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	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Cascades Health and Rehabilitation Center	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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on interview and record review, the facility failed to provide the required notice of transfer/discharge at the time of discharge or transfer to the hospital for 1 of 2 sampled residents (Resident 50) reviewed for hospitalization . This failure placed residents at risk for lack of knowledge of their rights related to transfers and discharges. Findings included . <RESIDENT 50> Resident 50 admitted to the facility on [DATE] with diagnoses which included congestive heart failure impacting fluid balance. Review of Resident 50's clinical record on 01/17/2025 showed the resident had a change of condition and was transferred to the emergency department on 12/15/2024. Review of Resident 50's clinical record on 01/17/2025 showed no documentation the required transfer/discharge notice had been provided to Resident 50. In an interview on 01/22/2025 at 11:50 AM, Staff B, Director of Nursing Services, stated a transfer form was being completed which was sent to the hospital with residents, but not provided to the resident themselves. Staff B stated they were not able to produce the notice of transfer/discharge or documentation of review for Resident 50. Refer to WAC 388-97-1020(2)(d)(e)

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 01/24/2025
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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on interview and record review, the facility failed to provide written bed hold notices at the time of transfer to the hospital for 2 of 2 sampled residents (Residents 50 and 72) reviewed for hospitalization s. This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed while in the hospital. Findings included . <RESIDENT 50> Resident 50 admitted to the facility on [DATE] with diagnoses which included congestive heart failure impacting fluid balance. Review of Resident 50's clinical record on 01/17/2025 showed the resident had a change of condition and was transferred to the emergency department on 12/15/2024. Review of Resident 50's clinical record on 01/17/2025 showed no documentation of bed hold notice was provided to Resident 50 when they were transferred to the hospital on 12/15/2024. In an interview on 01/22/2025 at 11:50 AM, Staff B, Director of Nursing Services (DNS), stated the process was that if the patient was able, the nurse would review the bed hold notice with the resident, or the business office would follow up with the resident or family and document that in the clinical record. Staff B stated they were not able to produce the bed hold notice or documentation of the bed hold review for Resident 50. 36787 <RESIDENT 72> Resident 72 admitted to the facility on [DATE], with diagnoses which included diabetes and left lower extremity/stump infection. Review of Resident 72's clinical record showed the resident was transferred to the hospital on 11/05/2024 for an infection and readmitted to the facility on [DATE]. Review of Resident 72's clinical record on 01/17/2025, showed no documentation the required transfer notice had been provided to Resident 72. There was no documentation of a bed hold being offered. In an interview on 01/22/2025 at 11:50 AM, Staff B, stated the facility did not obtain a bed hold for Resident 72 and should have and they are looking at the process now. In an interview on 01/23/2025 at 12:22 PM, Staff E, Licensed Practical Nurse stated they are to offer a bed hold when they send residents to the hospital and document that they offered it and if the resident agreed or declined the bed hold. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refer to WAC 388-97-1020(3)(c)(4)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on observation, interview and record review the facility failed to ensure assistance with bathing, nail care, grooming, and assist the residents out of bed for 3 of 4 dependent residents (Residents 20, 58 and 68) reviewed for activities of daily living (ADL's). Facility failure to provide the residents, who were dependent on staff for assistance with ADL's, placed the resident and others at risk for unmet care needs, poor hygiene, injury due to nail breakage, diminished dignity, and decreased quality of life. Findings included . Review of the facility policy titled, Activities of Daily Living, (ADL's) revised July 2015, showed the nursing assistants (NAC) will assist with ADL's based on the resident's individualized plan of care. These interventions will be on the Kardex (NAC guide to proving care), which was accessed in Point of Care (POC). <RESIDENT 58> Resident 58 admitted to the facility from the hospital on 09/28/2023. Review of Resident 58's care plan showed the resident preferred showers during the day on Sundays and Wednesdays and as requested. The resident required one-person assistance for bathing. Review of Resident 58's bathing documentation showed the resident had four showers in November 2024 (11/01/2024, 11/05/2024, 11/15/2024 and 11/19/2024). Review of the bathing documentation in December showed the resident had five showers (12/03/2024, 12/06/2024, 12/20/2024, 12/20/2024 and 12/27/2024). Review of the bathing documentation for January as of 01/24/2025 showed the resident had one shower documented for the month on 01/03/2024. There was no documentation of attempts to provide bathing the day after refusals. <RESIDENT 68> Resident 68 admitted to the facility on [DATE]. Review of Resident 68's care plan showed the resident preferred showers during the day on Tuesdays and Fridays and as requested. The resident required one-person assistance for bathing. Review of Resident 68's bathing documentation showed the resident had bathing four times in November (11/05/2024, 11/08/2024, 11/12/2024 and 11/26/2024). Review of the bathing documentation in December showed the resident had five showers (12/03/2024, 12/06/2024, 12/17/2024, 12/20/2024 and 12/24/2024). Review of the bathing documentation for January as of 01/24/2025 showed the resident had one shower documented for the month on 01/17/2024. There was no documentation of attempts to provide bathing the day after refusals. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/25/2025 at 12:39 PM, Staff R, Nursing Assistant Certified (NAC) stated Resident 68 did not refuse care. In an interview on 01/22/2025, the shower documentation was reviewed for Resident 58 and 68 with Staff B, Director of Nursing (DNS). Staff B stated the facility did not have specific shower aides and the NAC's were responsible for completing showers for their assigned residents. Staff B stated they provide two showers a week. Staff B stated the nurses should assign missed showers to the next shift and staff are to offer showers daily until their next scheduled day. Staff B stated this should be documented in the medical record. 