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	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Cascades Health and Rehabilitation	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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure potential abuse/neglect allegations were thoroughly investigated for 1 of 2 residents (Resident 2), reviewed for unexpected death. This failure placed residents at risk for unidentified abuse and/or neglect and a diminished quality of life.Findings included .Review of the facility policy titled, Abuse Investigation, updated [DATE] documented the center conducted thorough investigations of potential, suspected and/or allegations of abuse, neglect.in accordance with state and federal regulations. The center identified and interviewed others who might have knowledge of the allegations, maintained complete and thorough documentations of the investigation, and patterns, tends or events that would suggest abuse/neglect. Resident 2 was admitted to the facility on [DATE] with diagnoses to include bladder tumor, kidney disease and vasovagal response (fainting spell caused by a sudden, temporary drop in blood pressure). Resident 2 was admitted to the facility for skilled services with a discharge plan to return home. Review of the facilities incident report, dated [DATE], documented Resident 2 experienced a fall without fracture and an unanticipated death both with the same time of 5:30 AM. The incident report contained a nursing description, witness statement forms for three staff members, written statement from a visitor and a fall investigation checklist. The incident report documented the fall, and the unanticipated death were not witnessed, contradictory to the statements within the investigation. The investigation contained a statement by staff with no associated signed statement, which documented the police and 911 were called after Resident 2 was found on the floor, moved to their bed, provided oxygen, and subsequently stopped breathing, at which time they obtained the crash cart to start Cardiopulmonary Resuscitation (CPR). The incident report did not contain a timeline of events, who performed CPR, how long CPR was performed or names of the staff involved. In an interview on [DATE] at 12:50 PM Staff B, Director of Nursing Services, stated they expected an investigation for an unexpected death to contain witness statements from staff who were present, past medical history for the resident, review of diagnoses, and the investigation should be thorough. Staff B stated the state hotline was not notified for Resident 2's unexpected death because it was not suspicious. Staff B stated they were unaware the police were notified of Resident 2's unexpected death and the police report was not reviewed as part of the investigation. When asked how abuse or neglect was ruled out for Resident 2's unexpected death, Staff B stated the resident was incredibly ill and because of this their death was not unexpected. When asked if staff were interviewed independent of their written statements, Staff B stated they were and when asked where to find that information they stated it was scribbled on notes and in their memory. Reference WAC 388-97-0640 (6)(a)(b)

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 02/06/2026

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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 - Immediate jeopardy to resident health or safety 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 ensure staff immediately performed Cardio-Pulmonary Resuscitation (CPR) to 2 of 2 residents (Residents 1 & 2) who were found unresponsive (not breathing and without a pulse) and had a physician order to initiate CPR. Resident 1 had a signed POLST (Physician Order for Life Sustaining Treatment- a form indicating the resident's wishes to have or not have CPR) for life-sustaining care and services, facility staff were unable to locate Resident 2's POLST after they became unresponsive. The failure to train staff on the facility's expectation how to respond to a resident who required CPR, locate for immediate reference a resident's POLST/Advanced Directives, and accurately assess signs of irreversible death, resulted in staff not performing CPR for both residents, and placed other current residents who may need CPR at risk of not receiving life sustaining treatment and/or full medical interventions in an emergency, constituted in an Immediate Jeopardy (IJ-noncompliance that has caused or is likely to cause, serious injury, harm, impairment, or death to a resident). On [DATE] at 4:10 PM, the facility was notified of an IJ in F678. The IJ was determined to have begun on [DATE] when the facility failed to perform CPR immediately when a resident was found unresponsive without a pulse, was not breathing, and had a physician order to initiate CPR. The facility removed the immediacy on [DATE] at 3:04 PM, after educating staff in emergency response, reviewing their CPR policy, all residents' POLST forms for accuracy, CPR training for completion, and implemented a plan of correction to sustain ongoing compliance. Findings included . Review of the facility policy titled, Cardiopulmonary Resuscitation (CPR), updated [DATE] stated licensed nurses employed by the facility will have current CPR certification from American Heart Association or American Red Cross.CPR certification is reviewed routinely to validate current CPR certification for licensed nurses was maintained.CPR would be initiated for residents who have requested through advanced directives