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	03/04/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was free from sexual abuse by a staff member for 1 of 1 resident (Resident 1) reviewed for abuse. The facility failed to recognize and report the allegation immediately to protect the resident from the potential further abuse. This failure allowed the alleged perpetrator to continue to work with other residents and allowed them to still have access to Resident 1. Resident 1 who had a known history of domestic violence, was a victim of a home robbery by a past caregiver, experienced psychosocial harm when they experienced increased panic attacks, a change in their sleeping pattern and increased anxiety related to fear of the staff member. This failure placed residents at risk for potential sexual abuse, psychological harm, and a diminished quality of life.Finding included.Review of the facility policy titled, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, updated March 2025, stated sexual abuse was non-consensual contact of any type with a resident.includes but not limited to unwanted intimate touching of any kind.a mandated reporter is any employee of the facility.defined immediately as means as soon as possible, but not later than two hours after an allegation has been made.Resident 1 admitted to the facility on [DATE] with diagnoses that included bipolar disorder (chronic mental health condition characterized by intense mood swings), agoraphobia (fear of not being able to escape or get help), and anxiety disorder. The admission Minimum Data Set (MDS - an assessment tool) dated 11/10/2025 documented the resident had no refusal of care, no behaviors, and was dependent on staff for toileting and personal care.Review of Resident 1's care plan had a focus revised date of 12/26/2025, documented the resident had impaired psychosocial well-being with goals of care that included the resident will feel safe in this facility to process trauma. Interventions included but not limited to; cares in pairs, trigger behavior can come from a history of domestic violence and ensure the residents' safety.Review of the facility investigation dated 02/23/2026 at 6:57 PM, documented Resident 1 informed a staff member of a sexual assault allegation. Resident 1 identified Staff H, Nursing Assistant Certified (NAC) as the alleged perpetrator and stated Staff H stroked the inside of the resident's thigh and made inappropriate comments. Resident 1's description of the events showed Staff H had entered their room to change their brief, during the process Staff H stroked the resident's leg and told the resident they were hot. While Staff H was cleaning the residents' genitals, Resident 1 stated they made the area very wet [with the peri cleaning wipes] and the resident reported to Staff H that they did not need to be that wet. The resident's statement documented that Staff H replied, that's how it's supposed to be. The statement documented that Staff H asked Resident 1 whether they were single or married, and that Resident 1 stated they felt unsafe. The investigation conclusion documented the allegations made by Resident 1 had not changed or waivered, and they had clearly recalled the events multiple times, down to what color of clothes they were wearing. The conclusion also documented that Resident 1 stated they would not feel comfortable if Staff H was allowed to work at the facility.Review of Resident 1's nurse progress notes, dated 02/23/2026 at 5:44 PM, Staff C, Licensed Practical Nurse/Resident Care Manager, documented the allegation occurred on (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	02/22/2026 and the resident reported Staff H took an extended time while cleaning the residents genital area, touched their thigh and made comments that their skin was soft and that they were hot. The note documented that Resident 1 reported they were uncomfortable and requested to have the brief placed on them three times, but they kept cleaning and stated they needed to be wet.In an interview on 02/25/2026 at 1:30 PM, Resident 1 was able to recall the allegation. Resident 1 stated they placed their call light on for a brief change and Staff H entered their room. Resident 1 stated Staff H rolled the resident onto their back, and told them to lift their legs, the resident stated they told Staff H they could not. Resident 1 was tearful during the interview and continued to recall the allegation. Resident 1 stated that Staff H cleaned their thighs very slowly while telling them their skin was soft, and that they were pretty and hot. Resident 1 stated while Staff H was cleaning their genital area, they asked them to stop, and Staff H replied to them they were not wet enough. Resident 1 stated they asked Staff H to stop several