

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 12/17/2025
NAME OF PROVIDER OR SUPPLIER North Cascades Health and Rehabilitation		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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on interview and record review the facility failed to have a system in place that ensured grievances were initiated, logged, addressed and resolved timely in response to residents' verbal conveyance of concerns for 1 of 1 resident (Resident 1), who verbalized complaints. The facility's failure to initiate, log, investigate verbalized concerns, inform residents of the facility's findings and the actions taken, if any, prevented the facility from identifying care trends and determining if actions taken to resolve grievances were effective. These failures led to the resident repeatedly reporting the same issues without resolution and placed them at risk for feeling frustrated, unimportant, with diminished self-worth and decreased quality of life. Findings included. In an interview on 12/16/2025 at 9:38 AM, Resident 1 stated they had multiple concerns and grievances about their care. Resident 1 stated they had a meeting with the social worker and resident care manager on 12/15/2025 at which time they expressed multiple grievances. Resident 1 stated they had asked several times for information on how the facility handled pest control, the cleaning of their linen/clothing after pests were found in their room and was not provided any information. Resident 1 stated they had made multiple complaints regarding meal service and being served cold meals. In an interview on 12/16/2025 at 1:57 PM Staff F, Divisional Social Service, stated they were unable to locate the grievance log or any grievances for Resident 1. In an interview on 12/17/2025 at 10:50 AM Staff I, Nursing Assistant Certified, stated Resident 1 had many complaints. Staff I stated Resident 1 had voiced missing clothing, clothing that had shrunk when washed, and was unhappy since the pest control situation. In an interview on 12/17/2025 at 10:55 AM Staff G, Resident Care Manager/Licensed Practical Nurse stated they had a meeting with Resident 1 on 12/15/2025 and Resident 1 voiced multiple concerns. In a review of grievance logs provided for September, October and November 2025 showed no documented grievances for Resident 1. In a review of Resident 1's Electronic Medical Record documented no grievances voiced by them on 12/15/2025, no notation of a meeting with Resident 1 on 12/15/2025. In an interview on 12/17/2025 at 3:45 PM Staff A, Administrator stated they were unable to locate an up-to-date grievance log or grievances for Resident 1, stated Resident 1 was frustrated, and was working toward discharge. Reference WAC 388-97-0460</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>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to conduct thorough investigations for 5 of 6 residents (Resident 3, 4, 5, 6, and 7) reviewed for abuse and neglect. The failure to conduct thorough investigations placed all residents at risk for repeat incidents, potential injury, and unmet care needs. Findings included . Review of the facility policy titled, Abuse Investigation, dated 10/2022 stated it's the facility process to conduct a thorough investigation of potential, suspected, and/or allegations of abuse and neglect.the facility will identify and interviews involved persons, included the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation.</p> <p><RESIDENTS 3 and 4></p> <p>Review of an allegation dated 12/05/2025 revealed Resident 4 alleged that they were inappropriately touched by their roommate (Resident 3).</p> <p>Resident 3 admitted [DATE] with diagnoses which included cognitive impairment.</p> <p>According to Resident 3's care plan updated 12/03/2025, the care plan informed staff the resident had cognitive impairment, wandered aimlessly, and intruded on the privacy of others.</p> <p>In an interview and observation on 12/17/2025 at 10:00 AM, Resident 3 was sitting on the side of their bed. Resident 3 was hard of hearing but was able to engage in general conversation. Resident 3's responses were not consistent with questions asked, and Resident 3 was not able to answer general orientation questions or recall things like, what did you have for breakfast?</p> <p>Resident 4 admitted [DATE] with diagnoses which included cognitive impairment.</p> <p>Review of Resident 4's care plan dated 11/07/2025 showed Resident 4 had anxiety and exhibited paranoid and delusional behaviors.</p> <p>In an interview and observation on 12/17/2025 at 10:30 AM, Resident 4 was sitting in their wheelchair in the hallway. Resident 4 was not able to recall that they had a prior roommate but stated they were not able to sleep well because people open the door, look in at them, and then close it again. Resident 4, then quickly changed topics and spoke about the menu items written on the wall.</p> <p>Review of the facility investigation revealed the allegation was reported by staff without identifying which staff Resident 4 initially reported the allegation to. The investigation summary stated staff reported the resident statements to Staff F.