or POLST form to have CPR, and for residents that have not formulated an advanced directive &/or POLST form was in their medical record.POLST binder will be centrally located in a accessible location in an the event of an emergency the form would be utilized to direct the plan of care.in the event of a code blue event a staff member identifies a resident that was absence of pulse or breath, a staff member immediately seeks assistance from a licensed nurse and ask another staff member to announce a code blue, a staff member will be assigned to obtain the residents code status via POLST binder, and a licensed nurse will validate the residents code status and follow directions. Review of American Heart Association's guidelines for 2025, reviewed on [DATE] CPR should be initiated immediately when an individual has been found without a pulse or breathing. <RESIDENT 1> Resident 1 was admitted to the facility on [DATE] with diagnoses including endocarditis (infection of heart tissue), and sepsis (infection in the blood).Review of Resident 1's POLST form sign by a physician on [DATE], documented the resident selected attempt resuscitation/CPR in the even they had no pulse and were not breathing. Review of Resident 1's progress note dated [DATE] at 11:15 AM, the nurse documented they were informed the resident was unresponsive, they entered the resident's room, resident was not breathing and had no pulse. The nurse called for help, called 911, and notified the nurse practitioner who was at bedside. Review of Resident 1's progress note dated [DATE] at 1:02 PM, the nurse manager documented they notified the county coroner's office related to unexpected passing of the resident. There was no further documentation in Resident 1's medical record. Review of the POLST binders on the 1st and 2nd floors on [DATE] from 12:12 - 1:15 PM, the 1st floor binder listed only 1st floor residents by room, and the 2nd floor binder listed only 2nd floor residents by room. Three residents POLST forms were (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	not located in the correct room per the electronic medical records, and one POLST form was for a 2nd floor resident whose POLST form was still physically located in the 1st floor binder, on the 1st floor. Several residents on both floors had duplicate POLST forms that showed conflicting results, i.e. one form would elect to have CPR, and the other did not. In an interview on [DATE] at 1:20 PM, Staff M, Nursing Assistant Certified (NAC) was asked how to tell if a resident elected CPR if they were found unresponsive without a heart rate or breathing. Staff M stated they thought that information was in the resident's electronic individual service plan. Staff M stated if they found a resident that was unresponsive, they would check their vitals then get a nurse.In an interview on [DATE] at 1:25 PM, Staff D, Registered Nurse (RN) stated that in the event a resident was found to be unresponsive (no pulse and not breathing) they are to call for help, check the code status and initiate CPR if necessary. Staff D stated if they were unable to find the code status they are to provide CPR. Staff D stated they were told Resident 1 was found unresponsive and went to the resident's room on [DATE]. Staff D stated they had no pulse, and they were not breathing. Staff D stated they called for help, and went to the nurse's station, Staff D stated Staff C, RN/Assistant Director of Nursing (ADNS), and Collateral Contact (CC) 1, Nurse Practitioner (NP) came back to Resident 1's room with them, Staff F, RN, called 911. Staff D stated that Staff C, and CC1 assessed Resident 1 and found they were absent from pulse and breath. Staff D stated, no one started CPR. Staff D stated everyone was frazzled. Staff D stated emergency services arrived and they started CPR.In an interview on [DATE] at 1:33 PM, CC1 stated they were in another room when they heard that Resident 1 was unresponsive. CC1 stated they entered the resident's room and saw Staff C in the room assessing the resident with a pulse oximeter (finger device that measures heart rate and oxygen saturation) and there were no results on the meter. CC1 stated they then listened to Resident 1's heart and heard nothing. CC1 stated Staff D, and Staff F entered the room, and someone stated the resident was a full code. CC1 stated they remember stating we need to be sure and if they are we should start compressions, and then they walked out of the room to verify. CC1 stated to their knowledge no facility staff, or themselves started CPR on Resident 1. In an interview on [DATE] at 2:29 PM, Staff C, stated when a resident was found unresponsive, without a pulse or breathing, they should alert someone there was a code blue and start CPR. Staff C stated usually someone would be checking the residents' code status and if they were a full code you would continue with life saving measures until emergency services arrived. If the residents had not elected to not have CPR on their POLST or advanced directive they should stop CPR. Staff C stated they were notified by a therapist that Resident 1 had been unresponsive. Staff C stated they went to the room with Staff D, RN and found Resident 1 was not breathing and had no pulse. Staff C stated they thought Staff F was checking to see if the resident wanted CPR and was going to call 911. Staff C stated that shortly after they arrived in the room CC1 entered the room and wanted to assess the resident as well. Staff C stated CC1 said something along the lines of they had passed away,, just as Staff F had come