

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 04/13/2026
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide sufficient qualified staff to provide care and services for 18 of 23 sampled residents (Residents 1,6, 9, 19, 28, 30, 35, 50, 58, 60, 65, 79, 83, 95, 105, 115, 121, 124) and 3 of 5 family members that had concerns related to staffing. The facility had insufficient staff to ensure residents received prompt call light response, medications delivered timely, assistance with activities of daily living including nail care, restorative care and to ensure care was completed in accordance with established clinical standards, the facility assessment, and resident's needs and preferences. These failures placed residents at risk of experiencing feelings of frustration, vulnerability, diminished quality of life, and unmet care needs. Findings included .</p> <p><FACILITY ASSESSMENT>Review of the facility's assessment, reviewed 04/01/2026, showed the overall full-time employees needed for adequate staffing was 5 Registered Nurses, 5 Licensed Practical Nurses, 5 Nurses' Aides (NAC's) and 2 restorative aides. The facility assessment did not include shower aides.<STAFFING PATTERN>Review of the facility provided staffing pattern for the last 31 days, dated 03/08/2026 through 04/07/2026, showed a wide variance of 7 to 10 NACs on 31 shifts of 31 days. There were only 4 or 5 NAC's on for 6 of 31 days. <RESIDENT INTERVIEWS><RESIDENT 19>In an interview on 04/07/2026 at 10:27 AM, Resident 19 stated at shift change they wait over 30 minutes for their call light to be answered. They stated the facility used a lot of agency staff because a lot of the staff had quit.<RESIDENT 35>In an interview on 04/07/2026 at 1:01 PM, Resident 35 stated there were not enough staff at the facility, and the call light wait time was excessive, at times more than an hour to get help.<RESIDENT 1>In an interview on 04/07/2026 at 2:21 PM, Resident 1 stated that at shift change they don't dare ask for anything or they would be out of luck especially if they had to go to the bathroom. Resident 1 stated they lost their patience a few weeks ago while waiting and went to the bathroom and they slipped and their foot hit the wall. The resident stated their foot hurt and they were worried about their foot, so they called their surgeon and requested an x-ray.<RESIDENT 115>In an interview on 04/07/2026 at 2:53 PM, Resident 115 stated they had experienced some falls. They reported call light wait times are long during staff breaks and there were no other staff to cover for staff while on break resulting in call light times longer than 30 minutes. The resident stated they were going to have an incontinent episode, and they get really embarrassed if that happened. <RESIDENT 121>In an interview on 04/07/2026 at 3:05 PM, Resident 121 stated they have had to wait a long time for their call light to be answered. The resident stated when they first got there it was really rough and they waited hours and hours to get help.<RESIDENT 6>In an interview on 04/08/2026 at 8:38 AM, Resident 6 stated that usually around shift change, call lights take an hour or longer. They stated if they were having a heart attack that would not be good. <RESIDENT 60>In an interview on 04/08/2026 at 10:11 AM, Resident 60 stated there was a lot of staff turnover and they frequently had agency staff. Resident 60 stated call light response times were 20-30 minutes now. The resident stated call light response time had gotten slower over the last few months <RESIDENT 28>In an interview on 04/08/2026 at 9:07 AM, Resident 28 stated they experienced long call light wait times. The resident stated that by the afternoon, call (continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>lights start to get a little slacked and by the evening including last night they waited 30 minutes to get their call light answered after dinner. The resident stated it took until 11 PM to get shaved and washed up. They stated some days the facility was understaffed and there were call outs. The residents stated they waited to get pain medications, and for someone to respond to their IV pump including last night. They stated if they needed to get repositioned it took a while to get help. They stated they were not sure if the facility was truly understaffed or staff just had too many people to take care of. Resident 28 stated their medications were late too and they got it around shift change instead of 4:00 AM when it was ordered to be given. <RESIDENT 58>In an interview on 04/08/2026 at 9:48 AM, Resident 58 stated some call lights were answered in 5 minutes and with some it seemed like 5 hours before they were answered. Resident 58 stated that when they had a bowel movement, they would call and wait for a long time. The resident stated the facility did not have enough staff to get to the needs of the residents. Resident 58's family member, Collateral Contact 7 (CC7) was present and stated the facility did not have enough staff and they had observed an hour wait time for the staff to check in about pain medication. <RESIDENT 65>In an interview on 04/08/2026 at 11:04 AM, Resident 65 stated the facility did not have enough staff. They stated they did not get training and didn't know what they were doing. In an observation on 04/10/2026 at 9:50 AM, the call light for room [ROOM NUMBER] came on. Multiple staff members walked past the call light. At 10:10 AM, the call light turned to a flashing light. At 10:12 AM, Staff SDC got up, looked at the call light board and went to the room. The call light was turned off at 10:14 AM. <FAMILY INTERVIEWS>In a joint interview on 04/10/2026 at 12:45 PM, CC 5 and CC 6 stated that they had a family member downstairs that comes up and checks on Resident 56 because they don't get enough help. CC 6 stated there was so much staff here because the state was here. CC 6 stated there was never this many staff at the facility. They stated that after the surveyors left yesterday, the facility was a ghost town with barely any staff. CC6 stated that when they call the nurses' station on the 2nd floor of the facility that they called multiple times and no one answered. CC 6 stated they would call Resident 56's cell phone and have them put it on speaker phone to call for help. In an interview on 04/13/2026 at 10:20 AM, CC 1, Resident 41's family member, stated care had been good and bad. CC 1 stated that at times they come in to find their spouse covered in bowel movement (BM). They stated they put the call light on and wait and wait, and it could be 40 minutes to get help. CC 1 stated they noticed when (state