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	02/17/2026

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents with personal funds/resident trust accounts had ready access to their accounts during weekends for 14 of 15 residents (Residents 3, 31, 34, 10, 39, 42, 43, 44, 48, 49, 50, 52, 61, 62) reviewed for trust fund accounts and failed to manage and account for the personal funds in an interest bearing account of 1 of 1 residents (Resident 3). These failures placed residents at risk of not having access to their accounts during non-banking hours, a decreased sense of autonomy and a diminished quality of life.<READY ACCESS TO FUNDS>Review of trust fund list provided by facility on 02/09/2026 at 11:22 AM, documented 15 residents had trust accounts and of those, 13 had funds available.In an interview on 02/12/2026 at 9:56 AM Staff C, Business Officer Manager, stated if a resident wanted to obtain funds on weekends there was 40 dollars kept in the nurse's cart. Staff C stated there was a locked box with the narcotics that contained 40 dollars in a plastic envelope and a resident statement to show available funds for each resident. Staff C stated they pulled the envelope and reconcile the cash box at the end of every month. When asked about Resident 3's trust account funds availability on weekends, Staff C stated they had funds and had handwritten in their available amount on the statement. Staff C stated they could not provide the statement because they were discarded. In an interview on 02/17/2026 at 9:01 AM, Staff F, Registered Nurse (RN), stated they had worked weekends. When asked about the process for residents to access their trust account funds during the weekend, Staff F stated they would contact a nurse manager, did not deal with any money, and was not aware of a locked box containing trust funds.In an interview on 02/17/2026 at 9:36 AM, Staff M, RN stated if a resident wanted funds from their trust account on the weekend, they would need to contact the on-call manager and let them know.In an interview on 02/17/2026 at 9:51 AM, Staff D, Licensed Practical Nurse/Resident Care Manager, stated they worked on-call on the weekends, had not had residents ask for funds on the weekends, and if requested would need to contact the administrator or director of nurses to gain access to funds. Staff D stated the nurses did not have access to a locked box containing trust funds.In an interview on 02/17/2026 at 12:20 PM Staff A, Administrator stated the expectation was for trust funds to be available to residents twenty-four hours a day, seven days a week.<MANAGEMENT OF FUNDS>Resident 3 admitted to the facility on [DATE] with diagnoses to include vision loss in both eyes, history of fall with fracture, and history of stroke. Resident 3 stated their vision loss was permanent, was blind, and was learning braille.Review of Resident 3's quarterly minimum data set (MDS-an assessment tool) dated 12/25/2025 documented their brief interview for mental status scored a 15 out of 15 indicating normal thinking and memory.In an interview on 02/12/2026 at 9:56 AM Staff C, Business Office Manager, stated the facility was the payee (a person appointed to manage personal funds) for Resident 3. Staff C stated they spoke with Resident 3 and explained to them the facility was going to be their payee and they would have personal needs allowance (PNA) every month. When asked how they provided information to Resident 3, Staff C stated they explained to them verbally and provided copies of their statements. Staff C stated they provided Resident 3 with their billing statements every month, around the 20th, and trust account statements quarterly. Staff C stated the facility received Resident 3's social security payments (continued on next page)

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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	starting November 2025 as the payee. Staff C stated Resident 3 had not gotten any funds placed in their trust account and had their funds reserved in a different accounting system until they could get direct deposit of their social security.Review of the facility's trust fund ledger provided by the facility and dated 02/09/2026 showed Resident 3 had a zero balance in their trust fund.Review of Resident 3's billing statements from the facility documented a payment of $2832.00 was paid toward their bill on 11/03/2025 and 12/01/2025.Review of a transaction report dated 02/12/2026 documented Resident 3 paid $2726.22 on 11/01/2025 and 12/01/2025, contradictory to the billing statements.In an interview on 02/12/2026 at 10:42 AM Resident 3 stated they were unaware the facility had a trust account that held their PNA and did not recall any conversations with facility staff about it. In an interview on 02/12/2026 at 3:30 PM Staff A, Administrator stated Staff C handles the trust funds and billing. When asked about Resident 3's PNA and a zero balance in their trust account, Staff A stated they had just become aware of the issue and was being corrected that day.WAC Reference 388-97-0340.