

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 03/28/2025
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110</p> <p>Based on interview and record review, the facility failed to conduct thorough investigations for 3 of 3 residents (Residents 1, 2, and 3) whose investigations were reviewed for thorough investigations, and failed to log 1 of 1 (COVID - Coronavirus Disease 2019) communicable disease outbreak. The failure to log, and conduct thorough investigations placed residents at risk for repeat incidents, injury, and for unmet care needs due to a lack of thorough investigations after incident occurred. These failures placed residents at risk for repeat incidents and injury.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Abuse Investigation, updated October 2022, states the Administrator is the designated abuse coordinator and is responsible for overseeing staff that assist with investigations . the facility will identify, and interview involved persons that may have knowledge of incident . the facility will ensure complete and thorough documentation, investigate trends and patterns.</p> <p>Review of the facility policy titled, Freedom from Abuse and Neglect ., updated March 2025, the facility will investigate thoroughly all potential, and suspected allegations in accordance with state and federal laws .the facility will report in accordance with state and federal law.</p> <p><RESIDENT 1></p> <p>Resident 1 admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, diabetes, and malnutrition. The Quarterly Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], documents that the resident had severe cognition impairment, and was dependent on staff for toileting, bed mobility and transfers.</p> <p>Review of Resident 1's care plan dated 07/26/2024, documented that the resident was a maximum/substantial one person for transfers.</p> <p>Review of Resident 1's documentation survey report (Report that reflects the level of care provide to the resident) for February 2025 and March 2025 the documentation reflected that the resident's functional ability to transfer from chair/to bed was full dependence from staff.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility investigation dated 03/02/2025 at 5:15 PM, Resident 1 had a skin issue when the resident had been transferred from bed to the wheelchair. There were only two witness statements from the Nursing Assistant Certified (NACs) that transferred the resident on 03/02/2025 that they had assisted the resident with a transfer, both stated the residents foot scraped the bed during the transfer. In the Notes section of the investigation it was documented that on 03/04/2025 Resident 1's left ankle was swollen, and painful, and x-rays showed the resident had a fracture to the left foot. The investigation documentation showed the only predisposing factor was the resident had an impaired memory. There were no other statements from staff that worked with the resident over the 48 hours between the first injury and the fracture. There was no documentation to support the facility had ruled out abuse and neglect, as the care plan did not accurately reflect the level of care the resident required, and there was lack of a root cause analysis of how the injury potential occurred.</p> <p><RESIDENT 2></p> <p>Resident 2 admitted to the facility on [DATE] with diagnoses that included vascular dementia (cognitive decline caused by damage to the blood vessels in the brain. The Quarterly MDS assessment dated [DATE] documented the resident had severe cognition impairment with a history of falls.</p> <p>Review of Resident 2's care plan focus dated 10/04/2024, the resident was at risk for falls related to deconditioning, and balance problems. The care plan documented an intervention that was to provide assist with transfers and ambulation overnight due to high fall risk, dated 02/28/2025.</p> <p>Review of facility investigation dated 03/10/2025 at 3:15 AM, documented that Resident 2 was headed back to their room with a cup of coffee. The staff heard the resident yell and discovered them on the floor with spilled coffee. The nurse documented that the resident was disorientated and unable to state how they fell , and routine neurological assessments were started to rule out a head injury. The investigation had a neurological assessment sheet included as part of the investigation that was not completed thoroughly. The investigation lacked witness statements that the staff were following the care plan. The investigation lacked thorough evidence to rule out abuse and neglect.</p> <p><RESIDENT 3></p> <p>Resident admitted to the facility on [DATE] with diagnoses that included lung disease, an anxiety. The Admission MDS assessment dated [DATE] showed the resident had moderate impaired cognition and was a risk for falls.</p> <p>Resident 3's care plan dated 01/02/2025 showed they were at risk for falls related deconditioning, and balance problems. Interventions were to anticipate the resident's needs, keep the call light within reach, and to ensure door was always open.</p> <p>Review of the facility investigation dated 03/10/2025 at 4:15 AM, the nurse documented the NAC found the resident lying on the floor face down, and that the resident was unable to tell them how they fell , and routine neurological assessments were started to rule out a head injury. There was no neurological assessment sheet included in the investigation. The investigation included one fall statement that documented the last time the resident was checked was at midnight (4 hours prior to the fall). The investigation documented that the root cause analysis was due to poor safety awareness, and decline in condition, there was no evidence to support that included in the investigation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><OUTBREAK></p> <p>Review of the facility state reporting log on 03/21/2025, for February 2025 showed no evidence that there was a COVID outbreak in the facility.