

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

PRINTED: 08/20/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505092</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/31/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDERWOOD PARK CONV CTR LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2726 ALDERWOOD AVENUE 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 Alderwood Park Convalescent Center on 7/31/13. A sample of 4 current residents was selected from a census of 90.</p> <p>The following complaint was investigated as part of this survey:</p> <p>2845738</p> <p>The survey was conducted by: Rick Woodrum, RN, BSN Joy Kerns, RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services Aging and Long-Term Support Administration Residential Care Services, District 2, Unit B 3906 172nd St NE Suite 100 Arlington, WA 98223-4740</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>Lynne Booker</i> 8/20/13 Residential Care Services Date</p>	F 000	<p>RECEIVED AUG 27 2013 ADS/RCS Smoko Point</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Signature]*

TITLE

*Administrator*

(X6) DATE

8/23/2013

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 203 SS=D	<p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for</p>	F 203	<p>Social Workers will be instructed on the proper forms, which cover all the required information. Included in the instruction, will be the proper use of the form.</p> <p>Since no other resident is affected at present time and affected resident is remaining no other action will be taken.</p> <p>Administrator will monitor activities of this nature and make certain no issues are in conflict.</p>	<p>8/1/2013</p> <p><i>Original</i></p>
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F 203	<p>Continued From page 2</p> <p>nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, and record review, the facility failed to follow regulatory requirements related to a 30 day notice of a discharge they presented to 1 of 4 sample residents (Resident 1). This failure placed the resident at risk for violations of his rights.</p> <p>Findings include:</p> <p>Resident 1 was admitted to the facility [REDACTED] of 2013 with diagnosis of Alzheimer's dementia with behavioral disturbance. On July 17, 2013, the Department investigated an incident at the facility where the resident inappropriately touched a female resident. The Department entered the facility again on 7/31/13 related to another incident involving the same two residents.</p> <p>During a review of the Social Worker's notes found in the resident's chart, it was documented the resident and his Power of Attorney (POA) were given an involuntary discharge notice indicating the resident was to be discharged in 30 days, as the safety and welfare of other residents</p>	F 203			

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F 203	Continued From page 3 were endangered. The notice was given on 7/18/13. It directed the resident to contact an Ombudsman if the action of the facility was felt as unfair or in error. The notice did not include any information related to when the discharge would occur, a location to which the resident would be discharged or any information related to the resident's right to appeal the notice.  The Ombudsman was interviewed on 8/1/13 at 10:15 a.m. She stated she had not been contacted by either the resident or the POA. The POA was unable to be reached for comment.  When interviewed at 11:00 a.m. on 7/31/13, Staff A, a Social Worker, said the facility had developed it's own letter and it did not include some of the required information.	F 203			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to promote the dignity of 1 of 4 sample residents (Resident 1), by affixing a loud bell to the spokes of the resident's	F 241	This facility believes all residents and staff must be treated with dignity and respect. The facility must always make certain residents are protected from harm or limitation.  The resident sited has had the bell removed. This action of placement of loud bell will not be done in future.  The actions taken were for protection of a resident. The other resident involved was consulted and his/her	8/1/2013 mgcaug	

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F 241	<p>Continued From page 4</p> <p>wheelchair to announce his location to anyone within hearing distance. This failure placed Resident 1, as well as other residents in the facility, at risk for a diminished quality of life.</p> <p>Findings include:</p> <p>Resident 1 was admitted to the facility [REDACTED] of 2013 with diagnosis of Alzheimer's dementia with behavioral disturbance. On July 17, 2013, the Department investigated an incident at the facility where the resident inappropriately touched a female resident. The resident's care plan was updated shortly after and included the notation, "A device will be installed to alert staff of the resident's whereabouts."</p> <p>The Department entered the facility again on 7/31/13, related to another incident involving the same two residents. At 9:10 a.m., Resident 1 was observed in a hallway, sitting in a wheel chair. Attached to the wheel of the chair was a large hand bell. Every time the wheel moved, the bell would strike a spoke and make a loud clang. During an interview at 9:15 a.m. on the same day, Staff B, a nurse, was asked by the surveyor the reason for the bell. The nurse stated "I think it's because he tries to escape and go outside."</p> <p>A review of the resident's care plan revealed the facility attached the bell to alert staff when the resident was moving about. If he was observed to be in a room with female residents, he was to be removed. Additionally, 30 minute observations were to be made by unspecified staff.</p> <p>At 9:30 a.m., Resident 1 was asked by the surveyor if he was aware of the bell and it's sound. He replied "No."</p>	F 241	<p>F421 Continued:</p> <p>views taken into account. All actions taken in the future, will be reviewed with all residents in mind for dignity.</p> <p>The Director of Nursing will monitor activity on a individual basis and the Administrator will insure compliance.</p>		

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F 241	Continued From page 5  At 10:00 a.m., 8 residents were observed in a dining room, listening to an activity. During this time, Resident 1 wheeled himself into the dining room on multiple occasions. At 10:15 a.m., Resident 2 came out of the dining room and went to a nurse. She asked for the bell to be removed as it was disrupting the group activity. A nurse removed Resident 1 from the dining room and directed him to stay in a hallway. Several unidentified residents were heard to make negative comments related to the noise of the bell. One resident stated "It sounds like Damn Christmas around here." When asked by the surveyor, another resident commented she thought the purpose of the bell was to keep Resident 1 awake because it was keeping her awake.  At 11:00 a.m., Staff A, the social worker and the Director of Nursing Services (DNS) were interviewed. The DNS was informed by the investigator of concerns related to the bell and the possible demeaning and psychological effects of the consistent ringing. The DNS stated permission had been granted by the resident and his Power of Attorney for use of the bell. When asked by the surveyor, the DNS commented she didn't think the noise of the bell would bother the resident because of his level of cognition.  This is a repeat citation from 6/25/12	F 241		