STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505376	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Baker Care Center	2905 Connelly Avenue Bellingham, WA 98225

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 1 of 5 residents (Resident 45) reviewed for unnecessary medications, were free from unnecessary psychotropic medication (a drug that affects brain activities associated with mental processes and behavior). Failure to provide a valid diagnosis for the use of psychotropic medications placed residents at risk for receiving unnecessary psychotropic medications, for adverse events and diminished quality of life. Findings included . According to the facility policy titled Unnecessary Medication Policy (undated) showed: All medications must be supported by a documented diagnosis or clinical rationale. The Federal Drug Administration Black Box Warning for Risperidone (an antipsychotic medication) stated that elderly patients with dementia-related psychosis (mental disorder characterized by a disconnection from reality) who are treated with this medication are at a significantly higher risk of death. Risperidone is not approved for use in patients with dementia-related psychosis and included a black box warning related to an increased risk of death or stroke in dementia patients. Resident 45 was admitted to the facility on [DATE] with diagnoses to include dementia. According to the Significant Change Minimum Data Set (MDS - an assessment tool) assessment dated [DATE], Resident 45 had severe cognitive impairment. In an observation on 06/27/2025 at 12:49 PM, Resident 45 was propelling self in their wheelchair using their legs and arms, not exhibiting any signs of psychosis, and was easily redirectable. In an observation on 06/30/2025 at 9:48 AM, Resident 45 was in their room with a family member visiting, with no behaviors observed. Record review of Resident 45's physician's orders on 06/30/2025 documented an order dated 03/21/2025 for Risperidone 0.25 milligram (mg) by mouth in the morning and 0.5 mg by mouth at bedtime, related to dementia with behavioral disturbances. In an interview on 07/01/2025 at 9:09 AM, Staff D, Nursing Assistant Certified (NAC), stated that Resident 45 liked to wander in the hallways by self-propelling in their wheelchair. (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/01/2025 at 9:15 AM, Staff E, Licensed Practical Nurse (LPN) stated that Resident 45 was receiving Risperidone, and they monitored their behavior and documented them in their Behavior Administration Record (BAR). The behaviors listed were, anger/agitation, withdrawn, restlessness/exploring, despondence and shortness of breath. In an interview on 07/01/2025 at 9:45 AM, Staff F, Registered Nurse/Resident Case Manager, stated that prior to starting a resident on a psychotropic medication, they first obtained consent from the resident or family member, then set up a care plan and ensure monitoring for side effects and behaviors were in place. Staff F added that they ensured that the appropriate diagnosis was in place and if they didn't think the diagnosis was appropriate, they notified the provider. Staff F stated the provider would then do their research and ensure an appropriate diagnosis would be in place for the medication. Staff F reviewed the diagnosis for Resident 45's Risperidone and stated that dementia was not an appropriate diagnosis for Risperidone and they would review Resident 45's chart to find out why they were started on that medication. In an interview on 07/01/2025 at 2:00 PM, Staff B, Director of Nursing, stated that they talked to the provider and were informed that Resident 45 was started on Risperidone when they were still at their assisted living facility due to behaviors. Staff B handed me a copy of the provider progress note dated 05/29/2024 that showed Risperidone was started at 0.25 mg every afternoon for dementia with behavioral features. In the note, it was documented that Resident 45 was not taking medications and that the nurse reported increased confusion, especially in the afternoon and increased behaviors which were not easily redirected. There was no mention of attempts to use other interventions. In a telephone interview on 07/01/2025 at 3:30 PM, Collateral Contact 1 (CC1), Pharmacist, stated that they participated in the facility monthly psychotropic medication review and they reviewed residents' psychotropic medications. CC1 stated that a dementia diagnosis was not an appropriate indication for Risperidone use. CC1 reviewed Resident 45's Risperidone order and stated that the diagnosis was not appropriate and there should be a specific behavior added to the diagnosis for it to be appropriate. In