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	03/25/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43954 Based on interview and record review, the facility failed to ensure that 1 of 5 residents (Resident 155) reviewed for informed consent had received the information of risks and benefits of their proposed care related to psychoactive medications (substances that affect a person's mental processes, behavior and mood). This failure placed the resident at risk for potentially unknown or unwanted side effects, and decreased quality of life. Findings included . Facility policy titled, 'Psychoactive Drug Use', revision date of 10/15/2022, showed psychoactive drug documentation guidelines were to document in the resident's medical record, by the appropriate discipline on designated forms assessment as indicated: Resident/resident advocate notification, education, and consent of psychoactive medication. Resident 155 admitted to the facility on [DATE] with diagnoses to include right femur fracture, major depressive disorder, anxiety disorder and chronic pain syndrome. Review of Resident 155's admission orders dated 3/14/2025 documented provider orders for aripiprazole 5 milligrams (mg) daily related to major depressive disorder, duloxetine 30mg twice daily related to depression, and buspirone 20mg twice daily related to anxiety disorder. Review of Resident 155's Medication Administration Record, dated March of 2025 documented the resident received buspirone and duloxetine on day of admission in the evening of 03/14/2025 and aripiprazole on the morning of 03/15/2025. Review of Resident 155's electronic medical record (EMR) showed no documentation or signed consents related to psychoactive medication use for the admitted d 03/14/2025. In an interview on 03/24/2025 at 12:23 PM, Staff C, Social Services Manager stated the Resident Care Manager (RCM) nurses obtain consents for psychoactive medications. In an interview on 03/24/2025 at 1:41 PM, Staff D, Licensed Practical Nurse (LPN), RCM, stated they obtain consents for psychoactive medications at time of admission. Staff D stated they thought the previous psychoactive consents from Resident 155's last admission could be used. Staff D stated they obtained new psychoactive medication consents for Resident 155 on 03/21/2025 for the admission on 03/14/2025. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/25/2025 at 9:02 AM, Staff B, Registered Nurse (RN), Director of Nursing Services (DNS) stated they believe there was an issue due to Resident 155 being a re-admit and unfortunately the consents had been checked off they were completed on the 03/14/2025 admit. Reference WAC: 388-97-0260 (2)(a)(c)(d)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37890 Based on observation, interview and record review the facility failed to ensure resident care plans were reviewed and revised for 1 of 2 residents (Resident 51) reviewed for activities of daily living. This failure placed residents at risk for lack of appropriate care and services by the staff. Findings included . Resident 51 admitted to the facility on [DATE] with diagnoses which included history of strokes and was dependent on staff for activities of daily living such as grooming and hygiene. Review of Resident 51's care plan on 03/20/2025 documented the resident had their own teeth and was able to perform oral hygiene with supervision and cueing and preferred to use their electric toothbrush, initiated on 01/31/2025. In an interview on 03/18/2025 at 1:48 PM, CC1 stated Resident 51 had an electric toothbrush but they could tell it had not been used. CC1 stated they did not think the staff were brushing the resident's teeth. CC1 stated they had asked about it before, and they had checked recently and did not think the toothbrush was being used. In observations on 03/20/2025, 03/21/2025 and 03/24/2025, Resident 51's electric toothbrush was observed in the exact same position near the sink in the resident's room and was always observed to be dry. In an interview on 03/24/2025 at 10:47 AM, Staff F, Nursing Assistant Certified (NAC) stated Resident 51 was not able to assist with oral care, and they were not using the resident's electric toothbrush and only used foam toothettes (oral care swab) for oral care. Staff F stated they could not recall Resident 51 being able to participate in brushing their own teeth because they had too much shaking of their hands. Staff F stated Resident 51 had been on Hospice and they usually use the toothettes when people are on comfort care, but they were not sure what was in the resident's care plan regarding oral care. In a joint interview on 03/24/25 at 2:07 PM, Staff E, Registered Nurse, Resident Care Manager and Staff B, Director of Nursing Services, stated they updated the care plans and the care plans should be updated as changes occur such as a decrease in ability or change in orders. Staff E stated they were not aware that nursing assistants were only using toothettes for Resident 51's oral care. Resident 51 had been on Hospice services recently but had come back off and the care plan needed to be reviewed. Reference WAC 388-97-1020

