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	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Cascades Health and Rehabilitation	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)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 2 residents sampled for legal representative, (Resident 3) had an accurate designation of legal representative on file in the facility, in case of decreased capacity. This failure placed the resident at risk of violation of resident rights to appoint a legal representative for decisions.Findings included.According to the facility's policy titled, Advanced Directives, dated January 2025, showed that during the admissions process, the facility identifies the resident's primary decision maker or appropriate legal representative and invokes this person at any time the resident is assessed as unable to make relevant health care decisions.Resident 3 re-admitted to the facility on [DATE] with diagnosis of developmental delay.Review of facility medical record revealed, Resident 3 was their own responsible party and emergency contact to contact Collateral Contact (CC) 2 who was listed as family. There was no Durable Power of Attorney (DPOA) located.Review of Resident 3's Care Plan dated 12/29/2025 revealed, Resident 3 had impaired cognition secondary to developmental delay and directed staff to ask yes or no questions and to break tasks into one step at a time.Review of a provider note on 01/22/2026 at 00:00 revealed Resident 3 was an intermittently poor historian, so family assisted and the resident communicated more by body language.Review of a social service note on 01/05/2026 at 11:51 AM, documented they had called and left message for (CC 2, outside agency case manager) to call back so they could schedule a care conference for Resident 3.Review of an admissions progress note dated 01/15/2026 at 10:56 AM, documented they spoke with (CC 2), resident's case manager who okayed a room move into a semi-private room.Review of the facility Advanced Directive Form (POLST) and other consents for care in the medical record for Resident 3, revealed the resident signed their own consents/paperwork in the facility.In a phone interview on 01/26/2026 at 2:59 PM, CC 2 stated Resident 3's catheter came out and there was a delay in sending them to the hospital. CC 2 stated nurses kept telling them that the resident's family needed to call them but Resident 3 had no family. CC 2 stated Resident 3 had a DPOA (CC 4). CC 2 stated they notified CC 4, DPOA that Resident 3 was going to the hospital. CC 2 stated the facility came to them (CC staff) for questions/updates, but they are not the DPOA and they did not have a right to make decisions for the resident.In an interview on 01/28/2026 at 12:22 PM, Staff C, Licensed Practical Nurse/Resident Care Manager, was asked about facility staff coordinating care with outside agency companions rather than the DPOA. Staff C pulled up Resident 3's face sheet and showed the profile listed CC 2 as emergency contact #1 to notify and showed Resident 3 as their own responsible party. Staff C stated they were concerned about this on admit and questioned this as the resident was developmentally delayed. Staff C said they were also concerned again when they were reviewing Resident 3's POLST with them. Staff C stated CC 2 told them the resident could sign for themself. Staff C said they would add CC 4 as the DPOA on the face sheet. They stated admissions created the face sheets so between admissions and the business office they should verify if a DPOA is present. In an interview on 01/28/2026 at 3:43 (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

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 01/28/2026

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM, Staff B, Interim Director of Nursing stated they were unaware Resident 3 had a DPOA and CC 2 had never told them this. Staff B stated Social Services should confirm DPOA status.In an interview on 01/29/2026 at 1:58 PM, CC 4 stated they had been Resident 3's DPOA for a couple months. CC 4 stated they had never received any calls from the facility. CC 4 stated the facility should have known they were the DPOA and should have been contacting them for updates and transfers to the hospital. They stated they heard about the incident with the catheter from CC 2 and all updates were from CC 2 rather than the facility. Reference WAC 388-97-0240