an interview on 07/02/2025 at 1:00 PM, Staff B, Director of Nursing, stated the expectation is to review psychotropic medications when they are ordered, during the facility psychotropic meeting, and they audited the process monthly. The process was to audit the medication consents and diagnoses during the monthly meetings and stated they failed to identify the incorrect diagnosis for Resident 45. Refer to WAC 388-97-0620(1)(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop comprehensive care plans to reflect the resident's current medical status and/or to include all provided nursing services for 1 of 1 resident (Resident 54) reviewed for edema management, 1 of 2 residents (Resident 5) reviewed for discharge planning, and 1 of 2 residents (Resident 15) reviewed for dementia care. This failure placed residents at risk of not receiving needed care, decline in condition, and diminished quality of life. Findings included . <RESIDENT 54> EDEMA MANAGEMENT Resident 54 was admitted to the facility on [DATE], with diagnoses which included gastrointestinal issues, and vascular (veins) wounds with cellulitis (infection of the tissue) to both lower legs. Record Review on 06/30/2025 showed Resident 54 had orders for knee high elastic stockings ordered for lower extremity edema management on 06/18/2025, and orders for Lasix (a diuretic-removes excess water from the body) for edema on 06/26/2025. In an observation and interview on 06/26/2025 at 2:00 PM, Resident 54 was sitting up in their wheelchair in their room with elastic stockings visible on both feet. Resident 54 stated they have been having a lot of issues with their swelling in their feet. Resident 54 stated they have had swelling and issues with sores on their legs before. Review of Resident 54's care plan dated 06/30/2025 showed no care plan had been developed related to elastic stockings, edema or diuretic use. In an interview on 07/01/2025 at 2:12 PM, Staff F, Registered Nurse/RCM (Resident Case Manager), stated residents with edema should have edema monitoring and there should be side effect monitoring for diuretic therapy. Staff F stated they needed to update Resident 54's care plan to include those items. <RESIDENT 5> DISCHARGE PLANNING Resident 5 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (nervous system disorder), epilepsy (seizure disorder), left lower leg fracture and right leg fracture. Review of Resident 5's Care Area Assessment (CAA- a focused assessment to determine if a triggered area should be care planned), dated June 2025 showed they expressed interest in moving to an independent living facility. The CAA further documented that social services had assisted the resident with the process, but they had been denied at independent living facilities. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 5's care plan dated 12/23/2023 and 06/10/2025, showed a resolved focus for discharge planning. There was no current discharge care plan found for Resident 5. In an interview on 07/02/2025 at 8:54 AM, Staff G, Licensed Practical Nurse (LPN), RCM stated they were unable to find a current/active discharge care plan for Resident 5. Staff G stated Resident 5 did have a discharge care plan in the past. Staff G stated Resident 5 had expressed a desire to be discharged from the facility within the month, social services was involved, and they wanted to move to an independent living facility after healing from their recent fractures. In an interview on 07/02/2025 at 9:20 AM Staff J, Social Services, stated they were unable to locate a current and active discharge plan for Resident 5. Staff J stated they had met with Resident 5 multiple times about discharge planning and provided corresponding progress notes of the interactions. Staff J stated Resident 5 expressed wanting to discharge to an independent living facility once healed from their recent fractures. <RESIDENT 15> DEMENTIA CARE Resident 15 admitted to the facility on [DATE], with diagnoses that included dementia, high blood pressure, and peripheral vascular disease (circulatory condition that affects blood flow to limbs). Review of Resident 15's cognitive CAA dated 10/22/2024, showed no analysis of findings for cognitive loss/dementia and referred to the psychosocial CAA. In an interview on 07/01/2025 at 1:19 PM Staff K, NAC (Nursing Assistant, Certified), stated they work with residents with dementia, gently. Staff K stated they knew Resident 15 liked English tea and does not like to take showers. Staff K stated they did not work with Resident 15 often and deferred to the care plan, stating it would have more details about Resident 15's dementia-related care. In an interview on 07/01/2025 at 2:07 PM Staff G, NAC stated