</p> <p>In an interview on 03/21/2025 at 11:20 AM, Staff K, Infection Preventionist, there first resident that tested positive was on 02/21/2025, however that resident had been sent to the hospital. They did not have knowledge of the positive results till the 02/24/2025, then they tested others and notified the local health department. They then notified the state reporting agency on 02/25/2025 they had a communicable disease outbreak.</p> <p>In an interview on 03/28/2025 at 12:12 PM, Staff J, Registered Nurse (RN) stated all resident that have had an unwitnessed fall or cannot tell them how they fell they are required to start a neurological assessment sheet on them for 24 hours. Staff J stated if they have a fall or injury on their shift they try and start the investigation, but gathering statements from the staff that worked. Staff J stated then they turn the investigation over to the nurse manager to complete.</p> <p>In an interview on 03/28/2025 at 2:36 PM, Staff D, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) stated they start all investigations by gathering as much evidence as they can, including statements from all potential parties involved, reviewing the plan of care, and assessing the environment. Staff D stated that if a resident has had a fall that was unwitnessed or they are unable to advocate for themselves that they did not hit their head, the staff are to start a neurological assessment on the resident. The neurological assessment form has times when the staff are to complete the assessment, and it continues for 24 hours. Staff D stated they had originally started working on the investigation for the injury to Resident 1, when it was just an abrasion. Staff D stated after they learned of the fracture to their left foot, they turned the investigation over to Staff B, Director of Nursing Services (DNS). Staff D was not able to provide any information as to why the care plan had not been updated.</p> <p>In an interview on 03/28/2025 at 3:00 PM, Staff E, LPN/RCM stated the expectation was that the staff would conduct neurological assessments on any resident that had an unwitnessed fall or was not able to tell the staff how they fell. Staff E stated they follow up with the nurses to ensure they are completed accurately. Staff E was asked if they completed the investigation for Resident 2 unwitnessed fall, and they stated they were responsible. Staff E was asked why the neurological assessment had not been completed accurately, they stated they were not sure. Staff E was asked how they ruled out abuse and neglect for Resident 2, as it appeared the care plan was not followed. Staff E was unable to provide any further documentation. Staff E stated they were responsible for the investigation for Resident 3's unwitnessed fall. Staff E was asked why there was no neurological assessment completed on the resident, and they stated that the resident was on hospice services, and they were providing comfort. Staff E agreed a brain bleed would not be comfortable, and that they should have followed their fall protocol.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 03/28/2025 at 3:53 PM, Staff B, DNS stated the facility fall protocol was to start neurological assessments for all falls that were unwitnessed, or when the resident was unable to tell the staff how they fell . Staff B stated the expectation was they were completed accurately. Staff B stated that themselves or the Administrator (Staff A) review all the investigations for accuracy, and thoroughness. Staff B was not able to provide a root cause analysis as to how Resident 1's injury occurred. Staff B was not aware that the investigations for Resident 2 lacked accurate neurological assessment, or that the care plan had not been followed. Staff B was not aware that the was not a neurological assessment done for Resident 3, after an unwitnessed fall. Staff B was not aware they were required to log a communicable disease outbreak within 5 days of the event occurrence.</p> <p>Reference WAC 388-97-0640(6)(a)(b)(c)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110</p> <p>Based on interview and record review the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR - a federally required screening of all individuals who has both an Intellectual Disability (ID) or Related Condition (RC) and a serious mental illness (SMI) prior to admission to a Medicaid-certified nursing facility or a significant change of condition) form was completed prior to admission and according to the guidelines specified for 3 of 3 residents (Residents 4, 5, and 6) reviewed for PASRR. This failure placed residents at risk for not receiving timely and necessary mental health services, and decreased quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled, PASRR Process Policy and Procedure, revised 01/01/2025, states the facility will validate the Level I, if there were none, medical records or designee will obtain .if a Level II was indicated the social worker will validate, within a timely period . follow up as needed federal PASRR rules.</p> <p><RESIDENT 5></p> <p>Resident 5 admitted to the facility on [DATE] with diagnoses that included major depression disorder, and anxiety. Resident 5 was started on bupropion (anti-depressant medication) 75 mg on 03/07/2025, and Lexapro (anti-depressant medication) 5 mg on 01/04/2025.</p> <p>A review of Resident 5's medical record, a Level I PASRR dated, 11/20/2024 showed the resident qualified for a Level II evaluation. The Level 1 showed there was a 30-day exemption to the completion of the Level II, as the resident was not expected to staff in the facility for more than 30 days. The exemption stated that if the resident was there longer than 30 days a Level II must be completed.