37890 <RESIDENT 20> Resident 20 admitted to the facility on [DATE] with diagnoses which included advanced dementia and Diabetes. Review of Resident 20's quarterly Minimum Data Set (MDS- an assessment tool) assessment dated [DATE] showed the resident required extensive assistance with activities of daily living such as dressing and grooming. In an observation on 01/22/2025 at 10:58 AM, Resident 20 was lying in bed with their feet uncovered. The resident's toenails were observed to be thick and overgrown at least 1/2 inch and growing in various directions. The left great toenail was thick and growing inward toward the other toes. The left second toenail was growing straight upward from the toenail. The left third toenail was curved up and backward. The left fourth and fifth toenails were growing up and inward. The resident's right toenails were growing in a similar thick and overgrown manner. Record review of Resident 20's Treatment Administration Record (TAR) dated January 2025 showed weekly diabetic nail care completed by Licensed Nurses (LN). The TAR showed Licensed Nurse documentation of resident refusals or other of diabetic nail care with no corresponding documentation notes found. In an interview on 01/22/2025 at 11:22 AM, Staff O, Registered Nurse, stated LN's complete nail care for diabetic residents and document on the Administration record. Staff O stated they have a podiatrist who comes to the building to see some residents. Staff O stated Resident 20 was being seen by the podiatrist, so the LNs were not doing their nail care. Review of Resident 20's medical record on 01/22/2025 showed a history of podiatrist visits to debride (removing thick layers of the nail, trimming the nail) toenails with the most recent note being March of 2023. In an interview on 01/22/2025 at 12:01 PM, Staff C, Social Services Director, stated they coordinated the list of residents referred for podiatry. Staff C stated they had not had an in-house podiatrist for the past two years. Staff C stated they had just found a new provider who had been in to the facility on ce so far (earlier this month) and was supposed to have seen all the residents on the list. Staff C stated that Resident 20 was included in the group of residents who were supposed to have been seen. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/22/2025 at 12:34 PM, Staff B stated they had just started with a new podiatrist. Staff B reviewed documentation and noted that Resident 20 was supposed to have been seen but there was no documentation of the visit, and the next visit was not until March 18. Staff B stated they had not looked at Resident 20's feet. Staff B stated that the licensed staff would provide weekly nail care for diabetic residents and if care was not provided there should be a note indicating why, such as if a resident refused. Staff B stated if a resident needed a podiatrist the facility should be making and facilitating an appointment for the resident to go to an outside provider. Staff B stated there should have been intervention for Resident 20 to receive nail care to their overgrown toenails. Refer to WAC 388-97-1060(2)(c)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36787

Based on observation, interview and record review the facility failed to ensure 2 of 5 resident's (Resident's 58 and 68) received care and treatment in accordance with professional standards of practice and received the necessary care and services to attain or maintain their highest practicable level of well-being. This placed the residents at increased risk of discomfort, unmet care needs, and medical complications.

Findings included .

<RESIDENT 58>

Resident 58 admitted to the facility on [DATE] with diagnoses to include high blood pressure, dementia and constipation.

Review of Resident 58's physician orders dated 10/19/2023, showed staff were directed to give Milk of Magnesia (MOM-medication used to treat constipation) as needed if the resident did not have a bowel movement for three days, if no results from MOM, administer a Bisacodyl suppository as needed, if no results from suppository administer a Fleet enema and notify the MD if no results.

Review of the bowel monitoring documentation beginning 11/01/2024 showed Resident 58 had no bowel movement (BM) from 11/08/2024 until 11/14/2024, 11/15/2024 until 11/19/2024, 12/22/2024 to 12/29/2024 and 01/04/2025 to 01/09/2025, 01/14/2025 to 01/17/2025 and 01/18/2025 to 01/23/2025.

Review of Resident 58's Medication Administration Record (MAR) for November 2024, December 2024 and January 2025 showed no bowel medications were administered per physician orders to treat the constipation.

Review of a physician order dated 01/05/2025, directed staff to administer Hydralazine (blood pressure medication) every 8 hours as needed for a systolic blood pressure (SBP, top number) over 160 related to resident 58's hypertension (high blood pressure).

Review of Resident 58's January 2025 MAR showed Hydralazine was not administered as ordered on 01/20/2025 when Resident 58's systolic blood pressure was 180.

<RESIDENT 68>

Resident 68 admitted to the facility on [DATE], with diagnosis to include high blood pressure and anemia.

Review of Resident 68's physician's order dated 10/31/2024, showed staff were directed to hold Metoprolol and Lisinopril (blood pressure medications) if the SBP was less than 110.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note for Resident 68 dated 01/13/2025 at 9:06 AM, showed Advanced Registered Nurse Practitioner (ARNP) had given a verbal order to collect a Complete Blood Count lab draw (CBC) with diff (differential) on that day. The ARNP's verbal order had been placed for that day's collection. Review of Resident 68's January 2025 MAR showed an order to collect the CBC with diff on 01/13/2025. Review of Resident 68's clinical record on 01/22/2025, showed there had been no CBC drawn on 01/13/2025 or thereafter. In an interview on 01/22/2025 at 11:50 AM, Staff B, Director of Nursing (DNS) was asked about the missed CBC with diff on 01/13/2025. Staff B stated they were unaware of the missed labs and would look for documentation to see if the ARNP was notified. Staff B stated they looked and did not see a progress note that the CBC had been missed, and they would follow up. In an interview on 01/22/2025 at 12:11 PM, Staff B stated the nurses get an alert on their electronic medical record that will show when a resident had not had a BM for 3 days and the alert should remain until they have had a BM. Staff B stated the expectation was an abdominal assessment was to be completed, bowel medications would be given and the results documented in the medical record. Staff B stated the bowel protocol orders are to administer MOM 30 milliliters (ml), if there was no BM for 3 days, on day 4 if still no BM they are to administer Bisacodyl Suppository 10 milligrams, if there was no BM then the nurse would administer a Fleet enema 118 ml rectally and to notify the provider if no results. Staff B stated the medical records department conducts audits of the bowel records on weekdays and the results are reviewed at the morning meeting and the Resident Care Managers are then to follow up. In an interview on 01/23/2025 at 12:05 PM, Staff E, Licensed Practical Nurse (LPN) stated the facility bowel protocol. Staff E stated they pass the information on in report and the residents are on alert charting until they have had