</p> <p>The investigation included statements from Resident's 3 and 4 which were obtained by Staff F, Divisional Social Services. In an interview on 12/17/2025 at 12:31 PM, Staff F stated the incident had been reported to them by the facility social worker, Staff E, Social Services Director, on 12/05/2025 and they immediately went up and spoke to the two residents. Staff F stated the remainder of the investigation was completed by Staff C, (RDCO) Regional Director of Clinical Operations.</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 12/17/2025 at 12:45 PM, Staff E stated they were in the process of showing Resident 4 a new room when Resident 4 made the allegation about their roommate (Resident 3). Staff E stated they could not recall exactly what Resident 4 stated at the time but they were on their way out of the facility so they reported the allegation to Staff F. Staff E stated they believed they had met their reporting obligation by notifying Staff F. Staff E stated they had not been asked to write any type of statement to include in the investigation of the incident.</p> <p>Review of the incident investigation dated 12/05/2025 documented the facility concluded they could not substantiate abuse or neglect related to the cognitive impairment of both residents. The investigation included no other statements or attempts to gather information from assigned staff or staff on duty who may have had relevant knowledge of the circumstances or details of the alleged incident.</p> <p>In an interview on 12/17/2025 at 2:41 PM, Staff C stated they had completed the investigation into the incident and stated that both residents were so confused they did not have clear evidence that anything had actually occurred. Staff C stated they should have included Staff E's information in the facility report as the original reporter. Staff C confirmed that no other staff statements had been collected during the investigation.</p> <p><RESIDENT 5></p> <p>Resident 5 was admitted to the facility on [DATE] for end-of-life services with hospice care. The Quarterly Minimum Data Set (MDS-an assessment tool) dated 11/21/2025 showed the resident required substantial to maximum assistance for bed mobility and was dependent on staff for toileting care.</p> <p>Review of Resident 5's progress notes dated 11/29/2025 at 7:20 PM, showed the nurse was notified by the Nursing Assistant Certified (NAC) that the resident had fallen to the floor. The nurse documented that upon arrival in the room, the resident was found on the floor on the right side of the bed, pillow was placed under their head and there was noted bleeding from the back of the resident's head. The note read that the resident had responded I do not know what happened. Emergency services were contacted, and the resident was sent to the hospital for further treatment.</p> <p>Review of facility investigation dated 12/02/2025 at 3:00 PM, showed on 12/2/2025 the resident's roommate (Resident 6) told a staff member that Resident 5 had fallen out of bed because the NAC had been rough with the resident. The investigation showed Resident 6 overheard the NAC was verbally harsh and unpleasant towards Resident 5. The investigation showed the roommate heard the NAC tell the Resident 5 they were going to turn them, and they overheard Resident 5 say I'm too close to the edge and the NAC stated back to the resident you're fine. The roommate reported they then saw Resident 5 grab the privacy curtain, fall out of the bed, and hit their head on the side of the wardrobe. The investigation included 10 other residents were asked how was your care this weekend? one resident (Resident 7) reported verbal aggression by an unidentified NAC, and another resident (Resident 6) reported they had rough care by an agency aid. The investigation identified the NAC as Staff J. The investigation lacked any questions to other residents that were specific to the allegation. The investigation lacked any interviews with other staff who may have any knowledge of the allegation. The investigation included a statement from the alleged NAC (Staff J) which was not signed or dated by the NAC, only a typed statement.</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 12/17/2025 at 10:43 AM, Resident 5 stated they recalled they fell, and stated they still had a bump on the back of their head. Resident 5 stated it all happened so fast, it was hard to remember the details, I am 97 you know. Resident 5 said they feel safe if there are always two people in the room to assist with rolling back and forth, they are still very fearful of falling again.</p> <p><RESIDENT 6></p> <p>Resident 6 admitted to the facility on [DATE] with diagnoses that included irregular heart rhythm, and rheumatoid arthritis (immune disease that causes pain and swelling in joints). The Quarterly MDS dated [DATE] documented Resident 6 had intact cognition and no behaviors.</p> <p>Review of Resident 6's progress note dated 12/01/2025 at 11:51 PM, the nurse documented the resident had reported some pain to their right wrist and had requested to see the provider for possible x-ray.</p> <p>Review of Resident 6's progress note dated 12/03/2025 at 11:16 AM, the resident made an allegation of rough treatment to the Staff C.