| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954<br><br>36787<br><br>Based on interview and record review the facility failed to follow up on grievances for three of four residents (7, 21 and 22) reviewed for grievances. Additionally, the facility log failed to reflect grievances over the prior months. These failures to oversee the grievance process and track grievances through to their conclusions placed residents at risk for delayed or incomplete resolution, impaired quality of life, and placed them at risk for undetected abuse and/or neglect.<br><br>Findings included .<br><br>Review of the facility Grievance Policy, revised 01/17, revealed it was the policy of this facility to ensure that all residents and their family members were afforded the opportunity to express their concerns and suggest changes in facility policy. The facility would listen to and act promptly upon the grievance and recommendations from residents, family members, and advocacy groups.<br><br>Review of a facility policy titled, Lost Item Policy, dated 09/2004, showed that if a lost item was not located within three business days, the administrator was to decide what the restitution would be and notify the resident by the fifth business after the report of the lost item.<br><br>Review of October 2021, November 2021 and December 2021 grievance log showed there were three grievances for each month.<br><br>Review of January 2022 grievance log received on 01/12/2022, showed there was one grievance.<br><br>On 01/19/2022 at 4:00 PM, an updated January grievance log was provided to include four additional resident grievances.<br><br>RESIDENT 21<br><br>Resident 21 admitted to the facility on [DATE] with diagnoses to include a respiratory virus.<br><br>(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 |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a progress note dated 11/30/2021 at 12:39 PM, showed, Clothing: Granddaughter just phoned writer to ask why residents (21 and 22) are not being put in their new clothing supplied three weeks again. Granddaughter stated that as far as they could see, resident was in the same dirty t-shirt for the past 5 days.<br><br>Review of grievance log and grievance forms showed no grievances listed for Resident 21.<br><br>RESIDENT 22<br><br>Resident 22 admitted to the facility on [DATE] with diagnoses to include a respiratory virus.<br><br>Review of the residents progress notes failed to include the family concern as detailed in their spouses (Resident 21's) medical record.<br><br>In an interview on 01/12/2022 at 2:25 PM, the Administrator provided the January 2022 grievance log and acknowledged the grievance log could not be accurate with only one grievance listed on the 12th day of the month. They stated they could not locate the grievance for the resident listed and they would have the dietary manager work on this. The Administrator stated they were having department mangers go back and ask residents about any concerns.<br><br>In an interview on 01/13/2022 at 3:12 PM, Collateral Contact 7, a family member, stated they had complained to the facility that family members would visit, and their loved ones were in the same clothes for weeks in a row. They stated they had purchased them new clothes. There were times they were not changed for lengthy periods and had no shower for a week. They stated family had to shave Resident 21. They were told the facility was short staffed and behind. They stated once they complained, staff started to do it.<br><br>In an interview on 01/14/2022 at 10:48 AM, Staff D, Social Services, stated the Administrator was responsible for handling grievances and they were distributed to the responsible department managers based on the nature of the grievance.<br><br>In an interview on 01/25/2022 at 3:31 PM, the Director of Nursing Services (DNS) stated the grievance process had been handled by the prior Administrator and they were working on changing/improving the process.<br><br>42927<br><br>RESIDENT 7<br><br>Resident 7 admitted to the facility on [DATE]. According to the resident's Quarterly Minimum Data Set assessment, dated 10/11/2021, the resident had no cognitive impairment.<br><br>In an interview on 01/07/2022 at 9:35 AM, Resident 7 stated they were missing a pair of jeans, grey leggings, underwear, and 20 dollars. Resident 7 stated that they had reported the missing jeans to staff because they were very expensive.<br><br>Review of the December 2021 and January 2022 grievance logs on 01/13/2022, showed there was no documentation of missing items for Resident 7.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 01/13/2022 at 1:40 PM, Staff H stated that they were not aware of a specific form for lost items and that they were not aware of any missing items for Resident 7.<br><br>In an interview on 01/21/2022 at 10:15 AM, Staff CC, Licensed Practical Nurse, stated two weeks ago they helped Resident 7 complete a lost item form for missing clothing and 20 dollars. Staff CC stated that they placed it in the social services mailbox.<br><br>In an interview on 01/21/2022 at 10:58 AM, Staff DD, Administrator, stated that there was no grievance for Resident 7 on the January 2022 grievance log.<br><br>In an interview on 01/21/2022 at 11:14 AM, Staff DD provided a lost item form for Resident 7 that was dated 01/11/2022 with a follow up interview that was done by Staff H on 01/13/2022. The administrator reported that the grievance was not completed yet. A copy of the grievance was requested by the surveyor once it was completed, but no further information was received.<br><br>Reference WAC 388-97-0460 (1)(2) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890<br><br>Based on interview and record review the facility failed to report allegations of potential abuse for two of four residents (8 and 7) investigated for abuse. The failure of the facility to recognize and respond to abuse allegations within the required timeframe resulted in lack of timely investigation and placed residents at risk of being victims of unidentified and uninvestigated abuse.<br><br>Findings included .<br><br>According to the facility's policy titled, Abuse Prevention Policy and Procedure, dated 07/01/2020, all staff members and agents of the facility are mandatory reporters of abuse. It is the responsibility of the Director of Nursing and the Administrator of this facility to ensure that these policies and procedures were followed.<br><br>RESIDENT 8<br><br>Resident 8 admitted to the facility on [DATE] and was a long-term care resident. The resident had diagnoses which included Parkinson's disease (a disorder of the central nervous system affecting movement, often including tremors) anxiety, depression, and panic disorder.<br><br>According to the 10/12/2021 Quarterly Minimum Data Set (MDS) assessment, the resident had mild cognitive impairment and required extensive one to two person assistance for activities of daily living including transfers and toileting.<br><br>Review of the resident's care plan dated 01/25/2020 showed Resident 8 had a psychosocial well-being problem related to their anxiety, and dependent status:<br><br>They have created a strict routine including toileting schedule and will become extremely anxious when the schedule is deviated from by staff or circumstance.<br><br>In an interview on 01/07/2022 at 2:32 PM, Resident 8 stated there had been an incident a few months ago involving a transfer with a sit to stand (a machine used to assist with transfers) and stated they had told the staff they did not want to use the machine. They stated since they were able to walk to the bathroom they had refused to use the machine. They stated the staff then pulled my pants down and put me in the lifter (the sit to stand), then put me in the wheelchair and I had to use the bathroom, and it made me mess my pants. I felt that was abusive. They stated if the staff had let them walk to the bathroom like they wanted to instead of using the machine, they would not have had an incontinent episode. Resident 8 stated they had told the facility what happened at the time and the outcome was that they did not use that lift any more except with certain staff.<br><br>Review of the state reporting log for the previous six months did not show a logged incident matching the alleged incident.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 01/07/2021 at 3:46 PM, Staff E, Regional Nurse Consultant/Acting Director of Nursing Services (DNS), was notified of the allegation made by Resident 8 and that no corresponding incident had been found on the reporting log. Staff E verbalized this was an abuse allegation and stated they would follow up.<br><br>In an interview on 01/12/2022 at 11:31 AM, Staff E was asked regarding the status of the investigation for Resident 8 as there had been no verbal follow up and an updated state incident reporting log still did not include an entry for the allegation five days later. Staff E stated that they had been told by Staff F, former Administrator, that they recalled that specific allegation and that the allegation had been previously investigated. Staff E stated they were just confirming the time frame and would locate and provide a copy of the investigation for review.<br><br>In a follow up interview on 01/13/2022 at 9:15 AM, Staff E stated the investigation for Resident 8 had just been reported to the hotline the day prior. They stated that they had been unable to find an investigation and that follow up questions to the facility team had revealed that the allegation had not been previously investigated as stated. The resident had reportedly only voiced that they did not want to use the sit to stand machine but had not made any allegation of potential abuse prior to 01/07/2022. Staff E stated there had been no allegation before, so there had been no prior report or investigation. It was confirmed that the statements made by resident 8 on 01/07/2022 did include an allegation of potential abuse and had been reported to Staff E and then to Staff F, former Administrator, and that Staff F was reported to have stated that they already knew about the abuse allegation and it had been previously investigated, which was not the case. Staff E stated they were aware that this was now an unreported and uninvestigated incident for five days stating, yes, I know and I know that is a problem. Staff F was no longer employed at the facility.<br><br>The facility failed to recognize or act on an abuse allegation that was reported on 01/07/2022 until 01/13/2022.<br><br>42927<br><br>RESIDENT 7<br><br>Resident 7 admitted to the facility on [DATE]. The resident had a condition that caused a progressive decline of the neurological system. Review of the MDS assessment dated [DATE], showed the resident had no cognitive impairment.<br><br>In an interview on 01/13/2022 at 10:16 AM, Staff A, Registered Nurse/Resident Care Manager, reported that there had been an incident with Resident 7 and their previous roommate. Staff A stated that the incident had been reported to a staff member, but that the staff member did not report it to management staff until the next day. Staff A also stated the incident had not been reported to the state hotline until the next day.