STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505395	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stafholt Health and Rehabilitation of Cascadia	456 C Street Blaine, WA 98230

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on interview and record review, the facility failed to ensure 2 of 3 resident's (Resident 3 and 4) choice of bathing frequency was honored. The facility failed to provide and honor the resident's care planned bathing preference. This failed practice placed residents at risk for a diminish quality of life. Findings included . <RESIDENT 3> Resident 3 was admitted to the facility on [DATE] with diagnoses to include compression fracture of the fourth thoracic vertebra, anxiety, and weakness. Review of the care planned Activity of Daily Living (ADL) focus problem, dated 03/18/2024, showed Resident 3 preferred to take a bath three times weekly. Review of the March and April 03/18/2024 through 04/04/2024, Documentation Survey Reports, showed Resident 3 did not have a bath the first week they were in the facility and had two baths the following week until discharge on [DATE]. (Two baths within 18 days). In an interview on 04/04/2024 at 12:58 PM, Collateral Contact (CC) 1, Resident 3's family member stated they had talked to the staff about Resident 3's bathing preference and discussed their concern Resident 3 had not had a bath in over a week. <RESIDENT 4> Resident 4 was admitted to the facility on [DATE] with diagnoses to include Adult Failure to Thrive (when a resident has a loss of appetite, loses weight and is less active than normal), depression, mild cognitive impairment, and weakness. Review of the care planned ADL deficit focus problem dated 01/09/2024, showed Resident 4 preferred to take a bath once a week and was to receive a bed bath if they refused to have a shower. Review of the February, March, and April 2024 02/01/2024 through 04/04/2024, Documentation Survey Reports, showed the following baths or showers for Resident 4: (continued on next page)

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

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	February- received their weekly bathing preference up to 02/12/2024 and no other baths or showers were provided for the month of February. The resident was bathed three times. March- received a bath on 03/02/2024 and refused a bath or shower on 03/20/2024, 03/33/3034 and 03/25/2025 with no bed baths or shower provided for the month. The resident was bathed once in the month of March. April - refused a bath on 04/02/2024 and received no baths from 04/01/2024 through 04/04/2024. Resident 4 received four baths in 64 days. In an interview on 04/04/2024 at 1:58 PM, Staff E, Nursing Assistant Certified (NAC), stated they had worked at the facility for about two weeks, and they had not been assigned to provide a resident with a shower or bath. Staff E stated there was schedule of resident baths in a bath book at the nurse's station. In an interview on 04/04/2024 at 2:03 PM, Staff D, NAC, stated there was a bath book in the shower room and they charted in the resident's chart, in the electronic medical record when they gave a bath if a shower or bath was due that day. In an interview on 04/04/2024 at 4:18 PM, Staff C, Clinical Resource Registered Nurse, stated the residents should receive a bath or shower per the residents' preferred bathing frequency. Staff C stated if a resident refused a bath or a shower, the staff should document the refusal and reapproach the resident again at a later time. Staff C stated the staff should assess why the resident had refused care, they should have Social Services involved, and the staff should investigate why the resident refused care. Refer to WAC 388-97-0900 (1)(3)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on interview and record review the facility failed to provide the required refund for 1 of 4 sampled residents and/or their resident representative (Resident 1) within the required 30 days after the resident's discharge. This failed practice placed the resident and/or resident representative at risk of financial hardship. Findings included . Record review showed Resident 1 was admitted to the facility on [DATE] and was discharged from the facility on 11/21/2023. Review of a Complaint Resolution Unit report, dated 03/26/2024, showed the facility did not provide the resident/resident representative a refund for 10 days as the facility claimed they were owed money for supplies. In an interview on 04/04/2024 at 12:29 PM, Staff A, Business Office Manager, stated the facility had issued a refund of $3,147.42 for Resident 1 back in January 2024 and the refund check was mailed out on 02/05/2024, 75 days after Resident 1 was discharged . In an interview on 04/04/2024 at 5:00 PM, Staff I, Interim Administrator, stated the facility should send any refunds within 30 days of a resident's discharge. Refer