

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

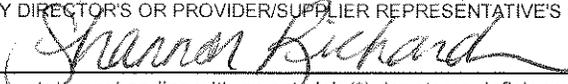
PRINTED: 09/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/29/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>SHUKSAN HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1530 JAMES STREET</b> <b>BELLINGHAM, WA 98225</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Shuksan Health Care Center on 08/22/14 and 08/29/14. A sample of 5 current residents was selected from a census of 44.</p> <p>The following complaints were investigated as part of this survey:</p> <p>3034523 3033230 3036382</p> <p>The survey was conducted by:</p> <p>Janet Thorson-Mador, RN, MN Patricia Rimar, RN, MSN</p> <p>The survey team is from:</p> <p>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> Residential Care Services</p> <p><u>9/12/14</u> Date</p>	F 000	<p>RECEIVED SEP 26 2014 ADSA/RCS Smokey Point</p>	
-------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  	TITLE  <i>Administrator</i>	(X6) DATE  <i>9/24/14</i>
--	-----------------------------------	---------------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/29/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHUKSAN HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1530 JAMES STREET</b> <b>BELLINGHAM, WA 98225</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241 SS=D	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide care to maintain the dignity of Resident 5, one of five sampled residents. This had the potential to diminish her quality of life.</p> <p>Findings include:</p> <p>Resident 5 had a history of dementia and depression, and was dependent on staff to meet her care needs. The most frequent MDS (Minimum Data Set) assessment dated 06/06/2014 reported she was frequently but not always incontinent of bladder.</p> <p>On August 22 at 2:10 p.m., the resident's family member stated that when he had been at the facility, the resident often had to wait to receive toileting assistance. "When the button (call light) is pressed, it takes 10 or 15 minutes before anyone comes. The person comes in, turns off the light, then takes some more time before they come in." He said that staff sometimes told the resident and himself that it was lunch time, or a new shift was coming in, so they would have to wait. He stated that Resident 5 had sometimes been incontinent while sitting and waiting, and that "She is resigned to it. She is in a wheelchair and can't get up."</p>	F 241	<p>F 241</p> <p>Resident #5 care need met to maintain resident's dignity.</p> <p>All residents' care needs assessed and care planned to maintain resident dignity, respect, and to promote quality of life. Call light audit conducted on all shifts for 3 days then will be conducted randomly no less than 2 times per month.</p> <p>All staff educated on promoting residents' dignity, respect, and quality of life.</p> <p>Social Services Director will complete satisfaction surveys with residents and their responsible parties at residents' care plan conferences. Results will be reported at quarterly QA meeting (or as needed if necessary).</p> <p>October 13<sup>th</sup>, 2014 corrective action complete.</p> <p>DNS and Administrator to monitor compliance.</p>	10/13/14 ②	

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

PRINTED: 09/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/29/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHUKSAN HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1530 JAMES STREET</b> <b>BELLINGHAM, WA 98225</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	Continued From page 2  During this interview, the family member pointed out a nursing assistant in the hallway, Staff G, who was talking to another resident. The family member stated that he had asked Staff G to help Resident 5, and that Staff G had not done so.  At 2:17 p.m. during this interview, Staff G came into the interview room, and the resident's family member said to her, "She (Resident 5) has to go to bed." Staff G answered, "I went in there and she didn't say anything." The family member said, "I told you she needs to go to bed." Staff G replied, "There must be a miscommunication."  On August 29 at 10:25 a.m. upon entering the facility, it was noted Resident 5's call light was on, and there were no nursing staff visible in the hallway. Staff K, who was near the nurses' station, said, "All the aides are in a meeting." Staff K did not answer the call light. The resident was observed lying in her bed. She said "I need a lot of help," and "I'm very disappointed in the last 24 hours," starting to cry. After five minutes, two staff persons came into the room. Staff F said the resident had mood swings, and that usually the call light meant she had to go to the bathroom.  Staff B was notified of the family member's complaint during an interview on 98/29/14 at 3:30 p.m. Facility records dated 08/19/2014 included an interview with Resident 5, in which she said she had experienced incontinence because her call light was not answered in time.	F 241			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	F 250			