<br><br>In an interview on 01/14/2022 at 11:01 AM, Resident 7 stated that there was a recent incident with their past roommate. Resident 7 stated that their roommate had yelled at them and slapped them on their arm.<br><br>Both residents remained roommates between the report of the abuse allegation and the time the facility initiated an investigation the next day.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | WAC Reference: 388-97-0640 (1), 2(b), 5(a), 6(b)<br><br>This is a repeat citation from the Statement of Deficiencies, dated 03/04/2021.<br><br>33954 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>29058<br><br>Based on interview and record review the facility failed to recognize, conduct a thorough investigation, and take appropriate corrective action as a result of investigation findings following an allegation of abuse for one of four residents (61) reviewed for abuse and neglect. This failure placed the resident at risk for unidentified abuse/neglect, potential ongoing abuse/neglect, and a diminished quality of life.<br><br>Findings included .<br><br>Resident 61 was a long-term care resident with diagnosis to include diabetes. The resident was alert and oriented and able to make their needs known.<br><br>In an interview on 01/07/2022 at 10:46 AM, the resident stated, they were treated aggressively by an aid last evening. The resident went on to say, they felt the aid was pushing them around, yelling at them to roll over, move this way. The resident stated they did not know the name of the aid and described the staff member as a very tall female aid. When asked if the resident had reported the interaction, the resident stated no. The allegation was immediately reported to the Administrator.<br><br>Review of the facility investigation revealed the resident had already reported the allegation to Staff J, Nursing Assistant Certified. In response Staff J, reported the allegation to Staff A, Registered Nurse (RN)/Resident Care Manager.<br><br>According to Staff J, Staff A stated the allegation did not need to be reported and an investigation was not started immediately.<br><br>The investigation included a performance improvement notification for Staff J with education on mandated reporting.<br><br>The investigation did not include any education to prevent re-occurrence to Staff A, who did not report or begin and investigation immediately.<br><br>In an interview on 01/13/2022 at 9:20 AM, Staff E, Regional Nurse Consultant/Acting Director of Nursing, stated understanding of the missing component to the investigation.<br><br>Reference: WAC 388-97-0640 (6)(a)(b)<br><br>This was a repeat deficiency from 01/19/2021 and 08/05/2021. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29058<br><br>Based on interview and record review the facility failed to incorporate the recommendations from the Pre-Admission Screening and Resident Review (PASARR) evaluation report into the resident's care planning for two of two residents (37 and 1) reviewed. This failed practice had the potential to diminish the resident's quality of life.<br><br>Findings included .<br><br>RESIDENT 37<br><br>Resident 37 was admitted to the facility on [DATE] with diagnosis to include depression. The resident was alert and oriented and able to make their needs known.<br><br>In an interview with Collateral Contact 5 (CC5) on 01/11/2022 at 10:42 AM, showed CC5 stated they purchased therapeutical items for the resident and had the items mailed to the facility. They received confirmation of delivery of the items with a date of 12/01/2021.<br><br>CC5 stated, they made multiple phone and e-mail attempts to contact Staff H, Social Services Director, to request the residents care plan showing incorporation of the items delivered for the resident and a signed invoice by the resident. CC5 continued to state, their requests went unanswered.<br><br>Review of the PASRR equipment purchase request dated 09/28/2021, showed supplies purchased for the resident included holiday cards, stationary supplies, art supplies and a charging cord. The purchase request documented, therapeutic supplies Necessary in order to fully implement the therapy or intervention for the resident.<br><br>In an interview with the resident on 01/12/2022, the resident stated they never received the items they were supposed to receive around the holiday times, stated they did not know what happened.<br><br>Review of the resident's care plan revealed the items where not incorporated into the resident's plan of care.<br><br>In an interview on 01/14/2022 at 10:57 AM, Staff H was asked about their role in the coordination with the PASRR agency. Staff H stated they currently did not have any residents that required coordination services. Staff H was then asked about Resident 37 and the items purchased for the resident by the PASRR agency, the PASRR agency contacted them numerous times and not received a response from them.<br><br>Initially, Staff H stated not having received any phone calls or e-mails from the PASRR agency, when asked to look in their e-mails, Staff H then stated, oh, I just now see the e-mails. Staff H was asked when the e-mails were sent to them, Staff H stated, a few weeks ago. When asked where the items that were delivered for the resident were, Staff H stated they did not know.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility failed to ensure specialized services were combined with services provided by the nursing facility, for the purpose of a continuous implementation of an individualized plan of care for the resident.<br><br>33954<br><br>RESIDENT 1<br><br>The resident admitted to the facility on [DATE]. According to the Quarterly Minimum Data Set (MDS) assessment, dated 10/01/2021, the resident had moderate cognitive impairment.<br><br>Review of an email from Collateral Contact 5 (CC5), to Staff H dated 12/13/2021, showed multiple requests had been made requesting the facility provide signed invoices (for supplies sent to the facility for residents) and revised care plans, and these were the same items/invoices the PASRR evaluator had previously attempted to contact/collaborate with the facility about.<br><br>Review of a shipping form, dated 09/20/2021, showed items shipped to the facility for Resident 1 included cotton paper stationery with envelopes, felt tip pens, and a book of 20 stamps.<br><br>Review of the resident's care plan, print date 01/11/2022, revealed no documentation the facility had incorporated the PASRR evaluator's recommendations/or the equipment/supplies provided into the resident's plan of care.<br><br>In an interview on 01/12/2022 at 10:10 AM, the resident was unable to provide any information about the supplies/equipment, or why they had not received them yet.<br><br>In an interview on 01/14/2022 at 10:49 AM, Staff H denied they had any knowledge of, or that they had had any contact with the PASRR evaluator regarding these supplies/equipment. Staff H was asked about emails to them from the PASRR evaluator, was unable to provide any information, and denied they received any emails from CC5.<br><br>Reference: (WAC) 388-97-1975 (8)(10) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0646<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify the appropriate authorities when residents with MD or ID services has a significant change in condition.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954<br><br>Based on observation, interview, and record review the facility failed to ensure Preadmission Screening and Resident Review (PASRR) assessments were completed accurately for all residents and reviewed following significant change in status as required for one of one resident reviewed (24) for Behavioral Health Services. This failure resulted in a delay in referral for level 2 PASRR services for Resident 24 and the potential for decreased quality of life.<br><br>Findings included .<br><br>Review of the facility policy titled, Admission Criteria, dated of 03/2019, showed the facility would follow the PASRR process as required.<br><br>Review of the PASRR level one form showed that residents were to be referred for level 2 evaluations if all three of the following criteria were met:<br><br>1- diagnosis of serious mental illness;<br><br>2- evidence of functional limitations related to mental illness; and<br><br>3- psychiatric treatment or significant episode or disruption requiring supportive services in the past two years.<br><br>Resident 24 admitted [DATE] with diagnoses of Chronic Obstructive Pulmonary disease (COPD), pulmonary nodule (a growth), respiratory failure, generalized anxiety disorder and alcohol use disorder.<br><br>Review of the resident's PASRR level one (dated 08/06/2021) showed the resident had indicators of serious mental illness (criteria 1) and was also identified as having evidence of functional limitations (criteria 2) related to mental illness.<br><br>Review of the resident's hospital history and physical information and social history dated 08/04/2021 showed the resident had 11 hospital admissions in the past year related to a pattern of COPD exacerbations, alcohol use and withdrawal. The resident had cycled between periods of homelessness and short stays at either skilled nursing facility or emergency housing through an outreach program. Review of these records showed the resident met PASRR level one criteria 3 for disruption requiring supportive services which was incorrectly marked as no on the PASRR level one form and was not identified by the facility as inaccurate.<br><br>The incorrect identification of criteria resulted in the level one assessment stating not requiring level 2 referral due to no indicators which was incorrect.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0646<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The resident admitted on Hospice Services which would have potentially been the correctly identified exemption at the time of admission and was not correctly identified. The resident's medical condition stabilized, and they were discharged from Hospice effective 11/01/2021 which required a Significant Change in Status Assessment with comprehensive care plan review. A PASRR review was required for a Significant Change in Status assessment and was not completed for Resident 24 who may have been eligible for and benefited from level 2 services at that time.<br><br>In an observation on 01/07/2022 at 11:54 AM, Resident 24 was in their room, sitting on their bed appearing disheveled, with long unkempt hair and beard. There was a piece of paper hanging outside the door with writing of varying sized letters, some capitalized and underlined with profanity and words like dying death camp and ear infection. There were similar papers hanging up inside his room, strewn across the floor, on the walls and a stack on the overbed table. A handmade chart was observed on the wall with statistics about COVID-19 and included phrases consistent with conspiracy theories. The resident spoke with fragmented thoughts and talked of the main office man trying to steal his money, plotted to give them COVID-19, and their brain was rotting because of an ear infection. Their voice was loud and angry at times when speaking. They had stated they wanted to leave but then suddenly stated, I am going to stay here, I like it here, they have food.