</p> <p>Review of Resident 5's medical record on 03/21/2025, showed no documentation that a Level II had been completed.</p> <p><RESIDENT 4></p> <p>Resident 4 admitted to the facility on [DATE] with diagnoses that included anxiety and depression. Resident 4 admitted with physician orders for fluoxetine (anti-depressant medication) 20 milligrams (mg) and alprazolam (anti-anxiety medication) 0.25 mg.</p> <p>A review of Resident 4's medical record, a Level I PASRR (a screening to determine if a resident may have a SMI/ID related condition and if positive a Level II PASRR was required), dated 03/06/2025 was completed 5 days after admission to the facility. The residents Level I showed they qualified for a Level II evaluation.</p> <p><RESIDENT 6></p> <p>Resident 6 admitted to the facility on [DATE], with diagnoses that included a traumatic brain injury.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 6's medical record, a Level I PASRR dated, 02/20/2025 showed the resident qualified for a Level II evaluation. The Level 1 showed there was a 30-day exemption to the completion of the Level II, as the resident was not expected to staff in the facility for more than 30 days. The exemption stated that if the resident was there longer than 30 days a Level II must be completed.</p> <p>Review of Resident 6's medical record on 03/25/2025, showed no documentation that a Level II had been completed.</p> <p>In an interview on 03/28/2025 at 2:12 PM, Staff L, Social Services Director state that the initial PASRR Level I was usually received through the admission department prior to the resident admitting to the facility. Staff L stated they usually review them for accuracy and check if the resident may qualify for a Level II evaluation. Staff L stated if they qualify for a Level II evaluation then they contact the PASRR coordinator, to arrange for that evaluation. Staff L stated if the resident has an exemption, they will place the name of the resident on their calendar to ensure the Level II was completed, before the residents stay goes past the 30-day exemption date. Staff L was asked why Resident 5 was not completed prior to the 30-day exemption date, and Staff L stated that they thought they spoke with the PASRR coordinator but were unable to provide any documentation that occurred. Staff L stated that was the same case for Resident 6 as well. Staff L stated they probably need to develop a better accounting system to track the exemptions. Staff L stated they were not made aware that Resident 4 was admitting over a weekend, and they did not admit with their Level I. Staff L stated they completed that late, when they returned to work and learned of the resident's admission.</p> <p>In an interview on 03/28/2025 at 3:53 PM, Staff B, Director of Nursing (DNS) stated they were aware that all residents admitting to the facility had to have a Level 1 PASRR prior to the admission. Staff B was not aware that Resident 4 admitted to the facility without a Level I. Staff B was not aware that Resident 5 and Resident 6 qualified for Level II evaluations, and both had 30-day exemptions. Staff B was not aware they both stayed past the 30-day exemption without receiving a Level II evaluation or follow-up.</p> <p>Reference WAC 388-97-1915(1)(2)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110</p> <p>Based on observations, interview and record review the facility failed to ensure residents were free from avoidable accidents when fall prevention care plans were not implemented for 1 of 3 residents (Resident 2) reviewed for accidents/incidents. These failures placed all residents at risk for lack of consistent interventions, unmet care needs, and a diminished quality of life.</p> <p>Finding included .</p> <p>Resident 2 admitted to the facility on [DATE] with diagnoses that included vascular dementia (cognitive decline caused by damage to the blood vessels in the brain), chronic pulmonary obstructive disorder (COPD - lung disease), and heart failure. The Quarterly MDS assessment dated [DATE] documented the resident had severe cognition impairment and had a history of falls.</p> <p>Review of Resident 2's care plan focus dated 10/04/2024, documented the resident was at risk for falls related to deconditioning, and balance problems. The care plan documented an intervention that was to provide assist with transfers and ambulation overnight due to high fall risk, dated 02/28/2025.</p> <p>Review of facility investigation dated 03/10/2025 at 3:15 AM, documented that Resident 2 was headed back to their room with a cup of coffee. The staff heard the resident yell and discovered them on the floor with spilled coffee. No evidence was included in the investigation that staff implemented the care plan and offered to assist the resident back to bed after they received a cup of coffee at the nurse's station.</p> <p>In an interview on 03/28/2025 at 3:00 PM, Staff E, LPN/RCM stated they had spoken with staff, and Resident 2 was not supposed to be allowed to transfer themself. Staff E was not able to provide any documentation that the staff had followed the care plan and that they provided the proper assistance as directed to in the care plan.</p> <p>In an interview on 03/28/2025 at 3:53 PM, Staff B, Director of Nursing Services stated the care plans for residents were updated by numerous departments and that it was a collective team effort. Staff B stated the care plan would be started on admission and then would build from the comprehensive MDS assessment. Staff B stated Resident 2 should have been assisted to get back into bed, per the resident's care plan. Staff B confirmed there was no documentation in the investigation to support the care plan was followed.</p> <p>Reference WAC 388-97-1060(3)(g)</p>		