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

PRINTED: 09/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>08/29/2014</b>
--	---	--	--

NAME OF PROVIDER OR SUPPLIER  <b>SHUKSAN HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1530 JAMES STREET BELLINGHAM, WA 98225</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 250	<p>Continued From page 3</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide medically needed social services to address depression in Resident 4, one of 5 sampled residents. This failure placed the resident at risk for unmet psychosocial needs.</p> <p>Findings include:</p> <p>Resident 4 had a history of depression, and was dependent upon staff for assistance with mobility and personal care. She took an anti-depressant medication daily, the dose of which was doubled on 08/20/14 at the request of the resident and family.</p> <p>The resident's most recent quarterly MDS (Minimum Data Set) assessment dated 06/26/14 indicated the resident had no mood or behavioral problems, including depression. The annual MDS assessment dated 10/02/13 did not include the care areas of psychosocial well-being, mood or behavior.</p> <p>On August 22 at 10:10 a.m., the resident was observed sitting in her room alone in a recliner chair with her feet elevated. She appeared to be asleep, the lighting was low, and she did not respond when spoken to. The resident was in the same position at 11:18 a.m. and at 12:11 p.m.</p>	F 250	<p>F 250</p> <p>Resident #4 was interviewed and psychosocial needs assessed and care planned as appropriate.</p> <p>All residents care plans reviewed and up to date. Care plans will be reviewed quarterly and as needed.</p> <p>All staff educated on signs and symptoms of depression in the elderly.</p> <p>Social Services Director to complete a Geriatric Depression Scale upon admit, quarterly, annually, and as needed. Findings for Geriatric Depression Scale will be reported to licensed nurse and Director of Nursing, and mental health consultant and physician as needed.</p> <p>October 13<sup>th</sup>, 2014 corrective action complete.</p> <p>Director of Nursing and Social Services Director to monitor compliance.</p>	<p>10/13/14 ⑧</p>
-------	--	-------	---	-----------------------

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

PRINTED: 09/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/29/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHUKSAN HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1530 JAMES STREET</b> <b>BELLINGHAM, WA 98225</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 250	<p>Continued From page 4</p> <p>According to the resident's care plan, she slept in the recliner instead of a bed.</p> <p>In an interview at 12:30 p.m., Staff C, the licensed nurse, said the resident preferred to stay in her room during breakfast, and would get up for lunch. The resident was still sitting in her chair at this time.</p> <p>On August 29 at 10:45, the resident was observed sitting in her recliner with her feet elevated. At 11:55 a.m., Staff C stated that the resident's anti-depressant was increased on 08/20/14, for which she was placed on "alert charting," to monitor for signs of depression and adverse medication effects. When asked, Staff C said that staff were not doing any other interventions related to the resident's depression. Staff C reported Resident 5 was capable of asking for the help she needed, usually talked to her daughter instead of facility staff, and chose to isolate herself.</p> <p>A nursing progress note dated 8/18/14 reported the resident had complained to her daughter of increased depression and being ready to die, that the resident was "pretty much bound to her chair and rarely gets out of her room per her choice." The nurse noted "Her quality of life is just pretty poor. Has complaints about needs not being met in a timely manner."</p> <p>On 08/19/14 at 5:15 a.m., record review revealed that the resident sustained bruising on her hands from a nursing assistant, Staff I. The incident report described that the resident repeatedly took her hands off the walker handles during a transfer, and Staff I kept placing the resident's hands back on the walker. The resident later</p>	F 250			

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

PRINTED: 09/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/29/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHUKSAN HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1530 JAMES STREET</b> <b>BELLINGHAM, WA 98225</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 250	Continued From page 5 reported that Staff I had hurt her and made her afraid, but also that "I am fine," and "everyone is nice."  During an interview on 8/29/14 at 3:30 p.m., Staff B was asked if there was any psychological assessment of the resident related to the doubling of the anti-depressant dosage. It was noted that the Psychotropic Medication History and Psych Med Review forms in the resident's medical record had not been updated to reflect the changed antidepressant dosage. Staff B said that a nurse practitioner had recommended the increase in the resident's medication, and stated the resident preferred to be in her room.	F 250			
F 323 SS=D	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 accidents to the extent possible for 4 of 5 sampled residents (Residents 1,2,3 and 4). This resulted in injuries for Residents 2 and 4, and falls with potential for injury for residents 1 and 3.  Findings include:	F 323			