<br><br>In an interview on 01/14/2022 at 10:47 AM with Staff H, Social Services Director, stated they were responsible for the PASRR process for residents which included reviewing level one assessments for accuracy and referral for level 2 assessments; however, Staff H stated they had been unaware of level 2 assessments or the requirements surrounding those and had not been completing them. Staff H stated they had not referred Resident 24 for a level 2 referral and had not been aware of the requirement to re-evaluate resident's PASRR eligibility with significant change assessments.<br><br>Reference (WAC) 388-97-1915; -1975<br><br>37890 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787<br><br>Based on interview, observation and record review the facility failed to provide assistance with activities of daily living to include personal hygiene and bathing for 6 of 6 dependent residents (1, 10, 21, 22, 26, & 39), reviewed for activities of daily living (ADL's). Facility failure to provide the resident, who was dependent on staff for assistance with grooming, and showers placed the resident and others at risk for poor hygiene, unmet care needs and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility policy titled, C.N.A. Standards of Care, undated, directed staff to provide oral care, wash hands and face in the morning and evening, shower per schedule and shave man/woman as needed.<br><br>RESIDENT 21<br><br>Resident 21 admitted to the facility on [DATE] and was dependent on staff for all care.<br><br>Review of the Admission Minimum Data Set Assessment, dated 11/07/2021, showed they required extensive assistance for bathing and no bathing had occurred in the lookback period. They did not reject care.<br><br>Review of the bathing documentation beginning on admission 11/01/2021, showed they received five showers in three months. Resident 21 received showers on 11/18/2021, 12/07/2021, 12/28/2021, 01/11/2022 and 01/18/2022.<br><br>RESIDENT 22<br><br>Resident 22 admitted to the facility on [DATE] and required assistance from staff for bathing.<br><br>Review of the Admission MDS, dated [DATE], showed they required extensive assistance for bathing and no bathing had occurred in the lookback period. They did not reject care.<br><br>Review of the bathing documentation beginning on admission 11/01/2021, showed they received five showers in three months. Resident 22 received showers on 11/11/2021, 12/07/2021, 12/28/2021, 01/11/2022 and 01/18/2022.<br><br>In an phone interview on 01/13/2022 at 3:12 PM, Resident 21 and 22's family member stated their loved ones were in the same clothing for weeks in a row and they went a week without showers. The family member stated (Resident 21) complained of itching and the family had to shave (Resident 21). When family expressed their concerns with staff, they were notified the facility was short staffed The family member stated after they complained to the facility, grooming improved.<br><br>RESIDENT 26<br><br>Resident 26 readmitted to the facility on [DATE] and required assistance from staff for bathing.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the Quarterly MDS, dated [DATE], showed they required minimum to moderate assistance for bathing and no bathing had occurred in the lookback period. They did not reject care.<br><br>Review of the current care plan showed the resident preferred to have one shower a week.<br><br>Review of the bathing documentation beginning on admission 11/01/2021 until 01/26/2022, showed they received two showers in three months. Resident 26 received showers on 11/10/2021 and 11/17/2021. There were no showers provided in December 2021 or January 2022. The resident had refused showers on six attempts in December and four attempts in January. There was no evidence showers were offered on the day following refusals.<br><br>33954<br><br>RESIDENT 1<br><br>The resident admitted to the facility 03/18/2020 and had diagnoses to include cerebral palsy (a disorder that affects a person's ability to move and maintain posture and balance). According to the quarterly MDS assessment, dated 10/01/2021, the resident had moderate cognitive impairment, and needed staff assistance with bed mobility, dressing, toilet use, personal hygiene, and bathing.<br><br>In an observation/interview on 01/06/2022 at 11:35 AM, the resident stated they wanted a shower as they hadn't had one in over a week. The resident was observed to have several days of beard growth, when asked about it, the resident stated they shaved when they showered.<br><br>Review of the resident's care plan, print date 01/11/2022, showed the resident was care planned they wanted two to three showers a week.<br><br>Review of the resident's bathing documentation for 30 days, print date 01/11/2022, showed the resident had been bathed on five days, and there was a refusal documented on four days.<br><br>In an interview on 01/12/2022 at 10:10 AM, the resident stated they wanted to bathe more often, and they used to bathe every day.<br><br>In an interview on 01/13/2022 at 1:41 PM, Staff A, Registered Nurse (RN)/Resident Care Manager (RCM), was asked about lack of care planned bathing for this resident, she stated she thought there was missed documentation more than anything else. Staff A stated to her knowledge the resident had very few bathing refusals.<br><br>RESIDENT 10<br><br>The resident admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease, adult failure to thrive (decline sometimes seen in older adults with chronic medical conditions, resulting in a downward spiral manifested by inactivity, depression and decreased functional abilities), and generalized muscle weakness. According to the annual MDS assessment, dated 10/12/2021, the resident had severe cognitive impairment, and had total dependence on staff for bathing.<br><br>In an interview on 01/14/2022 at 9:35 AM, the resident did not know when they had last bathed.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the resident's bathing documentation for 30 days, print date 01/14/2022, showed the resident was bathed only once, and staff had documented refusals on three dates.<br><br>Review of progress notes from 12/12/2021 through 01/11/2022 revealed no documentation staff had assessed why resident had refused to bathe, or what staff did to reschedule missed bathing.<br><br>In an interview on 01/20/2022 at 8:50 AM, the resident stated they were not being bathed often enough, when asked for specifics, resident was unable to provide additional information.<br><br>Review of the resident's care plan, print date 01/22/2022, showed there was no documentation how often the resident wanted to bathe.<br><br>Review of the resident's Oral Care documentation for 30 days, print date 01/11/2022, showed staff had documented oral care was done on 11 days, and there were 8 days that a refusal was documented.<br><br>In an observation/interview on 01/14/2022 at 9:35 AM, the resident's toothbrush was observed lying in the bottom of a basin with other toiletries. The resident was unable to state whether their teeth got brushed yet that day, or the day prior.<br><br>In an interview on 01/14/2022 at 11:20 AM, Staff A, RN/RCM, stated the resident had refused to bathe a lot, when asked why resident refused or what the facility was doing to accommodate the resident, she stated they were working on it. Staff A was asked about lack of documented oral care for the resident, she was unable to provide any information.<br><br>44110<br><br>RESIDENT 39<br><br>Resident 39 admitted to the facility on [DATE] and was dependent on staff for all care.<br><br>Review of Significant Change Minimum Date Set (MDS) Assessment on 12/05/2021 showed they required extensive assist for bathing and there was no rejection of care.<br><br>Review of Residents care plan on 01/11/2022 showed resident preferred to have one bath a week.<br><br>Review of the bathing documentation beginning on admission 10/08/2021 showed they received seven showers in three months. Resident 39 had no bathing in October with one refusal documented. There were two bathing entries on 11/19/2021, 11/26/2021, and one refusal. January the resident had one documented bathing entry and no refusals.<br><br>Reference: (WAC) 388-97-1060 (2) (c)<br><br>This is a repeat deficiency from 04/23/2021. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787<br><br>Based on observations, interviews and record review, the facility failed to 1) meet the needs or wants of the residents, 2) ensure there was sufficient numbers of nursing staff to provide care and services and to provide accurate and timely assessments, 3) ensure all residents received showers, 4) answer call lights timely, 5) deliver meals in a timely manner, and 6) to have enough staff to have consistent clinical systems in place to identify respiratory issues, practice proper infection control measures, identify skin, nutrition, bowel and bladder issues, and provide restorative programs for two of two units reviewed for staffing. These failures placed residents at risk for potential harm related to anxiety, feelings of frustration and vulnerability, unmet care needs and a diminished quality of life.<br><br>Findings included .<br><br>FACILITY ASSESSMENT<br><br>Review of the facility assessment, date last reviewed December 2021, showed staffing and scheduling was determined by the needs and acuity of the resident population. The assessment showed overall staffing was insufficient. The facility reported they had a high number of high acuity residents and a high number of residents who were dependent on extensive assistance. The facility had a high amount of residents with pain and falls with injuries. The facility assessment did not include the amount of direct care nursing staff or ancillary staff required to meet the needs of the facility residents.<br><br>STAFFING PATTERN<br><br>Review of the staffing pattern 12/04/2021 through 01/03/2022 showed the facility had four to five nurses on day shift, one nurse on the evening shifts and two nurses on the night shift. There were seven to eleven nursing assistants scheduled on day shift, four to eight on evening shift and two to seven on night shift.<br><br>RESIDENT INTERVIEWS<br><br>RESIDENT 18<br><br>In an interview on 01/07/2022 at 9:47 AM, Resident 18 stated it took an hour and a half for the call light to be answered between 3:30 AM and 5:00 AM. They stated call lights had been bad for the past two days and not the best on evening shift for the past two weeks.<br><br>RESIDENT 27<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 01/07/2022 at 9:52 AM, Resident 27 was laying in bed without their call light in reach. They stated they were previously in hospital administration. They said the first to be affected with staffing was the kitchen crew. They said the nursing department was very short-staffed, and if a nurse was busy, it would be 30 minutes to get assistance. The resident stated they had to just get up and go get help when needed.