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	02/10/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on interview and record review the facility failed to prevent psychosocial and physical abuse of 1 of 3 residents (Resident 1) reviewed for abuse and neglect. Resident 1, who had a well-known history of sexual trauma, experienced psychosocial and physical harm when during an episode of constipation, a Nursing Assistant Certified (NAC) proceeded to break up and remove the resident's impacted feces without their consent and outside their scope of practice even after the resident told the NAC to stop. Findings included . Review of Lippincott Nursing Procedures, 8th Edition, showed the procedure for digital fecal impaction removal began with verifying the practitioner's order including the following: * Explain the procedure to the patient, expected outcomes, and potential complications, * Inform the patient that a chaperone may be present during the procedure, * Obtain baseline vital signs because anal stimulation may cause a vagal response (a series of unpleasant symptoms that occur when the vagus nerve is stimulated), * Perform a complete gastrointestinal assessment, * Inform the patient you are about to perform the procedure. Instruct the patient to breathe deeply to promote relaxation and * Record the time and date of the procedure, the patient's response. Note any complications, the interventions taken and the patient's response to those interventions. Resident 1 admitted to the facility on [DATE] with diagnoses to include traumatic brain injury, anxiety disorder, major depressive disorder, cognitive communication deficit, expressive language disorder, unspecified voice and resonance disorder, need for assistance with personal care, and difficulty walking . (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

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	02/10/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's Level II Pre-Admission Screening and Resident Review (PASRR) Initial Psychiatric Evaluation Summary dated 06/03/2022, showed the resident had a childhood history of sexual abuse by a male and the facility's staff should be aware, especially as those childhood experiences could sometimes come up. The staff training and approaches included to be thoughtful with male caregivers who provided personal care and to ensure the resident was comfortable with this including if their cognition worsened overtime which could sometimes take individuals back to situations from their childhood. Review of Resident 1's Quarterly Minimum Data Set (an assessment tool) assessment dated [DATE] showed the resident was cognitively intact, usually made themselves understood and usually understood others. Review of Resident 1's care plan showed the following focus problems with corresponding interventions: * PASRR Level II recommendations for plan of care initiated on 07/09/2024. There was a history of childhood sexual abuse by a male. Be thoughtful if males provided personal care. Ensure the resident was comfortable with this if the resident's cognition worsened over time which could sometimes take individuals back to things from childhood. * Understanding history of trauma to avoid re-traumatization. Resident had a history of childhood sexual abuse initiated on 07/19/2024. History of childhood sexual abuse by a male. Be thoughtful if males provided personal care to ensure the resident was comfortable with this and including if the resident's cognition worsened over time which could sometimes take individuals back to things from their childhood. * Resident had a communication problem related to hearing loss, difficulty finding words, anxiety and becoming overwhelmed initiated on 05/31/2022. When staff were communicating with the resident they were to face the resident, make eye contact and speak slowly and clearly. Clarify that information was understood as needed. * Monitor/document for physical/nonverbal indicators of discomfort or distress, and provide follow-up as needed. Review of Resident 1's current Kardex (guide for direct care providers) showed the resident had a history of childhood sexual abuse by a male. Be thoughtful if males provided personal care to ensure the resident was comfortable with this and included if the resident's cognition worsens overtime which could sometimes take individuals back to things from their childhood. Identify yourself at each interaction. Face the resident when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. Use consistent, simple, direct sentences. Provide Resident 1 with necessary cues- stop and return if agitated. Review of Resident 1's January 2025 Documentation Survey Report v2 (the direct care givers/ NAC documentation) showed on 01/08/2025 on the dayshift, Resident 1 was incontinent of an extra-large smooth, soft, stool which was like a sausage or snake. Resident 1 did not have a bowel movement on 01/09/2025 or on 01/10/2025. On 01/11/2025 on the evening shift the resident was continent of a large stool which was like a sausage but with cracks on the surface. (continued on next page)