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record review the facility failed to identify a fall hazard for 1 of 2 residents (Resident 3) reviewed for accidents and failed to secure the doors of the soiled utility room and janitor room on 1 of 2 halls (East Hall). These failures placed the residents at risk for accidents, access to hazardous items, and diminished quality of life.Findings included. <FALL HAZARD>Resident 3 admitted to the facility on [DATE] with diagnoses to include vision loss in both eyes, history of fall with fracture, and history of stroke. Resident 3 stated their vision loss was permanent and they were blind.In a review of Resident 3's care plan dated 03/19/2024 documented resident was at risk of falls related to history of falls and impaired mobility with a goal to remain free of falls. Interventions related to environment included placing personal items and assistive devices within reach.In an observation on 02/09/2026 at 12:03 PM and 02/10/2026 at 9:43 AM Resident 3's room had a recliner next to their bed. A power strip was positioned next to the right side of the recliner and plugged into the electrical socket located behind the recliner. A radio, which was sitting on Resident 3's over bed table was plugged into the power strip. The power cord to the radio ran across the front of the recliner, unsecured and posed a tripping hazard.In an interview on 02/12/2026 at 3:35 PM Staff N, Nursing Assistant Certified, stated Resident 3 was a fall risk and required standby assistance for care as they were blind. When asked about the power strip next to the recliner, Staff N stated they were not aware the cord was there and placed the cords behind Resident 3's recliner, eliminating the tripping hazard.In an interview on 2/13/2026 at 9:53 AM Staff O, Maintenance Director, stated that they were not aware Resident 3 had a power strip in their room and if they had known about the power strip, they would have attached it to the wall. Staff O stated they had removed the power strip from Resident 3's room.<JANITOR CLOSET/SOILED UTILITY ROOM>On 02/09/2026 at 9:56 AM observed the Janitor closet on the East Hall had a sign that read this door is to remain locked at all times, the door was observed to be unlocked. The closet, which had a keypad entry system, contained a bucket and mop with several bottles of chemicals on shelving to include bleach.On 02/09/2026 at 11:07 AM observed the soiled utility room on East Hall unlocked. The door had a keypad entry system.On 02/10/2026 at 9:28 AM the Janitor closet on the East Hall was unlocked and easily opened.In an interview on 02/10/2026 at 9:28 AM Staff D, Licensed Practical Nurse/Resident Care Manager stated the doors were secured by a keypad entry system which had been malfunctioning and maintenance was working to repair them. Reference WAC 388-97-1060 (3)(g)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure treatment carts and medication carts were locked for 2 of 3 medication carts (West and East medication carts) and 2 of 2 treatment carts (West and East treatment carts). These failures placed residents at risk for having access to treatment supplies and medication not prescribed to them, missing medication, and access to medication by unauthorized individuals. Findings included . Review of the facility's policy titled, Medication Storage and Labeling, dated 10/31/2025, stated that all medications must be stored in compliance with all regulations. Storage requirements included medications to be stored in locked compartments. <UNLOCKED WEST MEDICATION CART>In an observation on 02/09/2026 at 2:48 PM, the [NAME] medication cart was observed unlocked and unattended. Staff I, Infection Preventionist (IP)/Registered Nurse (RN), was observed at the [NAME] nursing station. Staff I returned to the [NAME] medication cart at 2:52 PM.