to WAC 388-97-0300 (6)(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on interview and record review the facility failed to thoroughly investigate an allegation of potential abuse and neglect for 1 of 1 incident sampled resident (Resident 3) reviewed for abuse and neglect. This failed practice prevented the facility from identifying the potential extent and nature of the allegation of abuse and neglect and placed residents at risk of diminished quality of life. Findings included . Review of the facility's policy titled, Abuse Prevention, Identification, & Reporting, revised on 10/31/2017, showed the facility would conduct an investigation of alleged abuse and neglect, use observation, interviews, and record review to gather and corroborate information. Staff are mandatory reporters and required to fulfill the responsibility of reporting and they must notify the State Survey Agency. RESIDENT 3 Resident 3 admitted to the facility on [DATE] with diagnoses to include compression fracture of the fourth thoracic vertebra, anxiety, and weakness. Review of an email Collateral Contact (CC) 1, Resident 3's family member sent to Staff F Social Services (SS), dated 03/22/2024, showed Resident 3 had called and stated the night caregiver or nurse told them to urinate in their brief because they did not know how to put the resident's back brace on to take them to the bathroom. Please let me know what else we can do to help prevent neglect and abuse. Review of the facility's incident log and grievance log showed no entry for Resident 3's allegation. Review of Resident 3's progress notes showed no documentation of Resident3's allegation. In a phone interview on 04/04/2024 at 12:58 PM, CC 1, stated Resident 3 had told them that the night staff did not know how to put on their back brace to take them to the bathroom. CC 1 stated Resident 3 told them the staff person tried to find help but could not and told Resident 3 to void (urinate) in their brief. CC 1 stated they emailed Staff F, about the incident and Staff F did not reply to the email, but they called and said they would fix the problem. In an interview on 04/04/2024 at 1:58 PM, Staff E, Nursing Assistant Certified (NAC), stated that if a resident reported that a staff member had told them to use their brief to urinate, they would tell Staff B, Licensed Practical Nurse (LPN), and report to the State Hot Line. In an interview on 04/04/2024 at 2:03 PM, Staff D, NAC, stated if a resident reported a staff member told them to use their brief to urinate, they would let the nurse know and then call the number for abuse and neglect. Staff D stated that it was a dignity issue if a resident could not go to the bathroom, they should assist them. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/04/2024 at 2:13 PM, Staff F, stated they had received training in abuse and neglect in their new hire packet along with training on resident rights and about being a mandatory reporter. Staff F stated they had reported in the facility's Stand Up meeting, Resident 3's report of being told to void in their brief when the staff did not know how to apply Resident 3's back brace. Staff F stated they had also emailed the Resident Care Manager (RCM), Administrator, the Administrative Assistant, the MDS Coordinator, and the Medical Records Coordinator about Resident 3's complaint. Staff F stated they wanted everyone to be aware of the issue and it needed to be fixed right away. Staff F stated when a resident was told to urinate in their brief it was a resident right violation and needed to address it immediately, it was significant enough to warrant all hands-on deck. Staff F stated they did not feel the complaint rose to the level of potential abuse or neglect, but it warranted immediate action. Staff F stated they did not know if an investigation was completed. Staff F stated they had asked the RCM and the Director of Nursing Services to work with the staff and did not know if that occurred. In an interview on 04/04/2024 at 2:52 PM, Staff G, Registered Nurse (RN), stated Staff B, had educated the staff on applying Resident 3's brace and not to tell a resident to void in their brief. Staff G stated they thought Staff F had written out a grievance report on the complaint. Staff G, stated, Yeah, when asked if they thought Resident 3's complaint rose to the level of abuse and neglect. In an interview on 04/04/2024 at 3:00 PM, Staff H, RN, was asked what they would do if they received a resident report of staff asking them to void in their brief. Staff H stated they would inform the RCM. Staff H stated they believed it would rise to the level of abuse and neglect and they would definitely inform the RCM and would call the State Hot Line. In an interview on 04/04/2024 at 3:25 PM, Staff C, Clinical Resource RN, stated CC 1 had sent an email about Resident 3's complaint. Staff C stated the administration had indicated