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	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Cascades Health and Rehabilitation	4680 Cordata Parkway Bellingham, WA 98226

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of bed hold at the time of transfer to the hospital for 4 of 4 residents (Residents 10, 14, 33 and 52) reviewed for hospitalizations and bed holds. This failure placed the residents and/or representatives at risk of not having the necessary information to make an informed decision regarding their ability to return to the facility, Findings included .Review of facility policy titled Bed hold policy, dated April 2025, documented in section 5.2: Bed Holds. The Community will provide a bed hold notice in accordance with applicable regulations and discuss the bed hold note (if applicable) with the resident and responsible party of the time of transfer to an acute hospital. <RESIDENT 14>Resident 14 admitted to the facility on [DATE], with diagnoses to include anoxic brain damage (a severe, often permanent, acquired brain injury), diabetes, and pain. Review of Resident 14's Electronic Health Record (EHR) documented the resident discharged to the hospital return anticipated on:- 01/31/2026,- 02/16/2026,- 03/23/2026,- 04/05/2026. Further review of Resident 14's EHR for 01/30/2026 through 04/09/2026 showed there was no documentation of written bed hold information being provided to the resident at time of discharges to the hospital on [DATE], 02/16/2026, 03/23/2026, or 04/05/2026. <RESIDENT 33>Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's EHR documented the resident discharged to the hospital return anticipated on:- 01/16/2026, - 02/15/2026, - 03/07/2026. Further review of Resident 33's EHR for 01/15/2026 through 04/09/2026 showed there was no documentation of written bed hold information being provided to the resident at time of discharges to the hospital on [DATE], 02/15/2026, or 03/07/2026. <RESIDENT 52>Resident 52 was admitted to the facility on [DATE]. Review of Resident 52's EHR documented the resident discharged to the hospital return anticipated on 03/10/2026. There was no documentation in the EHR that a written bed hold notice had been provided to the resident at time of discharge to the hospital. <RESIDENT 10> Resident 10 initially admitted to the facility on [DATE] with a readmission date of 11/26/2025 with (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	diagnoses to include a pressure wound of the sacral region, stage three (deep, crater-like wound resulting from prolonged pressure), lumbar spina bifida (a birth defect where the lower spine doesn't close properly, leaving nerves exposed), paraplegia (paralysis of the lower half of the body), and diabetes type two (chronic health condition when blood sugar levels are too high because the body cannot properly produce or use insulin). Review of Resident 10's progress notes, on 11/16/2025 at 5:24 PM Staff R, Licensed Practical Nurse (LPN), documented that Resident 10 was transferred to the emergency room per physician orders. Review of Resident 10's EHR from 11/16/2026 through 11/26/2026 had no documentation of written bed hold information being provided to the resident at time of discharge to the hospital. In an interview on 04/10/2026, Staff H, LPN/Resident Care Manager, stated that the cart nurse on the floor should be doing the bed hold when sending a resident out to the hospital. Staff H stated that it would be documented in the progress notes if the resident accepted the bed hold but did not think it would be documented if it was offered and declined. Staff H stated there would not be scanned documents that the only documentation would be in progress notes. In an interview on 04/13/2026, at 1:30 PM, Staff A, Administrator stated that they were unaware of the correct bed hold process. Reference WAC 388-97-0120 (4)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the facility assessment addressed the physical environment, equipment, services, and other physical plant considerations that are necessary to care for its identified resident smoking population. Failure to thoroughly assess all factors associated with resident smoking placed residents at risk for adverse events related to smoking safety. Findings included . Review of the facility policy titled, Resident Smoking Safety ., updated January 2025 stated no smoking was allowed on the facility grounds, including parking lots, except in designated areas smoking areas were provided with metal cannisters for the disposal of smoking materials .smoking areas were provided with a portable properly rated fire extinguisher and a suitable number of code compliant smoking aprons. Resident who was assessed were required to safely store their smoking materials in a locked box in their room or lockable mailbox type container outside. In an observation on 04/07/2026 at 11:30 AM, there was a resident smoking area in the front facility parking lot which included a canopy style pop up tent, a fire extinguisher, metal smoking receptacles and smoking aprons. The smoking tent was observed blocking one of two accessible handicapped parking spaces. In an observation on 04/08/2026 at 2:00 PM the smoking area and items were observed to have been relocated to another area of the parking lot which was out of compliance with state and local requirements that prohibit smoking within 25 feet of entrances or windows that open. During a resident group interview on 04/08/2026 at 2:53 PM, Residents 30, 59 and 79 stated they kept their own smoking materials and had lock boxes in their rooms but said they did not have keys for their lock boxes. Review of the Facility assessment dated [DATE] documented the resident population included 8 residents identified with tobacco use. Further review of the Facility Assessment revealed no further documentation regarding physical environment, equipment or services necessary related to the identified resident smoking population. In an interview on 04/13/2026 Staff A, Administrator stated they were aware of issues regarding the location of the facility smoking area. Staff A was not aware of residents not having locking boxes with keys to keep smoking materials. Staff A did not have further information related to the Facility Assessment's lack of addressing the facility needs related to resident smoking. No associated WAC reference

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure smoking policies were implemented in accordance with applicable Federal, state and local laws and regulations regarding smoking, smoking areas, and smoking safety. Failure to ensure smoking areas were in compliance with the Americans with Disabilities Act which prohibits blocking handicapped parking spaces, and Revised Codes of the State of [NAME] which prohibits smoking within 25 feet of facility entrances or windows that open, impacted parking accessibility and created the potential for smoke intrusion into the facility. Findings included . Review of the facility policy titled, Resident Smoking Safety . updated January 2025 stated no smoking was allowed on the facility grounds, including parking lots, except in designated areas. In an observation on 04/07/2026 at 11:00 AM, the facility had two handicapped accessible parking spaces in the front parking lot to the left of main entrance to the building. A pop up canopy style tent was observed set up over one of the two handicapped parking spaces. A wooden post had been placed in the ground next to the canopy with a fire extinguisher. Smoking aprons and smoking receptables were observed placed in the area. There were two residents observed sitting under the canopy smoking. In an interview on 04/07/2026 at 1:30 PM, Resident 83 stated they were a smoker and had been in the facility since January 2026. Resident 83 stated the smoking tent had been in the same place since before they admitted . Resident 83 stated they had been concerned about the smoking area being in the parking lot and blocking one of the handicapped parking spaces. In an observation on 04/08/2026 at 2:00 PM, the smoking area was observed to have been relocated. The smoking canopy and related fire extinguisher, smoking aprons and receptables were now observed to the right of the facility entrance. The observed relocated placement of the smoking area was within 25 feet of the facility entrance and nearby windows that could open. In an interview on 04/13/2026 at 2:00 PM, Staff A, Administrator, stated they were aware there were issues with the location of the smoking area and stated that currently there was not a definitive plan regarding the smoking area or placement. Refer to the Americans with Disabilities Act Refer to RCWs 46.19, 46.61 and 70.160Refer to WAC 388-97-1780(1)(2)(a)(i)(d)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure grievances were reviewed promptly and thoroughly resolved with supporting documentation to prevent reoccurrences for 9 of 15 Residents (Residents 30, 47, 57, 65, 79, 95, 105, 122 and 124) reviewed for grievance process. The failure to resolve grievance concerns caused the uncertainty of the resident and/or resident representative receiving necessary care and services, having a diminished quality of life, and not being able to voice concerns with some type of resolution.Findings included . Review of the facility policy titled Grievance Procedure Policy, updated March 2025, documented the administrator was the designated grievance official and oversees the procedures. grievances were resolved immediately when possible and when not possible routed to the grievance official promptly. If the grievance involved abuse, neglect, exploitation, or misappropriation of resident property the Administrator was notified immediately and an investigation would begin. <RESIDENT 105> Resident 105 was admitted to the facility on [DATE] with diagnoses to include major depressive disorder and anxiety. In an interview on 04/07/2026 at 12:55 PM, Resident 105 stated the facility lost their blankets and clothes. The resident said they were upset they lost their black [NAME] blanket that had been given to them from their son who had since passed away. The resident stated they had reported this to the laundry department and had not received follow up and the facility had not offered to reimburse them. Review of Resident 105's personal belongings inventory dated 12/15/2025, showed the resident admitted with a blue and black electric blanket, a black and red blanket and another blue blanket. In a follow up interview on 04/10/2026 at 9:27 AM, Resident 105 stated the facility had not located their blanket or missing clothes yet. The resident stated they talked to someone in laundry and they told them that since they did not have the items written down on their inventory sheet, it was too bad and they probably would not get reimbursed for them. The resident stated the blanket they were missing was the red and black one. Resident 105 said it was not about the money. They stated although the [NAME] blanket was expensive, it was that their son had given it to them before they passed away. In an interview on 04/10/2026 at 10:20 AM, Resident 105 stated they needed assistance to get a new blanket and stated they were missing a tribal hoodie sweatshirt also. In an interview on 04/10/2026 at 1:40 PM, Staff G, Social Services Assistant stated Resident 105 mentioned they were missing their [NAME] blanket. Staff G stated the resident talked with Staff I, housekeeping supervisor, but they (Staff G) had not looked in the laundry room. Staff G stated the resident had been missing the blanket from their deceased son for several months. Staff G stated since the blanket was not on their initial inventory list, they were told from administration the facility would not reimburse the resident for it. In an interview on 04/13/2026 at 11:22 AM, Staff B, Director of Nursing stated the process for (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missing items was to search for the item or replace or reimburse if the item was determined to be missing while the resident was in the facility. Staff B was unaware of Resident 105's missing items. In an interview on 04/13/2026 at 12:22 PM, Staff F, Social Services Director (SSD) stated they met with Resident 105 and identified the missing [NAME] blanket was not the earlier grievance filed regarding a different geometric blanket. They said they completed a new grievance for the missing [NAME] blanket with black crabs on it. <RESIDENT 122> Review of the grievance dated 01/26/2026 at 1:56 PM, Resident 122, documented they last had a shower on 01/19/2026. The resident documented they had mentioned to staff they had been waiting for a shower for a couple of days; their hair was greasy and had buildup of dandruff flakes in their hair. Resident 122 wrote they were not offered a shower or bed bath on 01/23/2026. The investigation/findings documented Resident 122 had refused a shower on 01/23/2026 and a shower was given on the day the grievance was written on 01/26/2026. The grievance contained no supporting documentation of Resident 122's refusal of a shower or discussion with them about their grievance. The grievance was not signed by Resident 122. <RESIDENT 124> Review of the grievance dated 02/03/2026, Resident 124 documented they were showered in the shower room with a resident of the opposite sex in the stall next to them and they had experienced a two-hour call light response. The investigation/findings documented Resident 124 was brought into the shower room which was occupied by another resident of the opposite sex. The grievance showed Resident 124 denied feeling abused or neglected and the two hour wait time was not a problem as they did not time it. The investigation/findings failed to address the circumstances and details around the call light wait time and the grievance was considered resolved as it was isolated. Resident 124 did not want the aide to get in trouble and denied abuse/neglect. No other residents were interviewed, and no call light audits were completed to determine whether the grievance was isolated and rule out abuse/neglect. There was no mention of staff education or in servicing about call light expectations or avoiding showering of male and female residents in the shower room at the same time. <RESIDENT 47> Review of the grievance dated 03/06/2026 showed Resident 47 documented there were unclear communications from nurses. They had wanted pain medication and the nurse threatened them. Review of the investigations/findings showed Resident 47 stated the nurse told them to go back to their room because they were fighting with them and it was not time for their medication. The resolution was that nurses would give medications as ordered and Resident 47 denied feeling neglected or abused. No further interviews with residents/staff or information were documented to rule out abuse/neglect. <RESIDENT 95> Review of the grievance dated 03/05/2026 and documented received on 03/17/2026 (12 days after the date of the grievance) revealed Resident 95 documented that staff were not great at communication and follow through and call light response had taken longer than 30 minutes. Review of the investigation/finding showed Resident 95 was interviewed, and they reported call light wait (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	time longer than 30 minutes was rare and primarily involved agency staff. There was no documentation which determined the nature of the grievance, when or what shift the call light wait time was longer than 30 minutes, or a description of the nature of the communication issue and lack of follow through entailed. A call light audit was conducted during day shift only on 03/19/2026 and 03/20/2026 with no findings. There were no other call light audits completed to determine if a trend existed. An in-service education was conducted on 03/26/2026 (21 days after the date of the grievance) with the topic described as all staff and the content of the in-service was customer service and survey preparation. Review of the in-service documented attendees, none of which were agency staff. The grievance was not signed by the administrator and reviewed on date was blank. <RESIDENT 57> Review of the grievance dated 03/17/2026 at 7:30 PM, Resident 57 documented Staff W, Nursing Assistant Certified (NAC), had an attitude. Resident 57 documented they had been having difficulty keeping food down for the last week and when they informed the staff they had a bowel movement and needed to be