<br><br>RESIDENT 12<br><br>In an interview on 01/07/2022 at 10:33 AM, Resident 12 stated they had been a resident over six years at the facility. They stated, there was not enough staff and they were upset at the high amount of staff turnover. The resident stated they looked on the internet and read the facility no longer has 120 residents but 58 now, which they commented was not good.<br><br>RESIDENT COUNCIL MINUTES<br><br>Review of the resident council minutes for November 2021, showed one resident stated call lights were not answered timely. Another resident stated when sitting on the commode, they sometimes wait too long.<br><br>CALL LIGHT OBSERVATIONS:<br><br>The following call light observations were made:<br><br>RESIDENT 8<br><br>A continuous observation and interview with Resident 8 on 01/07/2022 between 1:57 PM and 2:58 PM showed the call light was observed on and unanswered for one full hour:<br><br>On 01/07/2022 at 1:57 PM, the call light initially observed on outside of the room. The resident's door was closed.<br><br>At 2:10 PM, the call light still on, Resident 8 heard calling out hellloooooooooo from behind the closed door.<br><br>At 2:27 PM, in an interview with the resident, knocked on the door and observed Resident 8 sitting up in their wheelchair watching television. They stated they often had to wait like this depending on who was there, and stated they had been sitting up since 11:00 AM and wanted to lie back down, my butt hurts.<br><br>At 2:29 PM, Resident 8 stated they were frustrated at sitting and waiting and stated they frequently sit like this and staff tell them they have to wait because they have too many people to take care of. The call light was observed still on.<br><br>At 2:58 PM, an Staff EE, Nursing Assistant Certified (NAC), responded to the light.<br><br>In an interview on 01/07/2022 at 3:01 PM, Staff EE stated they had just been sent over from the other unit and had gotten no report for their shift.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an observation on 01/21/2022 at 10:23 AM until 10:55 AM, call lights in 125, 126, 145 and 144 were on. At 10:35 AM, 158 came on. Staff D, Licensed Practical Nurse (LPN) asked Staff II, NAC to answer the call lights that were going off. Staff II responded, But I am going to break. Staff D stated, Please just answer the lights.<br><br>In an observation on 01/21/2022 at 10:41 AM, Staff R, Environmental Assistant walked up to the nurse's station and stated, Is there any CNA's here? I need 146 out of their bed to replace it. Staff R looked at this surveyor and shrugged their shoulders at me. This surveyor informed them I was not an employee here and they responded. Oh.<br><br>COLD FOOD<br><br>In a continuous observation on 01/06/2022 at 11:52 AM, hall trays were in the process of being passed on Unit A. The last tray was delivered at 1:08 PM.<br><br>RESIDENT 37<br><br>In an interview on 01/06/2022 at 12:31 PM, Resident 37 stated food is delivered cold every few days. The resident stated at [NAME] the sausage will be hot but their eggs were cold and they would send them back.<br><br>RESIDENT 59<br><br>In an interview on 01/10/2022 at 10:33 AM, Resident 59 stated their scrambled eggs and other food were cold for breakfast.<br><br>In an interview on 01/20/2022 at 1:48 PM, Resident 59 stated the food is cold and dry. The eggs are cold, everything is cold. Resident 59 stated they have to send the food back without eating due to the temperature.<br><br>STAFF INTERVIEWS<br><br>In an interview on 01/04/2022 at 2:02 PM, Staff GG, Registered Nurse (RN), stated, I had 48 people this morning when I came on this morning. There are more Coronaviruse Disease 2019 (COVID-19) positive people on the A wing. I am not a complainer, but this is so frustrating when I can't be a competent nurse.<br><br>In an interview on 01/06/2022 at 12:25 PM, Staff T, NAC approached and loudly said, will you shut this place down please? It is terrible, everybody is sick. We are short, the nurses are short. We can't do everything.<br><br>In an interview on 01/07/2022 at 10:35 AM, Staff E, Regional Nurse Consultant/Acting Directior of Nursing Services confirmed the facility had a staffing shortage. Staff E stated, We are staffing at half of what we need to be staffing.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 01/20/2022 at 10:19 AM, Staff C, RN stated today they had eighteen residents which is doable but when it is in the 30's that is a little much. They stated they once had 38 residents and it was very stressful. They stated they work 12 hour shifts and would not do sixteen hour shifts as two weeks prior there was a call in and no one relieved them.<br><br>In an interview on 01/24/2022 at 2:09 PM, Staff A Registered Nurse/Resident Care Manager (RN/RCM), acknowledged the facility had struggled with staffing due to COVID-19. Staff A was asked about unit oversight and nurse manager coverage. They stated Staff JJ, LPN/RCM had been covering for night shift and they had been pulled to work shifts on the floor for call ins or staff quitting. They stated they come to work every day to coordinate care for the unit and if staff called in they go home, try to get some sleep before they are due back to the facility. Staff A said they worked the floor sporadically. In December, they worked three shifts on the floor and in January it was frequent. Staff A stated a new Staff Development Nurse /Infection Preventionist was being trained at another facility.<br><br>In an interview on 01/24/2022 at 2:52 PM, Staff KK, NAC stated the management turnover has been difficult and they never knew what the expectations were. Staff KK stated they were frequently short staffed and residents did not get the care they needed. They stated showers were missed. Staff KK, stated staff are all burned out because of everyone being off due to COVID-19 and now staff were even working while they had COVID-19. They said agency was utilized for staffing, but they were still understaffed with agency.<br><br>37890<br><br>LACK OF SUFFICIENT STAFF TO ANSWER THE PHONE<br><br>In a phone interview on 01/19/2022 at 1:41 PM, Collateral Contact 2 (CC2), stated the facility seemed to be heavily understaffed because staff didn't even have time to answer the phone when they called the facility. CC2 stated they got hung up on four times by staff when they called and it made them a little on the hot side.<br><br>In a phone interview on 01/19/2022 at 1:57 PM, Collateral Contact 3 (CC3) stated they had tried to get through on the phone system many times and it was always very difficult, or sometimes impossible. CC3 stated after 5 PM you either couldn't get a hold of any staff, or the call would get dropped because staff were trying to transfer the call, but didn't know what they were doing.<br><br>In an interview on 01/20/2022 at 10:25 AM, Staff C, RN stated, when there was no receptionist they couldn't answer the phones and the phones just rang because they couldn't just leave the resident rooms. Staff C stated they believed a lot of appointments got missed because there was nobody to answer the phone. They stated, If a doctor was calling us, we wouldn't know. I have tried to call in sick, but kept calling and no one answered, so I ended up coming into work with a migraine. I can understand how the family feels when no one answers the phone. We have no phones on our carts. If there was someone around, we would try to answer the phone, but it is impossible.<br><br>In an interview on 01/24/2022 at 2:13 PM, Staff A, RN/RCM said the facility phone rings back to the nurses units once the front desk person leaves for the day. They stated there are no portable phones available, only the phones at the nurses station. Staff A stated the NAC's, nurses and ancillary staff should answer the phones.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | For further information regarding staffing:<br><br>Refer to F 602<br><br>Refer to F 641<br><br>Refer to F 677<br><br>Refer to F 686<br><br>Refer to F 688<br><br>Refer to F 690<br><br>Refer to F 692<br><br>Refer to F 698<br><br>Refer to F 770<br><br>Reference: (WAC) 388-97-1080 (1)<br><br>43954<br><br>33954 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890<br><br>Based on observation, interview and record review, the facility failed to identify targeted behaviors and the need for a professional assessment of the resident's mental health for one of one residents (24) reviewed for behavioral and emotional needs. This failure resulted in lack of resident centered interventions and goals, and increased risk for the resident to repeat patterns of unsafe discharges and re-hospitalization s related to mental health and substance abuse issues.<br><br>Findings included .<br><br>RESIDENT 24<br><br>Resident 24 admitted [DATE] with diagnoses of Chronic Obstructive Pulmonary disease (COPD) (a breathing disorder), pulmonary nodule (growth), respiratory failure, generalized anxiety disorder and alcohol use disorder.<br><br>Review of the resident's hospital history and physical information and social history dated 08/04/2021 showed the resident had 11 hospital admissions in the past year related to a pattern of COPD exacerbations, alcohol use and frequently admitting in alcohol withdrawal. The resident had cycled between periods of homelessness and short stays at either skilled nursing facility or emergency housing through a community outreach program. The resident was stated to have significant cognitive deficit due to alcohol use, and prognosis was listed as poor without social intervention.<br><br>The resident met criteria for level 2 Preadmission Screening and Resident Review (PASARR) referral upon admission but the level one assessment criteria was not identified correctly and not further reviewed during Significant Change in Status assessment on 11/01/2021. The resident had therefore not been referred for level 2 assessment to identify eligibility for potential mental health services available through the PASRR program.<br><br>In an observation on 01/07/2022 at 11:54 AM, Resident 24 was in their room, sitting on their bed appearing disheveled, with long unkempt hair and beard. There was a piece of paper hanging outside the door with writing of varying sized letters, some capitalized and underlined with profanity and words like dying death camp ear infection. There were similar papers hanging up inside his room, strewn across the floor, on the walls and a stack on the overbed table. A handmade chart was observed on the wall with statistics about Coronavirus Disease (COVID-19) and included phrases consistent with conspiracy theories. The resident spoke with fragmented thoughts and talked of the main office man trying to steal his money, plotted to give them COVID-19, their brain was rotting because of ear infection. Their voice was loud and angry at times when speaking. They had stated they wanted to leave but then suddenly stated, I am going to stay here, I like it here, they have food.