

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/23/2026
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)		
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 identify and report a potential allegation of abuse and/or neglect for 1 of 3 residents (Resident 1) and failed to report results of abuse and/or neglect investigations within 5 days for 3 of 3 resident investigations (Residents 1, 2, and 3) reviewed for abuse. The facility failed to report unexplained bruises found on Resident 1's arms, legs and torso and failed to report the results of a resident to resident (Residents 2 and 3) abuse allegation. This failure placed the residents at risk of further abuse, psychological distress, and diminished quality of life. Findings 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, documented the facility will report immediately all suspected and/or allegations of abuse, neglect, and exploitation of residents, misappropriation of resident property, mistreatment, and injuries of unknown source in accordance with state and federal law. <RESIDENT 1>Resident 1 admitted to the facility 06/10/2026 with diagnoses that include developmental delay since childhood, depression, and pain. The admission Minimum Data Set (MDS - an assessment tool) dated 06/16/2026 showed the resident had an intellectual disability, with severe impaired cognition. Review of the facilities investigation dated 06/16/2026 for Resident 1's skin concern documented that during a care conference the facility was alerted to a bruise on the resident's arm. The investigation note stated the resident was found to have bruising on left upper arm, abdomen, and both legs. In a phone interview on 06/22/2026 at 12:50 PM, Collateral Contact (CC) 1 stated that during a visit with Resident 1 on 06/16/2026 several bruises were observed on Resident 1's upper arms, upper leg area and several across the lower abdomen area. CC1 stated these were brought to the attention of the facility during a care conference on 06/16/2026 with a nurse manager present. Review of facility state reporting log provided on 06/22/2026, showed no logged results report for Resident 1's unexplained bruises to upper arms, torso or legs. <RESIDENT TO RESIDENT>Resident 2 was admitted to facility on 03/28/2025 with diagnoses that included bipolar disorder (mental health condition that causes extreme, uncontrollable shifts in mood, energy, and activity levels), anxiety and depression. The quarterly MDS dated [DATE] documented the resident had intact cognition. Resident 3 was admitted to the facility on [DATE] with diagnoses that included depression and anxiety. The quarterly MDS dated [DATE] documented they had intact cognition with physical behaviors towards others for 1 to 3 days of the look back period. Review of a facility investigation dated 05/29/2026 at 3:30 pm documented that staff found Resident 2 crying in their room and reported to staff that Resident 3 had verbally abused them outside at the smoking area. The investigation documented that Resident 3 was aggressive towards Resident 2, after they refused to give them a cigarette. Resident 2 stated they felt Resident 3 was invasive and followed them into the facility making comments. Review of facility state reporting log provided on 06/22/2026, showed no logged results report for Resident 2 and Resident 3's verbal abuse allegation. In an interview on 06/23/2026 at 3:08 PM, Staff B, Licensed Practical Nurse (LPN) stated any unknown bruising found on a resident, especially any that are on torso or upper legs should be reported to the state and (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigated. Staff B stated the facility was made aware of the bruises on Resident 1 during a care conference with the care manager on 06/16/2026. In an interview on 06/23/2026 at 3:37 PM, Staff A, Director of Nursing Services (DNS) stated all potential allegations of abuse and/or neglect should be reported immediately and reported on the state reporting log within five days. Staff A stated they were not in the building and had been unable to report and investigate the bruises on Resident 1 till Monday June 22nd, 7 days after they had been discovered. Staff A was asked who at the facility was responsible for reporting allegations of abuse and neglect, and Staff A stated everyone in the facility was. Staff A confirmed the bruises for Resident 1 should have been reported, and confirmed the investigations for Resident 1, and the resident to resident involving Resident 2 and 3 should have been logged as well. Reference WAC 388-97-0640(5)(a)(6)(a)		

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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 1 of 3 resident investigations (Resident 1) reviewed for abuse, and/or neglect. The failure to conduct thorough investigation into unexplained bruises to a resident placed all residents at risk for repeat incidents, potential injury, and unmet care needs. Findings included. Findings 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, documented the facility will conduct a thorough investigation of potential, suspected and/or allegations of abuse and neglect and injuries of unknown source in accordance with federal and state regulations. Resident 1 admitted to the facility 06/10/2026 with diagnoses that include developmental delay since childhood, depression, and pain. The admission Minimum Data Set (MDS - an assessment tool) dated 06/16/2026 showed the resident had an intellectual disability, with severe impaired cognition. Review of Resident 1's admission assessment dated [DATE] skin documentation showed the resident had a surgical wound site, no documentation of bruising to the resident's body. Review of Resident 1's medical record a progress note dated 06/16/2026 at 3:09 PM, documented by Staff A, Director of Nursing Services (DNS), documented during care conference caregiver noted that the resident had large bruise to upper left arm that measured 2 inches (in) by 2 in. The note did not mention any other bruises to the resident's body. Review of Resident 1's medical record a progress note dated 06/16/2026 at 9:22 PM, documented by Staff B, Licensed Practical Nurse (LPN) documented the resident was on alert for multiple bruises in front of the abdomen, back of right thigh of unknown origin. Review of the facilities investigation dated 06/16/2026, during Resident 1's care conference a Collateral Contact (CC) notified the facility that they had a bruise to their left upper arm that measured 2 centimeters (cm) by 5 cm, dark in color. In the investigation report it was documented that the residents were found to have bruises in their abdomen area and both of their legs. The conclusion of the investigation only addressed the bruise to the upper arm, there was no description (size, color, exact location) of the bruises found on the resident's abdomen region, or legs. There was no documentation provided in the investigation that abuse and neglect had been ruled out related to the unexplained bruises found on Resident 1. In an interview on 06/23/2026 at 11:40 AM, Staff A stated, I forgot to tell you about the other bruises for Resident 1. Staff A stated they were not aware Resident 1 had bruises in their abdomen and thighs till Friday morning on the 19th, and that they had not been in the facility, they did not investigate them till Monday morning on the 22nd. In an interview on 06/23/2026 at 3:08 PM, Staff B stated they were notified that Resident 1 had been found with unexplained bruises to their arms, abdomen and upper thigh area when they came on shift 06/16/2026. Staff B stated they were told that the nurse manager was notified of the bruises during Resident 1's care conference earlier in the day. Staff B stated they were told that they nurse manager was investigating the bruises. In an interview on 06/23/2026 at 3:37 PM, Staff A stated it was the expectation that all unexplained bruises were thoroughly investigated to rule out any potential abuse and/or neglect. Staff A stated they were alerted to a bruise on Resident 1's upper arm during the resident's care conference on 06/16/2026 towards the end of the day. Staff A was asked if a skin check was completed for Resident 1 after they found the bruise, as there was none provided in the investigation nor in Resident 1's medical record. Staff A stated yes, and provided a piece of paper from their desk, it was a drawing of the front of a person's body and backside of body, there were multiple x's marked on the abdomen, leg and arms and it was dated 6/16/2026 with a note that read multiple bruises there were no measurements or descriptions of the bruises. Staff A stated they thought the skin check was completed on the 17th and added they had not been in the facility. Staff A was asked about the progress note that was made in Resident 1's medical record on the evening of the 16th that documented the resident was on alert for unexplained bruises to arms, abdomen and (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upper thighs. Staff A added that they were not in the facility and were not notified of the other bruises till the morning of the 19th and did not start an investigation till the 22nd. Staff A confirmed all unexplained bruises should be investigated thoroughly to rule out abuse and neglect. Refer to WAC 388-97-0640(6)(a)		