changed they were told there was nothing in their brief. Resident 57 documented I don't need to be treated cruelly. The investigation/findings documented Resident 57 stated Staff W was rude to them when they asked them to reheat their soup. Education was provided to the resident on the facility policy of reheating food and Staff W was in-serviced on respect. The grievance was not escalated to an investigation. Findings failed to address the documented allegations of potential verbal/mental abuse and neglect or to address their concerns for not being able to keep food down. <RESIDENT 30> Review of the grievance dated 03/14/2026 and documented as received on 03/20/2026 showed Resident 30 documented their call light wait time was long. Resident 30 documented they were waiting to have their urinal emptied so they could use it. Resident 30 documented their urinal was full and because of not having them emptied, they had wet their pants. Review of the investigation/findings documented Staff FF, NAC, did not empty the urinal and one on one education was provided to them on 03/24/2026 by phone. The grievance was not escalated to an investigation and failed to identify and rule out potential neglect of Resident 30. The grievance was logged and reviewed by Staff A, Administrator on 03/24/2026. Review of the grievance dated 03/15/2026 and received on 03/20/2026 revealed Resident 30 documented they and another resident waited over 40 minutes for their call light to be answered. Resident 30 documented when Staff EE, NAC, arrived, they explained they had been on their break. Resident 30 documented they asked Staff EE about having their hall covered while on break and Staff EE, an agency NAC, provided a sarcastic response. The investigation/findings documented Staff EE did not provide care to the resident, passed off the care to another aide, and Staff EE would be blocked from picking up shifts at the facility. The investigation failed to identify what care had not provided and rule out neglect. The grievance was logged and reviewed by Staff A, Administrator, on 03/25/2026 (10 days after the grievance was dated). <RESIDENT 79> Review of the grievance dated 03/26/2026 revealed Resident 79 documented staff were telling them they could not help them with something due to not having additional help. Review of the investigation/findings documented Resident 79 stated staff came in their room and told them they don't have time or help to do things for them. Resident 79 was unable to describe the nursing (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistant that said they could not help them. An in-service education was provided to all staff, dated 04/01/2026, for the topic of call lights, a total of six NAC's signed the in-service roster, none of which were agency staff. The grievance contained no information or details about what care or services were not provided to Resident 79 or if there was a pattern of multiple residents making the same statement. No other residents were interviewed to determine if other residents were affected. Review of the incident reporting log dated 01/26/2026 through 03/31/2026 showed no logged entries to indicate any of the grievances reviewed were escalated to allegations of abuse/neglect. In an interview on 04/10/2026 at 11:23 AM, Staff N, NAC, stated there were red grievance forms that residents completed and signed. Staff N stated the resident, or they would put the completed grievance forms in the drop box close to the nurse's station. Staff N stated if they were given a grievance by a resident, they would put it in the grievance box. When asked if they would read the grievance, they stated they would not they would just place it in the box. In an interview on 04/13/2026 at 9:07 AM Staff G, Social Services Assistant, stated the grievance process for the facility included filling out a grievance form, which could be completed by either the staff or the resident. Staff G stated a grievance could be anything from missing items, to a roommate issue and when a grievance form would be filled out, a copy was made and provided to the department that needed to investigate. Staff G stated the grievances were read in the morning meetings with Staff A, Administrator. Staff G stated grievances should be resolved within 48 hours. When asked about the difference between a grievance and an allegation, Staff G stated an allegation was an incident that could cause harm such as a staff member being rude to a resident or physical with them. Staff G stated all allegations must be reported to Staff A within two hours. In an interview on 04/13/2026 at 9:43 AM Staff D, Licensed Practical Nurse/Resident Care Manager, stated there were several spots in which the grievances forms, pink in color, were posted. Staff D stated social services had educated residents and family members of where the grievance forms were located. Staff D stated the grievance box on the first floor was located on the wall in a black mailbox and the box was checked every morning by social services. Staff D stated they don't always read the grievances given to them by residents and would place them in the social services or Staff B's, Director of Nursing Services (DNS) box. When asked about the difference between a grievance and an allegation, Staff D stated a grievance was a concern like loud noise or a dietary preference, a situation in which there would be no harm or intent of harm, and an allegation would be about harm or unintentional harm. In an interview on 04/13/2026 at 11:45 AM, Staff B, DNS, stated the process for grievances included reading them immediately to determine if there was an allegation of abuse/neglect and if a report was required. If the grievance was determined to require a report, Staff A, Administrator, would be notified right away and then the facility would complete an investigation within five days. Staff B stated they thought the grievance boxes were located at the nurse's station and they were checked twice a day by social services. Staff B stated staff were educated to read the grievances, if they were provided to them, to ensure there was not an allegation of abuse or neglect. Staff B stated an allegation was an incident/situation that alleged abuse, neglect or misappropriation and a grievance was something a resident didn't like that doesn't cause harm. Reference WAC 388-97-0460

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 5 of 7 sampled residents (Residents 4, 6, 13, 18 and 104) were free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) as required. The facility failed to monitor and document behaviors and symptoms, and failed to document non-pharmacological interventions, and effective use of medication. These failures placed the residents at risk for medication-related complications and for receiving unnecessary psychotropic medication. Findings included .Review of the facility policy titled, Psychoactive Medication, dated June 2025 documented behavior monitoring is initiated to identify problem behaviors and specific behavior interventions are placed on the behavioral monitor for documentation by staff prior to initiation of psychoactive medications.if there are behavioral changes an evaluation is completed and documented as to cause of behaviors, alert charting, notification to all parties, behavioral monitoring is established, non-pharmacological interventions attempted. <RESIDENT 4> Resident 4 readmitted to the facility on [DATE], with diagnoses that included anxiety and depression. The Quarterly Minimum Data Set (MDS- an assessment tool) dated 02/10/2026 documented the resident had intact cognition, minimal depression, and displayed verbal behaviors towards other 1 – 3 days of the look back period. Review of Resident 4's care plan, print date 04/08/2026 documented the resident had impaired psychosocial wellbeing as evidence by behaviors requiring interventions and psychotropic drug utilization related to their anxiety, and resistant to care with refusal to take anxiety medication. Review of Resident 4's physician orders on 04/08/2026, documented the resident was prescribed buspirone (medication used to treat anxiety), duloxetine (medication used to treat depression) and hydroxyzine (medication used to treat anxiety). The three psychotropic medications were administered and received by the residents daily. There were no physician orders to monitor behavioral symptoms, no orders for non-pharmacological interventions, or if they were effective or not. <RESIDENT 6> Resident 6 admitted to the facility on [DATE] with diagnoses that included anxiety, depression, posttraumatic stress disorder (PTSD), and disorganized schizophrenia (severe disrupted thought processes, speech, and behavior). Review of Resident 6's care plan, print date 04/08/2026 documented the resident had impaired psychosocial wellbeing as evidence by behaviors requiring intervention and psychotropic drug utilization related to diagnosis of schizophrenia, PTSD, depression and anxiety. The goal was to have reduced and manageable behaviors through review date. Review of Resident 6's physician orders on 0408/2026, documented the resident was prescribed buspirone, duloxetine, quetiapine (medication used to treat schizophrenia symptoms), and trazadone (medication used to treat depression). The four psychotropic medications were administered and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received by the resident daily. There were no physician orders to monitor behavioral symptoms, no orders for non-pharmacological interventions, or if they were effective or not. In an interview on 04/10/2026 at 10:42 AM, Staff J, Registered Nurse (RN) stated that the nurses only document in the progress notes if a resident has behaviors, if they continue, they will place the resident on alert for three days to monitor those behaviors. Staff J stated they do not complete daily behavior monitoring for residents that were prescribe and took routine or as needed psychotropic medications. Staff J stated only the nursing assistant certified (NAC) document if they observe behaviors. In an interview on 04/10/2026 at 12:04 PM, Staff H, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), stated when a resident first admits they will monitor for behaviors for the first two weeks. Staff H stated that the social services department will update the care plan to the specific behaviors for that resident. Staff H stated social services department will also have the NACs document any observed behaviors. Staff H stated the licensed staff were not completing daily behavior monitoring for residents that were prescribed and took routine or as needed psychotropic medications, only NACs. Staff H was unable to provide any documentation for licensed nurses monitoring Resident 4 or Resident 6's behaviors. In a joint interview on 04/10/2026 at 1:37 PM, Staff F, Social Service Director and Staff K, Regional Social Service Director, Staff F stated they review resident's psychotropic medications on admission, quarterly and as needed. Staff F stated they discuss residents weekly in a clinical meeting, they review the behaviors that are documented, and progress notes. Staff F was asked if the behavior documentation was from licensed staff or the NACs. Staff K stated the documentation should only be by the licensed nursing staff, as they were to monitor behaviors, document appropriate non-pharmacological interventions that were used and if effective. Staff F and Staff K were unaware the licensed nurses were not monitoring behaviors, and which non-pharmacological interventions were used. Staff K was unable to locate any documentation by licensed nurses for monitoring of behaviors for Resident 4 and Resident 6. <RESIDENT 104> Resident 104 admitted to the facility on [DATE], with diagnoses that included dementia, anxiety and depression. The admission MDS dated [DATE] documented the resident had impaired cognition, minimal depression, and delusions with no displayed behaviors towards others in the look back period. Review of Resident 104's care plan, initiated 11/07/2025 documented the resident had impaired psychosocial wellbeing as evidence by behaviors requiring interventions and psychotropic drug utilization related to their anxiety, dementia without behavioral, psychotic or mood disturbance. Review of Resident 104's physician orders showed the resident was prescribed Quetiapine (anti-psychotic medication) twice a day beginning 12/31/2025. There were no physician orders to monitor behavioral symptoms, no orders for non-pharmacological interventions, or if they were effective or not. <RESIDENT 13> Resident 13 was admitted to the facility on [DATE] with diagnoses to include Alzheimer's Disease, anxiety, depression and delirium due to physiological condition. According to the Significant Change (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Minimum Data Set (MDS- and assessment tool), dated 01/09/2026, the resident had memory problems and had severely impaired cognition. Review of Resident 13's care plan with the print date of 04/08/2026 documented the resident had impaired psychosocial well-being as evidenced by behaviors requiring intervention and psychotropic drug utilization related to a diagnosis of delirium, anxiety and depression. A list of target behaviors included: anxious, crying, exiting/wandering, removal/attempted removal of Wander Guard Band, insomnia/not sleeping, panic, withdrawal, self-isolating. Review of Resident 13's physician orders on 04/09/2026, documented the resident was prescribed three psychotropic medications. Escitalopram (medication to treat depression) daily, Quetiapine (medication to treat delirium) daily and Lorazepam (medication to treat anxiety) as needed. The resident received Escitalopram and Quetiapine daily and the resident received Lorazepam twice in March 2026. There were no orders to monitor behavioral symptoms and no orders for non-pharmacological interventions. In an interview on 04/10/2026 at 8:15 AM, Staff P, LPN stated that if a resident had specific behaviors they need to monitor, the behaviors will be listed in the Treatment Administration Record for the nurses to document. If a resident does not have specific behaviors, then they don't document unless the resident had behaviors during their shift. They will document the behaviors in the progress note and place them on alert charting. Staff P stated that not all residents who were taking psychotropic medications had behavior monitoring. In an interview on 04/10/2026 at 12:04 PM, Staff H, LPN/RCM stated, for newly admitted residents that were on psychotropic medication, they put them on alert charting for behavior monitoring for two weeks. The social services department (SSD) then will review the behaviors and place them in the care plan. This will then be transcribed for the nursing assistants to monitor and document. Staff H could not provide documents to show that the nursing assistants were monitoring and documenting Resident 13's behaviors. In an interview on 04/10/2026 at 1:07 PM, Staff H stated that it's an expectation for the nurses to offer non-pharmacological interventions prior to giving any as needed medications. The non-pharmacological interventions will come out as a question for the nurse to answer prior to giving the as needed medication. Staff H could not provide documents that nurses provided non-pharmacological interventions prior to administering the Lorazepam to Resident 13. <RESIDENT 18> Resident 18 admitted on [DATE] with diagnoses which included frequent falls, Parkinson's disease (progressive disorder causing tremors, rigidity and affecting movement) and anxiety. Review of Resident 18's physician's orders on 04/08/2026, documented an order for Alprazolam (an antianxiety medication) ordered every 12 hours as needed for anxiety. Review of the Medication Administration Records for March 23-31, 2026 and April 1-7, 2026 showed the resident received as needed Alprazolam 6 doses in March and 8 doses in April. The administration records revealed each as needed dose was administered without documentation of any non-pharmacological interventions that had been attempted prior to administration, and no identified target behaviors exhibited which would necessitate medication being needed at the time. The (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	follow-up documentations stated effective with no further documentation. Review of routine behavior monitoring documentation in the record revealed that the only behavior documentation was completed by certified nursing assistants and did not correspond or relate to medication administrations. In an interview on 04/10/2026 at 9:23 AM, Staff P, LPN, reviewed the Alprazolam order for Resident 18 and stated they did not see anywhere in the Medication Administration fields to document if target behaviors or non-pharmacologic interventions had been attempted. Staff P was not aware of what behaviors Resident 18 had been exhibiting which had necessitated administering the antianxiety medication and stated, I don't know, it doesn't say. In an interview on 04/10/2026 at 9:28 AM, Staff H, stated the nursing assistants charted behaviors for their shift and nurses should be charting and establishing behaviors, and acknowledged there were no non-pharmacologic interventions or target behaviors associated with the as needed antianxiety medication for Resident 18. In a joint interview on 04/13/2026 at 1:01 PM, Staff A, Administrator and Staff B, Director of Nursing Services, Staff B stated they were unaware that the behavior monitor reports reflected only NAC documentation, and there was nowhere for licensed nurses to monitor residents behaviors, nowhere for them to document which non-pharmacological interventions were used and if they were effective or not. Staff A agreed that the licensed nursing staff should be the ones responsible for that documentation. Reference WAC 388-97-1060(3)(k)(i), - 0620(1)(a)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the level one Pre-admission Screening and Resident Review (PASRR- assessment/a federal requirement for Medicaid-certified nursing facilities to ensure individuals, especially those with mental illness, seeking admission are appropriately placed and receive necessary services) were referred and followed up on for 5 of 6 residents (Residents 11, 13, 73, 82 and 104) reviewed for PASRR. This failure placed residents at risk of unmet mental health services and a diminished quality of life. Findings included .