a BM. Staff E stated the medication parameter expectation was that the nurses follow the direction from doctors on when to give or hold medications. Staff E stated the nurses draw their own labs and if they cannot collect the lab, they can ask another nurse. Staff E stated they would pass onto the next shift if a lab was not collected as ordered. This is a repeat deficiency from Statement of Deficiency dated 03/08/2024. Reference WAC: 388-97-1060 (1)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 36787 Based on observation, interview and record review, the facility failed to ensure residents who engaged in smoking were assessed for adequate supervision to prevent injury from burns, provided a safe environment, necessary devices, and supplies to safely smoke, and to protect other residents from potential fire hazard for 2 of 2 residents (Residents 66 and 78) reviewed for smoking. These failures potentially placed all residents at risk for injury related to unsafe smoking practices and constituted an Immediate Jeopardy (IJ). The failed practice resulted in an IJ on 01/16/2025 when the facility failed to ensure residents, and the resident environment were safe from injury from burns and fire. The IJ was removed on 01/17/2025 after the facility-initiated safe smoking evaluations, skin assessments for burns and room inspections to ensure cigarette butts had been properly disposed of for Residents 66 and 78. A safe smoking location was provided with a safe disposal receptacle. Residents 66 and 78 were educated on the safe smoking location, safe disposal of cigarette butts in the smoking receptacle, and turning in their smoking paraphernalia when they return to the building. Staff were educated prior to their next scheduled shift to ensure awareness of the new smoking safety plan. Staff were directed to ask residents to show that they do not have any cigarette butts on their persons when they returned from smoking. Findings included . In an entrance conference interview on 01/16/2025 at 9:04 AM, Staff A, Administrator stated the facility was a non-smoking facility, and there were no residents in the facility who smoked. Record review of the facility policy titled, Smoke-Free Center, revised date of April 2014, showed smoking was prohibited for everyone on the property owned and operated by the center, including residents, employees, visitors, volunteers, consultants, contractors and government representatives. The policy included an italicized line that showed Center does not own the sidewalks and streets that border the grounds. Employees who see individuals smoking on the Center's grounds are encouraged to inform these individuals with courtesy, that the Center's policy prohibits smoking anywhere on the Center ' s grounds. Review of the Smoke Free Center Policy Acknowledgement form, updated November 2016 showed By signing this form, I acknowledge that I have been informed of and agree to follow the Smoke-Free Center Policy. If I am found in violation of this policy, I understand that I may be discharged from the Center according to applicable state and federal laws. <RESIDENT 66> Resident 66 admitted to the facility on [DATE] with diagnoses to include left and right below the knee amputations and nicotine/cigarette dependence. According to their Admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], Resident 66 had no cognitive impairment and no current tobacco use. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident 66's admission orders from the hospital dated 08/06/2024 showed staff were directed to place a nicotine patch 21 MG (milligrams) in 24 hours onto the skin daily, removing the old patch before applying a new patch. Review of the practitioner visit note dated 08/07/2024 showed Resident 66 had been smoking since age 10, three quarters of a pack (15 cigarettes) per day and had three cigarettes since admission. The resident reported they used cigarettes to cope with stress. Review of a note labeled Psych follow up dated 12/03/2024 at 7:15 AM, showed diagnosis of nicotine dependence and to encourage smoking cessation. Review of a note labeled Psych follow up dated 12/31/2024 at 10:15 AM, documented nicotine dependence and a behavioral intervention to encourage smoking cessation, provide reorientation and avoid overstimulation to prevent agitation. In an interview and observation on 01/15/2025 at 9:31 AM, Resident 66 was in their room which smelled heavily of cigarettes. Resident 66 appeared agitated and stated that they received a letter stating they would have to discharge from the facility. Resident 66 showed this surveyor their discharge notice that showed they no longer needed skilled nursing, had refused therapies and had been verbally abusive with staff. In an observation on 01/16/2025 at 7:50 AM, Resident 66 was observed smoking on the sidewalk outside of the facility. In an observation on 01/16/2025 at 8:44 AM, Resident 66 was in their wheelchair in their room. The hallway and room smelled heavily of cigarette odor. In an observation on 01/16/2025 at 10:40 AM, Resident 66 was in the hall being pushed in their wheelchair by a visitor. Resident 66 stated they were going outside for some fresh air. They stated As long as I have a pusher. I will get fresh air. In a joint interview on 01/16/2025 at 10:44 AM, Staff E, Licensed Practical Nurse (LPN) stated Resident 66 goes outside to smoke but they weren't supposed to. Staff D, Registered Nurse (RN) stated Resident 78 also goes out to smoke. Staff E stated both residents had been educated about smoking, many times by Staff C, Staff A, Administrator and Staff B, Director of Nursing Services (DNS). Staff E stated they did not have or keep the resident's cigarettes or lighter. Staff E stated they assumed the cigarettes and lighter are with the residents. Staff D said Resident 66's room always smells like cigarette smoke, but they didn't believe the resident had smoked in their room as they see them smoking outside. Staff D said Resident 66 refused their nicotine patches. Review of the clinical record 01/16/2025 at 12:28 PM showed there was no smoking safety evaluation or care plan about nicotine dependence or smoking for Resident 66. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an observation and interview on 01/16/2025 at 1:04 PM, the hallway outside room [ROOM NUMBER] smelled heavily of cigarette odor. Resident 66 was in their room and stated staff Get after them for smoking, especially (Staff C, Social Services). Resident 66 stated Staff C told them the state would not like them smoking and would make them quit. The resident stated Staff C told them they would probably have to have a staff member hold the cigarette for them. Resident 66 stated they started smoking at ten years old and staff knew they smoked when they admitted . The resident stated they smoke off the property and extinguished the cigarettes in their hands by twisting until the tobacco falls out. Resident 66 stated sometimes they will try to run over the cherry (lit portion of cigarette) with their wheelchair. Resident 66 had both hands in their sweatshirt pockets and shook them while stating they kept their cigarette butts in their sweatshirt pockets because there was no place to discard the cigarette butts outside. Resident 66 stated they cannot extinguish the cigarettes because they have no feet. Resident 66 stated they get mad at other people who smoke here and leave their cigarette butts on the ground. The resident stated they kept their cigarettes and lighter in their coat pocket in their room. There was an outline of a cigarette pack observed in their left inner coat pocket. Resident 66 stated they had tried Zyban (medication to aid smoking cessation) in the past and broke out in hives. Review of Resident 66's clinical record on 01/16/2025 at 12:28 PM, showed the facility had not assessed the resident for smoking safety and there was no care plan in place despite the resident's longstanding smoking history and nicotine replacement therapy in place from admission. The resident was at high risk to smoke given their current stressors of recent loss of both lower extremities and their sudden impaired mobility. In an observation on 01/16/2025 at 1:18 PM, Resident 66 was observed on the sidewalk smoking a cigarette with no staff present. Smoke was visible. There was no cigarette disposal receptacle present. The nearest garbage can was located right inside the door of the facility. The garbage can was plastic with a clear plastic liner in it. In an observation on 01/17/2025 at 7:55 AM, Resident 66 was observed sitting outside in their wheelchair on the sidewalk on the property next to a trash can. The resident was observed to roll the end of the lit cigarette with their finger and then place their hands in their pocket. No cigarette butts were located on the ground where they were seated. Review of Resident 66's facility smoking evaluation dated 01/16/2025 at 4:35 PM, was completed after the IJ was called. The assessment summarized the resident was on medications with the side effect of drowsiness. <RESIDENT 78> Resident 78 admitted on [DATE] with diagnoses to include left leg fracture, multiple heart conditions and nicotine dependence. According to the resident's Admission MDS assessment dated [DATE], showed the resident had no cognitive impairment and no current tobacco use. Review of the hospital discharge summary/orders dated 12/13/2024 showed Resident 78 was a patient that smoked. The orders directed staff to place a nicotine patch 21 MG (milligrams) in 24 hours onto the skin daily, removing old patch before applying a new patch. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a facility provider note dated 12/16/2024, showed Resident 78 was a current smoker of one to two packs a day and current user of smokeless tobacco/chew. Review of a weekly skilled Interdisciplinary (IDT) Meeting note dated 01/02/2025 at 12:34 PM, written by Staff B, Director of Nursing noted Resident 78 was smoking. Review of a progress note dated 01/13/2025 at 11:44 PM, showed Resident 78 arrived via taxi from the hospital emergency department around 11:30 PM, Alert and Oriented to person, place, time and event, appeared to be at baseline, and right away they wheeled themselves outside for a smoke, returned and asked for their pain pill. Review of Resident 78's clinical record 01/16/2025 at 12:21 PM showed there was no smoking safety evaluation or care plan about nicotine dependence, or smoking completed for the resident. In an interview and observation on 01/16/2025 at 1:40 PM, a black lighter was observed on Resident 78's overbed table. The resident stated they had a lot of stress over discharging, and they were only able to see half of their visual field in their right eye for the past 5 days. Resident 78 stated they chewed tobacco normally and they did not like smoking but could not chew in a place like this, related to their rules. The resident stated they go outside to smoke two to three times a day and the nurses remove their nicotine patch before they go out to smoke. Resident 78 stated they were not wearing their patch that day because they planned to go out and smoke a lot. The resident stated they go off property 30 or 40 feet to smoke. The resident stated to put their cigarette out, they knock the cherry off and twist the cigarette with their fingers. The resident stated they roll the cigarette paper into a small bit and put the cigarette filter in their pocket until they find a garbage can, The resident stated there were no ash trays or garbage cans outside so they come into the facility where there is a garbage can right inside the door and then they dispose of the filter there. In an interview and observation on 01/16/2025 at 2:29 PM, the black lighter was still present on Resident 78's overbed table. The resident stated they only had half a cigarette left and it is in their cigarette box in their coat pocket (pointing to their coat on the neighboring bed. The resident became irritated and asked, why, is it against the law? In an observation on 01/16/2025 at 2:45 PM, Resident 78 was observed to smoke unsupervised on the sidewalk outside the facility, they were observed to cross a high traffic parking lot to access the sidewalk. Resident 78 was observed to twist the end of cigarette to put it out, and then placed the cigarette butt in their pocket and self-propelled back across the high traffic parking lot into the facility. Review of Resident 78's clinical record showed the facility smoking evaluation dated 01/16/2025 at 4:38 PM was completed by the facility after the IJ was called. The assessment summarized the resident had no visual limitations and they were on medications with the side effect of drowsiness. In an interview on 01/24/2024 at 9:07 AM, Staff A, stated there would be more emphasis on screening new admissions and smoking safety. Reference: WAC 388-97-1060 (3)(g)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on interview and record review, the facility failed to ensure ongoing communication and collaboration with the hemodialysis (a mechanical way of removing waste from the body when the kidneys no longer function) center for 1 of 1 resident (Resident 335) reviewed for hemodialysis (HD) services. The failure to consistently and accurately complete resident's pre- and post-dialysis assessments and consistently ensure communication between the facility and dialysis center about what occurred during HD was completed, placed the resident at risk for unidentified medical complications and other potential/negative health outcomes. Findings included In a review of the facility's policy titled Dialysis, dated March 2015 stated the facility would communicate with the dialysis center by completing the Dialysis Transfer Form .the facility would require the dialysis center to provide the following information upon the resident's return from dialysis: - pre-dialysis and post-dialysis weight, the post-dialysis weight was used in lieu of the facility weighing resident, - labs and results of labs done at dialysis center, - medications given at the dialysis center, - follow-up care or procedure that needs to be done at the facility. If the facilities receiving nurse does not receive the requested information from the dialysis center, a call would be placed to request the information. If the dialysis center does not provide the information to the facility, the nurse would notify the Director of Nursing Services (DNS). The DNS would need to follow up with the dialysis center to obtain the information per the facility request. Continued non-compliance was referred to the facility's Medical Director. Resident 335 admitted to the facility on [DATE] and received dialysis treatment three days per week. Review of Resident 335's Order Summary Report print date 01/16/2025, showed their dialysis days were Tuesdays, Thursdays and Saturdays. The Dialysis Transfer Form was to be recorded by the dialysis center - document receipt - if not returned, call for copy. Pre- and post-dialysis vitals (measurements of the body's most important functions, such as breathing rate, blood pressure, and body temperature) every shift, on Tuesdays, Thursdays and Saturdays. Post-Dialysis weights only on dialysis days. In an interview on 01/17/2025 at 1:31 PM, Staff O, Registered Nurse (RN), stated that when Resident 335 returned from dialysis, they would check their vital signs and weight, and review the communication paper from the dialysis center. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/17/2025 at 1:32 PM, Staff Q, RN/Resident Care Manager (RCM) retrieved Resident 335's binder where the dialysis communication papers were kept. Staff Q stated that if the forms were not in the binder, they would be in the Medical Records office awaiting to be scanned into resident's electronic chart. Review of Resident 335's clinical record on 01/17/2025 at 2:00 PM, showed Dialysis Transfer Forms for dates 01/09/2025 and 01/11/2025 were missing. In an interview on 01/21/2025 at 9:39 AM, Staff N, Health Information Manager stated that they had scanned all the Dialysis Transfer Forms into Resident 335's electronic records. In an interview on 01/21/2025 at 10:35 AM, Staff Q stated they would look for the missing Dialysis Transfer Forms. Staff Q stated they were not aware on how to complete the form and deferred to the floor nurse. In an interview on 01/21/2025 at 10:38 AM, Staff O stated the facility floor nurse completes the top part of the form up to the pre-dialysis weight then the rest of the form was to be completed by the dialysis center. Staff O was asked what they do if the form comes back blank, and Staff O stated that they would call the dialysis center and follow up with them. Staff O was asked where they document the follow up call and they stated in the resident's medical record under their progress notes. Staff O stated when Resident 335 returns from dialysis, they assess the resident, look at the site and make sure nothing was abnormal. Review of Resident 335's January Treatment Administration Record (TAR) dated January 2025 showed the resident's dialysis dates were 01/02/2025, 01/04/2025, 01/07/2025, 01/09/2025, 01/11/2025, 01/14/2025, 01/16/2025, 01/18/2025 and 01/21/2025. The TAR showed where a Licensed Nurse was supposed to sign for receipt of the Dialysis Transfer Form, post-dialysis vitals and post- dialysis weights were blank for 01/11/2025 and 01/16/2025. Review of a progress note printed on 01/21/2025 showed Resident 335 did not show any notes regarding the resident's dialysis for dates 01/09/2025 and 01/11/2025. In an interview on 01/21/2025 at 2:30 PM, Staff Q stated they were not able to find the dialysis communication forms for Resident 335 for 01/09/2025 and 01/11/2025. Review of Resident 335's dialysis transfer form dated 12/31/2024, showed the top portion was completed by the facility but showed the pre-dialysis and post-dialysis weights were blank, and the rest of the form was blank. Review of Resident 335's December 2024 TAR showed the post-dialysis weight was not entered. Review of Resident 335's progress notes showed no notes that the facility staff had reached out to the dialysis center. Review of the 01/02/25 dialysis transfer form showed the bottom portion of the form was blank. Review of Resident 335's progress notes showed no facility staff reached out to the Dialysis Center. Review on 01/04/2025, 01/07/2025 and 01/16/2025 dialysis transfer form for follow up care and procedure that was required to be completed at the facility was blank. Review of the progress note for those dates showed no documentations that the facility staff reached out to the dialysis center for follow up. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 01/22/2025 at 12:11 PM, Staff B, RN/Director of Nursing Services stated that the process when a resident returns from the dialysis center, was the nurse was to assess the resident, obtain their vital signs and ensure they have the complete form and weight. Staff B stated that would be documented in the TAR. Staff B stated the expectation was the bottom part should be filled out by the dialysis center and if they left it blank the nurses were supposed to call the dialysis center to follow up and then document conversation in the residents' medical records in a progress note. Staff B stated they call the dialysis center weekly to request a copy of the resident's dialysis report and they review that. Staff B was not able to provide any documentation that showed the facility had followed up with the dialysis center. In an interview on 01/22/2025 at 3:10 PM, Staff P, Licensed Practical Nurse, stated they were not aware of the facility policy or process for when the dialysis transfer form's bottom portion was not completed appropriately. Refer to WAC 388-97-1900(1)(5)(c)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 37890 Based on interviews and record review the facility failed to ensure annual Certified Nursing Assistant (CNA) performance reviews were completed for 6 of 11 CNAs (Staff F,G,H,I,J and K) who had been employed longer than one year. This failed practice had the potential to negatively affect the competency of those CNAs and the quality of care provided to residents. Findings included . Review of facility employee records on 01/22/2025 showed the following CNAs hired greater than one year did not have annual performance evaluations completed for the prior year: - Staff F, CNA, date of hire was 05/18/2023, - Staff G, CNA, date of hire was 04/04/2023, - Staff H, CNA, date of hire 07/12/2023, - Staff I, CNA, date of hire 06/03/2009, - Staff J, CNA, date of hire 11/22/2023, - Staff K, CNA, date of hire 12/16/2006. In an interview on 01/22/2025 at 1:00 PM, Staff B, Director of Nursing Services, stated the facility was behind on completing annual evaluations for nursing assistants. Refer to WAC 388-97-1680(2)(b)(i)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on observation, interview, and record review, the facility failed to ensure 3 of 5 residents (Resident 26, 68 and 72) were free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) as required. The facility failed to ensure appropriate indication for psychotropic medications and to obtain consent including a discussion of risks and benefits of the psychotropic medication, monitor and document behaviors and or symptom. These failures placed the residents at risk for medication-related complications and for receiving unnecessary psychotropic medication. Findings included . As referenced in the Food and Drugs/Drug (FDA) Safety Information, anti-psychotic medications have serious side