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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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident’s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement a system to ensure Physician's Orders for Life Saving Treatments (POLSTs-a document the resident completes to declare their wishes for Cardiopulmonary Resuscitation [CPR] or No CPR) were in place for immediate access to nurses and failed to ensure each resident's electronic medical record (EMR) accurately and consistently reflected the resident's code status for 1 of 1 resident (Resident 2) related to lifesaving treatment orders. The failure to access and follow the POLST instructions for CPR or ensure the POLST was readily available for Resident 2 placed residents at risk for receiving unwanted CPR against their known wishes, avoidable trauma, and other negative health outcomes.Findings included . <Facility Policy>According to the facility's policy titled CPR policy, updated [DATE] showed the POLST or Advanced Directive (AD) is placed in a binder and located in a central and accessible location of the facility, or on each unit. In the event of an emergency, the form is utilized to direct the plan of care. In the event of a code blue event, staff member is assigned to obtain the residents code status via POLST from the facility binder. The licensed nurse validates the resident's code status by reviewing the AD or POLST and follow their wishes. CPR is initiated for those who have requested, through AD or POLST, to have CPR initiated when cardiac or respiratory arrest occurs. According to the facility's policy titled, Advanced Directive dated [DATE], showed that the residents have the right to request, refuse, and or discontinue treatment, to participate in or refuse experimental research and to formulate an advanced directive. The policy showed that during the admission process it is determined if an AD is in place and the POLST form is offered, or assistance is provided in filling out these forms if the resident desires to have one. <Resident 2>Resident 2 admitted on [DATE].Review of the hospital discharge summary printed at the facility on [DATE] at 8:35 AM, showed Resident 2 was DNR (Do Not Resuscitate) and referred to an Advance Care Planning note on [DATE].Review of a progress note dated [DATE] at 6:26 AM, showed around 5:00 AM to 5:30 AM the nurse was called by their coworker as Resident 2 was on the floor with a pillow under their head. Staff F, Licensed Practical Nurse stated they did not see any visible injury, so they transferred the resident to their bed. Staff F noted their body was warm and they felt a pulse on the resident's wrist while they were on the floor. The resident was not responding and their coworker said to get oxygen. Staff D returned to the desk and called 911 and they were instructed to tell their coworkers to start CPR. They relied the message while on the phone and were told medics were on their way. Staff F tried to get hold of the family, but they did not answer. Shortly after medics arrived and took over from facility staff, they announced Resident 2 had passed away Review of an incident investigation dated [DATE] at 5:30 AM, showed a family member of Resident 2's roommate came and stated they needed help. Resident 2 was on the floor on their right side, short of breath and gasping and had a pulse. Supplemental oxygen was placed but the resident stopped breathing and had no pulse. Staff J asked Staff F, LPN if Resident 2 was deemed a full code. They went to the nurse's station to check the POLST form but one was not located. Staff F called 911, Staff J, Registered Nurse (RN) went to get the crash cart and instructed a nurse's aide certified (NAC) to take over and continue CPR. Staff J went to look for the code status and call the family. Staff F located a Do Not Resuscitate (DNR) status in the discharge paperwork from the hospital and asked NAC to stop performing CPR. EMT came and took over related to no hard copy of the POLST from available. The resident was declared deceased by EMT's and chief of police talked to the family member .Review of a statement from CC 4, spouse of Resident 2's roommate wrote a statement that they observed Resident 2 calling out around (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5:00 AM, then sounds of the resident shuffling with their walker, their catheter was pulling and they were trying to get to the door. CC4 tried to lessen the catheter tension and pushed the call light on when suddenly Resident 2 slumped over with labored breathing and began to collapse. CC 4 did not want them to fall on the hard floor and tried to help cushion their collapsing body. A nurse's aide came and stayed with the resident while CC 4 went to find the nurse. CC 4 asked the staff if Resident 2 was DNR and they replied yes. CC 4 documented when medics arrived, they kept asking for the POLST paper, but it was evidentially online in their file. Later medics confirmed that the hospital had a DNR on file and at that point the medics stopped life saving measures.Review of the clinical record showed there was no POLST in Resident 2's chart. There was no documentation code status was discussed.Review of the [DATE] and [DATE] Medication Administration Record for Resident 2 directed staff as follows; For Advanced Directives and Code Status and/or POLST, see Disaster Recovery binder at nursing station.Review of the second floor POLST book on [DATE] at 10:15 AM showed no POLST's were available for 23 of 52 residents on the