<RESIDENT 82> Resident 82 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, schizophrenia, and unspecified psychosis. Review of Resident 82's Level 1 PASRR dated 02/22/2026 showed the resident was positive for a serious mental illness with indicators marked for mood disorders (depression), schizophrenia, and anxiety disorder. The service needs section documented there was no need for a Level 2 evaluation at this time due to an exempted hospital discharge, however if the resident stayed in the nursing home longer than 30 days, the Level 2 evaluation must be completed. Review of Resident 82's medical record on 04/07/2026 (16 days after the 30-day deadline) lacked any documentation that there had been a Level 2 request for evaluation completed, or that any communication with the PASRR coordinator had been completed. In an interview on 04/10/2026 at 1:37 PM, Staff K, Regional Social Services Director (RSSD) stated the PASRR were reviewed upon admission, and if there were any discrepancies they would follow up with the PASRR coordinator. Staff K stated that it was the expectation for all positive Level 1's to have a Level 2 evaluation or a Notice of Determination letter on file prior to admission of a resident. Staff K was asked what the process was for positive Level 1's with a 30-day exemption, and they stated they make a notification in their outlook calendar to send a request for Level 2 on day 24-25. Staff K stated they communicate with the PASRR coordinator monthly for follow up. Staff K was asked if there had been any communication with PASRR coordinator for Resident 82. Staff K stated they could provide that information. Staff K was asked where that information would be in the resident's medical record, and Staff K stated they would make a progress note, and/or it would be scanned in. In a follow up interview on 04/10/2026 at 2:35 PM, Staff K provided a copy of an email sent to the PASRR coordinator for Resident 82, it was dated 04/07/2026. Staff K could not provide any other documentation that they had submitted for the Level 2 to the PASRR coordinator for the 30-day exemption prior to the deadline. <RESIDENT 11> Resident 11 was admitted to the facility on [DATE] with diagnoses to include Post-Traumatic Stress Disorder (PTSD) (mental health condition triggered by experiencing or witnessing a traumatic event), depression, anxiety and psychosis (mental condition in which thought and emotions are so affected that contact is lost with external reality). Review of Resident 11's most recent Level 1 PASRR, dated 11/24/25, completed by Staff K, RSSD, documented they required a Level 2 PASRR referral. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 11's progress note dated 11/26/2025 at 8:09 AM, Staff K, documented they referred to and sent the Level 1 PASRR to the Level 2 PASRR evaluator. In an interview on 04/13/2026 at 11:00 AM, Staff K stated they had completed a progress note in April of 2026 related to follow up with the Level 2 PASRR evaluator. Requested Staff K, if there was documentation related to monthly follow up with the Level 2 PASRR evaluator and they stated they did not reach out monthly for follow up. <RESIDENT 73> Resident 73 was admitted to the facility on [DATE] with diagnoses to include dementia (decline in cognitive function, affecting memory, thinking, and behavior), depression, anxiety and psychosis (mental condition in which thought and emotions are so affected that contact is lost with external reality). Review of Resident 73's most recent Level 1 PASRR, dated 11/24/2025, completed by Staff K, RSSD, documented they required a Level 2 PASRR referral. Review of Resident 73's progress note dated 11/26/2025 at 8:06 AM, documented the Level 1 PASRR had been referred to and sent to the Level 2 PASRR evaluator. In an interview on 04/13/2026 at 12:01 PM, Staff K, stated Resident 73 had an invalidation from their previous PASRR, dated 04/03/2025. Staff K stated they were unsure if there was documentation of contact or monthly follow up with the Level 2 PASRR evaluator between 11/26/2025 and 04/07/2026. <RESIDENT 13> Resident 13 was admitted to the facility on [DATE] with diagnoses to include Alzheimer's Disease, Anxiety, Depression and delirium due to physiological condition. In a record review, Resident 13 had PASRR's dated 08/14/2026 and 11/24/2025 with Level 2 evaluation referral required for serious mental illness (SMI). Review of Resident 13's electronic chart did not show Level 2 evaluation documents. Record review of Resident 13's progress note dated 10/09/2025, Social Services documented that they notified PASRR Coordinator that resident remained at the facility as a long-term care resident. No mention regarding the follow up for the Level 2 evaluation. Record review of Resident 13's progress note dated 11/26/2025, Social Services documented that they reviewed Resident 13's PASRR and that Level 2 referral for evaluation was sent to the PASRR assessor. There were no other notes regarding the PASRR and follow ups on the Level 2 referral in Resident 13's progress notes until 04/08/2026. Social Services documented that they talked to the PASRR coordinator to follow up on the Level 2 referral on 11/25/2025 and was informed that the PASRR will be invalidated and documents will be sent. Resident 13 had been at the facility for 7 months. In an interview on 04/10/2026 at 1:36 PM, Staff K, stated that it was an expectation for newly admitted residents' PASRR's that require a Level 2 evaluation should have the notice of determination (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and/or invalidation upon admission. If it was not available, then they would reach out to the PASRR Coordinator to see the status of the Level 2 evaluation. Staff K could not provide documentation that they had followed up regularly with the PASRR coordinator regarding Level 2 evaluation for Resident 13. <RESIDENT 104> Resident 104 admitted to the facility on [DATE] with diagnoses to include dementia (a general term for problems with reasoning, planning, memory, and other thought processes) without behavioral, mood or psychotic disturbance (characterized by a loss of touch with reality characterized by altered thinking, perceptions, and behavior). Review Resident 104's Level I PASRR, dated 10/06/2025, a month prior to admission showed the resident had a serious mental illness (MI) indicator however psychotic disorder was not marked. The PASRR indicated a Level II PASRR was indicated. Comments added were Resident 104 takes anti-psychotic medication for dementia and had a history of depression with anxiety for which they were not currently medicated. Psychosis was not selected and there were no comments of such. Review of Resident 104's level II PASRR invalidation dated 11/01/2025 showed the resident had depression and anxiety and did not meet the criteria for a level II evaluation and recommendations for specialized services. Review of provider visits dated 11/11/2025, 12/31/2025, 01/08/2026 and 02/07/2026 showed the same assessment/plan for unspecified psychosis not due to a substance or known physiological condition. The notes documented repeated history of active auditory and visual hallucinations, a history of calling 911 frequently and wander and elopement risk. Review of a physician order showed Resident 104's anti-psychotic medication had to be increased on 12/31/2025. In an interview on 04/10/2026 1:52 PM, Staff G, Social Services Director, reviewed Resident 104's medical record and stated they could not locate a PASRR revision. Staff G stated they would talk to their team about it. They stated they were unaware of any PASRR issues. The PASRR was not revised when the Level 1 PASRR did not accurately identify the resident's psychosis and need for a Level 2 evaluation. Reference WAC 388-97-1915(2)(4)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure care plans were revised as needed for 5 of 9 sampled residents, 2 of 6 (Resident 56 and 105) reviewed for accidents, 2 of 3 (Resident 41 and 84) reviewed for skin issues, and 1 of 6 (Resident 46) reviewed for activities of daily living. This failure placed residents at risk of unmet needs, decreased quality of care related to outdated or inaccurate care plans, and a diminished quality of life.<ACCIDENTS> <RESIDENT 56> Resident 56 was admitted to the facility on [DATE] with diagnoses to include convulsions (episodes of uncontrollable shaking, jerking, or stiffening of the muscles), Parkinson's disease (a slow, progressive brain disorder that impacts movement), polyneuropathy (dysfunction of multiple nerves often causing numbness, tingling, or weakness, typically starting in the hands and feet) and anxiety. Review of Resident 56's admission minimum data set (MDS - as assessment tool), dated 02/18/2026, documented severe cognitive impairment. The MDS documented seizure disorder as an active diagnosis and no history of falls. Resident 56's end of Medicare Part A MDS, dated [DATE], documented one non-injury fall and one injury fall since admission. Review of Resident 56's order summary, print date 04/08/2026, documented seizure precautions every shift with an order date of 02/19/2026. Review of Resident 56's fall assessment dated [DATE], documented the resident was a high fall risk. In a record review of Resident 56's electronic health record (EHR), they had falls on 03/01/2026, 03/09/2026, 04/09/2026 and 04/10/2026. In a progress note for Resident 56 dated 02/18/2026, at 1:36 PM, Staff H, Licensed Practical Nurse (LPN)/ Resident Care Manager (RCM) documented Resident 56 had seizure activity and was transported to the emergency room. Review of Resident 56's hospital admission records from 02/11/2026, documented Resident 56 was a high fall risk and interventions in place at the hospital included safety checks and bed alarm. The hospital admission records also documented new onset seizures as an active issue. Review of Resident 56's after visit summary dated 02/18/2026, documented seizure disorder under diagnoses. Review of Resident 56's care plan, dated 02/12/2026, documented Resident 56 was at risk for falls related to deconditioning, gait/balance problems and interventions included to ensure the call light was within reach and to encourage the resident to use it, ensure the resident was wearing appropriate footwear, to use wheelchair when returning to facility with family, to keep the room free of clutter, and have a safe environment. The care plan did not have documentation of seizure precautions. In a joint interview on 04/10/2026 at 2:23 PM, Collateral Contact (CC) 5, and CC 6, stated that Resident 56 was a known high fall risk. They stated the facility wanted to put Resident 56's bed (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	against the wall upon admission due to being a fall risk, but family declined. CC 5 and CC 6 stated that after Resident 56's first fall, on 03/01/2026, that Resident 56 was supposed to get fall mats and only got fall mats after the third fall on 04/09/2026. CC 5 and CC 6 stated that they didn't think Resident 56 was checked on frequently enough and were concerned with the interventions in place. CC 5 and CC 6 also requested other interventions to further prevent falls and injury, and no other interventions were provided by the facility. In an interview on 04/13/2026, at 9:23 AM, Staff BB, Nursing Assistant Certified (NAC), stated that Resident 56 did suffer from seizures and tremors. Staff BB stated that for seizure precautions they monitored and notified the nurse of any seizure activity and made sure that they didn't hurt themselves. Staff BB also stated Resident 56 was a high fall risk, that they tried to get up on their own and that was when they fell so they kept Resident 56 in the hallway to monitor them closely. In an interview on 04/13/2026, at 10:56 AM, Staff C, Assistant Director of Nursing Services (ADNS), confirmed seizure precautions were on Resident 56's physician orders but not on the care plan. Staff C stated that they were unaware of what seizure precautions were. Staff C also stated that for a resident who is a high fall risk the facility would typically do fall mats for prevention of injury and bed positioning could be another intervention. In an interview on 04/13/2026, at 1230:PM, Staff B, Director of Nursing Services (DNS), stated they are not sure what seizures precautions were but they should be care planned along with the high fall risk. <SKIN ISSUES> <RESIDENT 84>Resident 84 was admitted to the facility on [DATE] with diagnoses that included diabetes, peripheral vascular disease (circulation disorder involving narrowing, blockage, or spasms in blood vessels), and venous insufficiency (circulation disorder involving narrowing, blockage, or spasms in blood vessels). The quarterly MDS dated [DATE] documented the resident had an infected diabetic foot ulcer with dressing orders. Review of Resident 84's wound documentation on 11/30/2025 documented the resident had developed a diabetic ulcer to their right heel. In an observation and interview on 04/07/2026 at 1:44 PM, Resident 84 was observed sitting upright on their bed, with their right heel lying flat on bed with an ice pack on top of the foot. The resident stated that the ice helped with the pain in between their pain medication. The resident stated the wound started a few months ago, they were applying lotion and a piece of skin just fell off. The resident stated they were going to an infectious disease doctor and have now been referred to see a podiatrist. The resident stated they were independent with their activities of daily living (ADLs) but would ring for help if needed. The resident stated they did wound care every day and once a week the wound specialist came to look at it. Review of Resident 84's care plan, print date 04/08/2026, documented the resident had a focus area they were at risk for pressure ulcer related to limited mobility, and on 12/02/2025 developed a right heel diabetic ulcer. Interventions listed education to the resident on skin breakdown, follow facility protocols for skin breakdown, inform if there was new skin breakdown, inspect skin while providing care, manage incontinence, and frequent turning and repositioning. The care plan lacked any individualized goals, or interventions for prevention and treatment of the resident's right heel wound. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 04/08/2026 at 1:53 PM, Resident 84 was observed returning to the facility with a shoe and sock on their right heel. In an interview on 04/10/2026 at 8:50 AM, Staff X, NAC stated that they used the Kardex (condensed version of the care plan) and the whole care plan to guide what type of care they delivered to residents. In an interview on 04/10/2026 at 10:42 AM, Staff J, Registered Nurse (RN) stated it was the Resident Care Managers (RCM) who updated the care plans, and if there was an inaccuracy they will report to them. In an interview on 04/10/2026 at 12:04 PM, Staff H, Licensed Practical Nurse (LPN)/RCM stated care plans were updated by all the interdisciplinary team (IDT), nursing section would usually be done by the MDS nurse or the RCMs. Staff H stated that the expectation was if there was a change needed the cart nurse should be able to make those changes and not wait for management to complete. Staff H stated that Resident 84 was supposed to be non-weight bearing to their right foot, however the resident continued to be independent with all ADL's and was struggling to keep control of their autonomy and was not following the guidance. Staff H was not aware there was no individualized goals, or interventions for prevention and treatment of the resident's right heel wound. <RESIDENT 41> Resident 41 was admitted to the facility on [DATE] with diagnoses including intracerebral hemorrhage (ruptured blood vessel bleeding into the brain tissue), generalized anxiety disorder and aphasia (difficulty talking). A review of Resident 41's admission MDS assessment, dated 01/06/2026, showed the resident did not have moisture associated skin damage (MASD, inflammation and erosion of the skin caused by prolonged exposure to moisture, such as sweat, urine, stool). Review of a progress note on 03/27/2026 at 11:00 AM, showed the resident had developed MASD. A review Resident 41's quarterly MDS assessment, dated 04/06/2026, showed the resident had MASD. Review of Resident 41's care plan, initiated on 12/29/2025, showed the resident was at risk for impaired skin integrity related to limited mobility. There was no care plan revision when the resident developed MASD. In an interview on 04/10/2026 at 1:21 PM, Staff C, Assistant Director of Nursing Services (ADNS) was asked about the MASD not care planned for Resident 41. Staff C stated Staff D, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) would follow that type of skin issue. In an interview on 04/13/2026 at 10:04 AM, Staff D stated a few of the staff revised care plans. They stated medical records reviewed them and RCMs reviewed them at care conferences. Staff D stated they did their own section. Staff D stated the MDS nurses revised them. They stated they thought they should do an audit of the care plans. <ACTIVITIES OF DAILY LIVING> (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 46> Resident 46 was admitted to the facility on [DATE] with diagnoses to include congestive heart failure (long term condition in which the heart can't pump blood well enough to meet the body's need), depression, anxiety, and peripheral vascular disease (disorder of blood vessels outside the heart that can cause pain, and numbness in the limbs). Review of Resident 46's quarterly Minimum Data Set (MDS - resident assessment tool) dated 01/07/2026 documented they were independent with toilet hygiene, upper and lower body dressing, shoes and socks, bed mobility, transfers, ambulation and was always continent of bowel and bladder. Review of Resident 46's Activities of Daily Living (ADL) care plan documented they required supervision for ambulation with their walker, 1 person assist with transfers, showers and dressing, occasional incontinence of bowel and bladder, and required 2-person assist for bed mobility and was dependent for assistance with shoe or sock needs. In an observation on 04/07/2026 at 10:13 AM, Resident 46 was observed to exit their room into the hallway ambulating with their walker independently. Resident 46 spoke to staff in the hallway and alerted them they were going to obtain their weight and then report to the nurse. Resident 46 was observed to ambulate to the scale independently, obtain weight independently and give their weight to the nurse. In an interview on 04/10/2026 at 9:22 AM, Staff S, Nursing Assistant Certified (NAC), stated they reviewed the resident's care plan or Kardex to know what care a resident required. Staff S stated Resident 46 was independent with their ADL's. In an interview on 04/10/2026 at 2:53 PM, Staff D, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), stated staff obtained information of resident care needs by review of their Kardex, and information from verbal pass down of previous shift during hand off/shift change. Staff D stated the care plan should be updated after a care conference, quarterly, when new orders were obtained, or if there was a change in resident needs. Staff D stated Resident 46 was independent with ADL's and was unaware what their care plan or Kardex directed related to ADL's. In an interview on 04/13/2026 at 09:38 AM, Staff B, Director of Nursing Services (DNS) stated their expectation was staff were to review the resident's care plan and Kardex to guide the care provided. Staff B stated their expectation was a resident's care plan and Kardex reflected the current needs of the residents. Staff B stated their expectation was care plans are updated at least quarterly and for any change of condition. Reference: (WAC) 388-97-1020(5)(b)

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	505393	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Cascades Health and Rehabilitation	4680 Cordata Parkway Bellingham, WA 98226

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **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 . <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 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 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview and record review, the facility failed to ensure that drugs and biologicals were labeled and dated, expired medications were removed in the medication cart and medications were not left at bedside unattended. Failure to label and date 2 of 2 intravenous (IV) medications, not dating insulin vials after opened, keeping expired medications in 2 of 4 medication carts and 3 random observations of medications at bedside unattended, placed residents at risk for adverse effects for receiving expired medications, taking the wrong medications and a diminished quality of life. Findings included .According to the facility policy titled Medication Storage, review date 01/2025 documented, note the date on the label for insulin vials and pens when first used. Outdated .are immediately removed from stock, disposed of according to procedures for medication disposals. <MEDICATION CARTS> In an observation on 04/08/2026 at 11:22 AM, inside Medication Cart B on the second floor, was an insulin pen with an expired date of 04/03/2026. According to Staff P, Licensed Practical Nurse (LPN) they were not aware that the insulin expired because they don't administer that during day shift. Staff P took the insulin out and disposed of it. In an observation on 04/08/2026 at 12:33 PM, inside the Medication Cart C on the first floor, two vials of insulin were observed opened. Both vials did not have a date when they were opened. In an interview on 04/08/2026 at 12:33 PM, Staff Q, Registered Nurse (RN) stated, upon opening an insulin vial, the staff should write the date it was opened on the vial. Staff P added, the insulin vials were only good for 28 days after they are opened. In an observation and interviews on 04/08/2025 at 12:50 PM, inside the Treatment Cart on the first floor, there were 11 packets of lubricating jelly with expired date of 11/30/2025 and 2 boxes of Saline Fleets Enema with expired dates of 06/2025 and 03/2026. Staff Q stated that all nurses are responsible for checking to make sure medications were not expired in the Medication or Treatment Carts. In an interview on 04/10/2026 at 3:00 PM, Staff B, Director of Nursing Services (DNS) stated they were not aware that there were expired medications and unlabeled insulin vials in the medication carts. They will look at the other carts to ensure there were no expired medications in them. <INTRAVENOUS MEDICATION> In an observation on 04/07/2026, at 2:32 PM, Resident 89 had an IV pole in their room, a bag half full of 0.9% sodium chloride with tubing attached including the IV catheter. No resident identifier label or date was observed on the IV pole, medication bag or tubing. The same observation was made on 04/08/2026, 04/09/2026, 04/10/2026 and 04/13/2026. In a review of Resident 89's, April 2026, medication administration record (MAR), documented that Sodium Chloride 0.9% was ordered 1000 milliliter (mL) to be administered one time a day for hydration and run over five hours with a start date of 04/01/2026 and discontinue date of 04/04/2026. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 04/10/2026, at 12:41 PM, Resident 56 had an IV pole in their room, a bag of 0.9% sodium chloride hanging from it, tubing and IV catheter (small, flexible, plastic tube inserted into a vein to deliver fluids or medications into the bloodstream) attached, without resident identifier label or date observed on it. In an interview on 04/13/2026, at 10:52 AM, Staff C, Registered Nurse/Assistant Director of Nursing, confirmed the IV medications for Resident 89 were not labeled or dated for the medication or IV tubing. Staff C stated that IV tubing expires after 24 hours and was unsure of Resident 89's IV medication order. <MEDICATION AT BEDSIDE> In an observation on 04/07/2026 at 11:49 AM, a blue bottle of liquid gas relief and white bottle of probiotic and daily fiber capsules were on the window ledge of Resident 64's room. Resident 64's overbed table had a bottle of TUMS (an antacid). In an observation on 04/07/2026 at 2:33 PM, a bottle of Advil was on the window ledge of Resident 121 room. Observed multiple prescription medications, unable to identify, located in a bag sitting on a chair across from Resident 121's bed. In an observation on 04/08/2026 at 10:25 AM Resident 3's bedside table had a liquid flu medicine and package of topical pain medication. In an interview on 04/13/2026 at 10:04 AM Staff D, Licensed Practical Nurse/Resident Care Manager, stated over the counter medications, supplements, and any prescribed medications were not to be kept at the resident's bedside. Staff D stated they were not aware Resident 3 and 64 had any medications at their room/bedside. In an interview on 04/13/2026 at 11:45 AM Staff B, Director of Nursing Services, stated residents should not have medications at their bedside. In the resident council meeting on 04/08/2026 at 2:42 PM, Resident 65 stated that on Easter (04/05/2026) night they came back to the facility at 9:30 PM and there was medicine on their roommate 72's overbed table. Resident 65 stated they asked Resident 72 why they hadn't taken their medicine that was sitting on their table. Resident 72 told them it was not time to take their medicine and they were told to take them in 2 hours. Resident 72 stated they had told Staff GG, agency LPN those were not their medications. At 2:57 PM, Residents 30, 37, 50, 61 and 79 stated both agency and facility nurses left medications at bedside for them to take independently. Reference WAC 388-97-1300(4)(a)(ii)(iii)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation and interview the facility failed to provide a nourishing, palatable, well-balanced diet that met residents' daily nutritional and special dietary needs, taking into consideration the preferences of each resident for 4 of 14 residents (Resident 19, 35, 119, and 121) reviewed for the facility meeting the dietary needs of each resident. This failure placed all residents at risk of unintended weight loss, malnutrition, depression, feelings of helplessness, and a diminished quality of life.Findings included . In an interview and observation on 04/07/2026 at 2:39 PM, Resident 121 stated the facility food does not look or taste good. The lunch tray was uncovered, on Resident 121's overbed table, pushed to the side of them, with three pieces of uneaten fish and a scoop of brown rice and carrots. In an interview on 04/07/2026 at 12:29 PM, Resident 119 stated their fish was cold and dried out. Resident 119 stated their coffee was warm for the first time ever. In an interview on 04/07/2026 at 1:01 PM, Resident 35 stated the food was terrible and they would not feed it to their dog. In an interview on 04/07/2026 at 10:29 AM, Resident 19 stated the facility food tasted terrible and was not appealing. Resident 19 stated the meals looked like canned food. In an observation of a two test trays on 04/10/2026 at 1:18PM showed the following: Temperature: Gluten Meal Temperature: 142.3 degrees main dish casserole, Pepper Casserole, mixed vegetables 117.8 degrees Regular Meal Temperature: 148.5 degrees for the main dish, Pepper Casserole, mixed vegetables 127.8 degrees Presentation: Gluten free meal diet had no roll and the regular diet meal had a roll. There were no condiments other than salt and pepper. There were no drinks as those are resident specific and poured by the staff prior to providing trays to residents. The casserole was molded into the scoop that was used to serve the food creating the presentation of institutional food/meals and not homelike. The vegetables were overcooked, very soft, and lacked color, translucent. Taste: The meat in the casserole was ground beef, quality was poor, meat did not have a consistency of typical ground beef, almost too lean, thinned. The dish lacked any spices or flavor and tasted like nothing. The dessert was a brownie with a dab of whipped topping. Reference WAC 388-97-1100 (1)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was stored under sanitary conditions in 2 of 4 snack/nourishment refrigerators. The failure to monitor and document refrigerator temperatures, label opened food/beverage items, discard expired food items in the unit refrigerators placed all residents at risk for their food to be contaminated, development of food borne illnesses, and consuming spoiled food.Findings included .In an observation on 04/10/2026 at 3:25 PM, the second-floor nourishment refrigerator contained 12 small bottles of drinkable yogurt, with an expiration date of 03/31/2026, dairy creamer with an expiration date of 2/2026, a plastic bag contained an undated to go box, and opened, undated, salad dressing in the door. During the observation, no temperature logs were observed. In an observation and interview on 04/10/2026 at 09:37 AM, the nutrition fridge on the first floor, showed there was a temperature log to be documented and signed daily. The temperature and signature boxes were blank for 04/08/2026 and 04/09/2026 and there was expired resident yogurt in the fridge, dated with an expiration date of 12/2025. Staff S, Nursing Assistant Certified (NAC), stated they were unaware of who was supposed to monitor the fridge temperature and food items inside. In an interview on 04/10/2026 at 1:13 PM, Staff U, Senior Regional Registered Dietitian, stated they threw out the expired yogurt and documented on the temperature log for today's date. Staff U stated they were unsure of who was responsible for monitoring the fridge's temperature and contents and confirmed the temperature log had no documentation for 04/08/2026 or 04/09/2026. Reference WAC 388-97-1100 (3)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to document and address issues raised by the Resident Council group for seven of seven months (September, October, November, December of 2025 and January, February and March 2026) meeting minutes reviewed. Failure of activity staff to document concerns and grievances filed by the resident council in the meeting minutes and failure to report back to the council group in writing with a response, rationale and action taken placed the residents at risk for having unresolved, ongoing care concerns. Findings included . Review of the facility policy, titled Resident Council updated January 2017, documented resident council members have the right to gather and discuss thoughts, ideas, or issues related to their care and treatment. The meeting begins by reading minutes from the previous meeting, then reviewing new and old business with an opportunity for members to express concerns. Concerns brought forth by the Council are resolved via the Center grievance policy. The center communicates a response and/or decisions to the Resident Council by the next meeting. Review of the resident council minutes for 09/17/2025 showed there were no issues or concerns with administration, nursing, maintenance, social services and activities. Review of the resident council minutes for 10/22/2025 showed there were no issues or concerns with administration, nursing, maintenance, social services and activities. The minutes showed there was no old business to discuss. Review of the resident council minutes for 11/19/2025 showed there were no issues or concerns with administration, nursing, maintenance, social services and activities. The minutes showed there was no old business to discuss. Review of the resident council minutes for 12/17/2025 showed there were no issues or concerns with administration, nursing, maintenance, social services and activities. The minutes showed there was no discussion of old business. Review of the resident council minutes for 01/21/2026 showed there were no issues or concerns with administration. The minutes showed an unidentified grievance was made by an unidentified resident. A maintenance concern related to heat in an unknown location was expressed and placed in the maintenance binder. A dietary concern regarding weekend meals was included in the minutes. The minutes showed there was no discussion of old business. Review of the resident council minutes for 02/18/2026 showed there were concerns discussed with the Director of Nursing Services, their concerns and issues which were unidentified in the meeting minutes. A concern about call lights being answered in a timely manner was documented. The minutes showed there was no old business to discuss. Review of a grievance dated 02/18/2026 showed resident council members reported slow call light response, call lights not being answered by nurses or during meals. Review of the resident council minutes for 03/18/2026 showed there were no issues or concerns with administration, nursing, maintenance, social services and activities. The minutes showed there was no old business to discuss. (continued on next page)