times at which they then applied the brief roughly. They stated Staff H returned to their room later that day to answer their call light. Resident 1 stated the incident occurred on a Sunday, and they had not been able to sleep since the incident.Review of Resident 1's nurse progress note dated 02/25/2026 at 3:43 PM, the resident stated they have had trouble sleeping related to the allegation of sexual abuse.Review of Resident 1's nurse progress note dated 02/25/2026 at 8:46 PM, the resident stated they were anxious and felt like they were having a panic attack and had abnormally high blood pressure.Review of Resident 1's medical record on 02/25/2026, showed one documented panic attack prior to the allegation and trouble sleeping had not been reported until after the allegation.Review of Resident 1's medical record documented a behavioral health note dated 02/26/2026 at 8:30 AM. The note documented the visit was prompted by the allegation of sexual abuse, and ongoing distress that the alleged perpetrator would contact the resident through social media. Resident 1 reported that they were experiencing panic attacks related to the allegation. The note documented Resident 1's thought process was linear, able to provide coherent narrative of the events, their affect was distressed and anxious when discussing the allegation, the resident showed no evidence of delusion and expressed concern about their safety. The note documented that Resident 1 had experienced an increase in panic attacks triggered by the recent sexual allegation and the resident's fearfulness the perpetrator will contact them on social media.Review of Resident 1's nurse progress note dated 02/26/2026 at 10:47 PM, showed Resident 1 became anxious and experienced a panic attack.In an interview on 03/02/2026 at 2:10 PM, Staff E, NAC, stated that around 2:00 PM on 02/22/2026 when they started their shift at the facility they were told by another staff member [Staff D, NAC] that they had switched rooms with Staff H due to the resident in room [ROOM NUMBER] [Resident 1], told them that Staff H had made them feel uncomfortable. Staff E was asked if Staff D stated exactly what had occurred and replied Staff H had made some comments to Resident 1, and that made them feel uncomfortable. Staff E recalled, later in the shift on 02/22/2026 and the next day, they had heard more of the story. Staff E stated they never reported the inappropriate behavior Staff D had told them about to anyone as they had not heard it first-hand. Staff E was able to confirm that they wrote the statement that was included in the investigation, that documented immediately heard from Staff D that Staff H was being inappropriate to Resident 1, as they had made them feel uncomfortable.In an interview on 03/02/2026 at 2:38 PM, Staff F, NAC, stated they worked evening shift (2:00 PM - 10:00 PM) on 02/22/2026. They and another caregiver were in room [ROOM NUMBER] assisting Resident 1's roommate with evening care, when Resident 1 stated to them that on day shift, Staff H sexually assaulted them while they were providing peri-care (cleaning of the genital and anal areas) and made weird comments. Staff F stated Resident 1 told them that they had kicked Staff H out of their room, but Staff H returned to the room to bring them ice water. Staff F stated they did not inform or report this information.In an interview on 03/02/2026 at 2:49 PM, Staff G, Registered Nurse, stated they were the assigned nurse for Resident 1 for the evening shift of 02/22/2026. Staff G stated they had no knowledge of the allegation until 02/23/2026 when Resident 1 informed them that Staff H had been inappropriate with them the prior (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	day. Staff G stated they recalled that the caregivers had informed them at the beginning of shift on 02/22/2026 that Staff H and another caregiver switched assigned rooms between room [ROOM NUMBER] and another room. Staff G stated they did not ask why they switched rooms, as staff did that all the time, so they did not think anything about it.In an interview on 03/03/2026 at 9:25 AM, Staff D stated during their shift (6:00 AM - 2:00 PM) on 02/22/2026 Resident 1 informed them that Staff H had made them feel very uncomfortable and said things to them which were inappropriate. Staff D stated that they went into Resident 1's room to answer the call light. Staff D stated Resident 1 told them that Staff H told the resident they were skinny and beautiful. Staff D stated Resident 1 said when Staff H was providing peri-care to them, they would wipe them different than all the other staff, they would take longer and it was gentle. Staff D was asked if they reported any of what Resident 1 told them to anyone, Staff D stated they told the nurse they were