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	10/02/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on interview and record review the facility failed to provide notification to the resident's representative of a change in treatment for 1 of 1 resident (Resident 4) reviewed for medication changes. This failed practice prevented the resident's representative from being informed and participating in care decisions. Findings included . Resident 4 was admitted to the facility on [DATE] with diagnoses to include chronic heart disease along with congestive heart failure, low blood pressure, and kidney failure. Review of a progress note dated 09/19/2024 at 11:53 PM, showed a new order for Lasix (medication used to treat fluid retention) 20 milligrams (mg) twice daily and a laboratory test ordered for to be completed 09/23/2024. Review of the September 2024, Medication Administration Record showed Resident 4 received a dose of Lasix 20 mg on the morning of 09/20/2024. In a phone interview on 10/02/2024 at 9:10 AM, Collateral Contact (CC)1, Resident 4's Representative stated they were not informed the resident had received a new order for Lasix. CC 1 stated while Resident 4 was at the hospital, the hospital staff told them Resident 4 should not receive Lasix due to Resident 4's kidneys function. In an interview on 10/02/2024 at 1:54 PM, Staff D, Licensed Practical Nurse/ Residential Care Manager, stated night shift had processed Resident 4's medication order for the Lasix and the resident's representative should have been notified of the new order. In an interview on 10/02/2024 at 5:00 PM, Staff C, Director of Nursing Services, stated the residents' representative should be notify of a change of treatment which would include medication changes. Refer to WAC 388-97-0320(1)(c)

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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(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	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on interview and record review the facility failed to ensure 3 of 3 residents (Residents 1, 2 and 3) who had orders for daily weights were weighed daily. This failed practice placed residents at risk of diminished quality of life. Findings included . <RESIDENT 1> Resident 1 was admitted to the facility on [DATE] with a diagnosis to include congestive heart failure. Review of Resident 1's care plan showed a focus problem of chronic congestive heart failure with an initiated date of 06/10/2024. The care plan included interventions to monitor the resident's weight as ordered and to monitor for signs and symptoms of congestive heart failure which included weight gain unrelated to intake and swelling of the legs and feet dated 06/10/2024. Review of the August 2024 Medication Administration Record (MAR) showed an order for daily weights in the morning for weight monitoring with a start date of 08/02/2024. Resident 1 had no documented weights fored 16 of 29 days in August 2024. Review of the September 2024 MAR showed Resident 1 had no documented weights three of 12 days they were in the facility for the month. <Resident 2> Resident 2 was admitted to the facility on [DATE] with a diagnosis to include congestive heart failure. Review of Resident 2's August 2024 MAR showed an order for daily weights related to congestive heart failure and to notify the provider if consistent gain or loss of two to three pounds from dry weight over three days. Resident 2 was not weighed for seven days in the month of August 2024. Review of Resident 2's September 2024 MAR showed the facility did not weigh Resident 2 for eight of the 31 days in the month. <Resident 3> Resident 3 was admitted to the facility on [DATE] with diagnoses to include congestive heart failure. Review of Resident 3's care plan showed a focus problem of congestive heart failure. The interventions included to monitor and document weight gain . (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	Review of Resident 3 's August 2024 MAR, showed an order for daily weights of which the facility failed to weigh the resident 13 out of 31 times for the month. Review of Resident 3's September 2024 MAR, showed Resident 3 was not weighed six out of 31 times for the month. In an interview on 10/01/2024 at 1:11 PM, Staff A, Registered Nurse (RN), stated they give the Nursing Assistant Certified (NAC) a daily communication sheet which would have listed the residents who needed to be weighed. Staff A stated the NAC's try to do most of the residents' weights but if they do not get to a weight, they pass the task onto the evening shift NACs to complete. Staff A stated the staff are to weigh the residents before breakfast. Staff A stated the resident weight would be documented in the Treatment Administrative Record (TAR) and some are set up to be documented in the MAR, so they were not missed. In an interview on 10/01/2024 at 1:29 PM, Staff B, Licensed Practical Nurse, stated NAC's know which residents need to be weighed as they were listed on the daily communication form. Staff B stated they ensure the residents who need to be weighed have a weight entered by clicking on a tab in the electronic medical records at the end of their shift. Staff B stated the nurses enter the resident's weight on the MAR or TAR and the NACs document the residents' weight in their section of the medical record. Staff B stated the section the NAC's document in does not auto populate into the MAR or TAR. In an interview on 10/01/2024 at 3:27 PM, Staff C, Director of Nursing Services stated the process for residents with daily weights are for the staff to obtain them. Staff C stated the electronic medical system would not flag on their dashboard if a daily weight was not obtained. Staff C stated they did not recall there was an issue with obtaining resident daily weights. Refer to WAC 388-97 1060 (3)