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	505393	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Cascades Health and Rehabilitation	4680 Cordata Parkway Bellingham, WA 98226

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the grievance log showed resident council concerns including rude staff and a dirty ice scoop were escalated to a grievance report and investigation on 03/18/2026. In a resident council group interview on 04/08/2026 at 2:12 PM, Resident 50 and Resident 79 stated grievances from the meeting were not followed up on. Resident 50 stated Staff E, Activity Director (AD) would provide them with the completed resident council meeting minutes. Resident 50 stated Staff E thinks they write there were no complaints voiced in the minutes because they heard the grievances and concerns and would pass the information on. Resident 65 stated the minutes were not accurate and the group had complaints for months and months that were not resolved. Resident 79 stated there were serious facility concerns and problems were not resolved. Resident 65 stated residents were scared to write a grievance. In an interview on 04/13/2026 at 1:11 PM, Staff E, was informed of concerns voiced in resident council that the minutes did not reflect that concerns were voiced during the meeting. The resident group reported that the minutes showed no concerns were documented, when they knew they had voiced them. Resident 50 stated that the resident council group did not know resolutions were in place the next month when old business was discussed. Staff E stated they escalated concerns to grievance forms from the resident council meeting. They acknowledged they wrote no concerns were voiced on the resident council minutes. Staff E stated that it would be a good idea to document the concerns on the resident council meeting minute form. In an interview on 04/13/2026 at 11:22 AM, Staff B, Director of Nursing stated no issues or concerns being identified on the resident council meeting forms was not accurate and needed to change. Reference WAC 388-97-0920 (4)(5)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to comprehensively assess and monitor the need for physical restraints for 2 of 2 residents (Residents 41 and 55) reviewed for physical restraints. The facility failed to assess, obtain consent and physician order, care plan and document ongoing evaluation of the need for the restraint. These failures placed residents at risk for harm and diminished quality of life. Findings included . The Centers for Medicare and Medicaid Services (CMS) defined Physical Restraints as Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual Appendix PP). A review of the facility policy titled, Physical Restraints and Enablers/Devices, updated in January showed the residents have the right to be free from any physical restraints imposed for purposes of discipline or convenience. A physical restraint is defined as any manual method, physical device, equipment attached or adjacent to the resident that meets the following criteria: 1). Is attached or adjacent to the resident's body, 2). Cannot be removed easily by the resident: and, 3). Restricts the resident's freedom of movement or normal access to his or her body The policy directed the facility staff if it is determined the device is restraining, the physician is contacted for orders for the specific type of device, the reason for use, and duration. Some physical or mechanical devices used as restraints may include directions such as release at least every 2 hours for exercise, position change, toileting, and/or to offer fluids. The resident is evaluated by the device evaluation on admission, readmission, annually and change in the resident's condition. Review of the manufacturer's website for the green position perfect wedge guidelines that clinical indications were to aid in providing and maintaining the turn angle of 30 degrees for people at risk for pressure injuries. For safety, the wedge should not be placed beyond the residents midline. <RESIDENT 41> Resident 41 was admitted to the facility on [DATE] with diagnoses including intracerebral hemorrhage (ruptured blood vessel bleeding into the brain tissue), generalized anxiety disorder and aphasia (difficulty talking). Review of Resident 41's quarterly minimum data set (MDS - an assessment tool) assessment dated [DATE], showed the resident had severe cognitive impairment, was not understood and needed two-person assistance with bed mobility and with transfers. The MDS also showed the resident was not currently using any form of physical restraints. In an observation on 04/07/2026 at 9:19 AM, Resident 41 was in bed sitting up, appeared to be attempting to climb over two green triangular 18.5-inch shaped wedges that were tucked under their (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fitted bed sheet, not removable by the resident. The right side of their bed was against the wall, and a grey fall mat was on the floor to the left of their bed. In an observation on 04/07/2026 at 2:39 PM Resident 41 was crying and trying to get over the wedges. An unidentified staff member went into the room and said, Do you feel stuck? In an observation on 4/08/2026 at 8:51 AM, Resident 41 was in bed, the bed was in high position. The resident was staring at their breakfast with no attempts to eat it while voicing unintelligible words. Two green wedges were placed under their fitted sheet. The resident was positioned in the middle of the bed, about 14 inches from the devices. In observations on 4/09/2026 at 8:37 AM, 11:37 AM and 1:50 PM, Resident 41 was in bed with three green wedges tucked under the fitted sheet lining the edge of their bed. In an observation on 04/09/2026 at 3:25 PM, Resident 41 was in bed with the privacy curtain pulled around them, their overbed table was up high and in the middle of the room , out of the residents reach. The three green wedges remained tucked under their fitted sheet. In a progress note dated 04/09/2026 at 4:19 PM, Resident 41 was found by housekeeping sitting on the floor with their buttocks on their fall mat, positioned parallel to their bed. The resident was assisted into their wheelchair and brought to the activity room for increased supervision. In an observation on 04/10/2026 at 9:25 AM, Resident 41 was in bed asleep, three green wedges were under their fitted sheet. In an observation and interview on 04/10/2026 at 10:15 AM, Staff T, Nurse's Aide Certified (NAC) was providing care to Resident 41. Staff T stated the green wedges were in place, so the resident stayed in bed and did not fall. In an interview on 04/10/2026 at 1:21 PM, Staff C, Assistant Director of Nursing (ADON) stated Resident 41 can get restless and tearful. Staff C stated they were not aware of green wedges lining the edge of the resident's bed. Staff C stated the green wedges should be used for positioning only and for no other reason. Informed Staff C of multiple observations and interview that NACs were using green wedges to line the side of the resident's bed. In an observation on 04/13/2026 at 10:07 AM, Resident 41 was in bed with one green wedge under their fitted sheet. At 11:49 AM, the resident was in bed, restless and there was one green wedge under their fitted sheet. At 12:52 PM the resident was in bed eating lunch; there were two green wedges under their fitted sheet. In an interview on 04/13/2026 at 10:20 AM, Collateral Contact 1 (CC 1), Resident 41's spouse was at bedside. CC 1 stated the green wedges were used to keep their loved one in bed. CC 1 stated they did not sign consents for them to be used to keep them in bed. Review of the resident's clinical records (Physician order sheets, Assessments and Evaluations, care plan and clinical progress notes), showed no evidence that the facility had comprehensively and accurately assessed the resident's condition that would warrant use of restraints. <RESIDENT 55> (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 55 admitted on [DATE] with diagnoses to include profound developmental delay, autism (condition characterized by challenges in social communication, restricted activities and repetitive behaviors) depression, anxiety disorder and history of falling with recent neck fracture. A review of Resident 55's admission MDS assessment dated [DATE], showed the resident had impaired cognition and needed one person assistance with bed mobility and transfers. The MDS also showed that the resident was not currently using any form of physical restraints. In an observation on 04/07/2026 at 9:29 AM, Resident 55 was restless in bed with a neck collar on. The resident's bed was against the wall (left side of the resident), and they were positioned in the middle of the bed with two green wedges positioned under their fitted sheet and a mat on the floor. The wedges would not be removable by the resident. In subsequent observations on 04/07/2026 at 9:35 AM, 12:44 PM and 2:34 PM, as well as 04/08/2026 at 9:02 AM, and 04/09/2026 at 8:50 AM, Resident 55 was in the middle of their bed with two green wedges under the fitted sheet, lining the edge of their bed. Review of the resident's clinical records (Physician order sheets, Assessments and Evaluations, care plan and clinical progress notes), showed no evidence that the facility had comprehensively and accurately assessed the resident's condition that would warrant use of restraints. In an interview on 04/13/2026 at 10:13 AM, Staff D, Licensed Practical Nurse/ Resident Care Manager stated they had not observed the wedges in residents' beds. Staff D stated the green wedges were supposed to be for positioning only and only with documented consent, and stated they had not seen any other use for them. Staff D acknowledged wedges used to line the bed would be a restraint. In an interview on 4/13/2026 at 11:22 AM, Staff B, Director of Nursing Services was informed of wedges used to keep residents in bed. Staff B stated they would fix that immediately as they should be used for positioning only. Reference: WAC 388-97-0620-1(a)(b) 2(d) 4(a)(b)(c)

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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** Based on observation, interview and record review, the facility failed to provide assistance with grooming, including shaving and nail care for 3 of 4 residents (Residents 89, 104 and 121) reviewed who were unable to carry out their ADL's (activities of daily living) independently. The failure to provide residents, who were dependent on staff for assistance with grooming, placed the residents and others at risk for poor hygiene, injury, unmet care needs and a diminished quality of life. Findings included . <RESIDENT 89> Resident 89 was admitted to the facility on [DATE] with diagnoses to include traumatic brain bleed, multiple sclerosis (chronic disease where the body's immune system mistakenly attacks the protective covering of the nerves in the brain and spinal cord), and chronic obstructive pulmonary disease (COPD - progressive, long-term lung disease that makes it hard to breathe). Review of Resident 89's admission minimum data set (MDS - an assessment tool), dated 01/05/2026, documented they were dependent for personal hygiene. Review of Resident 89's care plan, dated 12/30/2025, documented they were dependent on staff for grooming. In an observation on 04/07/2026, at 1:40 PM, Resident 89 was resting in their bed with prominent chin hairs and hair was unkempt. In an observation on 04/09/2026, at 9:33 AM, Resident 89 was resting in bed with several prominent chin hairs. In an interview on 04/10/2026, at 1:17 PM, Staff AA, Nursing Assistant Certified (NAC), stated that Resident 89 was dependent for all of their cares and that aides are responsible for shaving, and that shaving and nail care was typically done on shower days. In an interview on 04/13/2026, at 12:30 PM, Resident 89 stated they would like their chin hairs shaved off. In an observation on 04/13/2026, at 1:41 PM, Resident 89 was in bed with unbrushed wet hair, nails not trimmed and chin hairs not shaved. It was documented, in the shower binder, that Resident 89 had a bed bath on the day shift that day. In an interview on 04/13/2026, at 9:23 AM, Staff BB, NAC stated that Resident 89 was fully dependent on cares and that they have shaved their chin hairs in the past. Staff BB stated during showers was when they offered shaving and nail care. In an interview on 04/13/2026, at 12:30 PM, Staff B, Director of Nursing (DNS) stated that their expectation was residents activities of daily living were completed everyday including hair, shaving, and nail care. <RESIDENT 121> (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 121 was admitted to the facility on [DATE] with diagnoses to include type two diabetes (chronic condition where the body does not properly use or make enough insulin), bladder infection, and heart failure. Review of Resident 121's Care Area Assessment (care planning tool) dated 04/08/2026 documented they required assistance with all of their ADL's. Review of Resident 121's care plan dated 03/30/2026 documented they were dependent on staff for grooming, preferred showers twice a week on Sunday and Wednesday. Review of Resident 121's electronic health record dated 03/30/2026 through 04/09/2026 showed they had a bed bath on 04/01/2026, 04/05/2026, and 04/08/2026 and refused bathing on 03/30/2026. There was no documentation why a bed bath was provided, instead of Resident 121's preference for a shower. In an interview on 04/07/2026 at 2:33 PM Resident 121 stated they had not had a shower since their admission, only bed baths, and they were not adequate. Resident was observed to have facial hair, approximately a quarter to a half inch long. When asked about their facial hair, Resident 121 began to cry and stated they needed some help with things, and they were not getting the help. Resident 121 stated they required the use of a hair removal product rather than a razor because the razor left bumps on their face. On 04/09/2026 at 3:15 PM, observed Resident 121 lying in their bed, sleeping. Resident 121 was observed to have the same facial hair on their chin and neck area. In an interview on 04/10/2026 at 11:23 AM Staff N, NAC stated they knew how to care for residents through review of their Kardex (resident specific guide to care for a resident), from other staff and alert bulletins in the electronic medical record. Staff N stated they were responsible for the scheduled showers during their shift, which were preassigned. In