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview and record review, the facility failed to provide services that ensured a resident's abilities in activities of daily living (ADLs) did not diminish for 1 of 2 sampled residents (Resident 206) reviewed for activities of daily living. This failure put residents at risk for physical decline and decreased quality of life. Findings Included . Resident 206 admitted to the facility on [DATE] with diagnoses to include chronic ulcer of the foot, high blood pressure and altered mental status. Review of Resident 206's Brief Interview for Mental Status (BIMS-an assessment tool used to screen for cognitive impairment) dated 03/12/2025 showed a score of 12 out of 15, indicating the resident had moderate impairment. <ORAL CARE> Review of the Admission Minimum Data set (MDS-an assessment tool) assessment dated [DATE] showed Resident 206 required set up assistance for oral hygiene. Review of Resident 206's care plan dated 03/06/2025 documented the resident had their own teeth, was missing their front upper teeth and could perform oral hygiene independently after setting up. In an interview on 03/19/2025 at 9:56 AM Resident 206 stated they had not brushed their teeth for the day. In an observation on 03/19/2025 at 9:56 AM, Resident 206's toothbrush was in a kidney basin in the bathroom. The toothbrush contained visible white matter consistent with toothpaste in the bristles. The toothbrush was visibly dry and there were no visible signs of moisture in or around the kidney basin. In additional observations on 03/20/2025 at 9:45 AM, 03/21/2025 at 2:10 PM and 03/24/2025 at 9:32 AM Resident 206's toothbrush was in their bathroom, in the same location, in the same position as the observation on 03/19/2025. In an interview on 03/24/2025 at 9:32 AM Resident 206 stated they had not had their teeth brushed for many days. Review of Documentation Survey Report (completed nursing assistant tasks) for March 2025 documented Resident 206 was to have had daily oral hygiene assistance. In an interview on 03/24/2025 at 11:14 AM Staff D, Resident Care Manager (RCM) stated a resident must be offered oral care at least twice a day, before/after breakfast and at bedtime or as the resident requests. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<OFFLOADING BOOTS> Review of Resident 206's care plan dated 03/06/2025 showed they had required assistance with applying offloading boots when they were in bed. In an observation on 03/20/2025 at 2:50 PM Resident 206 was lying flat on their back in their bed. The offloading boots were observed on the resident's bedside table. In an interview on 03/24/2025 at 9:32 AM Resident 206 stated they wear the offloading boots sometimes and rely on staff to put them on. Resident 206 stated they did not refuse or decline to put the offloading boots on. Review of a progress note dated 03/20/2025 at 9:09 PM, showed Resident 206 was compliant with wearing offloading boots. In an interview on 03/24/2025 at 9:16 AM Staff K, Registered Nurse (RN), stated Resident 206 wore offloading boots as an intervention for treatment and prevention of a pressure ulcer. When asked how nursing ensures the offloading boots are placed on Resident 206, Staff K stated once a shift the nursing staff including the nursing assistants had prompts through their tasks on their computer and during their charting. In an interview on 03/24/2025 at 11:18 AM Staff D stated they had not known Resident 206 to refuse the use of the offloading boots. Staff D stated Resident 206 wore the offloading boots to provide added protection to their heels while in bed. Staff D was unaware of Resident 206 not wearing the offloading boots consistently when in bed. Reference WAC 388-97-1060(2)(a)(b)(3)(b)

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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** 37890 Based on observation, interview and record review, the facility failed to assess and implement resident centered pain intervention for one of four sampled residents (Resident 51) reviewed for pain. This failure placed residents at risk for unrelieved pain, lack of participation in therapy and a decreased quality of life. Findings included . Resident 51 admitted [DATE] with diagnoses which included strokes and history of falls, and a hospital acquired pressure ulcer of the sacrum. Review of Resident 51's Admission Minimum Data Set (MDS, a required assessment tool) showed the resident had cognitive impairment. The MDS showed the resident's pain was rated by resident interview and the resident response was that their pain was occasional, and the numeric rating was 9 on a scale of 0 through 10, with 10 being the highest. The MDS stated the resident had a non- stageable pressure ulcer. Review of Resident 51's most recent pain assessment dated [DATE] utilized the non-verbal pain scale and rated the resident's pain at a 5. The assessment documented the resident's pain goal was a 2, stated the resident had pain all the time, exhibited pain by moaning, grunting, wrinkled brow, rubbing body parts, frowning, grimacing, rocking and pounding. The pain assessment stated the cause of the pain was not able to determine. The assessment identified the pain locations as back and wound. Review of Resident 51's care plan for pain management dated 01/13/2025 documented Resident 51 had the potential for