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

PRINTED: 09/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/29/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHUKSAN HEALTHCARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1530 JAMES STREET BELLINGHAM, WA 98225</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 6 Resident 1</p> <p>Resident 1 was alert and oriented, at risk for falls, and required staff help to move from one surface to another. On 08/02/14, she reported concern about progressive lower extremity weakness, according to facility records.</p> <p>Record review revealed that on 08/10/14, the resident slid onto the floor from her bed, while a nursing assistant, Staff D, was attempting to assist her using a slider board. The care directives updated 07/30/14 posted in the resident's room included the assistance of 2 staff for slider board transfers.</p> <p>In an interview on 8/29/14 at 12:15 p.m., Staff E, a licensed nurse, said that when a resident's mobility status changed, the nursing assistants are verbally told "what the newest recommendation is."</p> <p>During an interview on 8/29/14 at 3:30 p.m., Staff B said that staff members did not refer to residents' care plans, which were "inaccurate." She said staff referred to the posted care directive signs in residents' rooms to know how to safely transfer residents. She said she was aware that some staff were not transferring Resident 1 correctly.</p> <p>Resident 2</p> <p>Resident 2 had dementia, and usually required the use of a Sit to Stand lift and the help of two staff to get up.</p> <p>Record review revealed that on 08/04/14, the resident sustained a bruise to her left inner arm</p>	F 323	<p>F 323</p> <p>Resident #1 and #4 investigation complete, care plan updated, and staff counseling completed. Resident #2 and #3 no longer at facility.</p> <p>All residents assessed for transfer safety with physical therapy and transfer status sheet posted on closet in resident room. All resident care plans reviewed and up to date. Care plans will be updated quarterly and as needed.</p> <p>All staff educated on reviewing resident transfer status sheets prior to transferring a resident.</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>October 13<sup>th</sup>, 2014 corrective action complete.</p> <p>Director of Nursing to monitor compliance.</p>	<p>10/13/14 ⑧</p>

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

PRINTED: 09/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/29/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHUKSAN HEALTHCARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1530 JAMES STREET</b> <b>BELLINGHAM, WA 98225</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 7</p> <p>and breast, 11 cm (centimeters) by 10 cm, during a transfer with the Sit to Stand lift. The incident report described that the bruise possibly occurred because the resident "put her arms down" during the transfer," and the strap that went behind the resident put pressure on her skin.</p> <p>The facility policy on the Sit-to-Stand lift included "Observe resident for any change in condition that would hinder ability to use Sit to Stand for transfer. If there is a change report to nurse to determine how to transfer patient without Sit to Stand lift." The resident continued to be transferred in this manner after this injury, until 08/22/14, when the care plan was changed to the use of a Hoyer lift, for residents who could bear no weight.</p> <p>On 8/22/14 at 12:30 p.m., Staff G and H were observed transferring the resident with the Sit to Stand lift. The strap was pressing firmly into the resident's sides and back, although she was grasping the handles throughout the transfer.</p> <p>In an interview on 8/22/14 at 12:55 p.m., Staff J, director of rehabilitation, stated that Resident 2's bruising could have been caused by her improper foot placement when using the Sit to Stand, and that she might need a staff member just to hold her feet. She was aware that the resident was still having problems with this transfer method, and stated that she would assess the resident later that day to see if she needed a Hoyer lift.</p> <p>Record review revealed that on [REDACTED] a licensed nurse requested an X-ray for Resident 2: "Resident continues to have pain in her shoulder and chest area LUE (left upper extremity) after becoming bruised during a 'red lift' (Sit to Stand)</p>	F 323		