Resident 15 was female care only. When asked how Resident 15's dementia manifested, they stated Resident 15 could be different from day to day, but was oriented to place and day, and used the newspaper to help with orientation. Staff G stated Resident 15 could become confused. Staff G described altered perceptions that Resident 15 had voiced in the past, specifically concerns about a scar (cesarean scar) being open and being concerned about it. Staff G stated they tried and reassured Resident 15 to make them comfortable and redirect their attention to a cup of tea or talk with them about their daughter. When asked how they knew how to care for residents and their dementia, Staff G stated they had worked as an aide for seven years, been through a lot of training related to dementia care and started their career by working in a dementia unit. Review of Resident 15's care plan dated 12/18/2019 showed they had a focus related to cognitive function due to impairment related to dementia. The goal was Resident 15 would be able to communicate basic needs daily. Interventions included asking close-ended questions, presentation of ideas, thoughts, directions to them one at a time and to use task segmentation. The care plan did not include all stated known behaviors and approaches for Resident 15. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/02/2025 at 1:05 PM, Staff B, Director of Nursing, stated care plans should be updated right away, and the expectation is that care plans are done on admission, with comprehensive assessments, and with changes in condition. Staff B stated care plans are necessary to provide communication to provide care. Reference WAC 388-97-1020(1),(2)(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 1 of 3 residents (Resident 15) reviewed for Pressure Ulcers (PU), were provided care planned interventions they required for the prevention of a PU. This failure to implement pressure reducing interventions in accordance with physician's orders placed residents at risk for PU development, pain and a diminished quality of life. Findings included . Resident 15 admitted to the facility on [DATE] with diagnoses that included dementia, high blood pressure, and peripheral vascular disease (circulatory condition that affects blood flow to limbs). Review of Resident 15's care plan, dated 12/03/2019 and revised on 03/15/2023, showed they had a focus area of skin at risk due to failure to thrive, advanced age and fragile/thin skin. The goal was Resident 15 would have no skin breakdown daily. Interventions included encouraging and assisting Resident 15 to reposition every two to three hours and as needed for comfort and to float heels (elevation of legs, typically with pillows, to prevent heels from touching the surface) when in bed for skin integrity to heels. Resident 15 was documented as having no PUs at the time of the 10/08/2024 significant change minimum data set (MDS- a required assessment tool) assessment. In a review of Resident 15's Care Area Assessment (CAA- a systematic process to determine if a triggered care area should be care planned), dated 10/22/2024, showed they were at risk for pressure areas and skin breakdown related to impaired mobility, incontinence of bowel and bladder, and advanced age with fragile skin. A review of Resident 15's Braden Scale (a risk assessment tool used to identify patients at risk of developing pressure ulcers), dated 06/03/2025, showed Resident 15 had no skin breakdown and were low risk for the development of a pressure ulcer. Review of Resident 15's Kardex (a nursing worksheet that includes daily care schedules/patient specific care needs) directed nursing assistants to float (elevate) both heels when in bed for skin integrity for heels. Review of Resident 15's Treatment Administration Record (TAR) for June 2025 showed a physician order for both their heels to be floated while in bed to maintain skin integrity. In observations on 06/26/2025 at 10:20 AM, 06/27/2025 at 1:01 PM, and 06/30/2025 at 10:04 AM, Resident 15 was in their bed and their heels resting flat on the mattress (not floated). In an observation and interview on 07/01/2025 at 3:37 PM, Staff H entered Resident 15's room and requested to readjust their pillows under their legs. Resident 15's heels were observed resting on the mattress with a single pillow located under their knees. Staff H was observed to readjust the pillow to float Resident 15's heels. Staff H stated Resident 15 often slid down in bed and needed repositioning and they tried to check on them frequently to make sure their heels were floated. Staff H stated Resident 15 would, at times, request to have the pillow used to float their heels