<UNLOCKED EAST TREATMENT CART>In an observation on 02/10/2026 at 1:12 PM, the East treatment cart was observed unlocked and unattended. The treatment cart had prescribed Nystatin powders (antifungal medication), Jublia (antifungal medication), Diclofenac gel (topical pain medication), Clotrimazole/Betamethasone cream (antifungal medication), and wound supplies. Several facility staff walked by the East treatment cart while unlocked and unattended.In an interview on 02/10/2026 at 1:19 PM, Staff D, Resident Care Manager/Licensed Practical Nurse, stated that they did not know why the cart was unlocked and the expectation was to have treatment carts locked when unattended. Staff D locked the East treatment cart. <UNLOCKED EAST MEDICATION CART>In an observation on 02/11/2026 at 2:51 PM, the East medication cart was observed unlocked and unattended. Staff G, RN was observed in the East nurses' station office. Staff G returned to East medication cart and stated they left it unlocked when they went inside the nurses' station. Staff G locked the East medication cart. <UNLOCKED WEST TREATMENT CART>In an observation on 02/13/2026 at 12:39 PM, the [NAME] treatment cart was observed unlocked and unattended. Staff F, RN was observed on the [NAME] medication cart. Staff F acknowledged the [NAME] treatment cart was unlocked and then locked the cart. In an interview on 02/17/2026 at 12:00 PM, Staff B, Director of Nursing/RN, stated that the expectation is that medication and treatments carts are locked unless a nurse is present. Reference WAC 388-97-1300 (2)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to ensure the dietary/culinary manager (Staff J) had proper qualifications. This failure placed residents at risk of receiving dietary services from staff without the required competencies and skills to carry out food and nutrition services.Findings included . Review of the facility provided position description for dietary/culinary manager, dated 06/2018, showed staff were to have one or more of the following required: Certified Dietary Manager (CDM), Certified Food Protection Professional (CFPP) with the Dietary Manager's Association Dietetic Technician, Registered, with the Commission on Dietetic Registration of the American Dietetic Association; or, Certification with the American Culinary Federation In an interview on 02/09/2026 at 9:42 AM, Staff J, dietary/culinary manager, stated they had been hired in March of 2025. Staff J was requested to provide their dietary/culinary manager certificate. In a follow up interview on 02/11/2026 at 10:21 AM, Staff J stated they had not completed the training for their dietary/culinary manager certificate. In an interview on 02/17/2026 at 12:20 PM, Staff A, Administrator, stated they were aware Staff J had not completed the dietary course and the expectation was for Staff J to complete the program. Reference WAC: 388-97-1160(2)(3)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff recognized and reported timely potential abuse allegations to the State Agency within 24 hours for 1 of 3 sampled residents (Resident 34) reviewed for abuse. This failure placed residents at risk for unidentified patterns of alleged violations and at risk for potential abuse. Findings included . According to the Nursing Home Guidelines, also known as the Purple Book, sixth edition, dated October 2015, documented, The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). Review of the facility titled, Event Management & Reporting, dated 09/16/2025, documented that the nurse will notify the immediate supervisor, who will determine whether to escalate to the Director of Nursing (DNS) or Administrator. External notifications will include timely reporting to the appropriate authorities such as State Agency for incidents that meet reporting criteria. Review of the facility policy titled, Abuse, dated 09/04/2025, documented that all forms of abuse, including verbal, are strictly prohibited. Training for staff will include recognizing abuse and reviewing facility procedures and legal requirements for reporting suspected abuse. <RESIDENT 34> Resident 34 admitted to the facility on [DATE] with diagnoses to include vascular dementia and anxiety. In a record review of Resident 34's Minimum Data Set (an assessment tool), dated 01/14/2026, documented that verbal behavioral symptoms directed towards others occurred one to three days during the assessment period. In a record review of Resident 34's care plan, dated 02/08/2026, documented that Resident 34 had a potential mood problem related to their cognitive impairment and dementia. The care plan documented an unsuccessful medication reduction for Fluoxetine (antidepressant) and the medication was restarted on 10/25/2025. The care plan documented the Fluoxetine medication was restarted related to Resident 34 being verbally and physically aggressive, fixating on another resident and wandering. In a record review of Resident 34's progress notes, dated 02/05/2026 at 10:05 PM, Collateral Contact 2 (CC 2) documented that Resident 34 was seen due to undesirable behaviors impacting other residents. CC2 documented Resident 34 