

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 07/18/2024
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 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</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 a safe and orderly discharge for 1 of 1 resident (Resident 1), reviewed for discharges Against Medical Advice (AMA). This failed practice placed the resident at risk of being unaware of their medications, treatments and follow up appointments, as well as resident and resident family frustration.</p> <p>Findings included .</p> <p>Resident 1 admitted to the facility on [DATE] with diagnoses to include a heart attack, an acute appendicitis, high blood pressure, diabetes (a disease affecting blood glucose), gastroesophageal reflux disease, depression and post-traumatic stress disorder.</p> <p>Review of Resident 1's care plan focus problem: Post Discharge Plan: Anticipated Discharge Location for Inpatient Rehabilitation dated 06/07/2024, with the following interventions: 1) provide the resident with a reconciled medication list upon discharge, 2) provide subsequent provider with reconciled medication list upon discharge, 3) provide contact information and date of service for post discharge health care providers and 4) provide education and guidance pertaining to care and treatment to be provided at the post discharge location.</p> <p>Review of Resident 1's Weekly Skilled Interdisciplinary Team (IDT) Meeting note dated 06/06/2024 at 10:11 AM, and on 06/13/2024 at 9:07 AM, both showed the resident's discharge plan was to return home.</p> <p>Review of Resident 1's Progress Note - discharge evaluation dated 06/20/2024, showed the resident was seen for discharge by their provider. The progress note showed that discharge planning had begun but Resident 1 had expressed the desire to leave before they had been cleared for discharge. Resident 1 was assessed during physical exam to be alert and oriented to person, place, time and situation as well as cooperative, and appropriate for mood and affect. Social Services had begun reaching out to Resident 1's family members for assistance. Resident 1 had done mildly well with therapy but remained weak, their blood glucose was modestly well controlled.</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 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident 1's Social Services note dated 06/20/2024 at 6:00 PM, showed the resident had gone to the Social Services Director multiple times that week and stated they were going home, and their family was on board with the plan. Therapy staff reported the resident had made great gains over the last week and appeared appropriate to discharge home very soon. The Social Services Director noted they were off on Friday 06/21/2024, and they agreed to meet on Monday 06/24/2024 to make a plan. There was no documentation found in the clinical record that showed Social Services had communicated with Resident 1's family regarding discharge.</p> <p>Review of Resident 1's Nursing Progress note dated 06/21/2024 at 5:49 PM, showed the resident wished to leave the facility AMA. All the AMA paperwork was electronically signed and explained to the resident.</p> <p>Review of Resident 1's communication with family chart note dated 06/21/2024 at 6:16 PM, showed the resident's daughter was notified the resident had visitors and decided to leave AMA despite having a discharge care conference scheduled for Monday 06/24/2024 and planned discharge for Tuesday 06/25/2024.</p> <p>In an interview on 07/18/2024 at 2:20 PM, Staff A, Registered Nurse/ Resident Care Manager, stated Resident 1 had an abrupt discharge. Staff A stated Resident 1 did not go home with anything, they did not want a copy of the AMA discharge or a list of their medications. Staff A stated Social Services would have set up home care and most discharged residents should be set up for home care on discharge. Staff A stated at discharge they would recap the resident's stay at the facility and would go over the residents' medications to ensure the resident had sufficient amount of medications until they could follow up with their primary physician after discharge. Staff A stated, Would have to check with Social Services, when asked if Resident 1's primary care provider had been notified of their AMA discharge. Staff A stated they were unsure of who was Resident 1's primary provider. Staff A stated they did not recall having any nursing issues with Resident 1's discharge. Staff A stated Resident 1 discharged to their family members home until their home repairs were completed.</p> <p>In a phone interview on 07/18/2024 at 2:46 PM, Collateral Contact (CC) 1, Resident 1's family member stated the facility would not release Resident 1's medications on discharge. CC 1 stated Resident 1's new medications that were for their heart burn and their Lasix (a potent diuretic (water pill) that is used to eliminate water and salt from the body) were not available and Resident 1 had to wait a week to obtain them. CC 1 stated the facility was going to set Resident 1 up for home care, but they did not set up anything for the resident.</p> <p>In an interview on 07/18/2024 at 3:35 PM, Staff B, Social Services Director stated they did alert the United States Department of Veterans Affairs (VA) and the home health was notified when Resident 1 left. Staff B stated they were going to talk about discharge and did not make a referral as they agreed to meet on Monday and Resident 1 was going to discharge on Tuesday. Staff B stated Resident 1 was still on therapy and had just been authorized to stay two or 20 days, was unsure the exact number of days authorized. Staff B stated, No, I did not make a home care referral. Staff B stated they could not make the referral as Resident 1 left AMA. Staff B stated they did not know if the resident's primary provider at the VA was notified of their discharge. Staff B stated, I guess I did not document, when asked if they documented notifying the VA.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 07/18/2024 at 3:41 PM, Staff C, Administrator, stated the expectation would be to do as much for the residents before they left AMA. Staff C stated residents would be discharged with their medications, and staff would try to set up home health. Staff C stated they did not think they could get an order for home care after a resident left the facility. Staff C stated they would complete a risk benefits and discharge AMA forms. Staff C stated they were not sure if everything was set up for Resident 1. Staff C stated Resident 1's discharge plan changed five times that week because they were going from one house then to another.</p> <p>In a phone interview on 07/23/2024 at 2:06 PM, CC 2, VA staff member stated the facility had not notified them of the resident leaving the facility AMA. CC 2 stated the Resident 1's family was who notified them of the resident's current situation, and current medications. CC2 stated the resident's family made the follow up appointments for Resident 1.</p> <p>Refer to WAC 388-97-0120(3)a</p>		