unit. In an interview at that time Staff G, [NAME] Clerk took the binder and confirmed there were missing POLSTS and there had been multiple room moves so the book was not up to date and needed to be audited.In an interview on [DATE] at 12:25 PM, Staff H, RN stated at this facility they do not have code status banner in the EMR, and they had to look in the POLST book for the resident's code status.In an interview on [DATE] 12:53 PM, Staff C, LPN/Resident Care Manager (RCM) stated that earlier today, Staff I, Health Information Manager (HIM) realized there were POLSTs not located in the binder and there was a stack of them to be scanned. Staff C stated they were not allowed to put the CPR status into EMR per company policy. Staff C stated this had been an issue as it was not helpful for the nurses to not have the POLSTS easily available in the medical record. Staff C stated if the hospital does not send a signed POLST, they look in the resident's hospital medical record for a POLST and if there was a recent one, they will use that. If not, they were to get a new POLST. Staff C stated the admit nurses tried to obtain POLST's and to remember to document their code status in the progress notes, but they have had 15 recent admits.In a follow up interview on [DATE] at 2:02 PM, Staff G, [NAME] Clerk had the POLST binders for the facility at the reception desk and said they were still auditing them. Staff G said the POLST process was when a new admit comes, the RCM's get the POLST signed then it goes to medical records and paper copies go to each floor. They stated if there was an Advanced Directive that should go into the POLST binders as well. Staff G stated the POLST's should also be scanned into the EMR. Staff G stated they audit the second floor POLST binders weekly but had been unable to for about two weeks since they were covering the reception desk. Staff G stated if there was no POLST for a resident they would notify the RCM. Staff G stated they only audit the second floor. Staff G stated Staff I, HIM also audited the binders. Staff G stated they did hear that Resident 2 did not have a POLST when they died.In an interview on [DATE] at 2:21 PM, Staff F, LPN stated on [DATE] night shift they were assigned to care for Resident 2, and they were in another room when they heard Collateral Contact (CC) 4, wife of Resident 2's roommate summoned them to come see Resident 2. Staff F stated they felt a faint radial (wrist) pulse so they went to check the residents' POLST, but they could not find the POLST in the binder. Staff F documented, they then looked in the EMR and could not find the code status, so they called the family, but no one answered. Staff F called Staff J, Registered Nurse (RN) for help and they called 911 and the 911 operator told us to start CPR because we could not find a POLST. Staff F documented that they started CPR and Paramedics arrived in less than 5 minutes. Staff F stated in the meantime, Staff G, RN found in Resident 2's hospital discharge paperwork it said Resident 2 wished for no CPR. Staff F stated, It was terrifying not finding the POLST, terrible. Staff F stated when family (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	called, they said they had given a copy of Resident 2's POLST to the facility and also mailed the original to the facility on admit. They stated they were not sure why we did not have it.In an interview on [DATE] at 2:14 PM, Staff I, HIM stated nursing should be obtaining the POLST after reviewing with the resident, then give the POLST to the doctor for signature, then Staff G, [NAME] Clerk would scan them to them and put them in the binders. Staff I stated the nurses are to look for the POLST/AD in the binder at the nurse station or sometimes they were located in the EMR under documents. Staff I stated the POLST's should be in EMR for staff to see as well. Staff I said the business office was responsible for uploading the AD and sometimes the AD would be in the binder or placed in the financial folder. Staff I acknowledged the nurses would have had difficulty locating financial files. Staff I stated they had heard Resident 2 passed but nothing about their POLST. Staff I stated they had just received three POLSTS they did not have and the POLST binders needed to be up to date with residents' wishes so nurses can easily access them. In an interview and observation on [DATE] at 3:36 PM, Staff G, ward clerk continued to have the POLST binders at the reception desk and stated they were still auditing and showed 4 POLSTS they had located but were not in the binders. In an interview on [DATE] at 3:43 PM with Staff B (Interim Director of Nursing) stated nursing staff should have access to the POLST. Staff B stated POLSTS were to be addressed on admission, it then went to the provider to be signed, a copy was placed in the binder until it was signed by the provider. Staff B stated social services should review POLSTS and make sure the AD and DPOA 's are in place. Staff B stated