exhibited verbally aggressive and abusive behaviors toward the new resident in their room. CC 2 recommended starting Buspirone (anxiety medication) twice daily for anxiety to help calm Resident 34 down and to curb undesirable behaviors, poor boundaries, irritability and impulsivity. In a record review of Resident 34's progress notes, dated 02/04/2025 at 4:50 PM, Staff K, Social Services, documented that Resident 34 continued to be verbally aggressive towards others. In a record review of Resident 34's progress notes, dated 01/12/2026 at 8:54 PM, Staff L, Registered (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse (RN), documented that Resident 34 was verbally aggressive towards other residents. In a record review of the incident reporting log from September 2025 through February 2026, no incident reports were documented on the log for Resident 34 pertaining to any abuse allegation. Previous 6 months of incident reports for Resident 34 was requested from Staff A, Administrator. On 02/13/2026, at 11:15 AM, an email was received from Staff A that stated they did not have any completed incident reports for Resident 34. In an interview on 02/10/2026 at 10:19 AM, CC 1, stated that Resident 34 has had issues with their roommate and especially other residents that had cognitive deficits. CC 1 stated that they moved Resident 34 to a private room as a result. In an interview on 02/10/2026, at 10:29 AM, Staff E, Resident Care Manager (RCM)/RN, stated that Resident 34 had sundowning behaviors (increased behaviors such as confusion, agitation, restlessness, that occur in people with dementia typically starting around dusk). Staff E stated that Resident 34 can have aggressive behaviors towards other residents and they were recently started on a new medication to help decrease behaviors. In an interview on 02/12/2026, at 2:19 PM, Staff E, RCM/RN, stated that there were no reports made for incidents involving Resident 34. In an interview on 02/13/2026, at 11:30 AM, Staff B, DNS/RN, stated that they would be investigating Resident 34's incidents and reporting to the state hotline. In a record review on 02/17/2026, at 10:00 AM, Staff B emailed a completed incident report for Resident 34 with a look back period of six months with an investigation and reported online to Residential Care Services. Reference: WAC 388-97-0640(5)(a)

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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** Based on interview and record review, the facility failed to conduct a thorough investigation of potential abuse allegations for 1 of 3 residents (Resident 34) reviewed for abuse. This failure to initiate, conduct a thorough investigation, and correct actual or potential alleged violations left residents at risk for unidentified and/or repeated incidents of abuse and a decreased quality of life. Findings included . Review of the facility's policy titled, Abuse, dated 09/04/2025, stated that all forms of abuse, including verbal, are strictly prohibited. Review of the facility's policy titled, Event Management & Reporting, dated 09/16/2025, documented that a risk report will be completed per facility process of incident management. The policy documented that for incidents involving abuse to follow state-specific guidelines for reporting. According to the Nursing Home Guidelines, also known as the Purple Book, sixth edition, dated October 2015, documented that, All alleged incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated. The Purple Book also documented, A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abuse, neglect, abandonment, personal and/or financial exploitation or misappropriation of resident property occurred, and how to prevent further occurrences. The investigation should end with the identification of who was involved in the incident, and what, when, where, why, and how the incident happened, including the probable or reasonable cause. It should also allow the nursing home to determine if the allegations were true or not true. <RESIDENT 34>Resident 34 admitted to the facility on [DATE] with diagnoses to include vascular dementia and anxiety.In a record review of Resident 34's Minimum Data Set (an assessment tool), dated 01/14/2026, documented that verbal behavioral symptoms directed towards other occurred one to three days during the assessment period. In a record review of Resident 34's care plan, dated 02/08/2026, documented that Resident 34 had a potential mood problem related to their cognitive impairment and dementia. The care plan documented an unsuccessful medication reduction for Fluoxetine (antidepressant) and the medication was restarted on 10/25/2025. The care