an interview on 04/13/2026 at 10:04 AM Staff D, Licensed Practical Nurse/Resident Care Manager, stated the only reason a bed bath would have been given to Resident 121 was if they refused a shower. Staff D stated they were not aware of Resident 121's preference and concern regarding use of a product rather than a razor to remove their facial hair. Staff D stated Resident 121's facial hair should have been addressed during their bed bath. On 04/13/2026 at 1:15 PM, observed Resident 121 in the hallway in their wheelchair. Resident 121 was observed wearing a hospital gown, engaged in conversation with the social worker, and had visible white course chin/neck hairs present. <RESIDENT 104> Resident 104 was admitted to the facility on [DATE] with diagnoses to include dementia, anxiety and depression. Review of the quarterly MDS dated [DATE] showed the resident had cognitive impairment and did not refuse care. Review of a provider note on 04/05/2026 at 9:44 AM, the note showed Resident 104's skin was very (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dry and scaly on the lower limbs and feet related to deficient hygiene care. In an observation on 04/07/2026 at 11:53 AM, Resident 104 was observed in their room. They had 1/2 inch long white chin hairs. Their fingernails were long and jagged. In an observation on 04/08/2026 at 12:11 PM, Resident 104 was in the dining room. There was no evidence of grooming to their facial hair or fingernails. Review of a provider note on 04/08/2026 at 12:22 PM, the note showed toenails thickened, discolored and brittle in keeping with onychomycosis. Skin very dry and scaly on the lower limbs and feet related to deficient hygiene care. In a provider note on 04/09/2026 at 12:00 AM, provider documented Resident 104 received help with nail trimming and showering, enjoyed the process, and had good care on the left side nails but some nails on the right side remain unsafe and need trimming. Patient's skin on legs is very dry and requires regular showering to hydrate skin and remove accumulated debris. In an observation on 04/09/2026 at 10:30 AM, Resident 104 was walking to the nurse's station. Their chin hairs and fingernails on their right hand remained long. At 2:14 PM, Resident 104 was in bed. The chin hairs remained and left hand fingernails had been trimmed. The right hand fingernails remained long and jagged. In an observation on 04/10/2026 at 12:11 PM, Resident 104 was in the dining room. The resident was in need of shaving to their chin and right hand nailcare. Review of the behavior monitors documented by nurses' aides showed Resident 104 refused care 02/12/2026. On 03/16/2026 the resident was neglecting self-care. There were no behaviors documented in April as of 04/13/2026. In an interview on 04/13/2026 at 11:22 AM, Staff B, DNS stated the NACs were responsible to shave men and women. Staff B stated the facility did not have an ADL policy. Reference 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** Based on observation, interview and record review, the facility failed to ensure 4 of 5 residents (Residents 28, 72, 104, and 106) reviewed 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. The facility failed to assess and document Resident's 72 and 106's for possible injury after abuse allegations. The facility failed to order mental health services as ordered for Resident 104. Additionally, the facility failed to ensure Resident 28 received care and treatment for their catheter. This placed the residents at increased risk for decline in conditions, unmet care needs, increased discomfort, psychosocial distress and less than optimal quality of care and life. Findings included . <RESIDENT 72> In an interview on 04/10/2026 at 11:51 AM, Resident 72 stated this week Staff GG, Licensed Practical Nurse (LPN) left pills for them to take when they wanted to. Staff GG then brought Resident 72 a narcotic and they did not want it. Staff GG told them they had to because they already popped it out from the narcotic card. Resident 72 stated they felt they could not refuse the pain pill and reluctantly took it. Resident 72 stated they had another concern that occurred two or three nights ago on night shift. The resident stated they had asked a female aide to go to the bathroom, but their roommate was in there. Resident 72 said the aide told them to put on a diaper and go in it and they would come back and clean them up. Resident 72 said they were shocked and thought that was gross that it was even brought up, that they couldn't believe that was even suggested to poop in a diaper then they would have stool on their skin. Resident 72 stated they had reported this to Staff C, Assistant Director of Nursing Services (ADNS). In an interview on 04/10/2026 at 1:14 PM, Staff C stated they had not heard these concerns from Resident 72. Review of the documentation for 04/10/2026 to 04/13/2026 showed there was no mention of allegations or monitoring for psychological distress. <RESIDENT 106> Resident 106 admitted on [DATE] with diagnoses to include cerebral palsy, seizure disorder, bipolar disorder and pain. During Resident Council meeting on 04/08/2026 at 2:38 PM, Resident 79 stated that on 04/06/2026, their roommate Resident 106 was given their dinner tray at 6:00 PM and no one came into change them or remove the dinner tray until 9:00 PM. Resident 79 stated Resident 106 was up soiled in their wheelchair from 6:00 PM to 9:00 PM with their dinner tray in front of them. Resident 79 stated, No one should be wet for 3 hours. Resident 79 stated they reported this to Staff G, who said they would look into it. In an interview on 04/10/2026 at 1:57 PM, Staff G stated they did not know about the allegation and if that was the case they would tell the DNS or Executive Director and they would tell them if they could call the hotline. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The allegations regarding Residents 72 and 106 were reported to Staff B, Director of Nursing on 04/10/2026 at 2:40 PM. Review of the documentation for 04/10/2026 to 04/13/2026 showed there was no assessment for skin injury, mention of allegations or monitoring for psychological distress. In an interview on 04/13/2026 at 11:22 AM, Staff B, DNS stated they were responsible to set up alert charting after the allegations regarding Resident 72 and 106. Staff B was not aware there had been no alert documentation for both residents. No additional information provided. <RESIDENT 28> Resident 28 admitted to the facility on [DATE] with diagnoses to include hereditary spastic paraplegia (rare genetic disorder characterized by stiffness and weakness in the legs) and neuromuscular dysfunction of the bladder (loss of bladder control). In an interview on 04/08/2026 at 9:07 AM, Resident 28 stated they were concerned about their suprapubic catheter (a thin tube inserted into the bladder through a small incision in the lower abdomen) because it needed to be changed every month and it had not been changed since they admitted to the facility. In a review of Resident 28's discharge orders from the hospital, dated 03/14/2026, timestamped 03/16/2026, documented they were to follow up with urology as scheduled on 04/05/2026 for their routine suprapubic catheter change. In a review of Resident 28's care plan dated 04/08/2026 documented they had an indwelling catheter (a tube inserted into the bladder) and to anchor their catheter to prevent urethral tears. In a review of Resident 28's Care Area Assessment (tool used to create care plan) for Urinary Incontinence and Indwelling Catheter dated 03/23/2026 documented they had an indwelling catheter. There was no documentation regarding Resident 28's type of catheter used or need for it to be changed monthly. In a review of Resident 28's Medication and Treatment Administration Record from 4/01/2026 to 04/08/2026 contained no documentation/order for a catheter change or for the scheduled urology appointment scheduled on 04/05/2026. In an interview on 04/08/2026 at 9:24 AM, Staff D, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), stated they would need to check if Resident 28 required or had an order to change their suprapubic catheter. In a follow up interview on 04/09/2026 at 9:26 AM, Staff D, stated they had contacted the urologist to obtain an order to change Resident 28's suprapubic catheter. Staff D stated they had reviewed the hospital discharge records which showed Resident 28 should have attended a urology appointment on 04/05/2026. Staff D, when asked about the process of ensuring discharge orders from the hospital were followed, stated there was a three-step process in place. Staff D stated the nurse who completed the admission would be the first to identify and implement the orders, resident care managers would then review and finally the Director of Nursing Services (DNS). Staff D stated Resident 28's scheduled appointment and catheter had been missed during the admission process. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/13/2026 at 11:45 AM Staff B, DNS, stated the facility expectation was that all orders received would be put into the resident's medical record right away. <RESIDENT 104> Resident 104 admitted to the facility on [DATE], with diagnoses that included dementia, anxiety and depression. The admission Minimum Data Set assessment dated [DATE] documented the resident had impaired cognition, minimal depression, and delusions. Review of a progress note dated 12/30/2025 at 8:42 AM, documented Resident 104 was displaying paranoid behavior and delusions that shift and they placed the resident on alert, notified the doctor via fax and the resident care manager (RCM) was aware. Review of a fax from the nurse to the provider on 12/30/2025 documented Resident 104 was displaying increased paranoid behavior and delusions. On 12/31/2025, the provider responded and ordered to increase Quetiapine (anti-psychotic medication) from 25 mg twice a day to 50 mg twice a day and to please arrange for behavioral health consult. Review of Resident 104's clinical record showed there was no record of a behavioral health consult having occurred. In an interview on 04/09/2026 at 2:09 PM, Staff D, confirmed there was no documentation or consultation from a behavioral health provider. Staff D stated social services were working on getting residents seen by behavioral health. Staff D stated they would make sure the resident was seen by behavioral health. In an interview 04/10/2026 1:52 PM, Staff G, Social Services Assistant could not locate any documentation resident was seen by behavioral health since admit. In an interview on 04/13/2026 at 11:14 AM, Staff F, Social Services Director stated they discussed the order for behavioral health in their care conference in January and they did not want it. Staff F stated they were not sure they had documented that. Review of care conference notes on 04/13/2026, did not include discussion of behavioral health consult. Reference WAC 388-97-1060(1)

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	505393	A. Building B. Wing	04/13/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to comprehensively assess and ensure timely and appropriate services/interventions were provided to maintain, increase and/or prevent a decrease in range of motion (ROM - was the extent that a joint can move within the expected [normal] range of values) for 1 of 4 sampled residents (Resident 3) reviewed for ROM and restorative nursing services. This placed residents at risk for developing new contractures (permanent, abnormal shortening of muscles, tendons, or skin) and/or worsening of existing contractures.Findings Included .Resident 3 was admitted to the facility on [DATE] with diagnoses to include history of stroke, which affected their dominant right side. On 04/08/2026 at 10:16 AM Resident 3 was observed in their bed. Resident 3 right hand was observed balled into a fist the with the exception of their ring finger and middle finger. No splints, hand rolls, or other devices were observed on or near them. Review of Resident 3' care plan, last revised 02/11/2026 documented they were not on any restorative programs. In an interview on 04/09/2026 at 11:40 AM, Staff HH, Director of Rehabilitation, stated Resident 3 had received an evaluation after returning from the hospital to make sure there was no decline or need for additional therapy. Staff HH stated they typically screened residents every quarter for changes/decline in their function. When asked about a tool used to screen residents for decline/change, Staff HH stated there was no tool used and they had worked with Resident 3 for a long time and knew their baseline, so if there was a change it would be communicated. Staff HH stated Resident 3 currently received physical therapy. In an interview on 04/09/2026 at 11:48 AM, Staff CC, Physical Therapist (PT) stated Resident 3 did not have any contractures with major joints, although they had limited range of motion to their right side due to their stroke. Staff CC stated Resident 3 was receiving physical therapy only and they used their right hand to hold on to the bar while standing with some assistance to open their right hand, citing their hand had spasticity (tightness of muscles). Staff CC stated Resident 3 did not have any known splinting device or interventions in place for their right hand and deferred to occupational therapy (OT). In an interview and observation on 04/09/2026 at 12:29 PM, Staff II, OT manually opened Resident 3's right hand, and thickened yellow matter was visualized on the palm of their right hand. Staff II stated Resident 3 had spasticity and had been treated with medication; however, Staff II did not know if they were still taking the medication. Staff II attempted to conduct a series of movements with Resident 3, but Resident 3 was unable to follow several prompts and directions due to their cognitive status. Staff II stated an OT evaluation would need to be completed. Staff II stated the condition of Resident 3's hand could develop a contracture if not addressed and left for several months. Staff II stated they would follow up with the provider and obtain an order for an OT evaluation. In an interview on 04/09/2026 at 12:44 PM, Staff JJ, Registered Nurse, stated Resident 3 was not on a restorative program. Staff JJ stated Resident 3 had been on a restorative program, but therapy had started working with them again and restorative ended. Staff JJ stated Resident 3's prior restorative program included bilateral upper extremity range of motion and transfers with the use of parallel bars, (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	until they were hospitalized . Staff JJ stated Resident 3 started with therapy services when they returned to the facility from the hospital. Staff JJ stated Resident 3 was at risk for contractures to their right upper and lower extremities including their shoulder and wrist. In an interview on 04/10/2026 at 10:51 AM, Staff KK, Restorative Aide, stated Resident 3 had been on restorative, but was no longer on the program. Staff KK stated Resident 3's restorative program focused on their right upper and lower extremities, not their right hand. Staff KK stated they had not worked with Resident 3 in a while, and they currently received physical therapy. Review of Resident 3's OT discharge note dated 08/14/2025 documented their right wrist's range of motion was within normal limits and flexion (joint action that reduces the angle between two bones) of 21 degrees. Review of Resident 3's OT evaluation dated 12/24/2025 documented they were not appropriate for OT services as they were at their baseline. Review of Resident 3's OT evaluation dated 04/10/2025 documented that they did not have any flexion in their right wrist, a 21-degree loss in flexion since at least 12/24/2025. Goals included Resident 3 would demonstrate ability to tolerate resting hand roll splint on right hand/wrist for one hour. In an interview on 04/13/2026 at 11:45 AM, Staff B, Director of Nursing Services, stated the facility expectation was that residents were evaluated by PT and OT as changes/decline were identified. Reference WAC 388-97-1060 (3)(d)