removed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/02/2025 at 9:11 AM Staff I, Registered Nurse (RN), stated Resident 15 had an order to float both their heels when in bed. Staff I entered Resident 15's room and requested to adjust the pillow under their legs. Resident 15's heels were observed touching their mattress with a single pillow under their knees. Staff I readjusted the pillow to ensure Resident 15's heels were floated. Staff I stated they checked Resident 15's positioning before checking off that their heels are floated in the TAR. Staff I stated if Resident 15's heels are not floated when checked, they readjust the resident to ensure their heels are floated before checking off on the TAR. In an interview on 07/02/2025 at 9:42 AM Staff G, Licensed Practical Nurse (LPN)/Case Manager, stated they were not aware Resident 15 was sliding down in their bed causing their heels not to be floated. Staff G stated a pillow should be folding when floating Resident 15's heels. In an interview on 07/02/2025 at 1:00 PM, Staff B, Director of Nursing, stated all elderly residents are at risk for PUs. Staff B stated they provided specialty mattresses, wheelchair cushions, and float their heels. Staff B stated Resident 15 was very particular and the staff needed to document their refusals and get creative on preventative measures, and document. Refer to WAC 388-97-1060(3)(b)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 3 of 3 residents (Residents 17, 54 and 160) were free of unnecessary drugs due to lack of monitoring and care planning of high-risk medications, including lack of assessment for anti-coagulant (blood thinning medication) use and edema (accumulation of fluid in the body) monitoring. These failures could result in unrecognized change in condition for Resident 54 related to lack of edema monitoring and Resident's 17 and 160 experiencing unrecognized signs and symptoms of bleeding while receiving an anti-coagulant medication and placed all residents at risk for adverse effects of high-risk medications. Findings included . Manufacturer recommendations regarding the use of Eliquis/Apixaban (anti-coagulant) stated the most common side effects were bleeding and bruising more easily. Indications for the use of the drug were that it was typically used to reduce the risk of stroke, prevent the formation of blood clots. <RESIDENT 17> Resident 17 was admitted to the facility on [DATE] with diagnoses to include aortic valve stenosis with insufficiency (heart condition where the aortic (heart) valve narrows) and atrial fibrillation (irregular heartbeat). Review of the Significant Change Minimum Data Set (MDS) assessment, dated 04/18/2025, identified the resident was taking an anti-coagulant. Review of the physician's orders dated 12/16/2022 showed Resident 17 was to receive Eliquis medication two times daily related to aortic valve stenosis. Review of Resident 17's care plan printed 06/27/2025 showed there was no care plan addressing the atrial fibrillation or goals for the use of the Eliquis medication; interventions to include monitoring, safety precautions and reporting were not developed. An anti-coagulation care plan would have included goals and interventions for the medication and would have directed staff on what kind of monitoring was needed and what to do in the event of an adverse reaction. Review of the April, May and June 2025 Medication Administration Records (MARs) showed Resident 17 was administered Eliquis twice a day. There was no monitor in place to monitor for signs and symptoms of bleeding events or bruising. <RESIDENT 160> Resident 160 admitted on [DATE] with diagnoses which included recent cardiac surgery. Review of Resident 160's physician's orders dated 06/25/2025 showed Apixaban twice per day related to heart disease. Review of the June 2025 MAR showed the resident was administered the apixaban twice per day as ordered. There was no monitor in place to observe for signs and symptoms of bleeding events or increased bruising. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 160's baseline care plan on 06/27/2025 showed there was no care plan addressing the use of Apixaban, or side effect monitoring for its use. In an interview and observation on 06/27/2025, Resident 160 was in bed with eyes closed, the resident's spouse was at the bedside stating that they were waiting to see the doctor and they had to place a catheter last night because (Resident 160) could not urinate, and now the resident had blood in the (catheter) bag. Resident 160's catheter collection bag was observed to be hanging on the lower bed frame and was full of bright red bloody urine. Resident 160's spouse stated Resident 160 had issues with bleeding in the hospital