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	09/05/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on observation, interview and record review the facility failed to ensure the residents' rooms, shower room and hallways for 1 of 2 floors were clean and free of damaged walls. These failed practices placed the residents on the first floor at risk of diminished quality of life. Findings included . In a phone interview on 08/27/2024 at 5:10 PM, Collateral Contact (CC) 1, Resident 2's family member, stated the facility did not appear to be clean. CC 1 stated they had to request the floor to be cleaned of food items from under the resident's bed. CC 1 stated the second floor was like a completely different business from the first floor. CC 1 stated there were stains on the walls on the first floor, it was unkept and not clean. In an interview on 08/28/2024 at 1:18 PM, Resident 4, stated sometimes the floor in their room did not get mopped and their room was not dusted. In an observation and co-interview on 08/28/2024 at 1:35 PM, Resident 3 and CC 2, Resident 3's family member, stated they did not find the environment clean. CC 2 stated they found the floors to be sticky and they would bring in their own Swiffer to clean Resident 3's floor. Resident 3 stated they did not recall their room to be cleaned by anyone. CC 2 stated they would pick up the trash in Resident 3's room and place the trash sack in the hallway outside the resident's room. Observed dark debris along the edge of the floors and various debris, straws, wrappers and candy on the floor under the resident's bed. In an interview and observation on 08/28/2024 at 2:00 PM, Resident 5, stated the first floor was not as clean as the second floor. Observed a gash on the wall next to the head of the resident's bed, noted a bluish/black stain on the wall under the resident's window. Black debris was observed along the edge of the floor next to the walls. On 08/28/2024 at 2:18 PM, large, gouged holes were observed in room [ROOM NUMBER]-2 in the sheet rock behind the head of the bed. (continued on next page)

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 08/28/2024 at 2:25 PM, observed the shower on the first floor to have brown substance on the floor in the first shower stall, under the shower chair that appeared to be feces. The shower chair in the first shower stall had a large amount of hair wrapped around each of the four wheels and a buildup of debris on the floors next to the walls. In an observation and interview on 08/28/2024 at 2:32 PM, Staff D, Restorative Aide, confirmed the observation in the first-floor shower of brown substance appearing to be feces and stated the aides were supposed to clean the shower stalls after they assisted residents with a shower. Staff D stated there was supposed to be cleaner to clean with in the shower room but there was no cleaner in the shower room at the current time. Staff D stated the signs on the wall were posted in three places in the shower room to remind to staff to clean after using the shower room. In an interview and observation on 08/28/2024 at 2:51 PM, Staff E, Administrator, stated maintenance had recently power washed the shower room on the first floor and were in the process of scheduling a time to regrout the grout in the shower room. Staff E confirmed the brown substance appeared to be feces under the shower chair with large amounts of hair wrapped around all four wheels. Review of the maintenance log on 08/29/2024 for the past three month for both the first and the second floor showed no reports of damaged sheet rock or wall damage. In an observation and interview on 08/29/2024 at 3:41 PM, Resident 1 stated they did not find their room particularly clean. Resident 1 stated, The cleaning of the shower room was left up to the aides to clean and it was not outstandingly clean. Resident 1 stated they had entered the shower room on the first floor and there were used towels and washcloths laying on the floor. Resident 1 stated there were signs in the shower room for the staff to do this or that, but they did not know that they followed the signs directions. The lower section of the resident's curtain was observed to have a large dark stain. In an interview on 09/05/2024 at 9:13 AM, Staff A, Housekeeper, stated they cleaned the front of the facility, and rooms 120 to 129 and the hallway. Staff A stated if they saw stains on the walls or curtains, they would clean them and if there were holes in the walls they would report them to maintenance. In an interview on 09/05/2024 at 9:20 AM, Staff B, Maintenance Assistant, stated they had recently started working at the facility and had just placed note pads at the nurses' stations for wall repairs the past weekend. In an interview on 09/05/2024 at 9:35 AM, Staff A stated they only would sweep and mop the resident's rooms. Staff A stated the prior month they had six and a half hours daily to clean 23 rooms. Staff A stated the deep cleaning for resident rooms was on a schedule. Staff A stated when a resident was discharged , they would complete a deep clean of the room. Staff A stated they were assigned a deep clean for rooms of discharged residents along with their normal rooms to be cleaned on six and a half hours daily. Staff A stated they were assigned six and a half hour days in June and July and then in August their hours were increased to eight-hour days. Staff A stated the work hours were based on the resident census, if the census was high their hours would go up and when the census was low their hours were cut. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 09/05/2024 at 10:01 AM, the wall to the right of the elevators on the first floor was damaged. In an interview on 09/05/2024 at 10:20 AM, Staff C, Housekeeping Manager, stated the deep cleaning schedule of resident rooms was based off a month-to-month schedule and each resident room would get a deep clean once a month. Review of the maintenance logs on the first floor on 09/05/2024 showed the following entries dated 08/29/2024: - room [ROOM NUMBER]-1 wall behind bed marked up - room [ROOM NUMBER]-2 touch up paint - room [ROOM NUMBER] -2 large hole behind bed - room [ROOM NUMBER] touch up paint - room [ROOM NUMBER]-1 hole in wall next to bed - room [ROOM NUMBER]-2 touch up paint - room [ROOM NUMBER] touch up paint - room [ROOM NUMBER]-2 wall behind bed has holes Reference WAC 388-97-0880 (1)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on observation, interview and record review the facility failed to ensure 1 of 3 residents (Resident 6), reviewed for falls received the implementation of an intervention to reduce the risk of further falls. This placed Resident 6 and other residents at further risk of falls, potential