switching rooms but did not tell them why, Staff D stated they wanted Resident 1 to feel safe in their own home.In a phone interview on 03/03/2026 at 10:20 AM, Staff H stated they were contracted staff that worked at the facility. Staff H stated they worked a double (6:00 AM - 10:00 PM - two shifts in a row) on 02/22/2026. Staff H stated they were assigned to care for Resident 1. Staff H stated they entered Resident 1's room to provide peri-care to them, provided the care, and afterwards Resident 1 informed them they did not want a male caregiver. Staff H stated they provided care to Resident 1 one more time that day. Staff H stated they performed care alone; they did not know the resident was cares in pairs. In an interview on 03/04/2026 at 11:20 AM, Staff C stated they were informed of the allegation on Monday 02/23/2026 at the end of the day. Resident 1 informed them that on 02/22/2026, Staff H touched them and demonstrated by pointing to their leg and inner thigh, and that Staff H made inappropriate comments. Staff C stated Resident 1 said they told Staff H to put their brief back on three times and they kept delaying and going slow while providing peri-care. Staff C stated Resident 1 had informed another caregiver so they switched rooms so Staff H would not care for them anymore that day. Staff C stated they had placed Resident 1 on alert monitoring after the allegation as they were having an increase in panic attacks. Staff C stated Resident 1 was having trouble sleeping and very anxious at night after the allegation.In an interview on 03/04/2026 at 12:06 PM, Staff B, Director of Nursing Services, stated that they were informed of the sexual allegation on 02/23/2026 around 5:15 PM via a phone call. Staff B stated they returned to the facility within an hour to start an investigation and report the allegation. Staff B stated Resident 1 had an increase in their panic attacks after the allegation and was fearful the alleged staff (Staff H) was going to contact them and their friends through social media.Cross reference: F609 and F610.Reference: (WAC) 388-97-0640(1)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure timely reporting of a sexual abuse allegation to the State Agency for 1 of 1 resident (Resident 1), reviewed for abuse/neglect reporting. This failure placed all residents at risk for potential unidentified and ongoing abuse and lack of protection from abuse. Findings included .Review of the facility policy titled, Abuse Reporting and Response updated October 2022 the facility will immediately report all suspected and/or allegations of abuse in accordance with state and federal law.events that involve allegations of abuse or result in serious bodily injury will be reported immediately but not later than 2 hours after.Resident 1 admitted to the facility on [DATE] with diagnoses that included bipolar disorder (chronic mental health condition characterized by intense mood swings), agoraphobia (fear of not being able to escape or get help), and anxiety disorder.Resident 1's admission Minimum Data Set (MDS - an assessment tool) dated 11/10/2025 documented the resident had intact cognition, no refusal of care, no behaviors, and was dependent on staff for toileting and personal care.Review of the state Secure Reporting and Tracking System (STARS) the facility reported the sexual allegation on 02/23/2026 at 7:22 PM. Review of the facility investigation dated 02/23/2026 at 6:57 PM, documented an alleged sexual allegation had occurred on 02/22/2026, Resident 1 was the victim, and identified Staff H, Nursing Assistant Certified (NAC) as the alleged perpetrator. The completed investigation included two statements from other facility staff. Staff E, NAC handwritten statement stated they were informed in shift report there had been a sexual allegation between Resident 1 and Staff H at the start of their evening shift (2:00 PM - 10:00 PM) on 02/22/2026. Staff F, NAC handwritten statement stated they were informed of the sexual allegation during their shift on 02/22/2026 (2:00 PM - 10:00 PM). Review of the nursing schedule dated 02/22/2026 documented that Staff H, worked two shifts, 6:00 AM - 2:00 PM, and 2:00 PM - 10:00PM.In an interview on 03/02/2026 at 2:10 PM, Staff E, NAC stated that on 02/22/2026 during their shift they were informed Resident 1 had reported to another staff member that Staff H had made sexually inappropriate comments to them and Resident 1 had felt uncomfortable. Staff E stated they did not report the sexual allegation.In an interview on 03/02/2026 at 2:38 PM, Staff F, NAC stated on 02/22/2026 evening shift (2:00 PM - 10:00 PM) Resident 1 had told them Staff H had sexually assaulted them and made inappropriate comments while they provided care. Staff F stated they did not report the allegation of