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	02/10/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's nursing progress notes dated 01/11/2025 showed the following entries related to the bowels: * 1:16 PM, two Senna - S (stimulant laxative medication) was given no bowel movement (BM) for two days, * 7:26 PM, the Senna - S was effective, * 8:20 PM, MiraLAX Powder (medication for constipation) was given, resident able to have a BM, but very hard, * 8:30 PM, Tylenol was given, pain to rectum from hard stool, * 9:30 PM, the Tylenol was effective, * 9:41 PM, The resident's groin and buttocks continued to be red as well as underneath the resident's right breast. The resident recently finished a seven-day course of an antifungal medication, and a note was left for the provider. (There was no documentation in the note to show the resident had a BM they were unable to pass or that a digital disimpaction was performed by staff, or how the resident tolerated the procedure.) Review of the incident report dated 01/24/2025, showed Resident 1 reported that two to three weeks ago they were feeling constipated. The resident stated they were in the bathroom with a NAC they had not seen before or since. The resident stated the NAC was helping them with toileting and communicated that they felt constipated and could not pass their stool. The resident reported the male NAC manually inserted their finger into the resident's rectum and removed the stool. The resident stated they had not given the male NAC consent to do that task and had asked them to stop. The resident reported the action by the NAC had reminded them of their childhood sexual abuse trauma. The resident's mental status was noted to be oriented to person, place, time and situation. The resident reported they had felt ashamed by the incident and had not reported it to anyone until that day. The root cause was noted to be the resident's past trauma of childhood sexual abuse, the resident was hard of hearing and the NAC was wearing a face mask and the resident was not able to read their lips. The NAC had a strong accent and that there was the potential of miscommunications between the NAC and the resident related to providing consent to touch the resident's rectum. Re-education was provided to the nursing staff to obtain consent from the residents prior to completing a task, effectively communicate task and inserting fingers into a resident's rectum for removal of stool was not in the NAC's scope of practice. Review and comparison of the in-service sign-in log to the facility staff roster showed 21 of 49 nursing staff were in-serviced on 01/25/2025 on clear, concise, respectful communication, active listening with attention to both verbal and non-verbal cues and to always explain what you are doing and why while allowing time for questions and consent. The in-service also noted a medical professional such as a nurse physician or physician assistant could digitally remove stool from a resident, but it was outside the NAC scope of practice. (continued on next page)

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	02/10/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Staff A, NAC's statement dated 01/24/2025, showed on 01/11/2025 , Resident 1 had called to be helped to the bathroom. Staff A noted they assisted the resident to the bathroom and gave them privacy by stepping out and waited for them to call when they were done. Staff A noted after waiting for 10 minutes they went back to check whether the resident was done. Staff A noted Resident 1 was still trying to push but the stool was not coming out. Staff A noted when Resident 1 stood up from the toilet they saw that the resident had bad constipation and the resident's stool was too hard for the resident to push but the stool was trying to come out. Staff A noted they told the resident lubricant could help and the resident had said OKAY. Staff A noted they told the nurse in charge who was passing medications in the opposite door, and the nurse had handed them the lubricant. Staff A noted they did not insert their fingers inside the resident's rectum but applied the lubricant and broke up the hard stool. Staff A noted they explained to the resident before touching them and they were okay and never asked them to stop at any point. Review of Staff B, Registered Nurse (RN), statement dated 01/24/2025 , documented Resident 1 had called for the nurse crying due to painful hard stool. Staff B noted they gave the resident as needed pain medication and MiraLAX to help with discomfort and constipation. Staff B noted Resident 1 did not mention anything about abuse. In an interview on 02/06/2025 at 1:42 PM, Resident 1, stated someone had entered their body without their permission. Resident 1 stated the person who entered my body caused me pain, it was very painful. Resident 1 stated I was disgusted and felt like they had been raped. Resident 1 stated that when they asked the staff member to stop, they did not. Resident 1 stated after they came out of the bathroom the medical nurse came into their room and saw the resident crying. Resident 1 stated they had asked the night nurse if they would talk to the administration about it after they came out of the bathroom as they were upset, and the nurse said they would tell the Director of Nursing Services. Resident 1 stated the medical nurse tried to comfort them and said they should have given them a laxative. Resident 1 stated they were so upset they had to wait to make a formal report of the incident and decided after a couple of weeks it was their obligation to report what happened so it would not happen to anyone else. Resident 1 stated it still bothered them, It bothers me in my dreams, it is like something traumatic and wished they would not remember it. Resident 1 stated they told, them to quit doing what they were doing but they kept doing what they were doing. Resident 1 stated, I did not want to tell anyone right then it was very disgusting. I could not think of what to do but to be as quiet as possible. Resident 1 stated they did not feel like screaming out even though it would have brought them help, I did not want anyone to know what was going on. In a phone interview on 02/10/2025 at 1:15 PM, Staff A, NAC, was asked about the evening the reported incident occurred on the evening shift of 01/24/2025 with Resident 1. Staff A stated they had worked the evening and night shift on that day. Staff A stated Resident 1 wanted to use the bathroom, and they assisted them to the bathroom. Staff A stated they went back and found the resident was complaining of pain to their bottom and had a hard constipated stool. Staff A stated they had gone to the nurse and explained the resident had a hard stool and the nurse had given them a packet of lubricant and did not say anything else. Staff A stated when the resident stood up to be cleaned, they broke the stool that was coming out of the resident's rectum. Staff A stated they were able to break the resident stool without placing their fingers in the resident's rectum and the resident did not tell them to stop. Staff A stated they told the nurse they had put the lubricant on the outside of the resident's rectum. (continued on next page)