they needed to do a grievance on the complaint and educate the staff members. Staff C stated they had sent screen shots of how to apply Resident 3's back brace to the night nurse so they could provide education to the nightshift staff. Staff C stated the Administrator did not complete the grievance process. Staff C stated the night shift staff that were involved were educated, they did the important part so hopefully that was some assurance, but the facility, obviously dropped the ball. In an interview on 04/04/2024 at 3:51 PM, Staff B, LPN, stated they were notified about Resident 3's complaint by email and it was discussed in the morning Stand Up meeting. Staff B stated it was decided Resident 3's complaint would be written up as a grievance. Staff B stated they were under the assumption the Administrator would write up the grievance report. Staff B stated they had called the night shift nurse and explained how to apply Resident 3's back brace and asked them to educate the night shift NACs. Staff B stated no in-service log was completed for the staff training, just verbal education was provided. Staff B stated CC 1's email was worded as if to take care of the complaint before it became abuse and neglect when asked if Resident 3's complaint rose to the level of abuse and neglect. Staff B stated the complaint was discussed by several people and it was determined it could be written up as a grievance per the Administrator. Staff B stated the staff were not interviewed nor asked to write any statements. Staff B stated the staff on duty on the night of the incident were facility hired regular staff. Staff B stated there was no investigation of the complaint that they knew about to see if this had been an issue with any other residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/04/2024 at 4:18 PM, Staff C stated they had expected Resident 3's complaint to be written up and filed as a grievance and the staff would be educated on how to apply Resident 3's brace and educated on appropriate communication with residents. Staff C stated, Yes, when asked if Resident 3's complaint rose to the level of abuse and neglect. Refer to WAC 387-97-0640 (5)(a)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on interview and record review, the facility failed to arrange hospice services for 1 of 1 resident (Resident 2) reviewed for hospice care. Failure to ensure hospice services were arranged or Resident 2 was transferred to a facility that offered Resident 2's preferred hospice agency denied the resident of their hospice benefit. Findings included . Resident 2 was admitted to the facility on [DATE] with diagnoses of fractured hip, Alzheimer's disease, heart arrhythmia, kidney disease, diabetes, hypothyroidism, high blood pressure, and weakness. Review of a Health Status Note dated 10/12/2023, showed Collateral Contact (CC) 2, Resident 2's family member informed the staff they would like a referral for hospice sent to a specific hospice agency. The Certified Physician Assistant was notified, and a telephone order was placed. Review of a Nutritional Review Note, dated 11/05/2023, showed Resident 2 was on hospice prior to hospitalization and a hospice referral was ordered. Review of Resident 2's medical record, dated 10/12/2023 through 01/05/2024, showed no documentation Resident 2 or CC 2 had received information regarding the facility's contracted hospice agency or informed of facilities available who contracted with the specific hospice agency CC 2 had requested. Review of a late entry Social Service Note dated 01/05/2024, showed Resident 2 was discharged and the requested hospice agency had accepted the resident on hospice services. Review of the facility's hospice agreements showed the facility had two hospice agreements. The specific hospice agency Resident 2 and CC 2 had requested had signed a hospice agreement with the facility on 03/29/2024. In a phone interview on 04/03/2024 at 2:25 PM, CC 2 stated, Resident 2 was found to be eligible for hospice back in October 2023. CC 2 stated they wanted Resident 2 to receive hospice services from a specific hospice agency. CC 2 stated the facility refused Resident 2 hospice services, refused to allow the specific hospice agency to enter the facility and did not offer to transfer Resident 2 to a facility who had the specific hospice agency they wanted. CC 2 stated the facility staff did not discuss different hospice agencies with them. CC 2 stated the facility staff would tell them they were working on it but thought the facility was stalling. In an interview on 04/04/2024 at 12:10 PM, Staff B, Licensed Practical Nurse, stated CC 2 had wanted a specific hospice agency to provide Resident 2 with hospice services and the facility did not have a contract with the specific hospice agency. Staff B stated the prior facility's Administrator was a big part of obtaining hospice contracts. No Associated WAC