sexual abuse.In an interview on 03/03/2026 at 9:25 AM, Staff D, NAC stated on 02/22/2026 during their shift (6:00 AM - 2:00 PM) Resident 1 had reported to them that Staff H had made sexual comments and touched them inappropriately while they had provided care. Staff D had switched rooms with Staff H and stated they thought that was enough to keep Resident 1 safe. Staff D stated they did not report the allegation of sexual abuse.In an interview on 03/04/2026 at 12:06 PM, Staff B, Director of Nursing Services stated the sexual allegation should have been reported immediately once the first staff member was informed of the allegation on 02/22/2026.In an interview on 03/04/2026 at 12:43 PM, Staff A, Administrator, was unaware that multiple facility staff had knowledge of the sexual allegation between Resident 1 and Staff H on 02/22/2026 and had failed to report.Cross reference F600Reference WAC 388-97-0640(5)(a)(6)(7)

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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 interviews, and record reviews, the facility failed to conduct thorough investigations for 2 of 4 residents (Residents 1 and 2) reviewed for abuse, neglect and/or misappropriations. 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 Investigations, updated October 2022 documented the facility will conduct a thorough investigation of potential suspected and/or allegations of abuse, neglect and misappropriations in accordance with state and federal regulations.the administrator is the abuse coordinator and will be responsible for overseeing the investigations.the facility will identify and interview involved persons including alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations. <RESIDENT 1>Resident 1 admitted to the facility on [DATE] with diagnoses that included bipolar disorder (chronic mental health condition characterized by intense mood swings), agoraphobia (fear of not being able to escape or get help), and anxiety disorder. The admission Minimum Data Set (MDS – an assessment tool) dated 11/10/2025 documented the resident had intact cognition and was dependent on staff for toilet care and personal grooming. Review of the nursing schedule for day shift on 02/22/2026 there were six NACs, four nurses that worked on the first floor (unit where Resident 1 resides). On the evening shift of 02/22/2026 there were six NACs and three nurses. Review of Resident 1's nursing progress notes dated 02/23/2026 at 4:05 PM, documented a late entry note made on 02/24/2026 at 9:06 PM, the resident had reported a staff member had made inappropriate comments while they provided peri-care (cleaning of the genital and anal areas). The note documented the nurse had escalated to the Resident Care Manager (RCM) and gave a written statement. Review of the facility investigation dated 02/23/2026 at 6:57 PM, documented an alleged sexual allegation had occurred on 02/22/2026, Resident 1 was the victim, and identified Staff H, Nursing Assistant Certified (NAC) as the alleged perpetrator. The investigation documented Resident 1 alleged that Staff H had touched them inappropriately and made comments that made Resident 1 uncomfortable on 02/22/2026. The investigation included two statements from two NACs that worked on the evening shift (2:00 PM – 10:00 PM), two nurse statements that worked evening shift, and a statement by the RCM. The two statements by NACs provided in the investigation both stated the sexual allegation occurred during the day shift (6:00 AM – 2:00 PM) on 02/22/2026. The investigation did not include any statements by any staff that worked on the day shift 02/22/2026. In the investigation one statement provided, named Staff D, NAC as who Resident 1 first reported the sexual allegation too, the facility did not interview Staff D nor get any statement from Staff D for the investigation. In an interview on 03/04/2026 at 11:20 AM, Staff C, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) stated they were informed of the sexual allegation on 02/23/2026 as they were leaving for the day. Staff C stated they notified Staff B, Director of Nursing Services (DNS) and started to gather information, however when Staff B returned to the facility around 6:00 PM they turned the investigation over to Staff B to complete. Staff C stated they were not involved in the investigation after that. In an interview on 03/04/2026 at 12:06 PM, Staff B, DNS stated they were responsible for the completion of the investigation for Resident 1's sexual allegation. Staff B stated they did not interview any staff working on the day shift of 02/22/2026. Staff B was asked why Staff D, NAC was not interviewed as they were named in the witness statement as being the first staff to have knowledge of the alleged sexual allegation, Staff