

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/22/2014
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NAME OF PROVIDER OR SUPPLIER SHUKSAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1530 JAMES STREET BELLINGHAM, WA 98225
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Shuksan Health Care Center on 10/16/2014 and 10/22/2014. A sample of 3 current residents and 1 discharged resident was selected from a census of 42.</p> <p>The following complaints were investigated as part of this survey:</p> <p>3045132 3047484 3045814</p> <p>The survey was conducted by: Janet Thorson-Mador, RN, MN</p> <p>The survey team is from: Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, Region 3, Unit B 3906 172nd Street NE, Suite 100 Arlington, WA 98223</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>Marilee Ferguson-Wolf</i> 11/14/14 Residential Care Services Date</p>	F 000	<p>RECEIVED NOV 19 2014 ADULTS POINT</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Spencer Richard</i>	TITLE Administrator	(X6) DATE 11/14/14
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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.

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F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<p>F 225</p> <p>Resident #1 allegation of potential abuse thoroughly investigated.</p> <p>All residents who allege potential abuse will have allegation thoroughly investigated.</p> <p>Staff A educated on completing thorough investigations.</p> <p>All allegations of potential abuse will be thoroughly investigated and reviewed by Director of Nursing and Administrator. Results will be reviewed at weekly risk management meeting.</p> <p>December 3, 2014 corrective action complete.</p> <p>DNS and Administrator to monitor compliance.</p>	<p>12/3/14</p>
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NAME OF PROVIDER OR SUPPLIER SHUKSAN HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1530 JAMES STREET BELLINGHAM, WA 98225		
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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate an alleged violation of verbal and physical abuse made by Resident 1, one of four sampled residents. This placed her and other cognitively impaired residents at risk for potential abuse, and did not meet requirements of the regulation at 483.13(c) (3).</p> <p>Findings include:</p> <p>Resident 1 had cognitive impairment and needed extensive assist with toileting and personal hygiene. According to her MDS (Minimum Data Set) assessment dated 10/09/14, she did not have mood or behavior issues, and did not have delusions or hallucinations.</p> <p>On 10/22/14 at 11:30 a.m., the resident was observed sitting in the dining room in a wheelchair. At 12:30 p.m., the resident was sitting in the dining room, glasses falling off, apparently asleep.</p> <p>A facility report made to the State hotline documented that on 10/02/2014 the resident was tearful at breakfast and somebody had told her "she was dead or shouldn't be alive." The facility documentation of the incident included information not reported to the State, including the resident's statement that a staff person had "spanked me because I'm bad." The resident's statements were not consistent regarding time, place, or perpetrator.</p> <p>During an interview on 10/22/14 at 12:15 p.m., Staff A was asked if the facility had investigated</p>	F 225			

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F 225	Continued From page 3 the resident's statement she was "spanked" and called "bad." Staff A said the facility had not. Staff A said the resident's statement was inconsistent and she was confused. The facility concluded the resident was upset over having a large bowel movement on the night shift, and another resident having "behaviors" across the hall from Resident 1. No staff providing care on the night shift prior to the complaint had been interviewed. During this interview, Staff A was asked if there was documentation that the resident's skin had been assessed after the report of being spanked. Staff A said that she had checked the resident's skin herself, but had not documented the skin assessment anywhere in the resident's clinical record.	F 225		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent an avoidable injury during care sustained by 1 of 4 sampled residents, Resident 4. The resident sustained a soft tissue injury to the left foot and questionable metatarsal fractures per X-ray. She required a new order for narcotic pain medication to manage	F 323		

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F 323	<p>Continued From page 4 pain caused by the injury.</p> <p>Findings include:</p> <p>Resident 4 had multiple health conditions including arthritis and depression. According to the MDS (Minimum Data Set) assessment dated 08/03/2014, the resident required the help of 2+ staff persons for mobility in bed, had impairment of both legs, had no pain and did not use pain medication.</p> <p>On 10/22/14 at 11:20 a.m., the resident was observed lying in bed. The left foot was bare, swollen and bruised, a pillow under it. Staff C, a nursing assistant, was observed changing the resident's incontinence brief alone. He turned the resident from side to side in the bed. Staff C stated the resident was "maximum assist" with turns, according to the care guide, and that this meant one staff person, unless the care guide said "2 persons." He stated he would obtain another staff person to assist him in moving the resident up in the bed after he was finished turning her.</p> <p>A facility incident report described on 10/12/14 the resident was being turned in bed by Staff D, and went over the opposite bed railing, her lower body falling out of bed. The resident sustained the left foot injury, and bruising to the abdomen due to the bed rail pushing into it. The care plan in place at the time included the use of the bed rails "per [resident's] preference for safety during care provision."</p> <p>Review of the medication administration record from October 1 to October 15, 2014 revealed the resident had no documented pain between</p>	F 323	<p>F 323</p> <p>Resident 4 bed mobility safety assessed and necessary changes made to care plan and resident transfer sheet in room.</p> <p>All residents' assessed for bed mobility safety with physical therapy and transfer status sheet posted on closet in resident room. All resident care plans reviewed and up to date related to bed mobility status. Care plans will be updated quarterly and as needed.</p> <p>All staff educated on reviewing resident transfer status sheets prior to assisting a resident with bed mobility.</p> <p>Random audits on resident transfers will be performed by DNS and therapy on all shifts at least three times per month.</p> <p>December 3rd, 2014 corrective action complete.</p> <p>Director of Nursing to monitor compliance.</p>	<p>(A) 12-3-14</p>
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F 323	<p>Continued From page 5</p> <p>October 1 and October 11. On October 12, 13, 14, and 15, the resident had left foot pain. A new order for narcotic pain medication for "severe pain" was implemented October 12, which the resident required at least once each day subsequently during the period reviewed.</p> <p>During an interview on 10/22/14 beginning at 12:15 p.m., Staff A said that the foot injury occurred when the resident's legs went down on the floor and the "foot bent under" when it made contact with the floor. When asked about the resident's bed mobility, Staff A said the resident needed two staff because she could be "overzealous" and pull herself over the edge of the bed. Staff A also stated the nursing assistant care directives since the injury included physical therapy instructions that staff were to stabilize the leg during turns in bed, necessitating at least two staff.</p> <p>The medical record included an order dated 10/16/14 for an ice pack to be applied to the resident's left foot as needed to treat the swelling. Review of the nursing treatment record (TAR) with Staffs A and B revealed no order for an ice pack. Staff A said the facility was in the process of getting orders computerized, and this order had not made it onto the TAR.</p>	F 323		