after the incident with Resident 2, they discussed the incident with their medical director who wanted the code status easily identified in the EMR. Staff B stated company policy is that they do not have a code status banner at the top of the EMR. Staff B stated if they were called to a code, they don't want to flip through a binder to find it but since they can't know from the medical record, they have to look in the binder. Staff B was asked about the investigation and if POLSTS were audited after the [DATE] incident to ensure no other residents were without a POLST or AD. Staff B stated they audited every POLST in the building and made a list of POLST's they still needed this morningIn an observation on [DATE] at 4:02 PM, The POLST binders remained at the reception desks out of reach of the nurses since 10:30 AM.REFERENCE: WAC 388-97-1060 (1)

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F 0689 Level of Harm - 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** Based on observation, interview and record review, the facility failed to provide an environment that was free from accident hazards over which the facility has control for 1 of 3 residents (Resident 1) reviewed for falls. Resident 1, who had a known history of falls experienced harm when the facility failed to safely administer medications which resulted in cumulative adverse effects contributing to a fall with a significant injury. Findings included .Review of the facility policy titled: Fall Management and Neurological Check, with a revised date of January 2025, stated care plans were updated to reflect individualized interventions to reduce falls and a systematic review of current interventions was completed post fall and root causes identified. Resident 1 admitted on [DATE] with diagnoses which included hypertension (high blood pressure, chronic kidney disease, heart failure) and vision deficit. Review of the fall risk assessment dated [DATE] showed the resident was assessed as at high risk for falls.Review of the admission Minimum Data Set (MDS- a required assessment tool) dated 08/26/2025 showed the resident had no history of falls reported in the 6 months prior to admission. Review of the associated Care Area Assessment (CAA) related to falls dated 08/26/2025 stated Resident 1 did not have a history of falls in the look back period. The CAA identified medications as risk factor and stated to proceed to the care plan related to risk for falls.Review of the care plan dated 08/20/2025 documented a care plan problem related to mood and behavior which identified the resident as taking several medications for mood and included side effects such as dizziness, drowsiness, unsteadiness and blurred vision and the potential for a drop in blood pressure when moving quickly from sitting to standing (orthostatic hypotension.) A care plan problem related to falls stated Resident 1 was at risk for falls related to deconditioning. The goals dated 08/20/2025 and revised 11/24/2025 stated the Resident 1 would remain free from injury related to falls. Care plan interventions included having the call light in reach, wearing proper footwear, keeping the room free of clutter, and reminding the resident to sit at the edge of the bed prior to standing to prevent orthostatic hypotension. The care plan did not include a focus area related to cardiac related blood pressure medications. Review of Resident 1's medical record on 01/28/2026 showed the resident began experiencing falls: On 12/06/2025, Resident 1 was documented as having a fall and hitting their head, a neurological assessment was done, a CT of the head showing no acute injury and laboratory tests were completed. One blood pressure medication was discontinued. There were no new interventions or updates made to the care planned fall interventions. On 12/11/2025, Resident 1 had a fall with no stated injury. There were no new orders and no changes to the care planned fall interventions. Further falls were documented on 01/08/2026 (the provider assessed the resident and noted orthostatic hypotension with significant drop in blood pressure upon standing and Positive for signs and symptoms of dehydration the resident received an intravenous fluid bolus), 01/09/2026 (Resident 1 slid out of their wheelchair in another resident room) and 01/10/2026, with no new orders, interventions or updates to the care plan. 01/12/2026 a pharmacist review noted frequent falls. There were frequent medication order changes due to dizziness, weakness and frequent falls. On 01/14/2026 at 11:30 AM, the resident had a fall in their room, striking their face and complaining of back pain. The resident was sent to the emergency department where they were assessed to have a right forehead hemotoma (a solid swelling of clotted blood in tissue) and an acute L2 (low back) vertebral compression fracture. The emergency department report stated the resident arrived stating I fell because of my blood pressure. Review of the facility medication