back into the room and stated the resident was a full code and required CPR. Staff C stated no one at the facility started CPR during that time, and that CPR was started when the emergency services personnel arrived. Staff C stated CPR should have started on Resident 1. In an interview on [DATE] at 2:42 PM, CC 2, Occupational therapist (OT) stated on [DATE] around 11:00 AM to 11:15 AM they went to Resident 1's room to conduct a therapy session with the resident. CC 2 stated the resident was observed in bed, with oxygen tubing to their nasal passageway via a concentrator that was running. CC 2 stated the residents did not wake up or respond. CC 2 stated they performed a sternal rub (applying a fist totheir chest and rub to arouse) with no response so they quickly left the room and grabbed Staff D, then quickly told Staff C and CC 1 as well, then they left (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the room. Review of an Emergency Medical Services (EMS) report printed [DATE] at 9:23 AM, for the EMS 911 call for Resident 1 on [DATE], documented the resident appeared unresponsive, skin, head and face appeared normal. The report showed the 911 call came in at 11:10 AM, EMS unit was notified at 11:13 AM, EMS unit was at bedside with Resident 1 at 11:24 AM, (14 minutes total time from call to bedside to start CPR). In a phone interview on [DATE] at 11:56 AM, Staff F, stated they overheard a therapy staff tell Staff D that Resident 1 was unresponsive. Staff F stated they saw Staff C, and Staff D enter Resident 1's room, then about a minute or so later they followed into the resident's room. Staff F stated they went to call 911 and exited the room. Staff F stated after they got off the phone with the 911 operator, they went back to Resident 1's room where Staff C, Staff D, and CC1 were present. Staff F stated CC1 was assessing Resident 1, no one had started CPR. Staff F stated they left the room since there were three licensed staff in the room. Staff F stated they were never asked by anyone to confirm Resident 1's code status, and that they never went to check their code status. Staff F stated the POLST binder was on the nurse's station counter open when they were calling 911. Staff F stated they did not remember when this occurred other than it was between 10:00 AM - and 12:00 PM. Staff F stated prior to this event? they remembered one of the NACs reported to them that Resident 1 had some trouble breathing., Staff F said the NAC told them they had helped the resident to breathe, the resident was ok now, and did not go re-check on the resident. In an interview on [DATE] at 2:25 PM, Staff G, NAC, stated they heard Resident 1 calling for help between 10:45 AM and 10:50 AM on the morning of [DATE]. Staff G stated Resident 1 appeared to be having difficulty breathing and talked them through some breathing exercises through their nose, while wearing oxygen supplementation via nasal tube. Staff G stated they assisted Resident 1 to get back into their bed, and informed Staff F, since Resident 1's nurse (Staff D) was on lunch that the resident had a few episodes of breathing concerns. Staff G stated when they left the resident, they were breathing fine, lying in bed with oxygen supplementation via a nasal tube, and appeared comfortable. In an interview on [DATE] at 3:11 PM, CC 3 stated they had held a therapy session with Resident 1 on [DATE] sometime after 9:00 AM that morning. CC 3 stated that the residents presented short of breath during their workout but did not seem out of the ordinary. Review of the preliminary facility investigation on [DATE], undated showed an audit was completed on [DATE] for the POLST binders located on the 1st and 2nd floor of the facility were up to date. Review of the completed facility investigation dated [DATE], documented a witness statement by a NAC that sometime around 10:50 AM they heard someone yelling Help, Help from room [ROOM NUMBER]. They entered the room to find Resident 1 in their wheelchair flailing their arms and yelling. The residents stated they could not breathe. The staff stated Resident 1 had oxygen on and they encouraged them to breathe. The resident calmed down and asked to be assisted to bed. When they were assisting Resident 1 with positioning in bed they began flailing around again and saying they couldn't breathe. The NAC stated in the statement they went to notify the nurse. The nurse (Staff D) was on break, so they left them a note on their med cart and informed the other nurse (Staff F). The investigation documented Resident 1 was found unresponsive by a therapy staff (CC 2) around 11:00 AM - 11:15 AM, they notified a nurse. The investigation documented that three licensed nurses were all in Resident 1's room and found them without a pulse and were not breathing. A fourth licensed nurse called emergency services (911). The investigation documented that no licensed staff started CPR on Resident 1. Emergency services personnel initiated CPR to Resident 1 when they arrived, the resident was pronounced dead by emergency services. The facility substantiated that the licensed staff failed to provide CPR services to a resident that had requested and needed life saving measures. In an interview on [DATE] at 12:19 PM, CC 4, Medical Director, stated their expectation was (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for anyone in the facility that was certified to perform CPR, would be following that protocol. CC 4 stated that CPR should be initiated while someone verified the residents' code status. CC 4 confirmed it was their expectation