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 01/19/2022 at 10:55 AM, Staff A, Resident Care Manager/Registered Nurse, stated the resident had delusions and often paced through the building, vandalized items in the facility such as signs or papers by writing phrases on them, sometimes writing profanity, often things about the coronavirus such as you are going to die. Staff A stated they were not aware of specific interventions for the resident's behaviors, which were not specified on the resident's care plan. Staff A stated it was possible that Resident 24 was being seen by Forefront which offered mental health services via telehealth. Staff A stated that Staff H, Social Services Director, assisted residents with those appointments using a tablet. Staff A could not locate any documentation in the resident's record to indicate that they were receiving those services.<br><br>In an interview on 01/19/2022 at 11:29 AM, Staff H, Social Services Director, stated that if residents were appropriate for Forefront they simply sent in a request to have the resident added to their schedule. Staff H stated the services were therapeutic so the recommendations did not include medications, but included approaches and recommendations. Staff H stated they were not aware if physician's orders for referral were needed or not and confirmed that Resident 24 was not part of their case load. Staff H stated that Resident 24 had grandiose thoughts and was very involved in conspiracy and political ideas, he would have to ask him not to post things outside of his room and often the resident would make accusations about mail missing, and they would go to his room together and it would be found. He stated they were letting him be himself, and stated the resident was talking about wanting to discharge but had not offered or assisted the resident with obtaining any mental health services which they may benefit from (such as Forefront). These services may be able to provide support to the resident and staff, identify triggers and approaches that could improve the resident's chances for a continued successful and stable living situation which has been the key to his physical health and had not been offered to the resident.<br><br>No associated WAC Reference<br><br>33954 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954<br><br>Based on interview and record review, the facility failed to ensure clinical records were complete, accurate, and accessible for six of 47 residents (1, 214, 215, 56, 19, 39) reviewed. The failure to: 1) document wound assessments, 2) ensure nurses completed documentation related to whether medications and treatments were given/done or not and that it was accurate, 3) to document behavior monitoring, 4) to maintain copies of Notice of Medicare Non-Coverage (NOMNC)(Medicare coverage form) forms and appeals of these coverage denials in resident clinical records,<br><br>These failures placed residents at risk for complications, decreased quality of life, and billing inaccuracies.<br><br>Findings included .<br><br>RESIDENT 1<br><br>The resident admitted to the facility on [DATE]. According to the Quarterly Minimum Data Set (MDS) assessment, dated 10/01/2021, the resident had moderate cognitive impairment.<br><br>In an observation/interview on 01/12/2022 at 10:10 AM, the resident was observed to have a white dressing on the left lower leg just above the ankle, the resident did not know why they had the dressing and they stated the nurses knew about it.<br><br>On 01/12/2022, a review of the resident's clinical record revealed no documentation about the wound on the left lower leg.<br><br>In an observation on 01/20/2022 at 10:55 AM, the resident's wound on the left lower leg was observed with Staff C, Registered Nurse (RN), the wound was observed to be 1x2x0.1 centimeters, and the center of the wound appeared pink and wet, and the area around the wound was purple/brown.<br><br>Review of Resident 1's January 2022 Medication Administration Records(MAR)/Treatments Administration Records(TAR)/Behavior Monitoring Records revealed no documentation related to the following:<br><br>-Behavior monitoring (swearing profanities at staff .) on 01/04/2022, 01/05/2022, 01/09/2022,<br><br>-Depressive behavior monitoring for treatment with Effexor (antidepressant medication), on 01/04/2022, 01/05/2022, 01/09/2022,<br><br>-Impulse control disorder behavior monitoring on 01/04/2022, 01/05/2022, 01/09/2022,<br><br>-Mood Stabilizer side effect monitoring on 01/03/2022, 01/04/2022, 01/05/2022, and 01/09/2022,<br><br>-Casirivimab-Imdevimab (COVID medication) administration or reason not given, on 01/05/2022 and 01/06/2022,<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Bilateral buttocks treatment, 01/04/2022,<br><br>-Apply ace wrap to both legs, 01/04/2022 and 01/05/2022,<br><br>-Dressing change on right leg, 01/05/2022,<br><br>-Apply antifungal powder to right abdominal fold, 0600 shift on 01/04/2022 and 01/05/2022,<br><br>-COVID 19 screening, 0600 shift on 01/04/2022 and 01/05/2022,<br><br>-Head of bed elevated related to shortness of breath on 0600 shift 01/04/2022 and 01/05/2022,<br><br>-Monitoring for antidepressant medication side effects on 0600 shift 01/04/2022 and 01/05/2022,<br><br>-Monitoring for opioid pain medication side effects on 0600 shift on 01/04/2022 and 01/05/2022,<br><br>-Offer to assist resident with wearing mask for COVID 19 prevention on 0600 shift 01/04/2022 and 01/05/2022,<br><br>-Vitals related to monoclonal antibody (COVID medication) treatment on 01/05/2022 and 01/06/2022.<br><br>In an interview on 01/13/2022 at 1:41 PM, Staff A, Registered Nurse (RN)/Resident Care Manager (RCM), was unable to provide any information about the wound on the left lower leg, she stated she didn't know anything about it. Staff A also stated she was unable to provide any information regarding the holes in documentation related to medications, behaviors, and treatments on shifts where staff failed to document anything.<br><br>RESIDENT 214<br><br>The resident admitted to the facility on [DATE] and discharged on [DATE].<br><br>Review of a Notice of Medicare Non-coverage (NOMNC) form, dated 12/13/2021, revealed the resident's Medicare coverage was to end 12/15/2021.<br><br>In an interview on 01/20/2022 at 2:17 PM, Staff H, Social Services Director, stated the resident appealed the NOMNC dated 12/13/2021 and won the appeal, and the facility issued a second NOMNC, but he was unable to provide a copy of the second NOMNC.<br><br>In an interview on 01/21/2022 at 12:55 PM, Staff H stated he was unable to find a copy of the NOMNC the facility issued after the resident had won the appeal or any documentation regarding the appeal the resident won regarding the first NOMNC.<br><br>RESIDENT 215<br><br>The resident admitted to the facility on [DATE] and discharged on [DATE].<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a NOMNC form, dated 12/10/2021, revealed the resident's Medicare coverage was to end 12/12/2021. Review of the form showed it was signed in the Patient/Representative space, but that signature was illegible. The form had another signature on it that was illegible.<br><br>In an interview on 01/20/2022 at 2:28 PM, Staff H stated he had signed in the Patient/Representative space, and that the Director of Admissions had signed in another made up spot on the form for a witness, neither signature was legible. Staff H stated he agreed that someone else would not know whose signatures staff had made. Staff H was unable to state why he signed in the Patient/Representative space.<br><br>In an interview on 01/24/2022 at 11:40 AM, Staff H, stated the resident had appealed the NOMNC dated 12/10/2021 and won, and the facility issued a second NOMNC. Staff H stated he was unable to provide a copy of the second NOMNC or the appeal the resident won.<br><br>36787<br><br>RESIDENT 56<br><br>Resident 56 readmitted on [DATE] and had diagnoses to include oral cancer and multiple mental health conditions.<br><br>Review of Resident 56's Behavior Monitoring, and TARs revealed no documentation related to the following;<br><br>-Behavior monitoring for monitoring for treatment with Quetiapine (anti-psychotic medication) on 11/16/2021, 11/13/2021, 11/28/2021, 01/04/2022, 01/05/2022, and 01/09/2022,<br><br>-Depressive behavior monitoring for treatment with Wellbutrin and Sertraline (anti-depressant medications), on 11/16/2021, 11/13/2021, 11/28/2021, 01/04/2022, 01/05/2022, 01/09/2022,<br><br>-Anxiety behavior monitoring for treatment with Clonazepam (anti-anxiety medication) on 11/16/2021, 11/13/2021, 11/28/2021, 01/04/2022, 01/05/2022, 01/09/2022,<br><br>-Weekly skin checks on 11/10/2021 and 01/05/2022,<br><br>-Oral care on 11/10/2021 at 07:00 AM, 10:00 AM and 1:00 PM, 11/14/2021 at 07:00 AM, 10:00 AM and 1:00 PM, 12/12/2021 at 1:00 PM, 12/13/2021 at 1:00 PM, 12/14/2021 at 1:00 PM and 12/17/2021 at 1:00 PM and 4:00 PM.<br><br>-Weekly weights on 12/15/2021, 01/03/2022 and 01/17/2022,<br><br>-Assistance with oral cavity packing on 12/02/2021 at 1:00 PM, 12/13/2021 at 1:00 PM and 12/14/2021 at 9:00 AM and 1:00 PM,<br><br>-Call eye clinic immediately if resident experienced floaters or flashes of light monitoring on 11/05/2021, 11/10/2021, 11/14/2021, 01/04/2022 and 01/05/2022.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 01/25/2022 at 3:23 PM, Staff E, Regional Nurse Consultant/Acting Director of Nursing Services was informed there were multiple charting omissions in the clinical records including MAR's, TAR's and Behavior Monitoring for multiple residents. Staff E was also alerted that on 01/04/2022 and 01/05/2022 entire resident charting was missed. Staff E stated those days were at the height of their Coronavirus Disease 2019 (COVID-19) outbreak. They stated Medical Records should be auditing for missed documentation.<br><br>44110<br><br>Review of facility policy titled, Requesting, Refusing, and/or Discontinuing Care of Treatment, dated February 2021 showed when a resident refused treatment or care the physician should be notified and documented in the medical chart.<br><br>RESIDENT 39<br><br>Resident 39 admitted to the facility on [DATE] with diagnosis of paralysis to right arm and right leg. According to the Significant Change MDS Assessment, dated 12/05/2021, the resident had severe cognitive impairment, and needed 2-person extensive assistance with bed mobility, dressing and toilet use, and needed supervision/setup for eating.<br><br>Review of the residents TAR for October showed a order that directed staff to remove the indwelling (long term use) catheter for a trial void. The order directed the staff to bladder scan the resident every shift and to replace the indwelling catheter when bladder scan showed more than 400 cubic centimeters (cc) of urine or above. Review of the documented bladder scan results:<br><br>** 10/18/2021 at 6:00 PM showed 430cc<br><br>** 10/19/2021 at 6:00 PM showed 475cc<br><br>Review of the resident progress note dated 10/19/2021 at 12:56 AM, Staff A, RCM documented the bladder scan showed 430 cc of urine in the bladder, an in-and-out catheter was performed. The indwelling catheter was not replaced on the resident as the order directed.<br><br>Review of progress note dated 10/19/2021 at 5:46 PM, a nurse documented during an assessment of the resident, their bladder was noted to be rigid, the resident had reported pressure, a bladder scanner was performed on the resident and showed there was greater than 400cc of urine in the bladder. An in-and-out catheter was performed on the resident. The indwelling catheter was not replaced on the resident as the order directed.