B reviewed the investigation and then stated, they must have missed that. Staff B were asked if they had interviewed any staff related to the allegation and stated they did not do any further interviews (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other than the statements that were gathered. <RESIDENT 2>Review of the facility investigation dated 02/09/2026 at 11:26 AM, documented that during narcotic count it was determined Resident 2 was missing narcotic medication. The facility was unable to establish the location of the medication, or if it was lost or mistakenly destroyed. The incident report contained a police report for theft made by Staff B and an email from Staff B to Staff A and J, documenting Resident 2's narcotic medication, was misplaced, inconsistent with the facility investigation. The incident report contained no witness statements and no statements from nurses who had recently worked the medication carts. In an interview on 02/25/2026 at 12:22 PM, Staff K, Registered Nurse-Assistant Director of Nurses, stated there was a medication destruction process and a disposal form used which was then faxed to the pharmacy when done. Staff K stated there was also a section in the narcotic books, on the bottom of the page, where two nurses were required to sign off confirming medications were destroyed. In an interview on 02/25/2026 at 12:28 PM, Staff B stated they had not reviewed any of the disposal forms faxed to the pharmacy for destruction of medications. When asked about the details of when nursing reported the missing narcotic medication, Staff B stated an agency night nurse had called them on 02/08/2026 and informed them of a problem with the narcotic count. Staff B stated they came in the following morning to look for the missing medications. When asked why the information in the incident report did not match their verbal statement, Staff B provided no additional information. Staff B stated they had not gathered witness statements or interviewed other nurses that had worked the medication cart prior to finding the medication missing. In an interview on 03/03/2026 at 2:07 PM, Staff L, Registered Nurse (RN) stated they had contacted Staff B the night of 02/08/2026 and notified them of the missing narcotics for Resident 2 during narcotic count at shift change. Staff L stated Staff B directed them to take a copy of the page from the narcotic book and put it in their box. Staff L stated they had worked for the facility since January 2026 and worked from 6pm to 6am. Staff L stated they did not see or meet Staff B prior to leaving the facility on 02/09/2026. Cross reference F600Reference WAC 388-97-0640(6)(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure physician orders for medications were followed for 1 of 3 (Resident 3) sampled residents. This failure placed residents at risk for unmet needs, injury, and ineffective and/or delayed treatments. Findings included .Resident 3 admitted to the facility on [DATE] with diagnoses to include seizures and fracture of the first lumbar vertebrae.Review of Resident 3's care plan dated 01/14/2026 documented Resident 3 had a seizure disorder with a goal for them to remain injury free from seizure activity.In an interview on 03/02/2026 at 9:30 AM Resident 3 stated their antiseizure medications were late several times and there were some nurses that understood the importance of their medications and some that did not. Resident 3 stated they had spoken with Staff M, Licensed Practical Nurse, about their concerns.In an interview on 03/02/2026 at 10:31 AM Staff M stated they had met with Resident 3 and discussed concerns about their antiseizure medication being given at the same time rather than spaced apart as prescribed. Staff M stated the nurse who had given the anti-seizure medication at the same time was educated to provide them at the same time. Staff M stated the identified nurse was an agency staff member, Staff N, Registered Nurse.Review of a grievance dated 01/29/2026 signed by Resident 3 documented the nurse was an hour late for giving evening medications on 01/27/2026, the nurse gave their antiseizure medications for evening with their antiseizure bedtime medications at 10 PM and they did not receive their pain medication. The grievance resolution documented that the nurse, unnamed, would no longer work with Resident 3 and be removed from working in their hallway, no other information was documented on the grievance.In a review of Resident 3's Medication Administration Audit Report from 01/31/2026 through 02/05/2026 documented Staff N administered their Divalproex Sodium Oral Tablet Delayed Release (an antiseizure medication) scheduled at 9:00 AM on 02/01/2026 at 12:29 PM, almost three and a half hours late.Reference WAC: 388-97-1620(2)(b)(i)(ii)