administration records for the month of January 2026, documented the resident had received three blood pressure medications prior to the fall on 01/14/2026 which had parameters (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	included in their orders to hold those medications when the resident's diastolic blood pressure (bottom number) was below 60. The blood pressure documented on 01/14/2026 was 112/58. The MAR also documented administrations when the residents blood pressure was below the ordered parameters on 01/01/2026, 01/04/2026 and twice since the fall on 01/26/2026 and 01/27/2027. Review of the facility incident investigation dated 01/14/2026 did not identify Resident 1 as having suffered injury from the fall. The incident investigation stated no injuries apparent at time of incident, despite the resident having obvious facial trauma, and the post incident section stated no injuries observed post incident. The level of pain and level of consciousness sections of the investigation were blank. The entire section of predisposing factors such as clutter in the environment, physical factors, or mental factors was blank. Staff statements stated the resident had been seen 30 minutes prior to the fall lying in bed and their blood sugar had been checked. Resident 1 was stated to have been wearing proper footwear and had last eaten at 9:00 AM. The investigation stated neurological checks were done but there was no documentation of them included in the report or in the resident record. The medication errors related to the blood pressure medications were not identified and medication risk factors previously identified in the CAA were not reviewed as part of the post fall investigation. The resident returned from the emergency department at 8:00 PM on 01/14/2025 with new orders for a pain management patch to their low back, and a new medication order related to additional findings of decreased liver function. There were no updates made to the care plan related to actual falls, fracture/pain management or medication side effect monitoring. In an interview on 01/28/2026 at 9:00 AM, CC1, resident representative, reported there were problems and overdosing with blood pressure medications since admission, the resident has had falls and needed fluids at one time related to dehydration. CC1 stated the resident has fallen several times, and was weaker, due to mismanagement by the facility. CC1 stated this has also impacted Resident 1 being able to do therapy stating, (Resident 1) used to be able to walk; Now she is weak and in pain. In an interview and observation on 01/28/2026 at 10:30 AM, Staff E, Registered Nurse, RN, was administering medications, Staff E showed the medication screen view and the orders and stated when a medication was selected that included a requirement to check a blood pressure or pulse, a box would appear to enter the value. Staff E stated Resident 1 had a parameter for the blood pressure medications. Staff E stated if the blood pressure or pulse was too low they should not administer the medication. Staff E stated Resident 1 had declined lately, was sleeping and staying in bed more and stated they were going to offer them a nutrition shake, because they did not eat breakfast today. In an interview on 01/28/2026 at 10:40 AM, Staff K, Nursing Assistant Certified, stated Resident 1 had been sleeping a lot lately, did not eat breakfast and used to be more independent. Staff K picked up Resident 1's uneaten breakfast tray and had notified Staff E that Resident 1 had not eaten and said they were not hungry. Staff K stated Resident 1 had a low bed because they had fallen and was not aware of any other fall interventions. Staff K stated Resident 1 used the call light, and could tell you what they needed. In an interview and observation on 01/28/2026 at 11:16 PM, Resident 1 was sitting up in their wheelchair and was observed with yellow and purple resolving bruising around their right eye. Resident 1 stated they have had a lot problems with their blood pressure and blood pressure medications. Resident 1 stated their memory was a bit fuzzy from the day of that specific fall, but they remembered standing at the sink and feeling dizzy, turning around to trying and sit on their bed and they fell. Resident 1 stated they told me I I broke my back and it still hurts. Resident 1 says they are using a pain patch on their back and it only helps a little. Resident 1 stated they had been having ongoing episodes of dizziness but never used to. and said their head sometimes just feels numb. Resident 1 stated they use the call light like they (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	tell her to, but it usually takes at least a half an hour for someone to come. In an interview on 01/28/2026 at 1:12 PM, Staff C, LPN, Resident Care Manager, stated the medication parameters were included with the orders in the administration screens but the system would not stop you if you administered a medication outside of a