STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505098	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shuksan Rehabilitation and Health Care	1530 James Street Bellingham, WA 98225

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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.

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to conduct thorough investigations for 2 of 3 residents (Residents 1 and 2) reviewed for abuse and neglect. The failure to conduct thorough investigations placed all residents at risk for repeat incidents, potential injury, and unmet care needs. Findings included .Review of the facility policy titled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, revised 09/21/2022 document showed the administrator was responsible for the overall coordination and implementation of the facility's abuse prevention program policies and procedures .the investigation will at a minimum include interviews of alleged perpetrators, and review all medical records. <RESIDENT 1>Resident 1 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (disease that affects the brain and spinal cord), and anxiety. Review of Resident 1's Quarterly Minimum Data Set (MDS - an assessment tool) assessment dated [DATE], the resident had intact cognition. The assessment documented the resident had pain almost constantly, and their pain effected their sleep and day-to-day activities. Review of Resident 1's care plan focus area dated 05/07/2025 documented the resident was at risk for pain related to spinal surgery, and infection to the site. Interventions included that the facility was to administer pain medication as ordered by the physician and giving within 30 minutes before treatment or care. Review of Resident 1's progress note dated 07/20/2025 at 10:34 PM, showed an electronic medication administration record (EMAR) note made by the licensed nurse that had worked the evening (2:00 PM - 10:00 PM) shift (Staff C, Registered Nurse) on 07/20/2025. The note stated that the next shift would administer the 10:00 PM pain medication dose as this nurse refuses to endure any further harassment or derogatory comments from this patient. Review of the facility allegation dated 07/21/2025 for an allegation that Resident 1 reported they felt Staff C, their nurse, had verbally abused them and withheld pain medication. The investigation documentation showed Resident 1 had requested pain medication on 07/20/2025 at 8:00 PM when it was scheduled to be administered and did not receive until 8:55 PM. Resident 1 reported they felt the staff had been punishing them and were making them wait for their pain medication. The investigation summary stated the resident had a history of targeting staff with allegations with the expectation of them losing their jobs. The investigation documented that the allegation was retaliatory, and abuse and neglect had been ruled out. The investigation did not include a thorough review of Resident 1's medical record, or validation of when the pain medication had been administered. The investigation lacked an interview with Staff C, the licensed nurse that worked on the shift that the allegation was made against. The investigation lacked interviews with other residents pertaining to their medication administration, and if they had concerns about the timeliness of medications and if they had experienced any verbal abuse by Staff C, the licensed nurse in question. <RESIDENT 2>Resident 2 readmitted to the facility on [DATE] with diagnoses that included demyelination of the central nervous system (breakdown of the spinal cord barrier can cause impaired coordination and muscle loss), anxiety and depression. Review of Resident 2's admission MDS dated [DATE] documented the resident had intact cognition, was dependent on staff for toileting and was always incontinent (inability to control) of bowel and bladder. Review of Resident 2's care plan focus area dated 08/05/2025 showed the resident had an activity of daily living performance deficit related to their impaired balance, weakness, deconditioning and the demyelinating (the loss or damage of the myelin sheath, the protective, insulating layer that surrounds nerve fibers in the brain and spinal cord) disease. Interventions included that the resident preferred female care givers only. Review of the facility allegation dated 08/15/2025 for an allegation that Resident 2 stated they had to wait one hour and 45 minutes to get their adult brief changed. The investigation documented that the resident was alert and orientated and able to make their needs known, had incontinence of bowel and bladder and wore adult briefs. The investigation summary stated a male staff member was informed by the resident that they needed their brief changed around 6:00 PM on 08/14/2025. The male staff member informed the resident that their female care giver was not available as they were assisting another resident to eat and would pass it on to them that the resident had requested to be changed. The investigation summary documentation showed that the resident was not provided incontinent care till sometime after 7:30 pm on 08/14/2025, and that abuse and neglect had been ruled out. The investigation timeline reflected the staff had knowledge that the residents needed incontinence care, and that the resident did wait for at least an hour and 30 minutes before they were provided care due to lack of female caregiver. The investigation failed to identify the potential neglect of