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, interview and record review, the facility failed to ensure residents were free from accidents for 2 of 3 residents (Resident's 18 and 56) sampled for accidents and for 4 of 6 sampled residents (Resident 30, 50, 79, and 105) reviewed for smoking. Failure to ensure smoking materials (cigarettes and lighters) were secured for a safe environment to protect other residents from potential fire hazard and failed to ensure residents did not experience falls placed residents at risk for avoidable injuries and diminished quality of life. Findings included . Review of the facility policy titled: Fall Management and Neurological Check, updated January 2025 stated a fall assessment was completed on admission and interventions were implemented based on the assessment. The care plan was reviewed quarterly and after a fall to determine effectiveness of current interventions and Licensed Nurses updated care plans to reduce or prevent falls. A systemic review of current interventions was completed post fall and root cause identified. <ACCIDENTS> <RESIDENT 56> Resident 56 was admitted to the facility on [DATE] with diagnoses to include convulsions (episodes of uncontrollable shaking, jerking, or stiffening of the muscles), Parkinson's disease (a slow, progressive brain disorder that impacts movement), polyneuropathy (dysfunction of multiple nerves often causing numbness, tingling, or weakness, typically starting in the hands and feet), depression, and anxiety. Review of Resident 56's admission minimum data set (MDS - as assessment tool), dated 02/18/2026, documented severe cognitive impairment. The MDS documented seizure disorder as an active diagnosis and no history of falls. Review of Resident 56's end of Medicare Part A MDS, dated [DATE], documented one non-injury fall and one injury fall since admission. Review of Resident 56's care area assessment (CAAs - specific health concerns triggered from the MDS), dated [DATE], documented falls as a triggered care area. The CAAs documented Resident 56 was taking high-risk medications, which included antianxiety and antidepressants, that could contribute to falls. The CAAs documented internal risk factors for falls included incontinence, Parkinson's disease, seizure disorder, cognitive impairment, anxiety, and depression. No environmental factors, such as poor lighting, obstructed walkway, slippery floors were documented as a contributing factor. No input from the resident or family was documented for falls. Review of Resident 56's fall assessment dated [DATE], documented they were a high fall risk. Review of Resident 56's order summary, as of 04/08/2026, documented seizure precautions every shift with an order date of 02/19/2026. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a record review of Resident 56's electronic health record (EHR), they had falls on 03/01/2026, 03/09/2026, 04/09/2026 and 04/10/2026. In a record review of Resident 56's progress note on 02/18/2026, at 1:36 PM, Staff H, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) documented Resident 56 had seizure activity and was transported to the emergency room. Review of Resident 56's hospital admission records from 02/11/2026, documented Resident 56 was a high fall risk with interventions in place at the hospital that included safety checks and a bed alarm. The hospital admission records also documented new onset seizures. Review of Resident 56's after visit summary, dated 02/18/2026, documented seizure disorder under diagnoses. Review of Resident 56's care plan, dated 02/12/2026, documented Resident 56 was at risk for falls related to deconditioning, gait/balance problems. Interventions included to ensure the call light was within reach and encourage resident to use it, ensure resident was wearing appropriate footwear. Care plan did not contain interventions related to seizure precautions. In a joint interview on 04/10/2026, at 2:23 PM, Collateral Contact (CC) 5, and CC 6, stated Resident 56 was known to be a high fall risk. They stated the facility wanted to put Resident 56's bed against the wall upon admit due to being a fall risk, the family declined. CC 5 and CC 6 stated after Resident 56's first fall, on 03/01/2026, Resident 56 was supposed to have fall mats and only received fall mats after the third fall on 04/09/2026. CC 5 and CC 6 stated they did not think Resident 56 was checked on frequently enough and were concerned with lack of the interventions in place. CC 5 and CC 6 also requested other interventions such as bed alarm and bed rails for further fall prevention and injury prevention and was declined by the facility. In an interview on 04/13/2026, at 9:23 AM, Staff BB, Nursing Assistant Certified (NAC), stated Resident 56 suffered from seizures and tremors. Staff BB stated for seizure precautions they monitored and notified the nurse of any seizure activity and made sure they did not hurt themselves during a seizure. Staff BB also stated Resident 56 was a high fall risk, they try to get up on their own and that was when they fall so they keep Resident 56 in the hallway to monitor them closely. In an interview on 04/13/2026, at 10:56 AM, Staff C, Registered Nurse (RN)/Assistant Director of Nursing Services (ADNS), confirmed seizure precautions were on Resident 56's physician orders but not on the care plan. Staff C stated that they were unaware of what seizure precautions were. Staff C stated for a resident who was a high fall risk the facility would typically do fall mats and bed positioning for prevention of injury. <RESIDENT 18> Resident 18 admitted on [DATE] with diagnoses which included frequent falls, Parkinson's disease and anxiety. Review of the Fall assessment dated [DATE] documented the resident was a high fall risk. Review of Resident 18's baseline care plan for mobility dated 03/23/2026 showed they required (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two-person assistance for transfers and walking was with therapy only. The initial care plan for falls dated 03/23/2026 showed the following fall prevention interventions: call light within reach, ensure proper footwear when in wheelchair or when ambulating and keep room free of clutter. Review of a progress note dated 03/26/2026 at 11:44 AM, documented Resident 18 was able to verbalize their needs when asked but was not initiating or using the call light for assistance and staff needed to anticipate their needs. Review of Resident 18's progress notes documented a fall, dated 03/26/2026 at 11:43 PM. Resident 18 was found sitting near the foot of the bed and a head laceration was observed. The resident was sent to the emergency room and returned within 24 hours with staples to their head laceration. The progress note stated at the time of the fall the bed was in a low position and there was a fall mat next to the right side of the bed. Review of the facility incident investigation dated 03/26/2026 stated Resident 18 had an extensive history of falls and this is the reason (they) are in the facility. Fall witness statement forms did not include care planned fall interventions such as the call light, footwear, or clutter. The summary of the fall was written on 03/30/2026 and stated planned interventions were to place their bed in low position and fall mat at bedside. Review of Resident 18's record documented a second fall on 03/28/2026 at 6:40 PM. The progress note stated Resident 18 sustained a non-injury fall in their room. Per staff statements, the resident's assigned nurse and nursing assistant were both off the floor at the time of the fall and completed the fall investigation fields stating N/A (not applicable). There was no nursing staff documentation of the details of the fall. Nursing assistant statements vaguely stated the resident was found on the floor, vital signs were taken and the resident brought to the nurse's station in a wheelchair. The record did not address care planned interventions. The post fall summary was completed on 04/01/2026 by Staff B, Director of Nursing Services, and stated interventions were implemented at the time of the incident. An additional intervention was planned to keep the resident in public areas after meals and encourage the resident to eat in the dining room. Review of Resident 18's care plan showed there were no updates made to the care plan following the fall on 03/26/2026. The additional fall interventions did not occur until after the resident experienced the second fall on 03/28/2026 and included: Bed in low position (added 03/29/2026) Fall mat next to the bed (added 03/29/2026) (does not specify right or left side) Frequent Safety checks (added 03/30/2026) Keep bed at appropriate height: low bed (added 03/30/2026 and updated 04/01/2026) Keep in public areas as resident allows, Encourage eating in dining room (added 04/01/2026) Wear non-skid socks (added 03/30/2026) Toileting program in morning, after meals and bedtime (added 03/30/2026) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In observations on 04/07/2026, 04/08/2026, and 04/09/2026, Resident 18 was observed to have a fall mat in the room which was sometimes placed on the right side of the bed, the left side of the bed, or leaned against the wall in the room. In an observation on 04/08/2026 at 2:32 PM, Resident 18 was sitting up in their room sitting on the left side of their bed with a lunch tray in front of them. Resident 18 was observed to begin leaning to the right and precariously reaching forward toward the floor toward an object on the ground near the bottom corner of the bed. There was no fall mat in place, as the overbed table was placed with the meal tray. Staff Y, NAC was nearby and was alerted. Staff Y stated, oh my gosh! and intervened to assist Resident 18. The fall mat was now observed on the right side of the bed. In an interview on 04/13/2026 at 9:44 AM, Staff C, stated they use the Morse Fall scale assessment on admission and then complete the baseline care plan. There was a care plan problem for falls that was done. If someone fell or there was a change in condition, then something needs to be done. If they fell, then they could fall again if we don't implement something. There should be an immediate intervention and investigation, and we review falls in our interdisciplinary team and find a root cause. If someone had a fall mat the care plan should say what side it should be on. In an interview on 04/13/2026 at 11:22 AM, Staff B, Director of Nursing Services, stated interventions should be reviewed and revised post fall under the fall risk care plan. The interventions should be based on the root cause of the fall. Regarding Resident 18, Staff B stated they were not sure why the care plan was not updated until after the second fall. Staff B stated they had noted that the staff witness statements for the 03/28/2026 fall had stated N/A and when asked if the post fall documentation included enough information to determine a root cause or if the care planned interventions were being followed, Staff B stated they were not sure, but that was information that should be on the form. <SMOKING SAFETY> Policy updated January 2025, Resident smoking safety independent and unsupervised. The policy revealed that all smoking materials, including cigarettes, electronic cigarettes and lighters are locked up including smoking materials for residents who are assessed to be supervised smokers. In an observation and interview on 04/07/2026 at 12:55 PM, Resident 105 was sitting in their recliner. The top dresser drawer contained three hard packs of cigarettes present. A whiteboard on their wall included a handwritten message that documented lighter and smokes should be locked in the lock box. There was an open orange lock box present with no cigarettes in it. In an observation on 04/08/2026 at 8:50 AM, Resident 105 was sitting in their recliner in their room, there were three packs of cigarettes in their top dresser drawer. In an interview and observation on 04/08/2026 at 2:00 PM, Resident 105 was sitting at a table in the dining room awaiting the resident council meeting with their pack of cigarettes and butane lighter on the table. During resident council meeting on 04/08/2026 at 2:53 PM; - Resident 50 stated they kept their cigarettes and lighter in a lock box, but they had no key for it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 50 stated when the facility secured them, they were missing 4 lighters and 2 packs of cigarettes. -Resident 79 stated they kept their smoking materials in their room otherwise it took 20 minutes to get a nurse to get them. The resident stated they had a lock box but, no key to it. - Resident 30 stated they kept their cigarettes and lighters in their room in a lock box. They stated they just didn't have a key to it. In an observation on 04/09/2026 at 8:50 AM, Resident 105 wheeled into the nurse's station with a gold refillable lighter in hand. Staff C, RN filled their lighter with lighter fluid stored in first floor medication room. In an interview on 04/13/2026 at 11:22 AM, Staff B stated the Administrator was responsible for the smoking safety of residents and nursing completed the smoking evaluations. Staff B was unaware Resident 105 had their cigarettes in an open dresser drawer and that some residents did not use their lock box or have keys to secure them. Staff B confirmed that the location of smoking materials should be included on the care plan. Staff B stated the cigarettes and lighters needed to be secured in their room or locked in the medication cart. In a joint interview on 04/13/2026 at 1:01 PM, Staff A, Administrator and Staff B, stated they were unaware smoking materials were not consistently secured. Smoking policy was reviewed with Staff A and B who acknowledged that the policy stated that the facility would ensure the residents had lock boxes and would secure materials in them. Staff A stated the residents had the right to refuse to lock up their smoking materials. Staff A was not aware there were concerns with the lock boxes and some did not have keys. This is a repeat deficiency from SOD's dated 01/24/2025, 03/28/2025 and 01/28/2026. Refer to WAC 388-97-1060(1)(3)(g)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate fluids to maintain hydration for 2 of 6 sampled residents (Resident 56 and 89) reviewed for hydration and 1 of 6 sampled residents (Residents 121) reviewed for nutrition. Failure to implement, monitor and accurately document fluids consumed to ensure fluid restrictions were implemented per provider's orders placed residents at risk for dehydration, fluid overload, and a diminished quality of life. Findings included . Review of the facility's policy titled, Hydration Program, dated May 2019, documented staff are to offer fluids to residents unless contraindicated by a physician order for fluid restrictions. The policy documented that water pitchers are available at bedside for residents not on fluid restrictions. <RESIDENT 89> Resident 89 was admitted to the facility on [DATE] with diagnoses to include a brain bleed, multiple sclerosis (a chronic autoimmune disease of the central nervous system where the immune system mistakenly attacks a protective coating that covers the nerve fibers), chronic obstructive pulmonary disease (COPD - chronic, long-term lung disease that makes it hard to breathe), and neuromuscular dysfunction of bladder (a condition where nerve damage disrupts communication between the brain and bladder, leading to loss of bladder control). Review of Resident 89's admission minimum data set (MDS - an assessment tool), dated 01/05/2026, documented severe cognitive impairment and an indwelling catheter. Review of Resident 89's quarterly MDS, dated [DATE], documented the resident had severe cognitive impairment and an indwelling catheter. In an observation on 04/07/2026-04/10/2026 and 04/13/2026, Resident 89 had an intravenous (IV) pole in their room with half a bag of 0.9% sodium chloride and tubing connected to it. Review of Resident 89's order summary, April 2026, documented 0.9% sodium chloride solution 1000 milliliters (mLs) IV one time a day for hydration over five hours active from 04/01/2026-04/04/2026. Resident 89's order summary documented thin liquid consistency, one on one assistance with meals, house supplement with meals, catheter output every shift, administration of a diuretic (water pill) one time a day for left hand swelling from 04/08/2026 - 04/13/2026, and Lactulose (a type of laxative) three times a day. The order summary documented foley catheter active as of 12/30/2025. Review of Resident 89's care plan, dated 12/30/2025, documented that their nutrition/hydration status was altered, needed maximum assistance for eating and drinking, and to observe for signs and symptoms of dehydration. Review of Resident 89's initial nutrition evaluation, dated 01/12/2026, documented estimated fluid needs of 1982-2180 mLs per day. Review of Resident 89's certified nursing assistant (CNA) documentation, 04/01/2026-04/07/2026, documented total fluid intake as follows: 04/01/2026 - 236mLs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/02/2026 - 716 mLs 04/03/2026 - 980 mLs 04/04/2026 - 460 mLs 04/05/2026 - 354 mLs 04/06/2026 - 772 mLs 04/07/2026 - 832 mLs Review of Resident 89's, March 2026, medication administration record (MAR) documented catheter output order was active as of 03/12/2026. House supplement with meals was documented active as of 03/11/2026. Review of Resident 89's, April 1st - 7th 2026 MAR, documented house supplement as consumed as follows: 04/01/2026-04/03/2026 - 360 mLs 04/04/2026 - 220 mLs 04/05/2026-04/07/2026 - 360 mLs Resident 89's April 2026 MAR documented IV medication 0.9% sodium chloride was documented as completed, for a total of 1000 mLs, on 04/01/2026 and 04/03/2026, two of four days ordered. In an interview on 04/07/2026, at 2:54 PM, Collateral Contact (CC) 2 stated that Resident 89 had leg cramps, dry lips and was not getting enough assistance with fluids and that is why they needed IV fluids. In an interview on 04/10/2026, at 12:30 PM, CC 4 stated they are concerned with Resident 89 not being hydrated enough. CC 4 stated the facility does not offer them enough water and they need full assistance to eat and drink. In an interview on 04/10/2026, at 1:17 PM, Staff AA, Nursing Assistant Certified (NAC), stated that Resident 89 needs full assistance to drink fluids and that they offer them fluids whenever in the room and that Resident 89 does not usually refuse. In an interview on 04/13/2026, at 9:23 AM, Staff BB, NAC, stated hydration can sometimes be an issue with Resident 89. Staff BB stated they do offer fluids to Resident 89 but they don't always respond and that they need full assistance for hydration. Staff BB stated their skin looks better now that they are more hydrated. In an interview on 04/13/2026, at 10:56 AM, Staff C, Assistant Director of Nursing (ADNS), stated they believe Resident 89 was on IV fluids for lack of fluid intake. In a phone interview on 04/13/2026, at 10:07 AM, Staff U, Senior Regional Registered Dietician, (continued on next page)