parameter. It was up to the nurse to view the entire order and to hold the medication based on the order. Staff C reviewed the administration orders for Resident 1 and the administration record and stated those were all errors, the medication should not have been given and the provider should have been notified. Staff C stated medication side effects would be on the care plans and should be updated when there were changes and reviewed after falls and the team reviewed falls during the daily stand up meetings. In an interview on 01/28/2028 at 2:28 PM, Staff B, Director of Nursing, stated administration of the blood pressure medication outside the parameter constituted an error and would need an investigation. Staff B stated they had not identified the medication errors while conducting the 01/14/2026 fall investigation for Resident 1 and had not identified medication as a contributing factor in that fall.Refer to F 760 - 483.45 (f)(2) - Residents Are Free of Significant Med ErrorsRefer to WAC 388-97-1060 (3)(g)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 3 residents (Resident 1) reviewed for falls were free from significant medication errors. Failure to follow physician ordered medication parameters for antihypertensive (blood pressure lowering) medications resulted in harm when Resident 1 experienced dizziness and a fall resulting in significant injury. Findings included .Review of the facility policy titled, Medication Administration Guidelines, dated 01/23 stated prior to administration of medication, review and confirm the orders for each individual medication. Resident 1 admitted [DATE] with diagnoses which included hypertension (high blood pressure) chronic kidney disease and congestive heart failure. Resident 1 had a history of falls. Review of Resident 1's physician's orders showed the resident had orders for:A diuretic (furosemide) (medication that lowers blood pressure by removing fluid from the body) once per day at 11:00 AM. The order instructed the nursing staff to hold the medication if the resident's systolic (top number) blood pressure was less than 100mm/Hg (millimeters of mercury), and/or the diastolic (bottom number) was less than 60mm/Hg. An antihypertensive medication (hydralazine)(lowers blood pressure by relaxing the smooth muscle in blood vessels) once per day at 11:00 AM. The order instructed the nursing staff to hold the medication if the resident's systolic (top number) blood pressure was less than 110mm/Hg (millimeters of mercury), and/or the diastolic (bottom number) was less than 60mm/Hg.An antihypertensive medication (lisinopril)(lowers blood pressure by relaxing the smooth muscle in blood vessels) once per day at 11:00 AM. The order instructed the nursing staff to hold the medication if the resident's systolic (top number) blood pressure was less than 100mm/Hg (millimeters of mercury), and/or the diastolic (bottom number) was less than 60mm/Hg. Review of Resident 1's Medication Administration Record (MAR) for 01/01/2026- 01/27/2026 documented: On 01/01/2026, blood pressure was documented as 132/54 (diastolic BP was below 60). The MAR documented that the resident was administered furosemide, hydralazine and lisinopril. On 01/04/2026, blood pressure was documented as 106/71 (systolic BP was below 110). The MAR documented the resident was administered hydralazine. On 01/14/2026, blood pressure was documented as 112/58 (diastolic BP was below 60). The MAR documented the resident was administered furosemide, hydralazine and lisinopril. Review of Resident 1's medical record, documented Resident 1 fell in their room on 01/14/2026 at 11:30 AM, striking their face during the fall and complaining of back pain. Resident 1 was transported to the emergency department where review of an emergency department summary report revealed the resident had a hematoma on the right forehead and an acute L2 (low back) compression fracture. Review of Resident 1's MAR for days following the fall, showed two additional days (01/26/2026 and 01/27/2026) that the blood pressure medications were administered when the resident's diastolic blood pressure was below 60. In an interview on 01/28/2026 at 9:00 AM, CC1, resident representative, reported there were problems and overdosing with blood pressure medications since admission, the resident has had falls and needed fluids at one time related to dehydration. CC1 stated the resident has fallen several times, and was weaker, due to mismanagement by the facility. In an interview and observation on 01/28/2026 at 10:30 AM, Staff E, Registered Nurse, RN, was administering medications, Staff E showed the medication screen view and the orders and stated when a medication was selected that included a requirement to check a blood pressure or pulse, a box would appear to enter the value. Staff E stated Resident 1 had a parameter for the blood pressure medications. Staff E stated if the blood pressure or pulse was too low, they would hold the medication and there would be a code entered that indicated the medication was not administered due to vital signs being outside the ordered parameter. In an interview and observation on 01/28/2026 at 11:16 PM, Resident 1 was sitting up in their wheelchair and was observed with (continued on next page)

