

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

PRINTED: 03/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505232</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/04/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>WOODLAND CONVALESCENT CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 FOURTH STREET</b> <b>WOODLAND, WA 98674</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 Woodland Convalescent Center on 03/04/2015. A sample of 5 residents was selected from a census of 50. The sample included 1 current resident and the records of 4 former/discharged residents.</p> <p>The following complaint was investigated:</p> <p>#3076226</p> <p>The survey was conducted by:</p> <p>Rebecca Christiansen, RN, MS</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services Aging &amp; Disability Services Administration 800 NE 136th Ave. Suite 220 Vancouver, WA 98684</p> <p>Telephone: 360-397-9550 Fax: 360-992-7969</p> <p> Residential Care Services      Date</p>	F 000			

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

TITLE

(X6) DATE

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.

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

PRINTED: 03/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/04/2015
NAME OF PROVIDER OR SUPPLIER  WOODLAND CONVALESCENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 310 FOURTH STREET WOODLAND, WA 98674		
(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 283 SS=E	<p>483.20(I)(1)&amp;(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS</p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to complete a discharge summary that included a recapitulation of the resident's stay for 3 of 4 residents (#s 2, 3 &amp; 4) reviewed for discharge planning. This failure caused the residents to lack appropriate discharge planning and proper communication of necessary information to continuing care providers.</p> <p>Findings include:</p> <p>1) Resident #2 was admitted to the facility on [REDACTED] 15 with diagnoses to include a [REDACTED] problems. The resident required oxygen for breathing, used a catheter to drain urine from the bladder and needed insulin injections several times a day to help manage blood sugars.</p> <p>According to the Minimum Data Set (MDS), an assessment instrument, the resident was alert and oriented, but required extensive assistance with activities of daily living (ADLs). The resident</p>	F 283		

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

PRINTED: 03/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/04/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  WOODLAND CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 310 FOURTH STREET WOODLAND, WA 98674
--	--

(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 283	<p>Continued From page 2</p> <p>had poor circulation and had experienced weight loss at the facility.</p> <p>The resident discharged home on [REDACTED]/15 to the care of a daughter.</p> <p>On 2/20/15, a "discharge summary" statement as part of the care plan indicated "Res (resident) will d/c (discharge) to home w/dtr (with daughter) when goals are met w (with) PT (Physical Therapy), OT (Occupational Therapy), NSG (nursing). Admitted w (with) [REDACTED]</p> <p>[REDACTED] The discharge summary statement did not include a recapitulation of the resident's stay or a final summary of the resident's status at the time of discharge.</p> <p>2) Resident #3 was admitted to the facility on [REDACTED]/14 with diagnoses to include [REDACTED]. The resident required a wheelchair for mobility.</p> <p>According to the MDS, the resident had some memory problems and required extensive assistance with ADLs. The resident was incontinent of bowel and bladder and was at risk for skin breakdown.</p> <p>The resident discharged home to the family on [REDACTED] 15.</p> <p>On 12/29/15, a "discharge summary" statement as part of the care plan indicated "Res to d/c to home w/ husband, dr and SIL (son-in-law) once dtr is trained to provide home care w/ HH (home health), med management, in necessary. Will</p>	F 283		
-------	---	-------	--	--

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

PRINTED: 03/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/04/2015
NAME OF PROVIDER OR SUPPLIER  WOODLAND CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 FOURTH STREET WOODLAND, WA 98674		
(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 283	<p>Continued From page 3</p> <p>update w/ specifics as goals are closer to be met". The discharge summary statement did not include a recapitulation of the resident's stay or a final summary of the resident's status at the time of discharge.</p> <p>3) Resident #4 was admitted to the facility on [REDACTED] 15 with diagnoses to include [REDACTED]. The resident required oxygen and several types of inhalers.</p> <p>According to the MDS, the resident required assistance with ADLs.</p> <p>The resident discharged home with a family member on [REDACTED] 15.</p> <p>On 2/2/15, a "discharge summary" statement as part of the care plan indicated "res admitted w/ [REDACTED] Res will d/c to home w/ family w/ PT, OT, NSG/oxygen once goals have been met". The discharge summary statement did not include a recapitulation of the resident's stay or final summary of the resident's status at the time of discharge.</p> <p>On 3/4/15 at 3:15 p.m., the Director of Nursing stated "We have not looked at our discharge planning process. We have new personnel, so we need to do some training on the recapitulation process".</p> <p>Refer to F 284</p>	F 283			
F 284 SS=E	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN	F 284			

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

PRINTED: 03/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/04/2015
NAME OF PROVIDER OR SUPPLIER  WOODLAND CONVALESCENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 310 FOURTH STREET WOODLAND, WA 98674		
(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 284	<p>Continued From page 4</p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to plan for and failed to ensure an orderly discharge for 3 of 4 residents (#s 2, 3, &amp; 4) sampled for discharge planning. Failure to ensure necessary services, medications and supplies for discharging residents placed the residents at risk for medical complications, poor adjustment and possible re-admission to a hospital or nursing facility.</p> <p>Findings include:</p> <p>1) Resident #2 was admitted to the facility on [REDACTED] 15 with diagnoses to include a [REDACTED] [REDACTED] problems. The resident required oxygen for breathing, used a catheter to drain urine from the bladder and needed insulin injections several times a day to help manage blood sugars.</p> <p>According to the Minimum Data Set (MDS), an assessment instrument, the resident was alert and oriented, but required extensive assistance with activities of daily living (ADLs). The resident had poor circulation and had experienced weight loss at the facility.</p>	F 284		

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

PRINTED: 03/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/04/2015
NAME OF PROVIDER OR SUPPLIER  WOODLAND CONVALESCENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 310 FOURTH STREET WOODLAND, WA 98674		
(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 284	<p>Continued From page 5</p> <p>The resident discharged home on [REDACTED] 15 to the care of the family. There was no indication the daughter knew how to manage the resident's insulin or catheter. It was not clear the family had been informed on caring for the pressure ulcers and preventing additional ulcers from developing. It was not clear the family had been informed of the weight loss or prevention of additional weight loss.</p> <p>On 3/2/15 at 2:25 p.m., Licensed Nurse (LN) A stated "I know diabetic teaching was done in the hospital. The daughter was the private care giver before the resident came here. I should have gone into more detail about those items in the resident record".</p> <p>2) Resident #3 was admitted to the facility on [REDACTED] 14 with diagnoses to include [REDACTED]. The resident required a wheelchair for mobility.</p> <p>According to the MDS, the resident had some memory problems and required extensive assistance with ADLs. The resident was incontinent of bowel and bladder and was at risk for skin breakdown.</p> <p>The resident was discharged to home with the care of family on [REDACTED] 15. Home Health was arranged, but an incorrect telephone number was listed on the discharge instruction sheet. A list of medications was given to the family. There was no indication the family was trained on prevention of skin breakdown, on transferring the resident into or out of a wheel chair or on management of bladder/bowel incontinence.</p>	F 284		

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

PRINTED: 03/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/04/2015
NAME OF PROVIDER OR SUPPLIER  WOODLAND CONVALESCENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 310 FOURTH STREET WOODLAND, WA 98674		
(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 284	<p>Continued From page 6</p> <p>3) Resident #4 was admitted to the facility on [REDACTED] 15 with diagnoses to include [REDACTED]. The resident required oxygen and several types of inhalers.</p> <p>According to the MDS, the resident required assistance with ADLs.</p> <p>The resident discharged to the home of the son on [REDACTED] 15. Oxygen was arranged as well as home health. There was no indication the family had received training related to administration of inhalers.</p>	F 284		