and had to have transfusions. Review of Resident 160's MAR on 06/30/2025 at 10:00 AM, showed the resident's Apixaban was placed on hold on 06/27/2025 related to blood in the urine. Resident 160 was transferred to the emergency department on 06/30/2025 related to continued bleeding and decreased blood pressures and was admitted to the hospital. In an interview on 07/01/2025 at 2:12 PM, Staff F, Registered Nurse, Resident Case Manager, stated care plans for new admissions have options for standard choices such as ADL (activities of daily living) ability, pain, nutrition and the admitting nurse reviewed the resident record and can add other appropriate problems. There was noted to be a standardized choice for psychotropic medications, but not for other medications such as blood thinners or diuretics. Staff F stated if someone was admitted on a blood thinner it should be on the baseline care plan. Staff F stated when the orders for blood thinners were entered, there was a space for additional documentation which was supposed to include the side effect monitoring, and Staff F reviewed Resident 160's orders and stated the order template for Apixaban was lacking that information, so it would have needed to be manually entered, and it was not for Resident 160. In an interview on 07/02/2025 at 1:05 PM, Staff B, Director of Nursing stated there had not been monitoring in place for Resident 17 and 160's anti-coagulants. Staff B stated they had just completed an audit of residents' anti-coagulant orders for any additional concerns. Staff B stated they would change the electronic medical record to auto-populate monitoring when anti-coagulant orders were received. <RESIDENT 54> Resident 54 admitted on [DATE] with diagnoses which included gastrointestinal issues, and vascular (veins) wounds with cellulitis (infection of the tissue) to both lower legs. Record Review on 06/30/2025 showed Resident 54 had orders for knee high elastic stocking ordered for lower extremity edema management on 06/18/2025 and orders for Lasix (a diuretic) for edema on 06/26/2025. Review of the Resident's MAR for the month of June 2025 showed no edema monitoring or side effect monitoring for the use of Lasix. In an observation and interview on 06/26/2025 at 2:00 PM, Resident 54 was sitting up in their wheelchair in their room with elastic stockings visible on both feet. Resident 54 stated they have been having a lot of issues with swelling in their feet. Resident 54 stated they have had swelling and issues with sores on their legs before. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/01/2025 at 2:12 PM, Staff F stated that resident's with edema should have edema monitoring and there should be side effect monitoring for diuretic therapy. Staff F stated they needed to update Resident 54's care plan. Reference WAC 388-97-1060(4)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure staff were following established guidelines related to Enhanced Barrier Precautions (EBP), which are infection control interventions designed to reduce the transmission of multi-drug-resistant organisms in healthcare settings, for 1 of 3 residents (Resident 19) reviewed for pressure ulcers. These failures placed residents and staff at risk for potential infection from cross contamination of infectious organisms. Findings included . EBP focuses on the use of gowns and gloves during specific high risk resident care activities and is implemented for residents known to be infected, colonized, or at increased risk for acquiring a multi-drug-resistant organism, including residents with chronic wounds or indwelling devices. Record Review on 06/30/2025 at 12:22 PM documented Resident 19 developed a pressure ulcer to the right heel related to a hard cast. The ulcer onset date was documented as 12/04/2024, when the hard cast was removed and the ulcer was discovered. The record documented the wound remained open requiring dressing changes. In an observation on 06/30/2025 at 12:22 PM, there were no EBP in place for Resident 19. In an interview on 06/30/2025 at 2:29 PM, Staff C, Infection Preventionist, stated EBP should be in place for residents with chronic or stagnant wounds. Staff C was not able to recall the current precautions for Resident 19. In an interview on 07/01/2025 at 1:06 PM, Staff G, Licensed Practical Nurse, Resident Case Manager, stated Resident 19's right heel wound was observed following removal of the hard cast in December, and stated it had not fully healed. Staff G confirmed the right heel wound was chronic and required EBP. In an interview on 07/02/2025 at 1:00 PM, Staff B, Director of Nursing stated Resident 19 should have been on EBP for the chronic wound. Reference WAC 388-97-1320(2)(b)