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 01/28/2026
NAME OF PROVIDER OR SUPPLIER North Cascades Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Actual harm Residents Affected - Few	yellow and purple resolving bruising around their right eye. Resident 1 stated they have had a lot problems with their blood pressure and blood pressure medications. Resident 1 stated their memory was a bit fuzzy from the day of that specific fall, but they remembered standing at the sink and feeling dizzy, turning around to try and sit on their bed and they fell. Resident 1 stated they told me I I broke my back and it still hurts. In an interview on 01/28/2026 at 1:12 PM, Staff C, LPN, Resident Care Manager, stated the medication parameters were included with the orders in the administration screens but the system would not stop you if you administered a medication outside of a parameter. It was up to the nurse to view the entire order and to hold the medication based on the order. Staff C reviewed the administration orders for Resident 1 and the administration record and stated those were all errors, the medication should not have been given and the provider should have been notified. In an interview on 01/28/2028 at 2:28 PM, Staff B, Director of Nursing, stated administration of the blood pressure medication outside the parameter constituted an error and would need an investigation. Staff B stated they had not identified the medication errors while conducting the 01/14/2026 fall investigation for Resident 1 and had not identified medication as a contributing factor in that fall. Refer to F 689 - 483.25 (d)(1)(2)- Free of Accident Hazards/supervision/devices Refer to WAC 388-97-1060(3)(k)(iii)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to ensure a system was in place in which residents' records were complete, accurate, accessible, and systematically organized for 2 of 3 residents (2 and 3) reviewed for accurate and complete medical records. The facility failed to ensure the medical records reflected an adverse event for Resident 2 and hospital visit report for Resident 3. These failures to not maintain complete and accurate medical records placed residents at risk for medical complications, unmet care needs, and diminished quality of life. Findings included .<RESIDENT 2>Review of an incident report investigation dated [DATE] at 5:30 AM, documented that Resident 2 had an episode of syncope (temporary loss of consciousness and posture due to insufficient blood flow to the brain) on the toilet around 2:00 AM. The nurse checked their vitals, and the resident was up in their chair for 30 minutes and then went to bed.Review of the clinical record including progress notes did not include the syncopal episode, assessment, vital signs or if the provider was contacted. Resident 2 passed away at 5:30 AM.In an interview on [DATE] at 2:21 PM, Staff F, Licensed Practical Nurses stated they were the nurse responsible for Resident 2 on night shift [DATE]. Staff F stated an hour or two before Resident 2 died, the nurses aide certified (NAC) brought the resident to the nurse's station and said the resident had passed out during a bowel movement while on the toilet. Staff F stated the residents' color was not good and they were up and down a little in their wheelchair. Staff F stated they asked the resident if they were good and had the NAC take their vital signs. Staff F stated their vital signs were at baseline and there was no further assessment other than asking the resident questions and taking their vitals. Staff F was unaware they did not document that (syncope episode) and did not notify the provider of the incident. They stated they should have charted it and would have but then Resident 2 died. <RESIDENT 3>Resident 3 went to the hospital on [DATE] for reinsertion of their urinary catheter (tube inserted into the bladder to drain urine).Review of the clinical record on [DATE] showed there were no hospital records from the hospital visit on [DATE].In an interview on [DATE] at 12:44 PM, Staff I, Health Information Manager (HIM) was asked to obtain the hospital records from Resident 3's hospital visit on [DATE].Review of the clinical record showed Resident 3's [DATE] dictation was obtained on [DATE] at 7:07 AM.In an interview on [DATE] at 2:13 PM, Staff I, HIM, was asked who was responsible for obtaining hospital records after hospital visits. Staff I stated the nurses usually would obtain them.In an interview on [DATE] at 3:43 PM, Staff B, Interim Director of Nursing stated hospital visits and adverse events such as syncope should be documented in the clinical record and accessible.No additional information was provided.Refer to WAC 388-97- 1720 (1)(a)(i-iv)(b)