2 received their medication they would just stare at the ceiling and CC 1 could not get them to respond to them. In an observation on 05/23/2024 at 1:35 PM, Resident 2 was lying in bed, the room lights were off, and their eyes were closed. Resident 2 appeared to be sleeping. In a phone interview on 05/24/2024 at 8:28 PM, CC 2, Resident 2's family member, stated they could not talk with the resident on the phone as Resident 2 was so drugged up. In an interview on 05/29/2024 at 3:26 PM, Staff B, RN, stated Resident 2's behaviors were that they would walk by themself and would fall. Staff B stated Resident 2 was started on Ativan and continued to walk but could see they were anxious. Staff B stated when they tried to talk with Resident 2 to explain the need to sit down, the resident would continue to walk. Staff B stated Resident 2 could not walk by themselves, they had poor safety awareness, and had a couple of falls. In an observation on 05/29/2024 at 4:21 PM, Resident 2 was lying in bed, lights were off, and the resident's eyes were closed. Resident 2 appeared to be asleep. In an interview on 05/30/2024 at 2:33 PM, Staff J, Nursing Assistant Certified (NAC)/ Restorative Aide, stated they would walk with Resident 2 who walked with a four-wheel walker. Staff J stated they would walk with the resident in the hallway or if it was busy they would go to the therapy department and walk with the resident for 15 minutes. Staff J stated the floor staff were cleared to walk with the resident as well. In an interview, Staff K, Anonymous Staff, stated they see Resident 2 sleeping and when they were up, they were not doing anything, just staring. Staff K stated Resident 2's behaviors were attempting to walk. Staff K stated Resident 2 would be in their chair all day and when they stood up the nursing staff would tell them to sit back down. In an observation on 05/30/2024 at 2:53 PM, Resident 2 was lying in bed and stated they needed some water. The resident's water was on the bedside table which was at the end of the resident's bed and out of the resident's reach. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505393	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Cascades Health and Rehabilitation Center	4680 Cordata Parkway Bellingham, WA 98226

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/30/2024 at 3:32 PM, Staff L, Activity Director, stated when Resident 2 admitted to the facility the resident was reading, they used to walk with them when Resident 2 did not need a two-person assistance to walk. Staff L stated Resident 2 used to love to go for walks, they would write, draw, and socialize and interact with the other residents. Staff L stated now Resident 2 was not able to write or draw, the connection was not there. In an observation on 06/03/2024 at 1:10 PM, 1:34 PM and 3:13 PM, Resident 2 was lying in bed. In an interview Staff M, Anonymous Staff, stated Resident 2 was restless and had a lot of falls. Staff M stated they would keep Resident 2 in the hallway a lot and found it worked best to let them walk with frequent reorientation. Staff M stated some days Resident 2 was steady and other days they were weak. Staff M stated they knew Resident 2 had declined while on the first floor. In an interview on 06/03/2024 at 2:56 PM, Staff F, NAC/Staffing Coordinator, stated Resident 2 required a mechanical lift for transfer when they took care of them on the second floor. Staff F stated Resident 2 had progressed to a two person assist and then to a one-person assistance. Staff F stated Resident 2 would get up from the bed by themselves and sometimes would walk in the hallway. Staff F stated some days Staff F stated they would sit with Resident 2, offer them something to eat or drink, offer music, or offer a magazine or picture books when the resident was having behaviors. In an interview 06/03/2024 at 3:28 PM, Staff N, NAC, stated Resident 2 used to come out of their room six months ago and go to the nurse's station and into the dining room. Staff N stated when Resident 2 moved to the first floor they initially walked with a walker with a one person assist. Staff N stated the behavioral interventions were in the electronic record. Staff N stated if Resident 2 was trying to get out of bed they should take them for a walk. Staff N stated Resident 2's behaviors were always trying to move out of their bed or getting up out of their chair. In an interview 06/03/2024 at 3:38 PM, Staff G, NAC, stated back in January 2024, Resident 2 started to decline. Staff G stated when Resident 2 first got there they would walk, talk, go down to meals in the dining room, then they started falling a lot. Staff G stated yesterday Resident 2 was sent to the emergency room . Staff G stated it had been challenging as Resident 2 trieds to do things they were not able to do. Staff G stated Resident 2's behaviors were trying to stand and rolling out of their bed. Staff G stated Resident 2 had falls from standing and being restless. Staff G stated Resident 2 seemed to get frustrated when they could not speak. In an interview on 06/03/2024 at 3:43 PM, Staff D, Licensed Practical Nurse, stated Resident 2's behaviors were restlessness, and impulsiveness, that was about it. Staff D stated Resident 2 would try to stand up, they would be fidgety in their chair and would try to pick up items off the floor that were not there or would put themselves on their fall mat on the floor when they were in bed. Staff D stated Resident 2 would sing gospel music. Staff D stated Resident 2 was taking Seroquel for their unspecified dementia, and they were monitoring their impulsiveness, delusions, getting up and down repeatedly, and unsafe walking. Staff D stated Resident 2 would love to get up and walk by them self if they could. Staff D stated the Ativan was for the resident's restlessness, anxiety disorder, behaviors for impulsive, delusions and paranoia but had not seen Resident 2 have paranoia, they were mostly anxious and restless about not being able to get up and walk. (continued on next page)

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	505393	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Cascades Health and Rehabilitation Center	4680 Cordata Parkway Bellingham, WA 98226

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/03/2024 at 4:10 PM, Staff B, stated they were monitoring for the side effects of Resident 2's Seroquel and not monitoring for the resident's anxiety or restlessness. Staff B stated Resident 2 was unsafely walking as why they were taking Seroquel and Ativan. In an interview on 06/03/2024 at 4:30 PM, Staff O, Social Services, stated the neurologist had prescribed Seroquel for Resident 2 as they were hallucinating, and they had osteomyelitis an infection of the bone. Staff O stated they thought the medication was prescribed due to Resident 2's agitation and they were endangering themselves. Staff O stated Resident 2's Seroquel was for their delusions, unsafe walking, and repeatedly getting up and down. WAC reference: 388-97-1060(3)(k)(i)