effects and can be especially dangerous for elderly residents. The use of anti-psychotic medications without an adequate rationale, or for the sole purpose of limiting or controlling expressions or indications of distress without first identifying the cause, there was little chance that they would be effective, and they commonly cause complications such as movement disorders, falls with injury, stroke, and increased risk of death. The FDA Boxed Warning, which accompanied, second-generation anti-psychotics stated, Elderly patients with dementia-related psychosis treated with atypical anti-psychotic drugs are at an increased risk of death. Review of the facility policy titled, Psychotropic Drugs, updated October 2022, showed residents with orders for psychotropic medications are evaluated and appropriate interventions implemented. The policy said residents taking a psychotropic medication, unless clinically contraindicated will undergo a gradual dose reduction in two separate quarters with at least one month between attempts. <RESIDENT 68> Resident 68 admitted on [DATE], with diagnoses to include bipolar disorder, behavioral and emotional disorder, and hyperactivity disorder. Review of Resident 68's Admission Minimum Data Set (MDS - an assessment tool) assessment, dated 11/06/2024, showed Resident 68 had mild cognitive impairment. The resident was coded not to have had any signs of psychosis such as hallucinations (perceptual experiences in the absence of real external sensory stimuli), or delusions (misconceptions or beliefs that are firmly held, contrary to reality). The resident was not taking any antipsychotic medication. Review of a fax order dated 01/07/2025, Olanzapine (anti-psychotic) one time daily for 7 days then one tab one time a day. The diagnosis/indication was listed as Schizophrenia, delusions, hallucinations, paranoia and acute psychosis. Review of the January Medication Administration Record (MAR) showed the Olanzapine was initially administered to Resident 68 on 01/08/2025 with the diagnosis listed as bipolar disorder, conflicting with the order. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 68's clinical record did not show a diagnosis of schizophrenia. <RESIDENT 72> Resident 72 admitted on [DATE] with diagnoses to include dementia, post-traumatic stress disorder, depression, dementia and anxiety. Review of Resident 72's Admission MDS, dated [DATE], showed Resident 72 was cognitively intact. The resident was coded not to have had any mood or behavior concerns, signs of psychosis such as hallucinations or delusions. The resident was not taking any antipsychotic medication. Review of a fax order dated 12/17/2024, showed an order for Ativan (anti-anxiety medication) 0.5 milligram (mg)by mouth twice a day as needed. The indication for the Ativan was listed as agitation or aggression, both inappropriate indications. Review of a fax order dated 01/03/2025, showed Risperidone (antipsychotic) 1 MG by mouth twice a day. The provider noted the resident consented to the medication. There was no diagnosis or indication for the new order for Risperidone medication. In an interview on 01/22/2025 at 11:50 AM, Staff B, Director of Nursing Services (DNS) said they understood that the signed fax noting consent obtained was not a complete consent as it did not show that the resident understood the indication for the Risperidone, risks and benefits and side effects of the drug were discussed. 44110 <RESIDENT 26> Resident 26 admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion, and changes in behavior and personality), and anxiety. The quarterly MDS dated [DATE] showed the resident had severe cognition deficit, had no depression, and was currently prescribed an anti-depressant. Review of Resident 26's physician orders on 01/16/2025 showed an order dated 07/23/2024 for Sertraline (anti-depressant medication) 75 milligrams a day for generalized anxiety disorder. Review of Resident 26's electronic medication administration record (EMAR) for December 2024 and January 01 - 17, 2025 showed the resident received the anti-depressant daily. Review of Resident 26's behavior administration record (BAR) for December 2024 and January 01 - 17, 2025 showed the facility was monitoring for depression with no documentation that the resident had experienced signs and/or symptoms of depression. Review of Resident 26's medical record for the last six months showed no documentation from the provider or pharmacist for exception of the use of an anti-depressant to treat anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/23/2025 at 12:22 PM, Staff E, Licensed Practical Nurse said the Resident Care Managers' obtain the psychotropic med consents, obtain diagnosis, discuss side effects of the meds and get the consents signed by the resident or responsible party. In a joint interview on 01/24/2025 at 9:08 AM, Staff A, Administrator and Staff B, DNS, Resident 26, 68 and 72's psychotropic indications were discussed. Staff A said they believed family of Resident 68 said they had schizophrenia. Staff B said Resident 68 has bipolar disorder and very complicated medical history. No additional information about the psychotropic medication was received. This is a repeat deficiency from 03/08/2024. Refer to WAC 388-97-1060(3)(k)(i)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 51312 Based on observation, interview and record review, the facility failed to ensure a medication error rate less than 5 percent (%, unit of measure). During observation of 34 opportunities for error, 1 of 2 Licensed Nurses (LN, Staff P), made thirty-one errors, an error rate of 91 %. This placed residents at risk for side effects, unnecessary medications, and/or reduced medication effectiveness due to improper administration. Findings included . <RESIDENT 46> A review of the January 2025 Physician's orders and Medication Administration Record (MAR) for Resident 46 showed one pill for blood sugar regulation was ordered to be administered at 7:00 AM, one injection for blood sugar regulation, one pill for iron deficiency, and one pain patch were due to be administered at 8:00 AM, and one aspirin tablet for blood clotting was due to be administered at 9:00 AM. During an observation of medication administration on 1/21/2025 at 12:07 PM, Staff P, licensed practical nurse (LPN) was observed administering medications to Resident 46. Staff P administered one injection for blood sugar regulation, one tablet for blood sugar regulation, one pill for iron deficiency, applied one pain patch, one magnesium tablet, one aspirin tablet for blood clotting. <RESIDENT 12> During an observation of medication pass on 1/21/2025 at 12:16 PM Staff P, administered Resident 12's medications: one pill for vitamin B deficiency, one pill for thyroid regulation, one pill for water retention, one pill for depression, one pill for blood pressure, one multivitamin, one pill for vitamin B, one pill for blood pressure. A review of Resident 12's January 2025 MAR showed the following orders: one pill for vitamin B deficiency, one pill for thyroid regulation due at 7:30 AM, one pill for water retention, one pill for depression, one pill for blood pressure, one multivitamin, one pill for vitamin B, one pill for blood pressure due at 8:00 AM. <RESIDENT 6> During observation of medication pass on 1/21/2025 at 12:49 PM, Staff P, administered Resident 6's medications: one pill for muscle spasm, one pill for depression, one pill for pain, one pill for iron deficit, one pill for blood pressure, one pill for water retention, one pill for neurological pain, one multivitamin, one antibiotic, one pill for mood, one pill for probiotic, one pill for potassium, and one pill for depression. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 6's January 2025 MAR showed the following orders: one pill for muscle spasms, one pill for depression, and one pill for pain due at 8:00 AM. One pill for iron deficit, one pill for blood pressure, one pill for water retention, one pill for neurological pain, one multivitamin, one antibiotic, one pill for mood, one pill for probiotic, one pill for potassium, and one pill for depression due at 10:00 AM. <RESIDENT 25> During observation of medication pass on 1/21/2025 at 12:55 PM, Staff P, administered Resident 25's medication: one pill for blood pressure, one pill for blood thinning, and one pill for Calcium. Review of Resident 25's January 2025 MAR showed the following orders: one pill for blood pressure, one pill for blood thinning, and one pill for Calcium due at 8:00 AM. All of the observed medications were administered greater than one hour beyond the ordered administration times. In an interview on 1/21/2025 at 1:59 PM, Staff P stated medications are considered late if they are administered 1 hour after they are due and that if they got behind, they could call for help from the Resident Care Manager (RCM). They also stated that late medications constituted medication errors. In an interview on 1/21/2025 at 2:47 PM Staff Q, Resident Care Manager, (RCM), stated when staff were running late passing medications, they were expected to call for help from the RCM, or another staff member. In an interview on 1/21/2025 at 3:00 PM, Staff B, Director of Nursing Service (DNS) stated if a staff member was running late passing medications, they should notify the provider to find out if the resident should skip a dose or still receive the medication and the resident or POA should be notified. Refer to WAC 388-97-1060(3)(k)(ii)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 51312 Based on observation, interviews, and record review, the facility failed to ensure 1 of 7 residents (Resident 46) observed during medication pass were free from significant medication errors. This placed the resident at risk for complications and decline in condition. Findings included . Review of the package insert for Lispro insulin showed the medication started to act 15 minutes after administration, with a peak time of one hour, and continued to work for two to four hours. The package inserts further stated taking too much Lispro insulin could cause low blood sugar, and the medication should be taken exactly as the doctor ordered. In an observation on 12/21/2025 at 12:07 PM, Staff P, Licensed Practical Nurse (LPN) was observed administering Resident 46's 8:00 AM Lispro insulin, four hours late. During an interview on 12/21/2025 at 12:07 PM, Staff P, was asked when Resident 46's blood sugar was taken. Staff P stated that they took Resident 46's blood sugar sometime around 6:00 AM. Review of Resident 46's Medication Administration Record (MAR) showed that Resident 46 had orders to receive four units of Lispro insulin at 8:00 AM on 1/21/2025 but the medication was documented as administered at 1:16 PM. The MAR also showed the resident should receive four units of Lispro insulin at 12:00 PM and that was documented as administered at 12:50 PM. In an interview on 1/21/2025 at 1:59 PM Staff P, stated that if medications are administered an hour late it was considered a medication error. During the same interview Staff P, stated they take resident's blood sugars in the morning when they arrived, not before administration of insulin. In an interview on 1/21/2025 at 2:47 PM, Staff Q, Resident Care Manager (RCM) stated they were unaware a nurse was passing medications late. Staff Q stated that if nurses were passing medications late, they should ask for help. In an interview on 1/21/2025 at 3:00 PM Staff B, Director of Nursing Services, stated that they checked with staff to see if anyone needed help and that the RCM should be checking with floor staff. Staff B also stated that when medications were late, the provider should be notified to provide direction. Refer to WAC 388-97-1060(3)(k)(iii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44110 Based on observations and interview the facility failed to ensure drugs and biologicals were stored in accordance with state and federal laws appropriately for 2 of 2 (1st Floor and 2nd Floor) Medication Storage Rooms. The facility failed to ensure Schedule II-V (Substances with a high potential for abuse which may lead to severe psychological or physical dependence) controlled medications were in a separate locked permanently affixed compartment not accessible to others. These failures left controlled substances to be unintended with access to drugs that should have been securely stored. Findings included . In an observation and interview on 01/17/2025 at 10:08 AM, in the 2nd floor medication storage room there was a refrigerator. In the refrigerator there was a black box that was not permanently affixed to the refrigerator. Staff U, Licensed Practical Nurse/Resident Care Manager confirmed the controlled substances were placed in the black box. Staff U stated they did not have a permanently affixed lock box for their Scheduled II-V's controlled substances that were required refrigeration. In an observation on 01/17/2025 at 10:15 AM, the 1st floor medication storage room had controlled substances stroed in a black box in the refrigerator that was not permanently affixed to the refrigerator. In an interview on 01/24/2025 at 9:08 AM, Staff A, Administrator confirmed that the scheduled II-V controlled substances that required refrigeration had not been permanently affixed in the black boxes in both refrigerators on both floors (1st Floor and 2nd Floor). Reference WAC 388-97-1300(2)

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 01/24/2025