</p> <p>Review of facility investigation dated 12/03/2025 at 3:00 PM, showed Resident 6 had reported that Staff J, NAC was rude and bossy, and demonstrated the NAC standing on the left side of the bed grabbing them by their right arm and jerking them towards the edge of the bed. The investigation lacked any further information regarding the residents' reports of pain to their right wrist. The investigation lacked an interview with alleged NAC about the specific allegation. The investigation lacked any questions to other residents that were specific to the allegation. The investigation lacked any interviews with other staff who may have any knowledge of the allegation. The investigation included a statement from the alleged NAC (Staff J) which was not signed or dated by the NAC, only a typed statement.</p> <p><RESIDENT 7></p> <p>Resident 7 was admitted to the facility on [DATE] with diagnoses including spinal stenosis (narrowing of spine causing pain and numbness), and diabetes.</p> <p>The Annual MDS dated [DATE] showed they had intact cognition.</p> <p>Review of Resident 7's progress note dated 12/03/2025 at 11:18 AM, the resident made an allegation of verbal aggression from a staff member.</p> <p>Review of the facility investigation dated 12/03/2025 at 3:00 PM, showed that Resident 7 had become startled when an NAC entered their room, the resident put their arm out in a defensive manner and the NAC then became verbally aggressive towards them. Resident 7 stated they could not remember exactly what was said, but the NAC stated, something along the lines of you better not hit me. Resident 7 reported they felt the NAC was aggressive and they felt threatened. The investigation lacked an interview with the alleged NAC about the specific allegation. The investigation lacked any questions to other residents that were specific to the allegation. The investigation lacked any interviews with other staff who may have any knowledge of the allegation. The investigation included a statement from the alleged NAC (Staff J) which was not signed or dated by the NAC, only a typed statement.</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 12/17/2025 at 10:58 AM, Resident 6 stated they try and keep an eye out for their roommate (Resident 5), they stated they could hear the conversation that day, and overheard Resident 5 tell the NAC (Staff J) they were afraid they were going to fall, and the NAC was overheard telling the resident they weren't going to, right before they fell. Resident 6 saw the resident fall and hit their head on the side of the wardrobe. Resident 6 stated the NAC was aggressive towards them once too, very rude, and once they grabbed their right arm hard.</p> <p>In an interview on 12/17/2025 at 11:19 AM, Staff G, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) stated that the previous administrator that left 11/14/2025 had been responsible for all allegation investigations. Currently the Regional Director of Clinical Operations (RDCO) has been completing the investigations, and they are assisting as needed. Staff G did not participate in the investigations in question.</p> <p>In an interview on 12/17/2025 at 12:30 PM, Staff E, Social Services Director and Staff F, Divisional Social Services, were asked if there were any more follow-up questions for the allegations against Staff J, NAC. Staff F stated they would have to get back to us. At 2:18 PM, Staff F returned and stated it's the facility policy to ask residents general open-ended questions, so they do not lead residents into answers.</p> <p>In an interview on 12/17/2025 at 2:40 PM, Staff C, RDCO stated that it was the facility expectation that staff who have knowledge of any allegation are expected to report accordingly. Staff C stated for that reason they did not interview any other staff for the allegations of suspected verbal and physical abuse of three residents. Staff C was questioned if there were any interviews with other residents that were specific to each individual allegation. Staff C stated it was the facility policy to ask open-ended general questions, so they were not leading residents into answers. Staff C confirmed they did not interview any other residents specifically regarding the work ethic or behavior of the alleged NAC. Staff C confirmed that Staff J was found not to follow care plans, and due to the series of complaints they asked the agency not to send Staff J to their facility anymore.</p> <p>Reference WAC 388-97-0640(6)(a)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents received care and services in accordance with professional standards of practice and their person-centered plan of care for 1 of 1 resident (Resident 2) reviewed for pressure ulcers and 1 of 1 resident (Resident 1) reviewed for weights and respiratory care. The failure to obtain physician ordered laboratory testing, weekly weights and provide respiratory care in accordance with physicians' orders placed residents at risk for continued infection, delays in treatment, unmet care needs and a decreased quality of life. Findings included . <RESIDENT 2></p> <p>Resident 2 re-admitted to the facility on [DATE] with diagnoses which included sacral pressure wound infection, history of pressure ulcers of the sacrum, hips and heel, and urinary tract infection.</p> <p>Review of Resident 2's hospital discharge orders dated 11/26/2025 showed the resident had orders for weekly laboratory tests which included:</p> <p>Weekly labs while on intravenous antibiotics which included: Check weekly ESR (Erythrocyte Sedimentation Rate- an indicator of inflammation) on the same day and to discontinue ESR labs once there were 2 normal results.