injury and diminished quality of life. Finding included . Resident 6 was readmitted to the facility on [DATE] following an acute care hospitalization for encephalopathy (damage or disease that affects the brain). Resident 6 diagnoses included seizure disorder, Parkinsonism (collection of movement symptoms associated with several conditions including Parkinson's disease), and pain. Review of Resident 6's care plan showed, the resident was at risk for falls related to deconditioning and gait and balance problems which was initiated on 07/11/2024. The interventions identified and dated for 07/11/2024, included ensure the call light was within the resident's reach, educate the resident about safety reminders, follow the facility's fall protocol, and for physical and occupational therapy. Review of the admission Minimum Data Set (MDS-an assessment tool) assessment dated [DATE], showed the resident was assessed to have moderately impaired cognitive function and had a fall since admission. Review of the admission fall Care Area Assessment (CAA), dated 07/18/2024, showed Resident 6 was identified as being at risk for falls. The resident's risk factors included requiring assistance with activity of daily living along with mobility and transfers. The CAA showed the facility would continue the plan of care for the resident's risk factors and prevention of falls. Review of the July 2024 and August 2024 incident reporting logs on 08/28/2024 showed Resident 6 had six falls since their admission to the facility on [DATE]. Review of the facility's fall investigation dated 07/13/2024, showed Resident 6 was found in their room on the floor, on the right side of their bed at 12:30 AM. Resident 6 had reported they were feeling hot, their fan on the bedside table was not working and the dayshift staff was unable to locate replacement batteries. Resident 6 reported they were trying to reach a piece of paper to fan themselves and attempted to reach their call light which was on the floor and rolled out of the bed. The facilities immediate action included making sure the call light was clipped within reach of the resident (this is a standard of practice and had been care planned on 07/11/2024), provide the resident with batteries for their fan, provide a plug-in fan, place nonskid socks on the resident and the NAC would do frequent checks on Resident 6 throughout the shift . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation of Resident 6's fall second fall on 07/13/2024 at 5:00 PM, showed Resident 6 was found on the floor lying on their right side. Resident 6 reported they were trying to show their roommate a paper and fell . The root cause analysis of the resident's fall was poor safety awareness and impulsive behavior. The intervention to help prevent future falls was to place a sign in the resident's room to remind them to call for assistance. No care plan was found in the fall investigation packet. Review of a nursing progress note dated 07/13/2024 at 9:36 PM, showed Resident 6 was experiencing extreme pain to their coccyx area. The provider was notified and ordered an X-ray. Review of the facility's investigation of Resident 6's fall on 07/19/2024, showed Resident 6 was found in their room, lying on their right side, on the floor. The time Resident 6 had fell was not clearly identified in the investigation. The time listed on the investigation was 1:03 PM, but the investigation packet had witness statements timed 12:05 PM and the Neurological Evaluation was noted to have begun at 12:00 PM. The interventions on the incident investigation showed the provider was notified, orthostatic vital signs were taken and to encourage fluids. Review of the care plan showed to educate and encourage the resident to not walk without assistance initiated on 07/21/2024. No interventions were noted to have been added to Resident 6's care plan after the 07/13/2024 fall, which showed the intervention after that fall was to place a sign in the resident's room to remind them to call for assistance. Review of the facility's investigation of Resident 6's fall on 07/29/2024 at 4:25 AM, showed the resident was found on the floor in their room. Resident 6 stated they did not fall but lowered themselves onto the floor to put on their shoes and waited for someone to help them to the bathroom. The root cause analysis was a self-transfer without assistance and poor safety awareness. The intervention identified on the 07/13/2024 fall, to place a sign in the resident's room to remind them to call for assistance continued not to be on the resident's care plan . Review of the facility's investigation of Resident's 6's fall on 08/06/2024 at 8:30 AM, showed Resident 6 was found lying on the floor in their room. The root cause analysis showed the fall resulted from impulsive behavior, poor safety awareness as the resident was trying to self-transfer. The intervention initiated after the fall was labs were completed to check the resident's Keppra (medication to treat seizures) level. Review of the attached Keppra laboratory report showed the blood level test was completed on 08/01/2024 five days prior to the resident's fall on 08/06/2024. The intervention identified on the 07/13/2024 fall investigation of placing a sign in the resident's room to remind them to call for assistance continued to not be on the care plan. In an observation and interview on 08/29/2024 at 5:03 PM, Resident 6 stated their sign to remind them to call for help was in their bathroom. In observation, there was no sign in the resident's bathroom or room to remind them to use the call light for assistance. Resident 6 stated they needed a sign on their wall and one hanging from the ceiling so they could not miss it to remind them to call for help. In an interview on 08/29/2024 immediately following the interview with Resident 6 at 5:03 PM, Staff H, Licensed Practical Nurse, confirmed there was no sign in Resident 6's room or bathroom to remind them to use the call light for assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/05/2024 at 11:47 AM, Staff F, Registered Nurse (RN), stated when a resident fell , the facility's clinical team would review and discuss the residents' falls and the interventions that were implemented to help prevent further falls. Staff F stated they were able to place interventions on the residents' plan of care. In an interview on 09/05/2024 at 12:03 PM, Staff G, RN/ Director of Nursing Services (DNS), stated the intervention to place a sign in Resident 6's room to remind them to use the call light for assistance should have been implemented. Staff G stated the Assistant DNS should make sure the interventions that were identified to help prevent resident falls were put into place. Reference WAC 388-97-1060 (3)(g)