NAME OF PROVIDER OR SUPPLIER: North Cascades Health and Rehabilitation Center		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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on observation, interview and record review, the facility failed to ensure that staff were complaint with Infection Prevention and Control Guidelines and standards of practice for 1 of 1 resident room (room [ROOM NUMBER]) that's on Transmission-Based Precaution (TBP), 1 of 4 residents' rooms (room [ROOM NUMBER]) that's on Enhanced-Barrier Precaution (EBP) and 1 of 1 resident during catheter care (Resident 45). The facility failed to ensure staff used appropriate hand hygiene practices in caring for a Clostridium Difficile [(C. diff) a highly contagious bacteria that can infect the gut and cause watery diarrhea] positive resident and when performing catheter care and wearing appropriate Personal Protective Equipment [(PPE) - specialized clothing clothing or gear worn to pretect for infection or illness] during high contact resident care activities. These failures placed all residents and staff at risk for potential infections. Findings include . Review of the facility policy titled, Transmission Based Precautions, dated May 2015 stated transmission based precautions are used based on Center for Disease Control and Prevention (CDC) criteria are established .contact precautions are implemented with residents with suspected or known C. diff and staff should wash their hands prior to exiting the room. Review of guidance from the CDC, titled, Clinical Safety: Hand Hygiene for Health Care Workers, revised 02/27/2024 states hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with water and soap or using an alcohol-based hand rub (ABHR) . Healthcare workers with all care of residents with suspected or known C. diff infection should always hand wash their hands with soap and water. Review of the facility policy titled, Enhanced Barrier Precautions, revised 03/26/2024 stated that enhanced barrier precautions (EBP) are used in conjunction with standard precautions . examples of residents that require EBP are residents with a indwelling device such as central lines require the use of EBP were staff would need to wear a gown and gloves. <TRANSMISSION BASED PRECAUTIONS> On 01/15/2025 at 10:00 AM, Staff L, Registered Nurse (RN)/Infection Preventionist (IP), reported that room [ROOM NUMBER] had one resident in the room (Resident 288) was on contact precautions for C. diff infection. In an observation on 01/15/2025 at 10:24 AM, room [ROOM NUMBER] had a sign outside of the room that stated Contact Precautions with instructions to wear a gown and gloves, and to clean their hands. Above that sign was another sign that stated, gel in and gel out, neither sign instructed staff or visitors to perform hand washing with soap and water due to type of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 01/15/2025 at 12:35 PM, an unnamed housekeeper was observed to be sweeping the floor in room [ROOM NUMBER], the unnamed housekeeper was not wearing a gown and had gloves on their hands. The staff member was observed to walk out into the hallway and grab the dustpan from the housekeeping cart and was observed sweeping the trash from the room. The staff member then dumped the trash with their gloved hands and replaced the dustpan on the house keeping cart in hallway. The staff member then removed their gloves, placed in the trash can and used ABHR to wash their hands. They then exited the unit. In an observation and interview on 01/15/2025 at 1:01 PM, Staff T, Nursing Assistant Certified (NAC) was observed to enter room [ROOM NUMBER], they wore a gown and gloves. Staff T was observed to enter room with lunch tray, they placed tray on the residents over the bed table with some of the residents' personal items, scooted the table closer to the resident. The resident then stated they did not want the lunch tray, and Staff T picked up the tray, placed it on the outside of the room on the supply bin outside the room. Staff T was then observed to remove their gown and gloves, exit the room and use the hand gel from the dispenser in the hallway. Staff T was asked why the resident in room [ROOM NUMBER] (Resident 288) was on contact isolation, they stated they were not sure and were just following the instructions of care on the isolation sign on the outside of the room. Staff T was not observed to wash their hands with soap and water. In an observation on 01/16/2025 at 12:56 PM, Staff R, NAC was observed to wear a gown and gloves as they entered room [ROOM NUMBER]. The room had contact isolation sign outside of the room, and a gel in and gel out sign as well. Staff R was observed to enter room with lunch tray, when resident did not want the staff placed on the sink in the room, removed their gown and gloves, picked up the tray from the sink and placed into the lunch cart in the hallway. Staff R then used the hand gel from the dispenser in the hallway. Staff R was not observed to wash their hands with soap and water. In an observation and interview on 01/16/2025 at 11:01 AM, Staff D, Registered Nurse (RN) was observed to enter room [ROOM NUMBER] without a gown and gloves on. room [ROOM NUMBER] had a sign outside the room that stated the resident was on EBP and directed staff to wear a gown and gloves with all high contact resident care activities such as device care. The resident (Resident 50) was observed to have a peripherally inserted central catheter (PICC) (a type of central line that would be inserted directly into a vein in the upper arm and was threaded into a larger vein near the heart). Staff D was observed to place gloves, but no gown on to remove blood from the residents PICC line. Staff D was asked why Resident 50 was on EBP, Staff D stated due to the PICC line they had in their arm. Staff D was then asked if they were supposed to wear a gown during the blood procedure, Staff D stated they were not sure. In a follow up interview on 01/16/2025 at 1:16 PM, Staff D stated they spoke to the infection preventionist and confirmed they should have been wearing a gown during that procedure, and that they had forgot they should have. In an interview on 01/22/2015 at 10:50 AM, Staff L, RN/IP stated that all staff were instructed to wash hands with soap and water when they go in and out of rooms that were on contact precautions, this includes residents with C. Diff. Staff L showed me the contact precaution sign they post at a residents' door who has C. Diff. Sign states clean hands, informed Staff L that the sign did not direct staff to specifically wash hands with soap and water. Staff L stated they will look for a signage that states staff to wash hands with soap and water and will post it on residents that are on precaution for C. Diff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50725 <HAND HYGIENE> Resident 45 was admitted [DATE]. Resident has a suprapubic catheter (a hollow flexible tube that is used to drain urine from the bladder through a cut in the lower abdomen). In an observation on 01/21/2025 at 10:59 AM Staff M, NAC, with gloved hands emptied the foley catheter bag of Resident 45 and when finished, using the same gloves took the resident's blanket down, and performed catheter care. After the catheter care, using the same gloves, covered resident with their blanket and touched the bed control, call light, TV remote and overbed table. In an interview on 01/21/2025 at 11:10 AM, Staff M stated, they do their infection control training online and recently had the training. When I asked what they will do with the gloves they wore right after they empty the catheter bag and right after the catheter care, they were not able to answer me. In an interview on 01/22/2025 at 10:40 AM, Staff L, RN/IP, stated that along with the Staff Development Coordinator(SDC) they provide training for Infection Control and Practices at least yearly to staff, they also provide on the spot auditing and have staff provide return demonstration such as hand washing. When I informed what I observed, Staff L and SDC stated they will conduct another training to the staff. Refer to WAC 399-97-1320(1)(a)