</p> <p>Review of Resident 2's medical record showed that an ESR was collected on 12/02/2025 which showed a result of 112, which was high and not a normal result. The following week, laboratory results on 12/09/2025 showed an ESR was included in the ordered laboratory testing, but the laboratory results did not indicate any result, stating there was an issue with the test. The record did not include documentation indicating any follow- up related to the missing ESR result. The following week, the ESR was no longer found included in the labs ordered for Resident 2.</p> <p>In an interview on 12/17/2025 at 3:40 PM, Staff C, Regional Director of Clinical Operations, stated they had not found further documentation related to the missing ESR for 12/09/2025; however, identified that the order had been discontinued on 12/12/2025 by the facility provider, with no further information provided.</p> <p><RESIDENT 1></p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses to include liver failure, high blood pressure, heart failure, and pulmonary hypertension (high blood pressure in the arteries of the lungs).</p> <p>In a telephone interview on 12/15/2025 at 12:49 PM, Resident 1 stated they had not had weekly weights as prescribed and hadn't had Continuous Positive Airway Pressure (CPAP-a device used to keep airways open) since admission to the facility. Resident 1 stated prior to admission to the facility, while they were in the hospital, they were told the facility had a CPAP for them to use.</p> <p>In a review of Resident 1's skilled/intermediate nursing facility hospital transfer orders dated 07/02/2025 documented they had physician orders for oxygen therapy and CPAP with pressure settings between 5-16 and an order for daily weights.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an observation on 12/16/2025 at 9:38 AM, and 12/17/2025 at 10:50 AM, Resident 1's room did not contain a CPAP device.</p> <p>A review of Resident 1's care plan dated 07/21/2025 documented the resident had oxygen therapy at night and hadn't been wearing a CPAP.</p> <p>A review of Resident 1's Medication Administration Record (MAR) for November 2025, and 12/01/2025 through 12/17/2025, documented Resident 1 had physician orders dated 07/03/2025 for Oxygen at 2 liters per minute with CPAP at hour of sleep (8 PM). The MAR documented a check mark indicating Resident 1 had been provided with a CPAP.</p> <p>A review of Resident 1's weights in their electronic health records documented the last weight was recorded on 11/12/2025. In a review of a physician note dated 12/10/2025 Resident 1 was documented to have chronic right heart failure and required daily weights and edema checks.</p> <p>In an interview on 12/17/2025 at 10:55 AM, Staff G, Resident Care Manager/Licensed Practical Nurse stated Resident 1 had orders for weekly weights and they were done on Wednesdays. When asked the rationale for Resident 1 to be on weekly weights, Staff G stated they did not know and that Resident 1 did not have chronic heart failure. Staff G stated Resident 1 had an appointment for a sleep study when asked about CPAP use. Staff G stated Resident 1 had not had a CPAP since they admitted to their knowledge. When Staff G reviewed Resident 1's medical record, they stated Resident 1 did have orders for CPAP since admission; however, there was a requirement to go through additional testing to secure a CPAP device, and they did not know why it had not been done.</p> <p>In an interview on 12/17/2025 at 3:40 PM, Staff C, Regional Director of Clinical Operations, stated their expectation was physician's orders were to be followed for weights and respiratory care. Staff C stated if a resident was admitted with orders for a CPAP and they did not have one of their own, one would be provided for them.</p> <p>Reference WAC 388-97-1060(1)(3)(b)(j)(vi)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident's received care and services in accordance with professional standards for one of one resident (Resident 2) reviewed for pressure ulcers. Failure to follow physician's orders for wound treatment and follow established standards of infection control procedures for wound care, placed residents at risk for adverse outcomes, wound deterioration, infection and decreased quality of life. Findings included . Review of the facility policy titled Skin Integrity, with a revised date of July 2025, documented that in the event a resident was admitted with or develops a skin ulcer/pressure ulcer, wound care was provided to treat, heal and prevent, if possible, further development of skin ulcers/pressure ulcers/wounds. Resident 2 re-admitted to the facility on [DATE] with diagnoses which included sacral pressure wound infection, history of pressure ulcers of the sacrum, hips and heel, and urinary tract infection. The resident had a history of Spina Bifida (a birth defect of the spinal column) resulting in bony deformities of the lower spine and legs/feet and incontinence. The resident was wheelchair bound at baseline. Review of the hospital discharge instructions related to the wound stated the resident was not to be up in a wheelchair and positioned far over on one side or