<br><br>Review of the resident's TAR for December and January showed an order that directed staff to reposition the resident every 2 hours and as needed for comfort with a start date of 12/03/2021. A review of the documentation showed:<br><br>** 12/01/2021 - 12/31/2021 refused was documented three times, and no documentation for three entries.<br><br>** 01/01/2022 - 01/11/2022 no behaviors noted was documented twelve times, refused was documented seven times, and no documentation provided for 9 entries.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In a review of progress notes 12/01/2021 through 01/11/2022 showed no documentation the physician was notified regarding refusal.<br><br>Reference: (WAC) 388-97-1720 (1)(a)(i)(ii)(iii)(iv)(b)(2)(d)(i)(m)(4)(a)(6)(a)(i)<br><br>This is a repeat citation from Statement of Deficiencies, dated 12/16/2021.<br><br>42927<br><br>RESIDENT 19<br><br>Resident 19 was most recently admitted to the facility on [DATE] with a diagnosis of pneumonia.<br><br>Review of a physician order, dated 04/20/2021, showed that oxygen (O2) tubing was to be changed and labeled with the current date weekly on Sundays.<br><br>Review of the December 2021 TAR showed entries that Resident 19's O2 tubing was changed on 12/21/2021 and 12/28/2021.<br><br>Review of the January 2022 TAR showed an entry that Resident 19's O2 tubing was changed on 01/04/2022.<br><br>In an observation on 01/06/2022 at 1:24 PM, Resident 19 had O2 in use. The O2 tubing had a piece of tape with 12-21 written on it.<br><br>In an observation and interview on 01/07/2022 at 10:17 AM, Resident 19 had O2 in use and the tubing had a piece of tape with 12-21 on it. Staff D, Licensed Practical Nurse (LPN), verified that the tape on the tubing was the date it was changed and verified that it was dated 12-21.<br><br>Review of a physician order, dated 05/15/2021, showed that staff were to ensure padding was in place on the O2 tubing to prevent injury to Resident 19's ears.<br><br>Review of the January 2022 TAR showed entries that staff had checked that the padding was in place on Resident 19's O2 tubing on 01/11/2022 at 6 PM and on 1/12/2022 at 6 PM.<br><br>In an observation on 01/12/2022 at 2:05 PM, Resident 19 had O2 in use and there was no padding on the tubing.<br><br>In an observation on 01/13/2022 at 9:57 AM, Resident 19 had O2 in use and there was no padding on the tubing. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0880<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110<br><br>Based on observation, interview, and record review, the facility failed to operationalize all components of the infection control program when there were multiple breaches in the program. The facility failed to ensure the staff were compliant with Infection Prevention and Control Guidelines and standards of practice for two of two wings. The facility failed to ensure oversight and implementation of screening visitors as required during a Coronavirus Disease 2019 (COVID-19) outbreak, to ensure the appropriate Transmission Based Precautions (TBP) were implemented with COVID-19 positive residents, failed to ensure the staff appropriately used personal protective equipment (PPE), failed to ensure appropriate hand hygiene practices, failed to ensure the staff cleaned and disinfected reusable medical equipment and failed to ensure clean linen were stored appropriately. These failures resulted in spread of COVID-19 infection throughout the facility with 44 COVID-19 positive residents, four hospitalization s (3, 35, 413, and 420) and the death of two Residents (2, and 3) related to COVID-19 infections constituting harm and placed all residents, and staff at risk for the spread of the COVID-19 virus in the facility and out into the community.<br><br>Findings included .<br><br>RESIDENT 3<br><br>Resident 3 admitted to the facility on [DATE], with diagnosis to include COPD, and heart failure.<br><br>Review of Resident 3's Documentation Survey Report v2 (Report of the residents' functional abilities) for December 2021, showed the resident had been independent with bed mobility, transfers, eating, and ambulation.<br><br>Review of Resident 3's Medication Administration Record for December 2021, showed the resident to have stable blood pressure, oxygen saturation levels at a baseline level and did not require oxygen.<br><br>Review of facility Minimum Date Set (MDS) Assessment note dated 01/01/2022 at 6:55 PM, showed the resident was alert and orientated to person, place, and time. They were independent with bed mobility, transfers, and personal care.<br><br>Review of a facility progress note dated 01/02/2022 at 3:33 PM, showed the resident had tested positive for the COVID-19 virus.<br><br>Review of a facility progress note dated 01/03/2022 at 10:04 AM, showed the resident had a decline in their oxygen saturation below a normal baseline, and the resident was placed on oxygen that the resident had not required prior to infection.<br><br>Review of facility progress notes for 01/04/2022 showed no documentation of the residents' health status in relation to their COVID-19 infection.<br><br>Review of a facility medication administration note dated 01/05/2022 at 5:25 PM, showed the resident was too drowsy to administer their blood pressure medication. There was no documentation of the residents' health status in relation to their COVID-19 infection.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0880<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | Review of a facility medication administration note dated 01/06/2022 at 10:38 AM, showed the residents bowel regulatory medications were held due to loose stool. There was no documentation of the residents' health status in relation to their COVID-19 infection.<br><br>Review of a facility progress note dated 01/07/2022 at 3:45 AM, the resident had increased respiratory rate, was having difficulty breathing, blood pressure was below a normal baseline, and not responsive to questions. The resident was transported to the hospital.<br><br>Review of the PeaceHealth Critical Care Admission Note dated 01/07/2022 at 10:12 AM, Resident 3 was critically ill due to septic shock most likely due to bacterial superinfection of COVID-19, severe brain disfunction, respiratory failure, with imminent threat of death.<br><br>In an interview on 01/25/2022 with Staff A, Registered Nurse/Resident Care Manager, informed that Resident 3 had passed away from COVID-19 at the hospital.<br><br>RESIDENT 2<br><br>Resident 2 was admitted to the facility on [DATE] with diagnosis to include dementia, depression.<br><br>Review of facility Minimum Date Set (MDS) Assessment note dated 12/29/2021 showed resident was pleasant and cooperative with cares, no discomfort, required one person assist for bed mobility and transfers.<br><br>Review of a facility progress note dated 01/02/2022 at 2:14 PM, noted resident had been exposed to COVID-19 and had tested positive for the virus.<br><br>Review of a facility progress note dated 01/03/2022 at 10:06 AM, showed the resident had experienced a decline in the oxygen saturation level below the baseline amount ordered.<br><br>Review of a facility progress notes dated 01/04/2022 through 01/09/2022 showed no documentation of the residents' health status in relation to their COVID-19 infection.<br><br>Review of a facility progress note dated 01/10/2022 at 12:32 PM, showed the resident had reduced lung sounds, was lethargic, not following direction.<br><br>Review of a facility progress note dated 01/11/2022 at 6:38 PM, showed the family had requested the resident be sent to the hospital but not using emergency services.<br><br>Review of a facility progress note dated 01/12/2022 at 12:01 PM, showed the resident had a thready pulse, overall decline, and new onset of weakness.<br><br>Review of a facility progress note dated 01/12/2022 at 11:55 PM, showed the resident passed away.<br><br>RESIDENT 420<br><br>Resident 420 was admitted to the facility 07/06/2017, with diagnosis to include dementia and high blood pressure.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0880<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | Review of the discharge summary from Peace Health Medical Center dated 01/12/2022, Resident 420 was admitted to the hospital for fatigue and shortness of breath related to COVID-19 infection they contracted at the facility. The discharge summary stated resident was admitted to the hospital for ten days with discharge diagnosis of COVID-19 pneumonia.<br><br>RESIDENT 413<br><br>Resident 413 admitted to the facility on [DATE], with diagnosis to include dementia, and high blood pressure.<br><br>Review of the discharge summary from Peace Health Medical Center dated 01/12/2022, Resident 413 was admitted to the hospital for cough and difficulty breathing related to COVID-19 infection they contracted at the facility. The discharge summary stated resident was admitted to the hospital for ten days with discharge diagnosis of COVID-19 pneumonia.<br><br>RESIDENT 35<br><br>Resident 35 admitted to the facility on [DATE], with diagnosis to include dementia, and low blood pressure related to change in position.<br><br>Review of the discharge summary from Peace Health Medical Center dated 01/21/2022, Resident 35 was admitted to the hospital for fever, altered mental status, and low oxygen in the blood related to COVID-19 infection they contracted at the facility. The discharge summary stated resident was admitted to the hospital for thirteen days with discharge diagnosis of COVID-19 pneumonia.<br><br><INFECTION SURVEILLANCE><br><br>Review of facility policy titled, Infection Prevention and Control Program, revised October 2018, showed:<br><br>- The Infection Prevention and Control Program (IPCP) were coordinated and overseen by an Infection Prevention specialist (someone trained in infection control).<br><br>- Process surveillance (adherence to infection prevention and control practices) and outcome surveillance (incidence and prevalence of healthcare acquired infections) are used as measures of the IPCP effectiveness; and<br><br>- Surveillance tools are used for recognizing the occurrence of infections .i.e., detecting outbreaks and epidemics, monitoring employee infection and adherence to infection control practices.<br><br>Review of facility policy titled, COVID-19 Infection Control Manual, Management During the Pandemic, revised 01/04/2022 stated:<br><br>- The screening staff are responsible for reviewing each entrant's screening answers and temperature reading.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0880<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | - The staff that are designated to perform the screening oversight process will receive training and successfully complete the demonstrated competency with their supervisor or the Infection Preventionist (IP) prior to staffing the location; and<br><br>- The screener will assure this is followed and notify the IP or Director of Nursing Services (DNS) and the screener's supervisor when facility access is denied.