surveyors) were there, there was more staff here. They stated it was not usually like this and there were so many staff out there now. <GRIEVANCES>Review of a grievance dated 02/03/2026 from Resident 124 documented they waited two hours for their call light to be answered. Review of a grievance dated 03/05/2026 and documented as received 03/17/2026 from Resident 95 documented call lights take longer than 30 minutes for someone to respond. Review of a grievance dated 03/15/2026 and documented as received on 03/20/2026, documented Resident 30 and their roommate waited over 40 minutes to get help. Resident 30 documented they were told by their NAC they had been on their break. Resident 30 asked them if they had another NAC to cover their break and they received a flippant answer. Review of a grievance dated 03/14/2026 and documented as received 03/20/2026 from Resident 30 showed they pushed their call light and waited a long time, so they left their room and asked an NAC to empty their urinals. Resident 30 documented the staff did not empty the full urinals which resulted in them wetting their pants. <RESTORATIVE CARE>In an interview on 04/10/2026 at 11:36 AM, Staff KK, Restorative Aide (RA) stated there were quite a few more RA programs now. Staff KK stated Staff LL, the RA was pulled from their RA duties once this week and tonight they were also pulled to work the floor rather than their duties. Staff KK stated last month was bad and they were pulled frequently to work on the floor rather than complete residents RA programs. <RESIDENT COUNCIL MINUTES>-Review of the resident council minutes, dated 02/18/2026, residents voiced call lights were not being answered timely. <RESIDENT COUNCIL MEETING>During a resident council meeting with the surveyor on 04/08/2026 at 2:26 PM;- Resident 50 stated Resident 105 pulled their call light out of the wall on several occasions after pushing the (continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>button so many times to get help to come. Resident 50 stated Resident 105 walked down the hall to the nurse's station with their diaper and pants to their knees to get help. Resident 50 stated they were left on the floor for long periods after they fell without receiving help. -Resident 79 stated they heard Resident 9 yelling help, help and they found then hanging off their bed with their head almost to the floor. Resident 9 stated they could not get anyone to help them, so they held Resident 90's head so it didn't hit the floor. Resident 79 stated when staff arrived, they stated they were not their resident. Resident 79 stated when staff pass the meal trays they don't respond to call lights and staff tell them they cannot provide care until everyone is done eating, which was a long time.-Resident 65 stated the facility was short staffed, residents fall, and showers were missed. Resident 65 stated they wrote letters to the staff about their care issues. They said at 4:00-5:00 AM, almost every call light was on. They look up and down the halls but cannot find a staff member.-Resident 30 stated they fell and laid on the floor for 45 minutes.-Resident 79 stated that two days prior, they asked staff why their roommate (Resident 106) was not getting their showers. The resident said staff told them it was because someone fell. Resident 79 stated Resident 106 was given their dinner tray at 6:00 PM and no one came to change them until 9:00 PM. Resident 79 stated their roommate was soiled and up in their wheelchair from 6:00 PM to 9:00 PM. Resident 79 stated no one should be wet for 3 hours.-MEDICATION ADMINISTRATION->Resident 83 stated nurses give them their dinner and bedtime medications together and they tell the nurses they are not to be given together.-Residents 30, 37, 50, 61, and 79 stated both agency and facility nurses leave their medications at bedside without observing if they take them.<STAFF INTERVIEWS>In an interview on 04/10/2026 at 9:41 AM Staff MM, NAC stated they were scheduled to give showers for the first time today. Staff MM stated the facility did not have shower aids scheduled and floor staff were responsible for doing their own showers. At that time Staff B, DNS told Staff MM there were shower makeups to give and to help pass meals at lunch. In an interview on 04/13/2026 at 10:06 AM, Staff D, RCM stated the facility was still short staffed. They stated there were call outs and something needed to be done about the call outs. Staff D stated it was very rough for staff to have their schedules changed to a 5-day schedule and they lost staff and morale was down as the staff who stayed were unhappy. Staff D stated that Staff MM helping out giving showers today was amazing. Staff D stated they went to above management even and voiced their concerns with staffing. They stated showers were missed since they had no shower aide. They said some NAC's have 3 to 4 showers to do besides being responsible to care for 10-11 residents. Staff D stated if they had 6 NAC's they had 10-11 residents and more if they only had 5 NACs. They stated they should have 6 NACs on downstairs but usually had 5. In an interview on 04/13/2026 at 1:01 PM, Staff A, Administrator, was asked if the Quality Assurance and Performance Improvement committee was aware of staffing issues. Staff A stated Really? then stated, Let's move on.No additional information was provided. Reference WAC 388-97-1080 (1)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>Based on observation, interview, and record review the facility failed to ensure the daily nurse staffing information was being posted in a place readily accessible to residents/visitors and included the required information on 2 of 7 days of the recertification survey. This failure placed residents, family members, and visitors at risk of not being fully informed of current staffing levels and resident census information. Findings included .In an observation 04/13/2026, at 9:55 AM, the facility's daily nurse staffing information was posted on a wall near the reception desk at the entrance of the building. The current nurse staffing information, dated of 04/13/2026, was posted and behind that was 04/10/2026, but the weekend dates were not found for 04/11/2026 and 04/12/2026.In an interview on 04/10/2026, at 9:50 AM, Staff Z, Staffing Coordinator, stated that they are responsible for posting the daily nurse staffing information and update throughout the day as needed.In an interview on 04/13/2026 at 10:00 AM, Staff Z, Staffing Coordinator, stated that no one fills out the daily nurse staffing information on the weekends since they are not there to do it. No reference WAC</p>		