plan documented the Fluoxetine medication is related to Resident 34 being verbally and physically aggressive, fixating on another residents and wandering. In a record review of Resident 34's progress notes, dated 02/05/2026 at 10:05 PM, Collateral Contact 2 (CC 2) documented that Resident 34 was seen due to undesirable behaviors impacting other residents. CC2 documented Resident 34 exhibited verbally aggressive and abusive behaviors toward the new resident in his room. CC 2 recommended starting Buspirone (anxiety medication) twice daily for anxiety to help calm Resident 34 down and to curb undesirable behaviors, poor boundaries, irritability and impulsivity. In a record review of Resident 34's progress notes, on 02/04/2025 at 4:50 PM, Staff K, Social Services, documented that Resident 34 continued to be verbally aggressive towards others. In a record review of Resident 34's progress notes, on 01/12/2026 at 8:54 PM, Staff L, Registered Nurse (RN), documented that Resident 34 was verbally aggressive towards other residents. In a record review of the incident reporting log from September 2025 through February 2026, no incident reports were documented on the log for Resident 34 pertaining to any abuse allegations. Previous 6 months of incident reports for Resident 34 was requested from Staff A, Administrator. An email was received on 02/13/2026 at 11:15 AM, from Staff A that stated they did not have any completed incident reports for Resident 34. In an interview on 02/10/2026 at 10:19 AM, CC 1, stated that Resident 34 had issues with their roommate and especially other residents that have cognitive deficits. CC 1 stated that they moved Resident 34 to a private room as a result. In an interview on 02/10/2026 at 10:29 AM, Staff E, Resident Care Manager(RCM)/RN, stated that Resident 34 had sundowning behaviors (increased behaviors such as confusion, agitation, restlessness, that occur in people with dementia typically starting around dusk). Staff E stated that Resident 34 could (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have aggressive behaviors towards other residents and was recently started on a new medication to help decrease behaviors.In an interview on 02/12/2026 at 2:19 PM, Staff E, RCM/RN, stated that there were no incident reports for Resident 34. In an interview on 02/13/2026 at 11:30 AM, Staff B, Director of Nursing/RN, stated that they would be investigating Resident 34's incident's and reporting to the state hotline. Staff B stated that when the investigations were finished they would provided.In a record review on 02/17/2026 at 10:00 AM, Staff B emailed a completed incident report for Resident 34 including a look back period of six months with an investigation and reported online to Residential Care Services. According to the incident report there were four missed opportunities for investigations identified on 02/04/2026, 01/12/2026, 10/23/2025, and 07/07/2025.Reference WAC 388-97-0640(6)(a)(b)

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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** Based on interview and record review the facility failed to ensure 2 of 3 residents (Residents 1 and 49) reviewed for quality of care received the necessary care and services in accordance with professional standards of practice to meet each resident's physical, mental and psychosocial needs. The facility failed to ensure that Resident 1 was appropriately assessed, monitored, and documented after returning from dialysis treatments and failed to set up and appropriately monitor Resident 49's side effects of an anticoagulant (blood thinner) medication. These failures placed the residents at risk for unrecognized or undetected medical complications and a decreased quality of life related to unmet care needs. Findings included .<RESIDENT 1>Resident 1 admitted to the facility on [DATE] with diagnoses to include dependence on renal dialysis (machine removes blood from the body, filters it through a dialyzer and returns the cleaned blood to the body), chronic kidney disease (long term condition in which kidneys gradually lose their ability to function properly), and congestive heart failure (long term condition in which the heart can't pump blood well enough to meet the body's needs).Review of Resident 1's provider orders showed they were to receive dialysis on Mondays, Wednesdays, Thursdays and Fridays at the kidney dialysis center. The facility was to collect the dialysis binder and complete the dialysis evaluation. Additionally, there was an order that showed staff were to check the shunt (a synthetic tube used to connect an artery to a vein) site for pain, redness, bleeding, swelling or non-functioning access