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North Cascades Health and Rehabilitation	4680 Cordata Parkway Bellingham, WA 98226

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that Resident 89 was taking Lactulose three times a day which was a lot and taking diuretic for 5 days in April. Staff U stated they don't have a lot of information regarding Resident 89 as they are interim until the facility hires a new dietician. <RESIDENT 56> Resident 56 was admitted to the facility on [DATE] with diagnoses to include Parkinson's disease (a progressive brain disorder that occurs when nerve cells in the brain die or become damaged), convulsions, and hypertension (high blood pressure). Review of Resident 56's MDS, dated [DATE], documented they had severe cognitive impairment. Review of Resident 56's progress notes on 04/10/2026, at 12:59 PM, Staff C, ADNS, documented Resident 56 had an unwitnessed ground level fall and after vital signs, blood pressure was low (82/58) and provider ordered IV hydration with 0.9 % Sodium Chloride. Staff C documented after about one hour of IV fluids Resident 56's blood pressure came back up to normal, 122/62. In an interview on 04/10/2026, at 12:56 PM, CC 5, stated that when they visit during lunch Resident 56's lunch tray was sitting on their bedside table, untouched because staff did not assist them. CC 5 was worried about hydration as family provided two water bottles from home that Resident 56 preferred and when they come to visit, they are empty half of the time. In an interview on 04/13/2026, at 12:30 PM, Staff B, Director of Nursing, stated they expect their residents to be hydrated and assistance as needed to be hydrated. <RESIDENT 121> Resident 121 was admitted to the facility on [DATE] with diagnoses to include type two diabetes (chronic condition where the body does not properly use or make enough insulin), bladder infection, and heart failure. In an observation on 04/07/2026 at 2:33 PM, Resident 121 was in their bed, water cup on their overbed table filled with ice water. Review of Resident 121's hospital Discharge summary dated [DATE] documented their diet was carbohydrate controlled with fluid restriction of 1500 mLs in 24 hours and daily weights per facility protocol. Review of Resident 121's care plan dated 03/30/2026 documented a baseline care plan which included an intervention of a fluid restriction of 1500 mLs. during meals. Review of Resident 121's weights from 03/30/2026 through 04/07/2026 showed one weight was taken at admission, 207 pounds. Review of Resident 121's care area assessment (tool used to create individualized care plans) dated 04/08/2026 documented that they had a diagnosis of diabetes, received a therapeutic diet, carbohydrate controlled, their meals were monitored and weights taken per protocol. Resident 121's fluid restriction was not documented as consideration. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 121's order summary as of 04/07/2026 documented no orders for their fluid restriction. Resident 121's diet dated 03/30/2026 was consistent carbohydrate diet with regular texture and thin liquid consistency. Review of Resident 121's provider progress note dated 04/07/2026 documented an order to maintain their fluid restriction as tolerated and continue regular diet with attention to sodium intake. Review of Resident 121's progress notes dated 03/30/2026 through 04/10/2026 showed no refusals of the fluid restriction or that they exceeded the fluid restriction. Review of Resident 121's Medication Administration and Treatment Administration Record (MAR/TAR) for 04/01-04/10/2026 showed no documentation related to the 1500 mLs. fluid restriction ordered and an order for weekly weights every Monday starting 04/06/2026 with no weight documented. Review of Resident 121's Nutritional Evaluation, dated 04/10/2026 documented the admission nursing evaluation indicated a fluid restriction of 1500 mLs., but was not documented in the orders. Resident 121's weight was noted to be 207 pounds on 03/30/2026 and showed no additional weights. Resident 121 was documented to be at risk for malnutrition related to their current intake being at the low end of nutrient needs and noted no significant weight loss. There was no documentation regarding the amount of fluids Resident 121 had consumed since admission. Review of Resident 121's nursing assistant documentation report for 04/01/2026 through 04/11/2026 documented they consumed more than 1500 mLs. of fluid five out the eleven days. Review of Resident 121's meal slip/orders from the kitchen, contained no information regarding the ordered fluid restriction and a total amount of fluids provided at meals totaled 828 mLs. In an interview on 04/13/2026 at 10:04 AM, Staff D, Licensed Practical Nurse/Care Manager, stated nursing they were responsible for ensuring orders for the fluid restriction were placed in the MAR/TAR and must have overlooked it. Staff D stated Resident 121 was on a carbohydrate-controlled diet and does not follow their fluid restriction. Staff D stated they were not aware Resident 121's diet order did not capture their fluid restriction. In an interview on 04/13/2026 at 11:45 AM, Staff B, Director of Nursing Services, stated the facility expectation was for physician orders to be put into the clinical record right away. Staff B stated residents were to be weighed daily for the first three days following admission. Reference WAC 388-97-1060 (3)(h)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 3 residents (Resident 89) reviewed for respiratory care. The facility failed to follow physician orders, ensure that appropriate orders for oxygen administration were to include flow rate and to develop a comprehensive respiratory care plan. These failures placed residents at risk for unmet needs, potential negative outcomes and a diminished quality of life. Findings included . Review of the facility's policy titled, Respiratory Care, Oxygen Administration, dated December 2017, documented that oxygen is administered per physician's order. Physician orders should specify method of administration, liter flow, and parameters for duration and/or frequency of administration. Resident 89 admitted to the facility on [DATE] with diagnoses to include acute and chronic respiratory failure with hypoxia (tissues and organs in the body do not receive enough oxygen to function properly), and chronic obstructive pulmonary disease (COPD - progressive, long-term lung disease that makes it hard to breathe). Review of Resident 89's admission Minimum Data Set (an assessment tool), dated 01/05/2026, documented yes to oxygen use. Review of Resident 89's physician orders documented checking oxygen levels every shift and administer supplemental oxygen if oxygen was less than 90% active as of 01/08/2026. Resident 89 had Albuterol Nebulization Solution via nebulizer (a machine that turns liquid medication into a fine mist that you breathe in through a mask) every six hours as needed for wheezing or shortness of breath active as of 12/30/2026. Review of Resident 89's care plan, dated 12/30/2025, had no documentation related to their oxygen needs, respiratory medications or respiratory diagnoses. In an observation on 04/07/2026, at 12:39 PM, Resident 89 was wearing oxygen via nasal cannula (flexible plastic tube that sits inside the nostrils to deliver oxygen) with a flow rate of 2 liters per minute (lpm). In an observation on 04/10/2026, at 9:26 AM, Resident 89 was wearing oxygen via nasal cannula with a flow rate of 2.5 lpm. In an observation on 04/13/2026, at 12:30 PM, Resident 89 was wearing oxygen via nasal cannula with a flow rate of 3 lpm. In an interview on 04/10/2026, at 1:17 PM, Staff AA, Nursing Assistant Certified (NAC), stated Resident 89 is always on oxygen and that they check their oxygen levels every shift and that their oxygen levels have been in the high 90's. In an interview on 04/13/2026, at 9:23 AM, Staff BB, NAC, stated that Resident 89 always wears oxygen and that they check their oxygen levels every shift. In an interview on 04/13/2026, at 10:56 AM, Staff C, Assistant Director of Nursing/Registered Nurse (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(RN), stated that Resident 89's oxygen order documents to only put oxygen on when their oxygen level in less than 90%. Staff C stated that oxygen should be on Resident 89's care plan and that the oxygen order should include the flow rate. In an interview on 04/13/2026, at 12:30 PM, Staff B, Director of Nursing stated that their expectations for oxygen physician orders would be to have the oxygen flow rate and to have oxygen be included in the care plan. Refer to WAC 388-97-1060(3)(j)(vi)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a system in which residents' records were complete and accurate for 2 of 5 residents (Resident 28 and 121). This failure placed residents at risk of not having their medical records accurate and incomplete information being considered when making medical decisions.Findings included . <RESIDENT 28> Resident 28 admitted to the facility on [DATE] with diagnoses to include hereditary spastic paraplegia (rare genetic disorder characterized by stiffness and weakness in the legs) and neuromuscular dysfunction of the bladder (loss of bladder control). Review of Resident 28's discharge orders from the hospital, dated 03/14/2026, timestamped 03/16/2026, documented they had suprapubic catheter change. Review of Resident 28's care plan dated 04/08/2026 documented that they had an indwelling catheter (a tube inserted into the bladder) and did not specify which type of catheter or any specific care instruction related to this specific catheter. Review of Resident 28's Medication and Treatment Administration (MAR/TAR) for March 2026 and 04/01/2026 through 04/08/2026 showed missing documentation for catheter output for the following: Evening Shift 03/17/2026 Day Shift 03/22/2026 Overnight Shift 03/22/2026 Day Shift 03/27/2026 Evening Shift 04/02/2026 Day and Evening Shift 04/05/2026 Day and Overnight Shift 04/06/2026 <RESIDENT 121> Resident 121 was admitted to the facility on [DATE] with diagnoses to include type two diabetes (chronic condition where the body does not properly use or make enough insulin), bladder infection, and heart failure. Review of Resident 121's MAR/TAR from 04/01/2026 through 04/09/2026 showed missing documentation for their medicated vaginal cream on 04/02/2026, output from their drain on 04/04/2026 evening shift and 04/06/2026 on the overnight shift, and ear drops on 04/06/2026 evening shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/13/2026 at 9:43 AM Staff D, Licensed Practical Nurse/Resident Care Manager, stated it was the expectation of the facility to have nurses and nursing assistants complete their charting. Staff D stated there was a report printed out daily and they reviewed the missing documentation and contacted the staff responsible to complete their charting but was more difficult to hold agency staff accountable. Reference WAC 388-97-1720 (1)(a)(i-iv)

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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** Based on observation, interview and record review, the facility failed to ensure infection control practices were followed for 1 of 2 residents (Resident 28) observed for would care and 1 of 6 staff (Staff R) observed for medication administration. These failures placed residents at risk of potential infection.Findings included .<WOUND CARE OBSERVATION> Resident 28 was admitted to the facility on [DATE] with multiple decubitus ulcers (injuries to the skin and underlying tissue caused by prolonged pressure on the skin) on their buttocks and bilateral legs, osteomyelitis, hereditary spastic paraplegia (inherited progressive weakness and stiffness in the legs, affecting mobility over time) and suprapubic catheter. Review of Resident 28's Treatment Administration Record (TAR) dated April 2026 documented they had Enhanced Barrier Precautions (EBP) related to implanted medical device and wounds. In an observation on 04/09/2026 at 11:02 AM, outside of Resident 28's room, there was EBP signage, which directed staff to use additional Personal Protective Equipment (PPE) of gown and gloves during high-contact resident care. Staff C, Registered Nurse (RN)/ Assistant Director of Nursing (ADNS) was observed to provide wound care to Resident 28 without wearing a gown. During Resident 28's wound care, Staff C, was observed to don (put on) and doff (take off) gloves, without performing hand hygiene (hand washing or alcohol-based hand rub - ABHR) in between. In an interview on 04/10/2026 at 2:38 PM, Staff C, confirmed Resident 28 had EBP, and stated they forgot to wear a gown during wound care. Staff C stated the proper PPE should have included a gown. Staff C stated they did not have their ABHR with them to complete hand hygiene between donning and doffing gloves. In an interview on 04/13/2026 at 9:38 AM, Staff B, Director of Nursing Services (DNS), stated their expectation for EBP was staff were to read the signage and don a gown and gloves before they enter the room for any resident contact. <MEDICATION ADMINISTRATION> In an observation and interview on 04/08/2026 at 4:15 PM, Staff R, Licensed Practical Nurse (LPN), put gloves on without hand hygiene then cut a pill in half. With the same gloves Staff R went to the resident's room and administered the medication. Staff R took their gloves off and went to their Medication Cart and touched the computer mouse. Did not observe Staff R performed hand hygiene. Staff R was asked when they would perform hand hygiene, and Staff R stated they should have done hand hygiene before putting gloves on and after taking gloves off. In a joint interview on 04/09/2026 at 2:30 PM, Staff V, Registered Nurse (RN)/Infection Disease Nurse (IP Nurse) and Staff B, Director of Nursing Services (DNS), Staff V stated, it's an expectation that staff should perform hand hygiene before putting gloves on and after taking gloves off. Staff B stated that staff should not be wearing gloves while going into a resident's room and hand hygiene should be done prior to putting gloves on and after taking gloves off. Reference WAC 388-97-1320(1)(a)(c)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 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