the other when in bed to offload pressure to the wound. Review of Resident 2's sacral wound care orders on 12/16/2025 documented: 1. Cleanse with wound cleanser, 2. Apply medicated foam (methylene blue/Gentian Violet), prescribed solution (Dakin's) moistened fluffed gauze to the base of the wound and into undermining/tunneling, 3. Secure with Bordered gauze, 4. Change Daily and PRN (as needed), if soiled, saturated or dislodged, In an interview and observation on 12/16/2025 at 10:45 AM, Resident 2 was in bed lying on their back with the head of the bed elevated. Resident 2 stated their wound had gotten worse. Resident 2 stated they would start going out of the facility to a wound clinic in January. Resident 2 stated the in-house wound team were worried about how close the wound was to their anus. Resident 2 stated they were not supposed to be spending so much time on their bottom and stated the wound team told them it makes a big difference. Resident 2 stated they were able to move themselves over on their left side but needed help to move to their right side due to the size and swelling in their left leg. (The resident's left leg was noted to be substantially larger than the right leg with lymphedema swelling (firm, heavy, thickened skin with orange peel texture, due to trapped lymph fluids). Resident 2 was asked about their current position on their back and the resident shrugged and stated they are aware they were supposed to turn off their back, but stated they were not comfortable on their side for very long. Resident 2 verbalized being knowledgeable about their wound and wound care, and stated they were supposed to be getting a packing in the wound before the foam dressing and was able to recall many of the prior treatments that had been tried. Resident 2 stated they have had a lot of wounds come and go over the years. Resident 2 stated the nurses were having to change the dressing often because of loose stool and the dressing becoming contaminated. Resident 2 stated they were told the stool was what caused the infection. An observation of wound care occurred on 12/17/2025 at 10:52 AM, with Staff H, Registered Nurse. Resident 2 was observed to roll themselves over onto their left side and then a nursing assistant assisted to hold the resident's right leg over. Staff H was observed entering the room with gown and gloves donned outside the room. Staff H opened packages and prepared supplies with clean gloves prior to removing the soiled dressing. The dressing was observed to be bunched upward and had been visibly soiled with stool. There was no packing in place inside the wound bed observed during removal of the soiled dressing, only the outer dressings. Staff H was observed to remove their gloves and reach into their side pocket of their uniform pants to retrieve a second pair of gloves and don them. There was no hand hygiene observed between glove changes and staff uniforms are considered dirty. Staff H sprayed and cleansed the wound using wound cleanser spray and gauze pads. Staff H removed their gloves and retrieved another pair of gloves out of their uniform pocket and donned them prior to removing a blue foam dressing and cutting some of the edge off with scissors, also retrieved from their uniform pockets. Staff H was asked regarding the wound care orders, specifically, if there were orders for any packing that went into the wound bed, and staff H stated no, there is no packing. Resident 2 stated oh, I thought there was supposed to be packing. Staff H stated, no. Staff H placed the blue foam over the opening of the wound and then placed a bordered foam dressing over the top, completely covering the resident's anus under the border of the dressing. Staff H removed their gloves and washed their hands at the sink prior to exiting the room. In the hallway, Staff H was asked to clarify the wound care orders and stated, they are going to change the orders today, but new orders</p>		

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Hire a qualified full-time social worker in a facility with more than 120 beds.</p> <p>Based on interview and record review, the facility failed to employ a qualified social worker when reviewed for qualifications of a social worker for a facility licensed for more than 120 beds. This failure placed residents at risk of not having access to medically related social services, inability to coordinate care, and a diminished quality of life. Findings included .Review of the facility's daily census report provided on 12/16/2025 at 10:58 AM, showed that the facility had 122 available beds. During an interview on 12/16/2025 at 1:47 PM, Staff F, Divisional Social Services, stated the acting social services director, Staff, E, Social Services Director, did not hold a bachelor's degree or qualifications. Staff F stated two new social service staff were hired on 12/15/2025. Staff F stated they had actively sought to fill the social service position with a person who had the required qualifications and had been at the facility at least weekly to support Staff E. During an interview on 12/16/2025 at 3:51 PM, Staff E, stated the prior social service director left employment with the facility on 11/3/2025 and they took over the role as social services director the same day. Reference WAC 388-97-0960 (2)(a)(b).</p>		