<br><br>In an interview on 01/03/2022 at 2:30 PM, Staff E, Registered Nurse (RN)/Regional Nursing Consultant (RNC), stated they had 25 positive COVID-19 residents, and 11 positive COVID-19 staff members. The current IP had placed their two weeks' notice to the facility and had not been at the facility. Staff E stated they were not sure how they were going to set up the building to manage the positive COVID-19 residents, nor did they know where the source of the COVID-19 outbreaks had started. The facility was unable to provide their infection surveillance plan for the current COVID-19 outbreak. The facility was unable to provide a system for tracking current infections in the facility.<br><br>In an interview on 01/04/2022 at 11:45 AM, Staff E stated the current IP would not be returning to the facility. The facility had hired a new IP, who would be training at another facility. A line listing was requested regarding the current COVID-19 outbreak, which was not provided.<br><br>On 01/06/2022, the facility had not provided a surveillance and tracking system for current infections in the facility.<br><br>In an observation on 01/12/2022 at 8:15 AM, the surveyor placed on a N-95 respirator mask and face shield before entering the building, there was no staff observed at the front desk monitoring for visitors.<br><br>In an interview on 01/12/2022 at 1:30 PM, Staff N, Nursing Assistant Certified (NAC), stated they were supervising the front desk where visitors enter. Staff N stated the desk was not supervised at night; their shift started at 8:00 AM.<br><br>In an observation on 01/13/2022 at 6:45 AM, the surveyor placed on a N-95 respirator mask and face shield before entering the building, there was no staff observed at the front desk to monitor for visitors entering the facility.<br><br>In an observation on 01/14/2022 at 8:31 AM, the surveyor placed on a N-95 respirator mask and face shield before entering the building, there was no staff observed at the front desk to monitor for visitors.<br><br>On 01/18/2022, the facility had not provided a surveillance and tracking system for current infections in the facility.<br><br>On 01/21/2022 at 9:15 AM, the facility had not provided a surveillance and tracking system for current infections in the facility.<br><br>On 01/24/2022 at 9:30 AM, the facility had not provided a surveillance and tracking system for current infections in the facility.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0880<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | On 01/25/2022 at 9:30 AM, the facility had not provided a surveillance and tracking system for current infections in the facility.<br><br>In an interview on 01/25/2022 at 9:30 AM, Staff E stated the newly hired IP had not been onsite in the facility since their hire date. Staff E stated the facility's current IP was not really anyone, there are some nurses here doing some of the things like reporting but we do not have enough staff right now so we are just doing what we can. Staff E stated the newly hired IP, Staff O, RN/IP, who had been training with another staff member offsite, had been working remotely on their infection tracking system.<br><br>In an interview on 01/25/2022 at 1:26 PM, Staff E stated Staff O, was responsible for the infection control practices in the facility. Staff E stated Staff O had tracked the last three weeks of infections in the facility, and prior to that the facility had completed some of the infection control tracking. Staff E stated that they were unclear if the infection control tracking was completed and was unable to locate any surveillance that was done by the facility prior to December 2021.<br><br>On 01/26/2022 at 2:30 PM, the facility had not provided a surveillance and tracking system for current infections in the facility.<br><br><PERSONAL PROTECTIVE EQUIPMENT><br><br>Review of policy titled, COVID-19 Transmission-based Isolation Precautions PPE Reminders for Healthcare Personnel (HCP), updated 01/04/2022, showed:<br><br>- Before entering the resident's room, the required PPE is gown, gloves, eye protection, and a N-95 respirator mask.<br><br>- Discard gown before exiting the resident's room; and<br><br>- A gown and gloves should not be worn outside of the resident's room.<br><br>Review of facility policy titled, COVID-19 Infection Control Manual, Management During the Pandemic, revised 01/04/2022, showed:<br><br>- To only use the respirator model and size for which the staff member had been fit tested . N95 respirators vary by model and size. Improper fit will likely result in inadequate protection. Respirator should not be used if damaged; and<br><br>- Residents should wear face masks that cover their nose and mouth, in accordance with Center for Disease Control (CDC) recommendations.<br><br>Review of BYD Care manufactures product guidance, undated that was provided by the facility showed proper use of facility approved N95 respirator BYD2232 straps were to be placed behind neck and crown of head. If elastic bands were damaged do not use as the respirator would be ineffective.<br><br>In an interview on 01/04/2022 at 1:23 PM, Staff II stated they were unsure which residents in the facility had tested positive for COVID-19 and had not been instructed on when they should wear PPE.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0880<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | In an interview on 01/04/2022 at 2:02 PM, Staff GG stated they had not been instructed on when to wear PPE.<br><br>In a phone interview with the Department of Health for [NAME] State on 01/06/2022 at 1:30 PM, with Collateral Contact (CC) 8 Epidemiologist, and CC 9 Epidemiologist, stated they had instructed the facility that all direct care givers should be wearing full personal protective equipment, that included a fit tested N95 respirator, proper eye protection, an isolation gown, and gloves. They stated they instructed the facility they would need to remove and apply a new isolation gown for every resident regardless of COVID-19 status.<br><br>In an observation on 01/06/2022 at 12:23 PM, Staff B, RN, was observed to have a teal N95 (BYD2232) respirator in place and the straps were noticeably cut and tied behind their ears.<br><br>In a continuous observation on 01/06/2022 at 1:04 PM, Staff P, RN/Regional Educator, was observed to exit a COVID-19 positive resident room wearing a PPE isolation gown. Staff P then shut the door of the resident's room and stood in the hallway and spoke to another staff member. Staff P was observed to remove their gown and gloves at the same time, opened the COVID-19 positive resident room door and placed the items into a trash can inside the resident room. Staff P then shut the resident's door, walked across the hall two doors down and used hand gel and performed hand hygiene.<br><br>In an observation on 01/07/2022 at 1:15 PM, Staff Q, Restorative Aide (RA), had a teal N95 (BYD2232) respirator on, the straps were noticeably cut, and tied behind their ears.<br><br>In an observation on 01/07/2022 at 1:29 PM, Staff B was observed to have teal N95 (BYD2232) respirator on, the straps were noticeably cut, and tied behind their ears.<br><br>In an observation on 01/07/2022 at 2:12 PM, Staff B was observed to exit a known COVID-19 positive resident room and had a teal N95 (BYD2232) respirator on, the straps were noticeably cut, and tied behind their ears.<br><br>In an observation on 01/07/2022 at 2:14 PM, Staff R, Environmental Assistant (EA), was observed to be wearing gloves while they pushed a known COVID-19 positive resident in their bed down the hall from one wing to another wing. The resident was observed to not have a face mask on in the hallway during the transfer.<br><br>In an observation on 01/07/2022 at 2:35 PM, Staff Q was observed to have a teal N95 (BYD2232) respirator on, the straps were noticeably cut, and tied behind their ears.<br><br>In an observation on 01/13/2022 at 8:25 AM, Staff I, Licensed Practical Nurse (LPN), was observed to enter a known COVID-19 positive room and did not put on the appropriate PPE before entering the resident's room. A Special Contact Droplet isolation precautions signage was next to the resident's door that directed staff to place gloves, an isolation gown, a respirator, and eye protection on before entering the room. An accessible PPE bin (a place for staff to easily access PPE before entering a room) was observed to be present.<br><br>In an observation on 01/13/2022 at 8:45 AM, Staff I was observed to enter a known COVID-19 positive room and did not put on the appropriate PPE before entering the room. There was a Special Contact Droplet isolation precautions sign posted next to the resident door.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0880<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | In an observation on 01/14/2022 at 12:12 PM, Staff Q was observed to have a teal N95 (BYD2232) respirator on, the straps were noticeably cut, and tied behind their ears.<br><br>In an observation and interview on 01/20/2022 at 10:09 AM, Staff S, NAC, exited a resident's room, their N95 was observed to not be worn correctly as both straps were towards the bottom of their neck. Staff S stated they could not wear the respirator correctly because they were unable to put their hair up to keep the respirator strap in place.<br><br>In an observation on 01/20/2022 at 10:11 AM, Staff B was observed to have a teal N95 (BYD2232) respirator on, the straps were noticeably cut, and tied behind their ears.<br><br>In an observation on 01/21/2022 at 9:11 AM, Staff B was observed to have a teal N95 (BYD2232) respirator on, the straps were noticeably cut, and tied behind their ears.<br><br>In an observation on 01/24/2022 at 9:11 AM, Staff B was observed to have a teal N95 (BYD2232) respirator on, the straps were noticeably cut, and tied behind their ears.<br><br>In an observation on 01/24/2022 at 9:12 AM, Staff T, NAC, was observed to have a white N95 respirator on, the straps were noticeable cut, and tied behind their ears.<br><br>In an interview on 01/24/2022 at 10:50 AM, Staff U, RN, was observed to not be wearing a N95 respirator and their mask was sliding off their face exposing their nose and top of their mouth. Staff U stated they were fit tested for a N95 at another facility, however this mask was their personal one brought from home.<br><br>In an observation and interview on 01/24/2022 at 2:50 PM, Staff V, (LPN), was observed to have their N95 with cut straps, and it was tied behind their ears. The mask was observed to poorly fit to their face.<br><br>In an interview on 01/25/2022 at 1:26 PM, Staff E stated all staff were required to wear a fit tested approved N95 respirator at this time.<br><br><TRANSMISSION BASED PRECAUTIONS><br><br>Review of the facility policy titled, COVID-19 Transmission-based Isolation Precautions Personal Protective Equipment (PPE) Reminders for Healthcare Personnel (HCP), updated 01/04/2022, showed:<br><br>- Special Contact/Droplet Precautions directed staff to place gloves, an isolation gown, a respirator, and eye protection on before entering the room for COVID-19 infected, suspected or who have been exposed to COVID-19 cases; and<br><br>- COVID-19 positive resident's room doors should be closed.