that the nurse practitioner should have given guidance to start CPR on Resident 1. In an interview on [DATE] at 1:09 PM, Staff B stated that it was the facility policy that facility staff are initiating CPR on any resident that was found not breathing or without a heartbeat. Staff B stated that while one staff member performs CPR, someone else can alert emergency services and verify code status on the resident. Staff B stated in the event the resident did elect CPR, staff are to continue CPR until emergency personnel arrive and take over, if they did not want CPR the staff can stop life saving measures. Staff B stated that Resident 1 should have had CPR. <RESIDENT 2> Resident 2 was admitted to the facility on [DATE] with diagnoses to include bladder tumor, kidney disease and vasovagal response (fainting spell caused by a sudden, temporary drop in blood pressure). Review of the facilities incident report, dated [DATE], showed Resident 2 experienced a fall without fracture and an unanticipated death both with the same time of 5:30 AM. The incident report contained a nursing description, witness statement forms for three staff members, written statement from a visitor and fall investigation checklist. The incident report documented the fall, and the unanticipated death were not witnessed. The investigation report showed a statement by staff with no associated signed statement, which documented the police and 911 were called after Resident 2 was found on the floor, moved to their bed, provided oxygen, and subsequently stopped breathing, at which time they obtained the crash cart to start CPR. The incident report did not contain a timeline of events, who performed CPR, how long CPR was performed or names of the staff involved. Review of EMS report, dated [DATE], showed EMS was notified at 5:01 AM of Resident 2's condition. EMS arrived at Resident 2's bedside at 5:13 AM and the narrative documented Resident 2 as unresponsive, CPR was initiated but stopped, and it was unclear why CPR was not in progress at EMS arrival. In an interview on [DATE] at 3:02 PM Staff J, Licensed Practical Nurse (LPN), stated they did not perform any CPR on Resident 2. Staff J stated they had assisted another nurse get Resident 2 back to bed and placed oxygen on them after finding a pulse. Staff J stated they went to the nurse's station and attempted to find Resident 2's code status but were unable to locate it. Staff J stated Resident 2 was found about 4:30 AM and EMS arrived within five to six minutes.In an interview on [DATE] at 9:38 AM Staff E, LPN/Staff Development stated licensed nurses were required to have up to date and current CPR certification, however the nursing assistants were not. When asked if Staff I, Nursing Assistant Certified (NAC) and Staff H, NAC had current CPR certification, Staff E stated there were no current CPR certifications on file for either NAC. In an interview on [DATE] at 10:47 AM Staff I, NAC stated they did not provide CPR to Resident 2 on [DATE]. Staff I stated Staff H, NAC, motioned to them to come and help with Resident 2. Staff I stated Resident 2 was in bed and they assisted Staff H with placement of a rescue board under Resident 2 in bed. Staff I stated they counted respirations while Staff H completed chest compressions. Staff I stated they counted to about 25 and then Staff H stopped compressions. Staff I stated they did not have a current CPR certification. Staff I stated they did not witness any other staff member provide CPR to Resident 2. In an interview on [DATE] at 12:53 PM, Staff H stated they provided 30 - 50 chest compressions to Resident 2 on [DATE]. Staff H stated they were directed by Staff L, Registered Nurse (RN) to go to Resident 2's room and start CPR. Staff H stated they started last rounds with Staff I about 3:30 AM and decided to leave Resident 2's hall for last to allow them to sleep. Staff H stated they were almost done with rounds in the longest hall, which usually took about an hour, when they were directed to go to Resident 2's room. Staff H stated Staff J and Staff L along with the downstairs nurse, Staff K were all at the nurse's station about 10-15 (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	minutes prior to being told to start CPR on Resident 2. Staff H stated they did not take over CPR for any of the nurses and as far as they knew were the only one who provided CPR to Resident 2. Staff H stated they stopped providing chest compressions when Staff L and Staff K, RN came to Resident 2's room. Staff H stated they asked the nurses for the AMBU (manual bag to provide respirations) and if they needed to continue CPR. Staff H stated Staff K and Staff L just stood there and said nothing and provided no direction. Staff H stated they told Staff K and Staff L they were tired and unable to continue CPR. Staff H stated they had been certified for CPR in the past, did not know if they were current on their certification as they had lost their certification card.In an interview on [DATE] at 2:27 PM Staff K, RN stated they were called by Staff L, RN to assist with finding Resident 2's code status. Staff K stated they received the call after 4:00 AM. Staff K stated they did not provide any CPR to Resident 2 and did not go to their room or assess them in any way. Staff K stated they brought the crash cart upstairs and Staff J and Staff L were both at the nurse's station looking for Resident 2's code status.In an interview on [DATE] at 12:50 PM Staff B stated CPR must be provided to residents if their code status was not known. Refer WAC 388-97-1060(1)