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	04/02/2026

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure adequate pain management was provided for 1 of 3 residents (Resident 1) reviewed for dental care. This failure had the potential to result in a decreased quality of life for Resident 1, who was experiencing dental pain. Findings included .Resident 1 admitted [DATE] and was a long-term care resident at the facility. In an observation and interview on 03/30/2026 at 10:40 AM, Resident 1 was in bed and stated they still had a sore tooth. Resident 1 opened their mouth to point out the left lower molar area. Resident 1 was observed to have many missing, broken teeth with silver colored prior dental work visible on many teeth. Resident 1 was observed to place her hand across their left lower jaw while speaking and hold it there. Resident 1 stated they had been to the dentist and was told they needed to see a doctor first before they could pull out their teeth. Resident 1 stated there was more than one bad tooth but one in particular that was hurting and was painful all the time. Resident 1 thinks all they got for tooth pain was Tylenol and stated it did not work very well. In an interview on 04/01/2026 at 2:11 PM, Staff D, Certified Nurse Aid, stated Resident 1 had to eat soft foods. Staff D stated Resident 1 said their tooth hurt all the time, had been for a while. Resident 1 could brush their own teeth and Resident 1 said the tooth hurt when it got touched. Record review on 04/01/2026 showed Resident 1 was experiencing tooth pain greater than 1 month. Record review of facility provider orders on 04/01/2026 showed orders for downgraded diet to softer textures on 03/08/2026 related to the resident's complaint of tooth pain and inability to chew foods. Resident 1 was seen by a dentist on 03/18/2026 related to tooth pain and orders included antibiotics for tooth infection (completed on 03/26/2026), with follow-up appointment pending for dental extractions (removals of affected teeth.)Review of the resident's most recent pain assessment showed it was completed in January of 2026 and did not include dental issues or pain. Review of the resident's care plan on 04/01/2026 showed a care plan problem related to arthritis pain, which had not been revised to include dental pain. Review of the resident's provider orders on 04/01/2026 showed orders for routine Tylenol (over the counter pain medication) three times per day routinely since November of 2025 related to difficulty walking. The provider orders also included Tylenol as needed every 6 hours for head and leg pain which was noted to have been administered 12 times in the month of March. Review of a provider's progress note and order dated 03/24/2026 documented the resident was complaining of continued tooth pain and an order was added for a topical medication to be applied to the gum area as needed for complaints of tooth pain. Review of the Resident's Medication Administration records on 04/01/2026 showed the topical medication had only been administered once since 03/24/2026. In an interview on 03/30/2026 at 3:13 PM, Staff C, Resident Care Manager, stated the resident's original dental appointment was in February but was delayed because they had gotten sick. The resident was not seen until March 18th and then needed a course of antibiotics. The medical clearance form had been completed, and the guardian was supposed to be setting up the next appointment. Staff C stated there was no date yet. Staff C stated the tooth was sore, which was the reason for the downgraded diet and stated there was a new order for topical medication. Staff C had not completed a new pain assessment for Resident 1 and was not aware that the new topical pain medication order had not been utilized. Reference WAC 388-97- 1060 (1)(2)

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure pharmaceutical services included processes for the provision, monitoring and/or use of medication related to devices involving 1 of 1 resident (Resident 2) reviewed for anticoagulant (blood thinning) medications. Failure to perform quality control testing on test meters had the potential to result in inaccurate measurement of therapeutic drug levels. Findings included . Review of the Coag-Sense Professional User Guide copyright 2023 documented directions for use for control testing of Protime/INR (measure to determine therapeutic levels of anticoagulant medication) meters stated there were 2 Low Control Strips, 2 High Control Strips and a Control Activation Solution shipped with each test strip kit. Controls should be tested immediately upon receipt of each new lot number. The user guide provided instruction on how to perform testing and interpretation of the results to determine if the meter was providing accurate results. Resident 2 was admitted [DATE] and returned to the hospital on [DATE]. The resident re-admitted on [DATE] and returned to the hospital on [DATE]. The resident had orders for Warfarin (anticoagulant medication to prevent blood clots) which is monitored by Protime/INR testing with a therapeutic target goal range. Resident 2 had an INR goal range of 2-3. Resident 2 INR results during their stay showed: 02/12/2026 INR High 3.2 with orders to hold anticoagulant medication. 02/13/2026 INR Low 1.5 with orders to resume anticoagulant medication. 02/18/2026 INR Low 1.7 orders to increase anticoagulant medication dose.03/12/2026 INR High at 3.2 Hold anticoagulant medication 03/13/2026 INR 3.0 Resume anticoagulant medication 03/20/2026 INR Critical High 5.3 Anticoagulant held. Resident 2 had symptoms of bleeding and was sent to the emergency department and admitted . In an interview and observation on 03/30/2026 at 12:50 PM, Staff C stated the facility checked INRs within 24 hours of admission. Staff C stated the facility did their own INR testing in the facility and tracked the results on a flowsheet for each resident. An observation of the flowsheet for Resident 2 showed it was incomplete, staff C acknowledged it was missing several of the INR tests done while the resident was in the facility. Staff C was present for an observation of the testing supplies in the facility medication room, where Staff C stated there was just one INR meter for the facility and it was in a zippered canvas case. The case included the coag-sense meter and test strips sealed in thick packaging which included lot numbers and expiration dates. Staff C was observed to remove a large box labeled coag-sense test strips from the cupboard which was opened and not full. The box confirmed the supply counts as stated in the professional users manual stating there were 2 High and 2 Low control strips sent in each box as well as control solution. The lot numbers on box were observed to match the lot numbers on the test strips inside the box and the strips that were inside the canvas meter case. Staff C stated the meters were control tested each time a new box was opened. Staff C stated there was no process for documenting control testing suggesting that staff might sign the box. There was no such signature observed on the box. It was observed that there were 2 High and 2 Low control strip packages unopened still remaining in the box which matched the lot numbers on the side of the box. Staff C was asked if this would indicate that the control testing for this box of strips had not been done, and Staff C stated that is what that would mean. Staff C was asked how the facility would know if results obtained were accurate if the control checks had not been done and Staff C stated they did not know. Staff C stated there were currently no residents in the facility receiving warfarin, and Resident 2 had been the only recent resident with warfarin ordered. Staff C confirmed these strips had been in use during the time Resident 2 was in the facility receiving INR checks. In an interview on 04/01/2026 at 4:00 PM, Staff B, Director of Nursing stated there had not been a system to document the quality control checks on the INR meter and stated they were implementing a tracking system. Staff B stated the expectation was the quality control tests were conducted when a new box of strips was opened and documented. Refer to WAC 388-97-1300(1)(b)(ii)