pain related to pneumococcal arthritis, hernia, history of pain the left knee and sacral wound. The goal was that Resident 51 would express an acceptable level of pain either verbally or non-verbally. The interventions included to administer medications as ordered by the provider and to monitor and document effectiveness and side effects. Review of Resident 51's physician's orders documented orders for Suboxone (a combination pain medication) twice per day routinely, and Tylenol three times per day routinely. Review of the current Medication Administration Record on 03/24/2025 showed Resident 51 had a pain monitor three times per day (each shift) and the resident's pain was frequently documented as 0. There were 11 instances the pain rating was higher than 2 (the resident's stated goal). In an interview on 03/18/25 at 1:52 PM, CC1, Family member of Resident 51 stated there was a problem with controlling the pain, stating it had been hell, and they come to visit and sometimes Resident 51 is in agony, and expressed frustration with some changes to medication. CC1 stated Resident 51 is able to tell them when they have pain. Review of Resident 51's physician's orders documented an as needed order for Morphine Sulfate (an opioid pain medication), able to be administered every four hours as needed for moderate to severe pain. The resident's orders did not include any as needed medication option for mild to moderate pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation of wound care on 03/20/2025 at 1:23 PM, Resident 51 was lying in bed, Staff E, RN, Resident Care Manager, raised the resident's bed up and lowered the head of the bed, and Resident 51 made a groaning sound. Staff E asked Resident 51 if they were in pain, and the resident did not provide a verbal response, but continued groaning and exhibited a furrowed brow as the head of the bed was lowered, and while being turned on their side in the bed the resident was visibly stiffened and verbally stating oh, oh, oh. A medicated ointment was applied to the resident's sacral wound and as it was being applied the resident stated ow, ow, ow. Staff E stated, I would say they have pain with the wound. The most recent noted administration of the resident's as needed medication was on 03/20/2025 at 2:00 AM. In an observation on 03/21/2025 at 11:13 AM, Staff F, Nursing Assistant Certified (NAC) and Staff E were transferring Resident 51 to bed using a mechanical lift. Staff F explained to the resident they are going to get up and the resident was trying to position their arms across their chest, and the resident kept reaching out to hold onto the lift straps. At 11:19 AM, the lift started to raise, and the resident's body position curved into the sling, and they began loudly humming and stiffened up, then made a ah, ah and a moaning sound as Staff F held onto their feet to raise up their legs to navigate their position toward the bed. When the moving stopped the resident would relax and Staff E commented that the resident relaxed quickly after the movement stopped. When asked if they were having pain, Staff E stated it might be, but that they relax quickly. When asked if this is an anticipated response to being moved, Staff F stated yes, (Resident 51) always does this when we move them. In an observation on 03/24/2025 at 10:58 AM, Staff G, Physical Therapy Assistant, was working with Resident 51 in the facility therapy gym. Resident 51 was seated in their wheelchair. The last documented as need pain medication was last given to Resident 51 on 03/20/2025 at 2:00 AM. Staff G was noting that Resident 51 was resisting movement to extend their legs and arms stating, when we attempt, (they) push back and was attributing the reaction to the prior strokes the resident suffered from. Resident 51 stated I hurt, and Staff G stated where? to which the resident pointed at the left side of their chin. Staff G asked if this was their chin or their tooth, and Resident 51 said the word tooth. At 11:19 AM, Staff G was attempting to cue Resident 51 to kick their legs at a ball and then said they were going to stretch. When Staff G manipulated Resident 51's left leg they stated ow. Staff G asked, where is your pain? and the resident reached out and touched their left knee. Staff G stated, now we know. In a joint interview on 03/24/25 at 1:55 PM, Staff E stated they are using the non-verbal pain assessment for Resident 51, and it references frowning, moaning, and rapid breathing. Staff E stated the resident had not been consistent with yes/no responses and that they quickly relax again if uncomfortable. Staff B, Director of Nursing Services, stated they had not identified that there was not an option for as needed medication until the resident's pain was assessed to be moderate to severe. Staff E and Staff B were made aware of observed concerns that Resident 51 was communicating pain which was already identified through prior assessments and pain interview with the resident, and anticipated points of the day such as transferring, therapy and wound care were observed to show the resident exhibiting both verbal and non-verbal pain. Staff B stated they should look at pre-medicating before known situations such as therapy or wound care. Reference WAC 388-97-1060(1)