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	02/10/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 02/10/2025 at 1:41 PM, Staff C, NAC, stated if they were providing care for a resident who was constipated, had visible hard stool in their rectum, and was unable to eliminate/pass the stool, they would let the resident have time and notify the nurse to see if there was anything that could be given to the resident. Staff C stated they would not try to remove the hard stool as it was out of their scope of practice. In an interview on 02/10/2025 at 1:50 PM, Staff D, NAC, stated if they were providing care for a resident who was constipated, had visible hard stool in their rectum, and were unable to eliminate/pass the stool, they would clean the resident up the best they could and let the nurse know the resident had a stool they could not pass. There was nothing they could do but tell the nurse. In an interview on 02/10/2025 at 2:01 PM, Staff E, NAC, stated if while they were providing care for a resident who was constipated, had visible hard stool in their rectum, and were unable to eliminate/pass the stool they would not go out of the scope of their practice. Staff E stated they would let the nurse know and would not remove or attempt to remove the stool. In an interview on 02/10/2024 at 2:07 PM, Staff F, NAC, stated if while they were providing care for a resident who was constipated, had visible hard stool in their rectum, and were unable to eliminate/pass the stool, stated they would just go asked the nurse to give the resident a stool softener. Staff F stated they would not try to remove the stool as they would be scared, they might hurt the resident. The following licensed nurses were asked what they would do if an NAC reported a resident was constipated and had visible hard stool in their rectum that they were unable to pass. In an interview on 02/10/2025 at 2:12 PM, Staff G, RN, stated if an NAC reported a resident was constipated and had visible hard stool in their rectum that they were unable to pass, they would place lubricant around the resident's rectum. Staff G stated they would not have the NAC apply lubricant as it was not in the NAC's job description. In an interview on 02/10/2025 at 2:21 PM, Staff H, RN stated if an NAC reported a resident was constipated and had visible hard stool in their rectum that they were unable to pass, they would notify the doctor and see what the precautions and the facility policy directed. Staff H stated they would see about a stool softener but ultimately, they would follow the facility's policy and procedures. Staff H stated they would not provide the NAC with lubricant to apply on the resident's rectum. In an interview on 02/10/2025 at 2:57 PM, Staff I, RN/DNS, stated it was their expectation for the nurse to assess the resident's situation. Staff I stated Staff B did not say why they did not assess the resident prior to giving the NAC the lubricant. (continued on next page)

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	02/10/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	In a phone interview on 02/11/2025 at 11:49 AM, Staff B, RN stated on the evening of the reported incident they were working on the medication cart. Staff B stated the NAC had come to them and reported Resident 1 had an impacted hard stool they could not pass. Staff B stated they did not assess the resident after the NAC reported the resident's issue. Staff B stated they were down by the resident's room but was in the middle of something. Staff B stated, It just happened I think I was in the middle of something, I guess. Staff B stated in the past they had experienced placing lubricant on the outside of the rectum so that was what they did in the same instance. Staff B stated they, themselves had not placed the lubricant on Resident 1's rectum. Staff B was asked if it was okay for a NAC to break up stool they could see in a resident's rectum. Staff B stated, No, it can cause injury, and it is just not very safe. Staff B stated they had been an NAC, and they knew as a NAC they were not allowed to do that. Staff B stated the resident ended up passing the stool. Staff B stated Resident 1 was crying and said their stool was hard and painful to pass. Staff B stated they were not for sure if they were in the in-service training on 01/25/2025 and was unable to recall what the in-service was about. Refer to WAC 388-97-0640 (1)