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

PRINTED: 09/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/29/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHUKSAN HEALTHCARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1530 JAMES STREET BELLINGHAM, WA 98225</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 8</p> <p>transfer. Winces when upper chest/lower shoulder are touched."</p> <p>During an interview on 8/29/14 at 3:30 p.m., Staff B was asked about a skin tear of unknown origin that Resident 2 sustained on 07/24/14, which was not on the incident log. Staff B said that the skin tear should have been reported.</p> <p>Resident 3</p> <p>Resident 3 had dementia, and required the assistance of one staff to help her turn in bed. She experienced a fall at the facility on 7/27/14 when trying to transfer out of a wheelchair alone.</p> <p>On 8/8/14, according to facility records, the resident was found on the floor by her bed at 10:40 p.m. A nursing assistant had helped her to bed, and forgotten to activate the bed alarm, which should have alerted the staff if the resident was attempting to get out of bed.</p> <p>During an interview on 8/22/14 at 11:40 a.m., Staff B said that resident alarm systems were not on the resident care directives, and that some interventions were just "known" by the staff without being posted.</p> <p>Resident 4</p> <p>Resident 4 was admitted with mobility needs and depression. She fell on 05/14/14 and sustained bruising of her hands trying to use a walker with a staff person assisting her on 8/19/14. Her most recent care guide for mobility included having two staff persons assist her with transferring into and out of a chair.</p>	F 323		

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

PRINTED: 09/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/29/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHUKSAN HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1530 JAMES STREET</b> <b>BELLINGHAM, WA 98225</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 9 On 08/29/14 at 10:50 a.m., the resident was observed being assisted by Staff F to transfer from a commode to a recliner after toileting. Staff F performed the transfer alone. After the transfer, Staff F, when asked, said "The nurses are OK with us transferring her with one person."  The licensed nurse, Staff C, during an interview at 11:55 a.m., found the recent care directives for Resident 4. He said she required a two-person assist with transfers.  Staff B, the director of nursing, was notified of this observation during an interview on 8/29/14 at 3:30 p.m.	F 323			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain clinical records that were accurately documented and readily accessible.	F 514			

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

PRINTED: 09/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/29/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHUKSAN HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1530 JAMES STREET BELLINGHAM, WA 98225</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 10</p> <p>This had the potential to affect the care of all residents in the facility, and made it impossible to evaluate the mobility status of 4 of 5 sampled residents (Residents 1, 2, 3 and 4) in a review of accidents.</p> <p>Record review of MDS (Minimum Data Set) assessments on 08/22/14 revealed that Residents 1, 2, 3 and 4, who had experienced recent accidents involving mobility, may have experienced declines in their ADL (Activities of Daily Living) abilities over the preceding months.</p> <p>During an interview on 08/29/14 at 3:30 p.m., Staff B said that the facility staff were not correctly entering coding data to accurately reflect residents' ADL status. Therefore, the facility was not able to discern if some residents' abilities were actually declining, or if there were errors in the MDS coding.</p> <p>When asked during this interview to provide records for restorative exercise programs for the sampled residents, Staff B was unable to locate these records in the facility, or to determine if those residents were receiving restorative services. Staff B said that Staff L, who directed the restorative program, would know, but Staff L was not working that day. On 09/04/2014, Staff L submitted documentation indicating Residents 1, 4 and 5 were receiving restorative services. On 09/05/2014, Staff L stated in a phone message that Residents 2 and 3 were not receiving restorative services.</p>	F 514	<p>F 514</p> <p>Resident #1 and #4 clinical records are accurate and accessible. Resident #2 and #3 are no longer at facility.</p> <p>All residents' clinical records are accurately documented and readily accessible.</p> <p>All nursing personnel trained accessing medical records when requested by state authorities.</p> <p>Medical records will conduct audits after admission, quarterly, annually, and as needed. Audits will be reviewed by DNS and results will be monitored at quarterly QA meeting.</p> <p>October 13<sup>th</sup>, 2014 corrective action complete.</p> <p>DNS to monitor compliance.</p>	10/13/14 8	