<br><br>In an observation on 01/04/2022 at 12:25 PM, room [ROOM NUMBER] had no visible signage to communicate to staff the type of precautions and the appropriate PPE to be used. The facility reported that room [ROOM NUMBER] was a COVID-19 positive room.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0880<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | In an observation on 01/04/2022 at 12:56 PM, room [ROOM NUMBER], a designated COVID-19 positive room, had no visible signage to communicate to the staff the type of precautions and the appropriate PPE to be used. The nearest PPE observed was located on the other side of closed fire doors and was not readily available near the entrance to the resident's room.<br><br>In an observation on 01/04/2022 at 12:57 PM, room [ROOM NUMBER] had a special Droplet/Contact isolation sign on the wall next to the door. The signage directed staff to keep the resident's door shut, the door was observed to be open, and Resident 29 was observed in the room. Review of Resident 29's care plan showed no safety assessment had been completed and there was no direction to staff to keep the resident's door open.<br><br>In an observation on 01/04/2022 at 12:58 PM, room [ROOM NUMBER] had no visible signage to communicate to staff the type of precautions and the appropriate PPE to be used. The facility stated room [ROOM NUMBER] was a COVID-19 positive room.<br><br>In an observation on 01/04/2022 at 12:59 PM, room [ROOM NUMBER] was designated to be a COVID-19 positive room and there was no visible signage present to alert staff of the appropriate PPE to be used. There was no signage to communicate to staff what type of precautions or what appropriate PPE should be used.<br><br>In an observation on 01/04/2022 at 1:00 PM, room [ROOM NUMBER] was designated to be a COVID-19 positive room. There was no signage to communicate to staff what type of precautions or what appropriate PPE should be used.<br><br>In an observation on 01/04/2022 at 1:01 PM, room [ROOM NUMBER], which was identified as a COIVD-19 positive room, had no visible signage to designate to staff the type of precautions and the appropriate PPE to be used. The door was observed to be open. Review of Resident 56's care plan showed no safety assessment had been completed and there was no direction to staff to keep the resident's door open.<br><br>In an observation on 01/04/2022 at 1:02 PM, room [ROOM NUMBER], which was identified as a COVID-19 positive room, had no visible signage to designate to staff the type of precautions and the appropriate PPE to be used.<br><br>In an observation on 01/04/2022 at 1:03 PM, room [ROOM NUMBER], which was identified as a COVID-19 positive room, had no visible signage to designate to staff the type of precautions and the appropriate PPE to be used. Per facility provided list Resident 28 was assigned to room [ROOM NUMBER] and was positive for the COVID-19 infection.<br><br>In an observation on 01/04/2022 at 1:04 PM, room [ROOM NUMBER], which was identified as a COVID-19 positive room, had no visible signage to designate to staff the type of precautions and the appropriate PPE to be used. Per facility provided list Resident 1 was assigned to room [ROOM NUMBER] and was positive for the COVID-19 infection.<br><br>In an observation on 01/04/2022 at 1:05 PM, room [ROOM NUMBER], which was identified as a COVID<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0880<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | -19 positive room, had no visible signage to designate to staff the type of precautions and the appropriate PPE to be used. According to the facility provided list, Resident 18 was assigned to room [ROOM NUMBER] and was positive for the COVID-19 infection.<br><br>In an observation on 01/04/2022 at 1:07 PM, room [ROOM NUMBER], which was identified as a COVID-19 positive room, had no visible signage to designate to staff the type of precautions and the appropriate PPE to be used. The door was observed to be open. Review of Resident 55's care plan showed no safety assessment had been completed and there was no direction to staff to keep the resident's door open. Per facility provided list Resident 55 was assigned to room [ROOM NUMBER] and was positive for the COVID-19 infection.<br><br>In an observation on 01/04/2022 at 1:09 PM, room [ROOM NUMBER], which was identified as a COVID-19 positive room, had no visible signage to designate to staff the type of precautions and the appropriate PPE to be used. The door was observed to be open. Review of Resident 12's care plan showed no safety assessment had been completed and there was no direction to staff to keep the resident's door open. Per facility provided list Resident 12 was assigned to room [ROOM NUMBER] and was positive for the COVID-19 infection.<br><br>In an interview on 01/04/2022 at 1:23 PM, Staff II, NAC stated they were unclear as to exactly which residents were positive. Staff II stated it kept changing throughout their shift.<br><br>In an observation on 01/13/2022 at 7:36 AM, room [ROOM NUMBER] had a special Droplet/Contact isolation sign on the wall next to door. The signage directed staff to keep the resident's door shut, the door was observed to be open, privacy curtain pulled, lights are off, audible snoring heard from room.<br><br>In an observation on 01/21/2022 at 9:08 AM, room [ROOM NUMBER] had a special Droplet/Contact isolation sign on the wall next to door. The signage directed staff to keep the resident's door shut, the door was observed to be open, and Resident 52 was observed in the room. Review of Resident 52's care plan showed no safety assessment had been completed and there was no direction to staff to keep the resident's door open.<br><br><HAND HYGIENE><br><br>In an observation on 01/12/2022 at 9:20 AM, Staff S, NAC, and Staff W, NAC, performed incontinent care on Resident 10. While the resident was on their back the staff unattached the resident's adult incontinent brief and cleaned the front groin area. Staff S turned the resident while Staff W cleaned the residents bottom, a small amount of brown feces was visible. Staff W then placed a clean adult incontinent brief on resident, turned the resident onto their back to secure the brief, and arranged the residents bedding, all without taking off the feces contaminated gloves. Staff W was asked and did not respond why their contaminated gloves where not changed.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0880<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | In a continuous observation on 01/24/2022 at 9:36 AM, Staff X, Housekeeper (HK), was observed to push a housekeeping cart down the hallway with gloves on both hands. Staff X parked the cart in front of a resident occupied room, grabbed a blue sponge from the cart and entered the resident's room with same gloved hands. At 9:41 AM, Staff X exited the room with same gloved hands and reached into their pocket and grabbed a set of keys. With the same contaminated gloved hands opened the drawer on the cart and removed a basket with bottles and brushes and entered the resident's room. At 9:46 AM, Staff X exited the resident's room with the same gloved hands, reached into their pocket, grabbed a set of keys, and opened a drawer on the cart to return the basket. Then Staff X was observed with the same contaminated gloves placed a blue sponge into a trash bag that was attached to the housekeeping cart then grabbed a broom and a dustpan and entered a resident's room. Staff X exited the room without changing their gloves or performing hand hygiene, placed the broom and dustpan back on the housekeeping cart. Staff X then was observed to remove their gloves, apply hand gel to their hands, placed another pair of gloves on and pushed their housekeeping cart down the hall to another room.<br><br><UNIVERSAL MEDICAL EQUIPMENT><br><br>Review of the facility policy titled, COVID-19 Infection Control Manual, Management During the Pandemic, revised 01/04/2022, stated shared medical equipment should be cleaned and disinfected between residents.<br><br>In an observation and interview on 01/24/2022 at 10:34 AM, Staff U, was observed to remove a pulse oximeter (gadget to take the resident's pulse and oxygen levels) off Resident 19's finger and placed the device in their top pocket of their shirt and exited the resident's room. Staff U stated that universal medical equipment (which included a pulse oximeter) was to be cleaned after each use but did not have any disinfectant present. Staff U was not able to respond why the pulse oximeter was placed into their pocket without being cleaned.<br><br><LAUNDRY SERVICE><br><br>In an observation on 01/21/2022 at 10:17 AM, a laundry bin was seen to be overflowing with clean hospital gowns and sitting directly next to a hand washing station. There was a large clear trash bag full of clean transfer slings (a device used to transfer a resident using a mechanical lift) was sitting directly on the ground under the sink of the hand washing station.<br><br>In an observation on 01/21/2022 at 11:01 AM, a laundry bin was seen to be overflowing with clean hospital gowns and placed next to a hand washing station and a large clear trash bag was full of clean transfer slings and sitting directly on the ground under the sink of the hand washing station.<br><br>In an interview on 01/21/2022 at 11:21 AM, Staff Y, Housekeeping Manager, stated the clean gowns and slings were from the hospital, however they could not guarantee staff were aware to not use them and stated it would be possible for a staff member to walk in and remove to use on a resident.<br><br>In an observation on 01/24/2022 at 11:03 AM, an open laundry bin of clean gowns was sitting next to the hand washing station, and a large clear trash bag of clean transfer slings was sitting on the floor next to a laundry bin.<br><br>In an interview on 01/25/2022 at 2:37 PM, Staff E, Regional Nurse Consultant stated the outbreak included 44 residents that tested positive for COVID-19.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 01/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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 0880<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | The facility failed to ensure there was lack of infection surveillance and tracking of infections throughout the facility, there was failure to ensure staff properly donned PPE within close contact with COVID-19 positive residents, there was failure by staff to perform proper hand hygiene, and failure to properly disinfect universal equipment after direct contact with a resident. These breaches in infection prevention and control practices led to the spread of COVID-19 virus throughout the facility that subsequently led to the outbreak of 44 residents with COVID-19, which resulted in the hospitalization of four residents (3, 35,413, and 420) and the death of Resident 3, and Resident 2. These failures were a continuation of non-compliance for the facility regarding their infection prevention and control practices from 11/10/2021.<br><br>Reference WAC 388-97-1320 (1)(a)(c)(2)(a)(b)(c)(3)(5)(c)(e)<br><br>This is a repeat citation from Statements of Deficiencies, dated 11/10/2021 and 01/19/2021.<br><br>33954 |