site every hour for six hours.Review of Resident 1's Treatment Administration Record (TAR) dated February 2026 documented staff were to complete Part A of the dialysis communication record, print the document and send with the resident to the dialysis center. Additionally, staff were to verify that Part B of the dialysis communication record was returned with the resident and complete the dialysis evaluation upon their return. There was an order that documented staff were to check the shunt site for pain, redness, bleeding, swelling or non-functioning access site every hour for six hours, order initiated on 01/09/2026. There was only one box to document at 11:00 PM on Mondays, Wednesdays and Fridays that these checks had been completed, there was no documentation space available for Thursdays and no way to document the required six hourly assessments. Review of Resident 1's Medication Administration Records (MAR) dated February 2026 documented staff were to collect the dialysis binder and complete the dialysis evaluation every Monday, Wednesday, Thursday and Friday, which was initiated on 11/10/2025. Review of Resident 1's dialysis care plan documented staff were to check vital signs (blood pressure, heart rate, oxygen, respiration rate) after dialysis visits and validate the dialysis communication record returned to the facility with the resident. Additionally, there was an intervention to monitor the access site upon return from dialysis for bleeding, redness, swelling or non-functioning.Review of Resident 1's Dialysis communication binder that contained the dialysis evaluations from October 2025 until February 2026 showed Part A was completed by facility staff before the resident went to dialysis and Part B was completed by the dialysis staff prior to returning to the facility. There was no other place for facility staff to document an assessment or other information after the resident returned to the facility.In an interview on 02/17/2026 at 9:59 AM, Staff D, Resident Care Manager (RCM) stated after a resident returns from dialysis, their shunt site and vital signs should be monitored every hour for up to six hours. Staff D stated they input the orders in the TAR in a way that nurses would document vital signs, and site assessments every hour.In an interview on 02/17/2026 at 11:35 AM, Staff B, Director of Nurse Services (DNS), stated their expectation for dialysis monitoring after a resident returned to the facility would consist of vital signs, checking the dialysis site, and they were not sure if there was a specific time frame the resident should be monitored. Staff B stated they thought the facility nurses were filling out Part B on the dialysis communication record after the resident returned to the facility and stated there was no other dialysis communication form for additional documentation. Staff B verified that Resident 1's Part B of their dialysis communication (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	02/17/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	records were completed by the dialysis staff. <RESIDENT 49>Resident 49 was admitted to the facility on [DATE] with diagnoses to include embolism (obstruction of an artery, typically by a clot of blood or air bubble) of left popliteal vein (knee joint) and acute embolism and thrombosis (formation of a blood clot in a blood vessel) of left femoral vein (thigh).Review of Resident 49's provider orders documented apixaban (blood thinner to treat and prevent blood clots) was ordered on 11/29/2023 to be administered twice daily related to their embolism and thrombosis.Review of Resident 49's MAR's, dated December 2025, January 2026 and February 2026, documented they had received apixaban since 11/29/2026 and there was no monitor in place to watch for and identify possible side effects of the medication.Review of Resident 49's TAR, dated December 2025, January 2026 and February 2026, showed there was no monitor in place to watch for and identify possible side effects of the medication.Review of Resident 49's anticoagulant care plan, initiated on 11/29/2023 by Staff D, RCM, documented they were at risk for abnormal bleeding due to anticoagulant use with an intervention to monitor/document/report to the provider any signs, or symptoms of bleeding such as bleeding gums, nose bleeds, or unusual bruising.In an interview on 2/17/2026 at 9:59 AM, Staff D, RCM, stated if a resident is on an anticoagulant medication, there should be a monitor set up in the TAR to monitor for the side effects of bruising, and bleeding and that it should be documented by the nurse every shift that they monitored for those side effects. Reference WAC: 388-97-1060(1)(4)